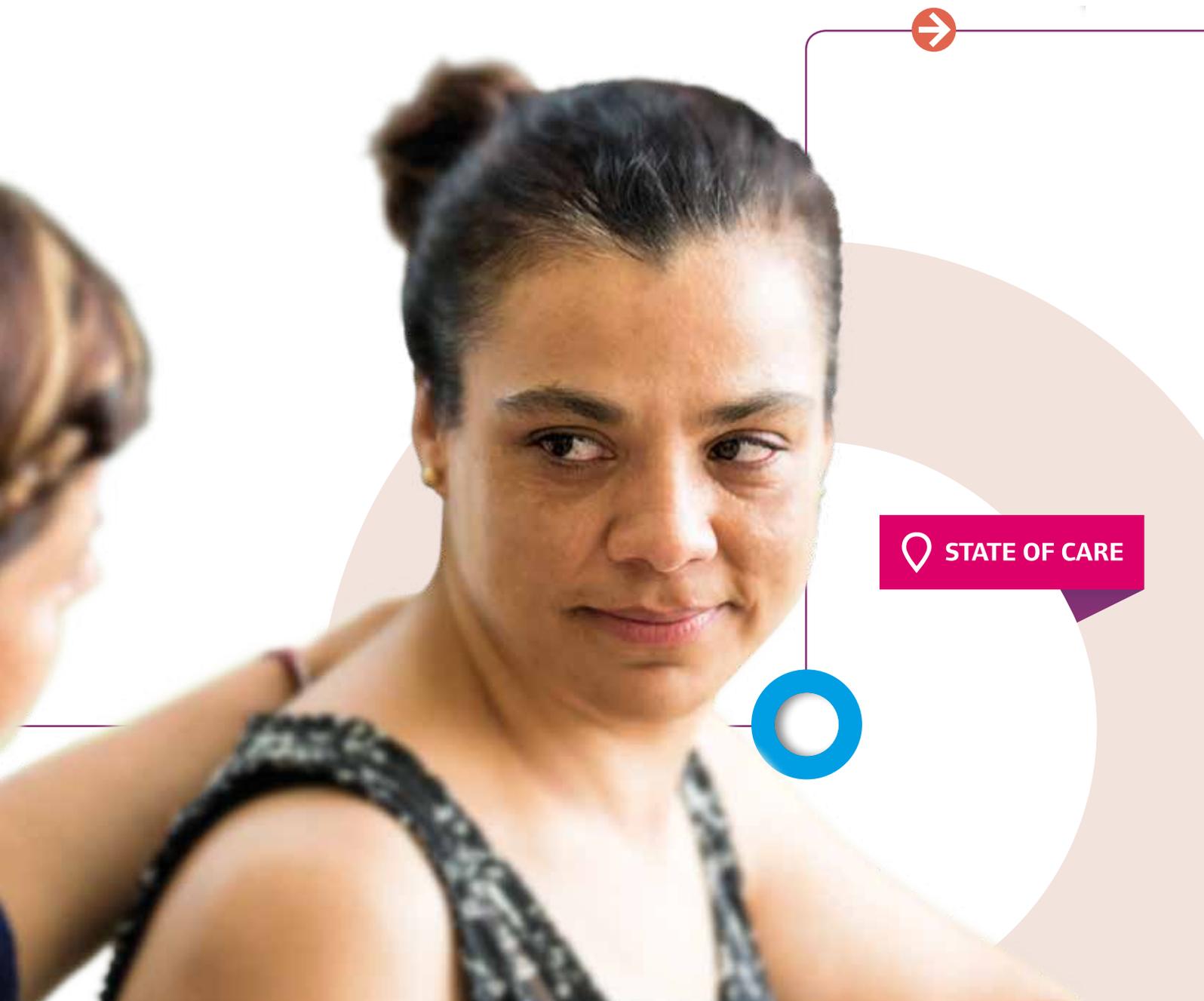


# Monitoring the Mental Health Act in 2016/17



STATE OF CARE



Care Quality Commission

**Monitoring the  
Mental Health Act in  
2016/17**

Presented to Parliament pursuant to Section 120D(3) of the Mental Health Act 1983

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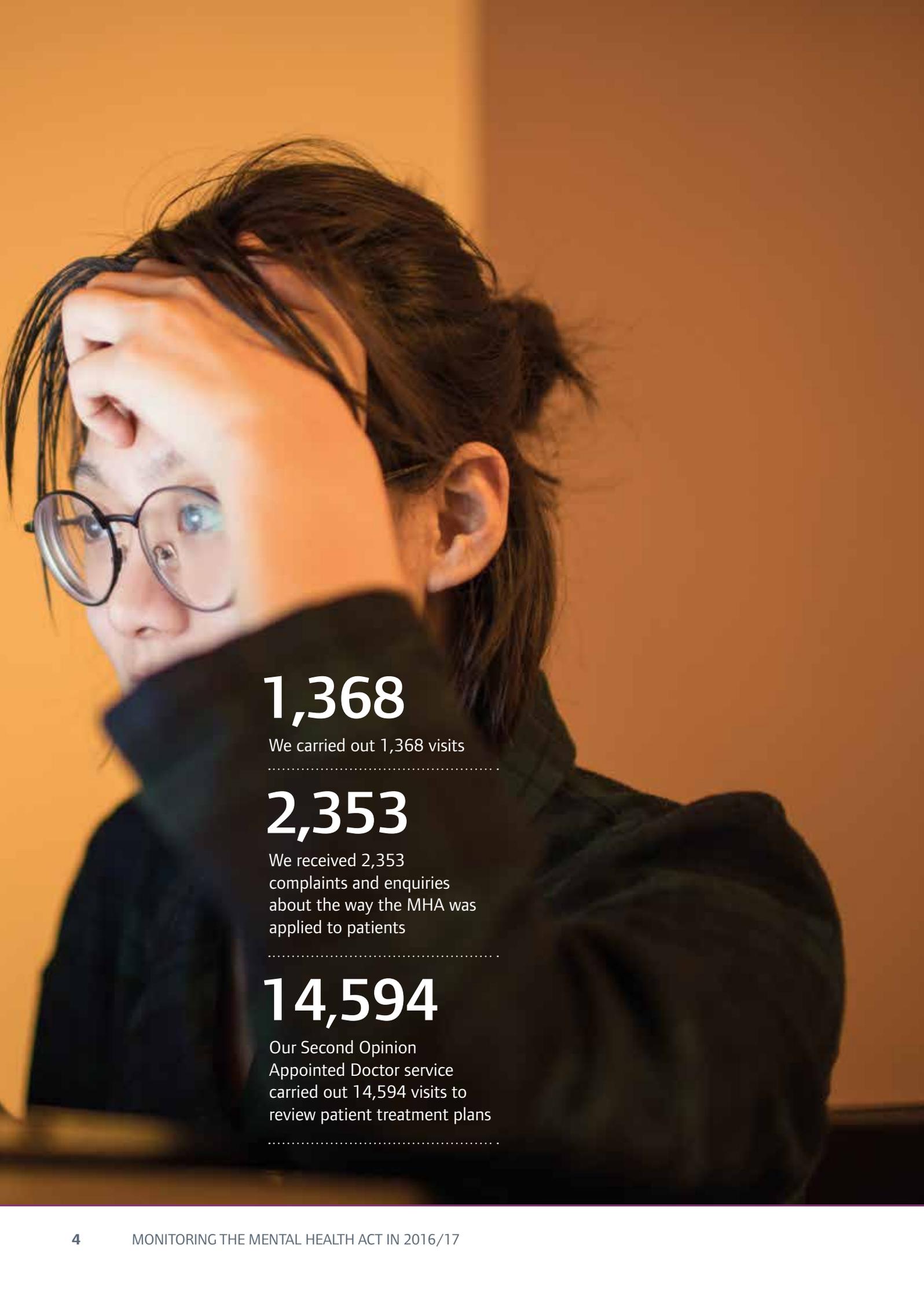
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**1,368**

We carried out 1,368 visits

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**2,353**

We received 2,353 complaints and enquiries about the way the MHA was applied to patients

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**14,594**

Our Second Opinion Appointed Doctor service carried out 14,594 visits to review patient treatment plans

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# Foreword

Mental health has never been higher on the national agenda. In our report on the state of care in mental health services published in July 2017, we commented on the fact that more people than ever are receiving treatment and care for mental health conditions. In some respects, this is a good thing because it is in part due to more people being willing to seek help because of a reduction in the stigma associated with mental ill-health. However, this increase in demand has also contributed to a mental health system that is showing signs of strain; including problems of access, pressures on staffing and unsafe environments on some mental health wards.

The number of people detained in hospital under the MHA has increased in recent years. In some parts of the country, mental health wards now admit few informal patients. In previous MHA reports, we have commented on the limited understanding of the factors that have contributed to this change. In January 2018, we published a report, based on evidence gathered during visits to local areas, and proposed eight hypotheses that could explain the increasing use of the MHA. Our findings support the view that changes to legislation alone may not have a major or immediate effect on the use of the MHA or rates of detention for specific groups.

Our MHA reviewers across the country have reported progress in some aspects of practice relating to the use of the MHA. However, in other aspects, we see no evidence of improvement from previous years. In particular, we continue to be concerned about the quality of care plans, discharge plans and physical health checks.

In 2017, we committed to carrying out focused work on some aspects of the use of the MHA that require closer scrutiny. In our state of care in mental health services report, we highlighted that more than 30 years after the introduction of mental health legislation that enshrined the

principle of least restriction, some patients still receive overly restrictive care. To encourage improvement in this area of treatment, our report on restrictive intervention programmes published in December 2017 identified five NHS mental health trusts that have developed strategies and implemented approaches to reducing the need for restrictive interventions; including physical restraint. We will build on this good practice, including working with the Department of Health and Social Care to move towards greater understanding and implementation of the least restrictive option.

It is likely that, for a person whose first experience of mental health care is detention under the MHA, their perception of mental health services, and their willingness to engage with future care, will be greatly influenced by their experience of care provided during that initial admission. It is therefore vital that, while developing community services that can minimise the need for admission, services do not lose sight of the importance of also providing high quality inpatient care for those who need it.

The MHA review, chaired by Professor Sir Simon Wessely, should act as an important lever for improvement in some of the areas of concern we have highlighted in recent reports. CQC will continue to play its part in highlighting good practice, encouraging improvement and acting on behalf of people so everyone gets the help they need when they need it.

I am grateful to the many patients who have shared their experiences with us on visits, and to our Service User Reference Panel and External Advisory group for their invaluable input into this report.



**Paul Lelliott**  
Deputy Chief Inspector of Hospitals (Mental Health)



# Summary

It is CQC's job to look at how health services in England are applying the Mental Health Act (MHA) and to make sure that patients' human rights are being protected. We carry out visits to check how mental health services are providing medical treatment to people detained under the MHA and are supporting patients to recover. We assess provider management systems and processes to make sure they have effective governance in place over the use of the MHA. We also check that staff are being supported to understand and meet the standards set out in the MHA Code of Practice for patients in their care.

This report provides an account of our activities and data on our findings from the last reporting year. Where possible, we include comparable data with previous years. As this report fulfils our statutory duty to report to Parliament on the way the MHA is working, we have also summarised information from other associated publications. The number of Second Opinion Appointed Doctor (SOAD) visits arranged by CQC continues to be high, and medication reviews of patients detained in hospital is now the highest ever. In previous reports, we have noted our ongoing concern with the current treatment powers, and whether clinicians capture patient views on proposed treatment with medication in the first three months of their detention. We expect the independent MHA review will be considering how this may work better for patients in future.

We have seen limited or no improvement in key areas raised in previous years. In particular, we found:

- No improvement in the recording in care plans of evidence of patient involvement, of the views of patients about their care, or of whether clinicians had considered the least restrictive options for care.
- No reduction in the number of patients whose physical health had not been assessed through examination on admission.
- No reduction in the number of records examined that showed that patients had not been informed of their legal rights on admission.

In addition, 15% of the records we examined showed that patients were not automatically referred to advocacy services where they lacked capacity to decide whether to do so themselves.<sup>a</sup>

Footnote:

a Figures not reported in 2015/16.



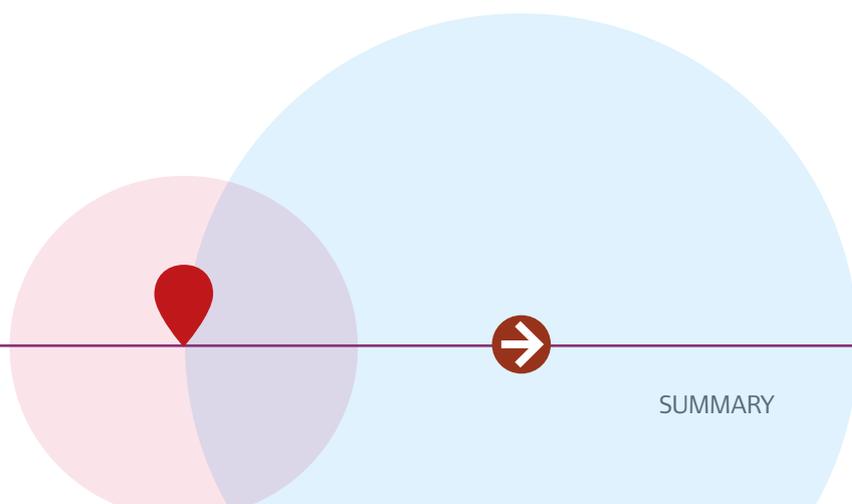
In our last MHA report, we committed to looking at the local impact of the rising use of compulsory detentions. We completed a programme of visits and engagement with patients, providers and national agencies in 2017 and published our report in January 2018. The report found no single reason for the increase, but proposed eight hypotheses informed by views of patients and mental health professionals that may be the basis for future enquiry.

### **Review of the Mental Health Act 1983**

In 2017, the Queen's speech set out the government intention to review and reform the MHA. In October 2017, the Prime Minister announced the appointment of Professor Sir Simon Wessely, a former President of the Royal College of Psychiatrists, to carry out an independent review of mental health legislation and practice. The government requested Sir Simon to provide an interim report in early 2018, and a final report containing detailed recommendations on its priorities by autumn 2018. The report will consider:

- why rates of detention are increasing – what can be done to reduce inappropriate detention and improve how different agencies respond to people in crisis
- reasons for the disproportionate number of people from certain ethnic backgrounds, in particular Black people, being detained under the MHA, and what should be done about it.

As the independent monitoring body for the MHA, we will be a part of the Independent Review's Advisory panel and working group, using the intelligence we gather to help inform the evidence gathering of the Review. To help the Review identify practical solutions that can help to improve areas of practice, we will complete a collaborative evaluation of the way the MHA Code of Practice (2015) has been implemented with patients, providers and experts. This work will take place throughout 2018 and we will share the findings throughout the year.



# Introduction

This report sets out the Care Quality Commission's (CQC) activity and findings from our engagement with people subject to the Mental Health Act 1983 (MHA) and review of services registered to assess, treat and care for people detained using the MHA. We use information gathered from across our activities to report on the quality of care people are receiving while detained. We also look at how providers use the MHA to make sure people have access to the right care and treatment when they have, or appear to have, a mental disorder, and their own health or safety, or other people's safety needs protection.

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. The MHA also provides more limited community-based powers, community treatment orders (CTO) and guardianship.

The MHA not only provides powers for clinicians to intervene in the interests of a person's health or safety, but also includes safeguards for people's rights when they are detained or treated under the MHA. It does this by setting rules and requirements for professionals to follow. Statutory guidance for mental health professionals and services is set out in the MHA Code of Practice. Doctors, managers and staff in provider services and Approved Mental Health Professionals (AMHPs) should have a detailed knowledge of the Code and follow its guidance, or document the justification for not doing so in any individual case.

## How we work

CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. We visit and interview people currently detained in hospital under the MHA, and we require actions from providers when we become aware of areas of concern or areas that could improve. We also have specific duties under the MHA, such as to provide a Second Opinion Appointed Doctor service (see page 38), review MHA complaints (see page 42) and make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also work to highlight and seek action when we find practices that could be a breach of human rights standards during our MHA visits. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM carry out regular visits to places of detention to prevent against torture, inhuman or degrading treatment. Find out more information about this important role and our activities in the UK NPM annual reports.<sup>b</sup>

## Our data

To prepare this report, we analyse data from our activities with patients and local services throughout the year, including our MHA activities and our comprehensive inspections of mental health services.

We make hundreds of MHA visits each year, to meet with patients and understand their individual experiences, address concerns and collect information about the improvements local services can, or will, be taking based on our findings. When we bring together the information collected from talking with patients, carers and staff and reviewing care records, it allows us to understand how the MHA is working and where things need to work better for patients. We also analyse information from

other national agencies including NHS Digital, NHS England and the Tribunal Service.

During our visits, we will triangulate information by first speaking with patients and then reviewing records. We will also discuss our findings with staff during the visit to understand local processes and record systems. This means we often report on 'what we have found in care records' but will always try to understand if this is a recording, quality or care issue during the visit and explain this in the detailed reports back to the local leadership team. In this year's annual report, we present our findings to set out:

- **Part 1:** How is the Mental Health Act working?
  - An overview of the key findings and themes from our activities. Similar to the local reports we produce, we continue to report against the Code of Practice standards to help services and policy makers cross reference our findings against legislation and statutory guidance.
- **Part 2:** CQC and the Mental Health Act
  - An account of our statutory duties in monitoring the MHA.

Our Deputy Chief Inspector of Hospitals (lead for mental health), national professional advisors, and analysts have supplemented, and in some cases, corroborated, our analysis and findings. This is to make sure that our report represents what we are seeing in our wider work with the mental health sector and our inspections of services.

Unless otherwise stated, data in this report relates to the year ended 31 March 2017.

Footnote:

b [www.nationalpreventivemechanism.org.uk](http://www.nationalpreventivemechanism.org.uk)



## Part 1

# HOW IS THE MENTAL HEALTH ACT WORKING?

The main picture of our findings on the Mental Health Act in action.



## Part 2

# CQC AND THE MENTAL HEALTH ACT

An outline of CQC's statutory duties in monitoring the Mental Health Act.





## Part 1

# HOW IS THE MENTAL HEALTH ACT WORKING?

The main picture of our findings on the Mental Health Act in action.

## Key points

We have seen limited or no improvement in the key concerns we have raised in previous years. The MHA review is likely to consider these issues because the creation of statutory duties (including duties to record or follow specific processes, or duties on managers to make sure that they take place) may provide an additional lever to effect change.

We found no evidence of:

- patient involvement in 32% of care plans reviewed
- patient's view being taken into consideration in 31%
- consideration of the patient's particular needs, or the least restrictive options for care, in 17% of care plans
- discharge planning in 24% of care plans.

One in 10 records examined showed that patients had not been informed of their legal rights on admission.

Staff on 15% of wards did not automatically refer Independent Mental Health Advocacy Services to patients who lack capacity to decide whether to access support themselves.

Despite a requirement to identify hospitals that are able to take patients in cases of special urgency, delays in accessing beds are creating difficult situations where patients are left untended in the community, or held in police custody without lawful authority.

We frequently raise concerns over whether clinicians have recorded evidence of their conversations with detained patients over proposed treatment, or recorded the patients' views on that treatment, as well as whether the patient consents, refuses consent, or is incapable of consent.

In 8% of records examined, patients' physical health had not been assessed through examination on admission.

32% 

No evidence of patient involvement in 32% of care plans reviewed

31% 

No evidence of the patient's views in 31% of care plans reviewed

17% 

No consideration of the patient's particular needs, or of the least restrictive options for care, in 17% of care plans

24% 

No evidence of discharge planning in 24% of care plans

11% 

More than one in 10 records examined showed that patients had not been informed of their legal rights on admission

15% 

Fifteen per cent of wards did not automatically refer to advocacy services patients who lacked capacity to decide whether to do so themselves

8% 

In 8% of records examined, patients' physical health had not been assessed through examination on admission

# The Independent Review of the Mental Health Act

In this section, we provide an overview of the independent review of the MHA taking place throughout 2018, and what CQC is doing to support it.

## Background

In 2017, the government appointed an independent review to examine the way providers currently use the MHA, and how it affects patients, professionals and the public. The review will make recommendations to improve the MHA but also look at related practices. This will be the first review of the legislation since the Richardson report in 1999 that led to the Mental Health Act 2007 changes.

The review is led by an independent panel of experts including a service user representative, and is chaired by Professor Sir Simon Wessely. The chair and vice chairs will be gathering and considering evidence throughout 2018. This includes a general call for evidence and a targeted survey for patients and carers. The review will produce an interim report in early 2018 to set out priorities, and publish a final report that makes recommendations by the end of 2018.

## Purpose of the review

The purpose of the review is to understand the causes of the issues with the way the MHA is currently working. This includes looking at concerns about the rising uses of the MHA, the disproportionate number of people from Black and minority ethnic groups detained each year, and stakeholder concerns that some processes are out of step with a modern mental health system.

The review's chair and vice chairs have been clear they are open to a broad review of the MHA, informed by the consultations they are carrying out and looking at practice-based solutions to problems that will not be resolved by changes in legislation or guidance. We particularly welcome this approach, as many of the concerns we report on would need a change in practice, resource or culture to deliver sustainable improvements to outcomes for patients. This could also mean more rapid results from the work of the review, if local services can adopt the recommendations and national agencies can support this.

This broad approach means in advance of the initial report in early 2018, there is limited information about the specific recommendations that will appear in the final report. The published terms of reference show that the panel will consider concerns about:

- the balance of safeguards available to patients, such as tribunals, second opinions, and requirements for consent
- the ability of the detained person to determine which family or carers have a say in their care, and of families to find appropriate information about their loved one
- that detention may in some cases be used to detain rather than treat
- questions about the effectiveness of community treatment orders, and the difficulties in getting discharged
- the time needed to make decisions and arrange transfers for patients subject to criminal proceedings.

## CQC and the Independent Review

As the independent body monitoring and reporting on the way the MHA is applied in England, we have a duty to support the work of the review by providing any evidence that could inform and encourage improvements for patients. As part of the National Preventive Mechanism, we also have a duty to review and comment on proposed changes that affect mental health legislation and support any improvements to prevent ill-treatment of detained patients. Our independent role also requires us to be clear about our involvement with the panel and associated groups, offering evidence to support the work of the panel but remaining independent from setting new policy, standards, or drafting legislative changes.

In 2018, we will be working to support the panel by preparing summaries of information and accounts from our previous mental health publications, and sharing information we gather during our activities. Our visiting teams have raised awareness of the review and supported patients who are currently detained to share information directly with the panel. They have encouraged patients to complete the survey or feed back their experiences of how the MHA is working.

We will inform the review by using our work on evaluating how services have implemented the MHA Code of Practice 2015 and the effect this has for patients. This will include looking at the practice-based problems and solutions that will form part of the final report to government. We will also publish updates from this piece of work throughout the year so that patients, professionals and providers have access to our findings in advance of our next MHA report.

We have developed the information below based on our reports published since the MHA changed in November 2008.

### **Rights and safeguards for patients**

We have consistently found problems with patients receiving their rights and providers supporting them to exercise them. This includes problems with the way rights are explained to patients and referral or support available for the Independent Mental Health Advocates. This year, we found no evidence that patients had been informed of their rights on admission in one in 10 patient records examined. Records also suggest that 15% of patients who lacked capacity had not been referred to the statutory advocacy services for support, although this is now a recommendation of the Code of Practice.

### **Care planning**

In each of our reports, we have highlighted the importance of respecting and involving people in decisions and planning their care and treatment, acknowledging that the MHA is not only about maintaining the safety of patients but also aimed at restoring autonomy through recovery. In every report since 2008, we have highlighted difficulties with care planning processes for people subject to the MHA.

This year, we found no evidence of patient involvement in 32% (1,034) of the care plans we reviewed. In 2011/12, the comparable finding was no evidence in 15% (658) of the care plans reviewed. Poor record-keeping rather than poor patient involvement might explain some of these results, but our 2017 Community Survey for mental health patients also reported that 24% of the 11,569 respondents had said they had not been involved in their care planning.

The expectations for involving people or reflecting their views in care planning is clearly set out in the Code and in wider guidance and policy such as the Care Programme Approach and NICE quality standards.<sup>1</sup> Therefore, a solution needs to identify the practice challenges in this area and look at how to improve embedding recovery-based approaches and involving patients. We would also encourage the panel to consider whether new statutory requirements about patient involvement and care planning could be effective.

### **Consent to treatment**

In previous reports, we highlighted that clinicians do not always make sure safeguards are in place when they treat patients without consent. We reported concerns in the way clinicians and staff involve patients, acknowledge patient views and show medical necessity and proportionality, as required by the Code, when treating patients without consent. For example, in our 2012/13 report we highlighted a lack of a written record of assessment of patient consent or capacity at the point of admission in 26% (508) of the records we reviewed. In our 2015/16 report, we acknowledged that in light of the European Court of Human Rights' (ECHR) judgment

“Reviewing the Act isn't just about changing the legislation. In some ways that might be the easy part. The bigger challenge is changing the way we deliver care so that people do not need to be detained in the first place. In my experience it is unusual for a detention to be unnecessary - by the time we get to that stage people are often very unwell, and there seems few other alternatives available.

But that does not mean this was not preventable or avoidable. The solutions might lie with changes to the legislation, but could also come from changes in the way we organise and deliver services. It would also be naïve to deny that much wider factors, such as discrimination, poverty and prejudice, could be playing a role.”



**Sir Simon Wessely**  
Independent Review Panel Chair (2017)

in *X v Finland*, the MHA provision that consent “is not required” in the first three months of treatment with medication for mental disorder may fail human rights standards.<sup>c</sup> Even if it does not, it may provide too broad a power to clinicians, when we continue to find issues with patient involvement across our visits.

In our reports, we have also noted the disparity between the safeguards in place for neurosurgery for mental disorder (NMD). NMD involves the destruction of brain tissue, and requires a CQC-appointed panel to approve the treatment and certify that the patient provides valid consent. We have also noted a disparity in the procedure for Deep Brain Stimulation (DBS), for which there are no safeguards at all. This regulatory gap needs to close, and the law in England should recognise the need to provide safeguards over the use of DBS equivalent to those for other, older types of NMD.

### **Parity of esteem**

We are responsible for receiving all notifications of the deaths of people subject to the MHA. We have reported on what we found from visits and the notifications about physical health care for detained patients. This includes our concerns about patients’ access to GP services and hospital staff not completing patient health assessments on admission. These factors increase the existing risks for mental health patients dealing with long-term conditions and side effects from medications and premature death. In this year’s report, we found that 45% (84) of people who died of natural causes reported to us were aged from 21 to 70 years old. Services need to identify patients’ physical health conditions at the earliest possible stage of admission, to support improved outcomes and their recovery.

### **Restrictive interventions**

In previous reports, such as our annual MHA reports and wider reports on the state of care in mental health services, we have expressed concern about the wide variation across services in how frequently staff use restrictive interventions, apply the guiding principles and adhere to the recommendations of the Code. This is an area of practice that is not set out in current legislation, although this may change if the Mental Health Units (Use of Force) Bill is passed into law.

We have identified problems in some services with access to (and quality of) training, and insufficient attention to de-escalation and prevention rather than reaction to difficult behaviour. Patients are not always given the opportunity to have a debrief after a restrictive intervention, both to address any traumatising aspects of that intervention and to consider whether to make an advance statement over preferences for the future.

### **Code of Practice**

As well as providing statutory guidance on how providers should apply the MHA in the most humane way possible, the MHA Code sets out the general principles that should be upheld by all who use it. However, in law, both the Code’s specific guidance and its principles are no more than recommendations, unless they directly relate to the specific duties in the MHA itself. It may be that having such principles in a Code, rather than on the face of the statute itself, is a weakness of the MHA. It is certainly a contrast to other, comparable statutes, such as the Mental Capacity Act or the MHA in Scotland. In previous reports, we have highlighted that there is great variation between wards, services and providers in how they apply the Code. Most recently, we looked at how providers had implemented the 2015 changes and found that less than half of the wards we visited had provided staff with any form of training on the revisions, or updated policies and procedures to reflect the new requirements in the statutory guidance.

The reasons for this may include training budgets being reduced, a failure to recognise the importance of the Code’s guidance in providing quality care in a human rights framework, or the length and detail of the Code acting as a barrier to it being implemented effectively. Our inspection teams have issued requirement notices to individual providers to improve how they apply the Code locally. We will share our work on the review of how

Footnote:

- c In 2012, the ECHR ruled that similar provisions of the Finnish MHA, which provided clinicians with authority to enforce medication against the will of a patient in the early stages of detention, did not provide adequate legal safeguards to patients.

the Code is implemented with the panel. However, our experience so far suggests that improvements in some of the areas covered by the Code may need more than guidance alone.

### **National figures on the use of the Mental Health Act**

NHS Digital is responsible for collecting data across the health and social care system including the use of the MHA. In previous years, NHS Digital collected MHA information from an annual return by providers called the KP90. The KP90 did not provide patient level data, but counted the number of times the MHA had been used throughout the year. It also provided snapshots of the number of people detained under the MHA. From 2016/17, NHS Digital asked all mental health providers to use the Mental Health Services Data Set (MHSDS) as the submission route, as it can be linked to patient data including contacts with services both before and following detention. MHSDS also allows us to look at demographic information including rates of detention for different groups or by ages, ethnicity and gender.

Submission to MHSDS is mandatory for any NHS funded care, including by independent sector providers. Information collected through MHSDS provides a comprehensive national picture of the use of specialist mental health services to help inform commissioning, clinical audit, research, service planning, inspection and regulation, monitoring government policies and legislation, local and national performance management and benchmarking, national reporting and analysis.

In the first report using the new data, NHS Digital highlighted that there had been shortfalls in the number of providers that had completed the MHA returns through MHSDS. This included no return at all, partial returns or poor quality returns that made the data unusable in the national report. Although CQC is not responsible for the data collection, we regulate all services that treat patients under the MHA and will look at how they manage data including how services submit to national data collection systems. As part of our assessment of whether an organisation is well-led, we consider the data submitted to external organisations and how providers are benchmarking their performance

to make improvements and inform discussions with commissioners.

In December 2017, we used the NHS Digital published data to identify where providers had submitted previously to the KP90 but their MHSDS return did not show similar numbers or they had failed to return at all. We wrote to providers to notify them of our concerns and their mandatory duties, and asked them to look into the matter. If they are still providing services to detained patients, we ask them to provide their plans to improve.

The project is ongoing but we have heard that some providers and their commissioners had not been aware of problems with their data. Services have told us they are committed to benchmarking and using MHA information for continuous improvement, with some highlighting other programmes to do this including participation in the NHS Benchmarking Network and discussions with local or regional services to share data. Some services have also identified issues with local clinical record systems, where simple changes have rectified issues with data returns to improve their submissions. For example, one provider database that did not have the 'Mental Health Act Category' field marked as mandatory in their local records system, would have submitted a null return to MHSDS if this had not been changed. Other providers have flagged that although they are returning MHSDS data, they were not aware that they should also return MHA data if it is applicable to people using services. Some independent healthcare providers have also identified systems issues and problems gaining access to the digital connection that would enable them to submit data to NHS Digital.

We will continue to work with services, NHS Digital and NHS England to improve this. But we encourage all providers to review their local MHA information and identify any differences between this and their individual MHSDS reports, taking action to improve. We will monitor improvement with this through our well-led reviews of mental health services and through engagement with NHS Digital.

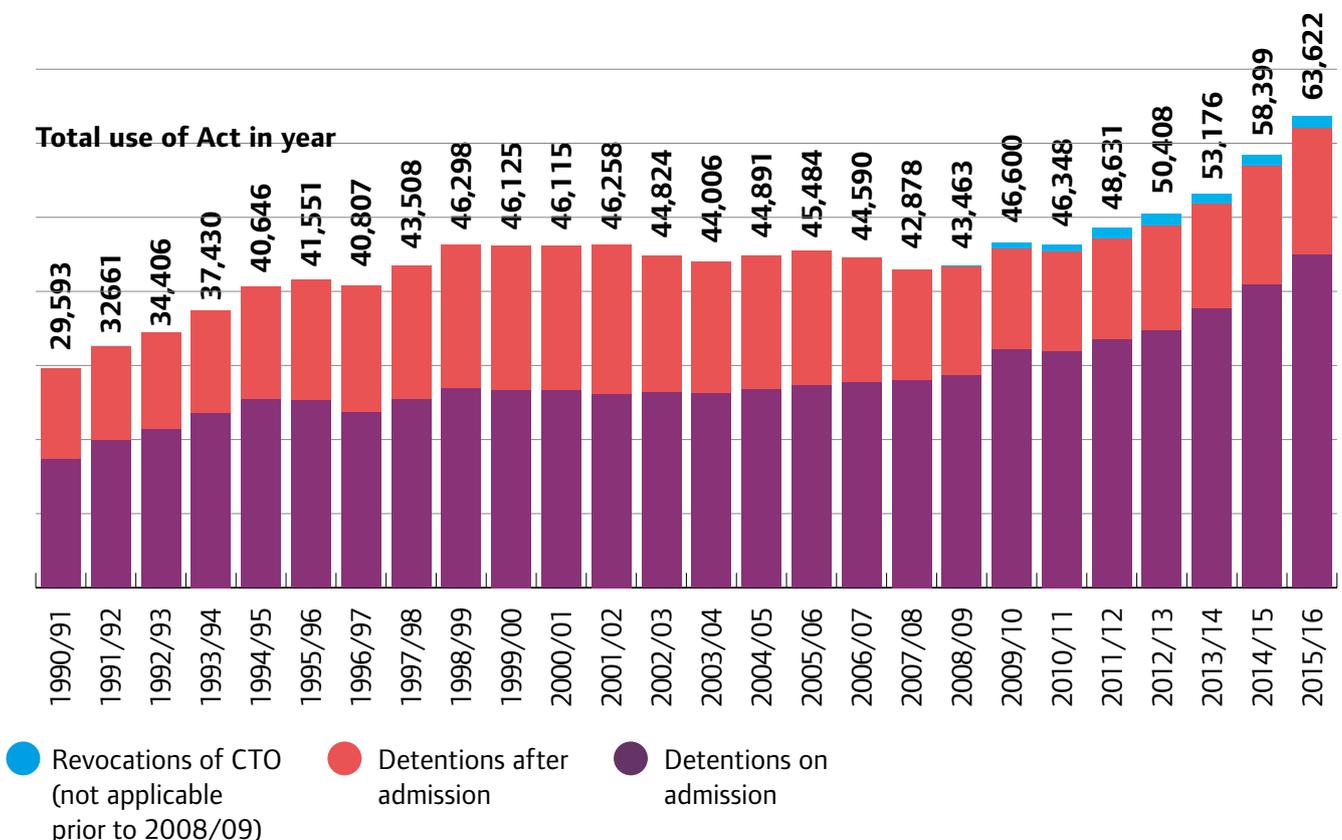
## 1.1 Assessment, transport and admission to hospital

National data from the last 25 years shows an increasing use of the MHA to treat people in hospitals. Figure 1 shows how many times the MHA has been used, but not how many people are being detained. This is because it does not tell us whether the same person has been detained more than once in the same period. This is the case for the data set used up to but not including 2016/17. It also does not tell us what happened to the patient before or after their hospital admission, nor their race, any other protected characteristic, age, diagnosis, housing situation or economic status.

From 2005/06 to 2015/16, the reported number of uses of the MHA to detain people in hospital increased by 40%. There was a 9% increase from 2014/15 to 2015/16 rising to 63,622 uses of the MHA.

Figure 1 shows that, in marked contrast to substantial rises in the 1990s and since 2010, there was a steady reduction in the number of detentions from 2000 to 2009. We speculate that this might have been due to the introduction of specialist community mental health teams following publication of the National Service Framework for Mental Health in 1999.<sup>2</sup>

**Figure 1** Detentions in hospital under the Mental Health Act, 1990/91 to 2015/16



Source: NHS Digital, KP90 / Mental Health Services Data Set (MHSDS)

## Focus visits to review the rising uses of the Mental Health Act

In January 2018, we published our findings from visits with 12 local services in 2017. This work followed previous reports by NHS Digital that showed continued rises in the numbers of times services are using the MHA over the last decade. We have shared the report and our findings with local services to encourage review and greater analysis by local boards, commissioners and services to identify themes. We have also committed to working with the Department of

Health and Social Care, the MHA independent review, NHS Digital, NHS England and NHS Improvement to look at ways that our findings can inform the supporting work initiatives to improve the way the MHA is being used for patients.

As expected, no single cause emerged from the visits and the engagement with patients, carers, professionals and services. We grouped the factors that are likely to have contributed to the rise in the number of detentions into four themes:

### 1. Changes in mental health service provision and bed management

More frequent readmissions – either as part of a plan of care or because of premature discharge.

Loss of specialist community teams offering alternatives to admission.

Pressure on beds preventing early, informal admissions or leading to discharge without adequate support being in place to stay well once out of hospital.

### 2. Demographic and social change

Increase in population size and in sections of the population 'at risk' of detention (especially older people with dementia).

Rising inequality and social exclusion (for example rising homelessness).

Impact of alcohol and substance misuse.

### 3. Legal and policy developments that have influenced practice

2007 reform of MHA widening definition of mental disorder and of treatment.

Increasing awareness of the factors of *de facto* detention as a result of the Bournemouth judgement and Mental Capacity Act led to more use of MHA for those lacking capacity.

Greater police awareness of mental disorder leading to more diversions from the criminal justice system.

### 4. Data reporting and data quality

Improved completeness of local returns that inform national data sets.

Duplicate entries – including double-counting when a detained patient is moved from one ward or provider to another.

We did not expect this qualitative work to identify all of the detailed factors that might cause the rising use of the MHA. We also knew that it would not allow us to make confident statements about the extent to which each of

the factors have contributed to the rise. However, based on the four themes, we developed eight hypotheses that we think are likely to cover all factors that might have made some contribution. These might be the basis for future enquiry.

## Our hypotheses for the rising rate of detention

- The apparent rise in rate of detention since 2010 is in part due to the national data return being more complete or to an increase in duplicate returns.
- More people are being detained on more than one occasion during a calendar year than was previously the case.
- As bed numbers have fallen, more people with severe mental health problems are living outside of a hospital setting and so are at greater risk of being detained.
- Some people are being detained under the MHA who would previously not have been detained. This is because clinicians are applying the criteria for detention differently to people with certain types of disorder (such as dementia or personality disorder). It could also be because more people with mental health problems are coming to the attention of mental healthcare workers (for example, through schemes that divert people from the criminal justice system).
- People who need admission and would previously have agreed to informal admission are now refusing and are being admitted as detained patients.
- Admissions (some of which would be formal) that could previously have been prevented are now not being prevented because less restrictive alternatives in the community are not available.
- There has been an increase in the total size of the population of England and an increase in the size of those sections of the population that are more at risk of detention.
- There has been an increase in the prevalence of risk factors for detention, such as social exclusion and problematic, untreated drug and alcohol misuse.

We can be confident about a number of our conclusions.

There is no single cause for the rise in rates of detention this decade. It is highly likely that a range of factors are at play both nationally and locally.

The rise in part suggests a system under considerable pressure. Staff in some areas have limited access to community services that can act as true alternatives to admission. At the same time, these services may not have a bed available for an admission when it is needed. This creates a dilemma for both patients and staff, and reduces the likelihood of avoiding detention – either by providing a less restrictive community alternative or by an informal admission to prevent further deterioration. In some places, this might amount to a vicious cycle where pressure on beds leads to clinical practices that increase the likelihood of patients being detained, which itself increases the pressure on beds.

We found no evidence that professionals are using the Mental Health Act to admit people who do not meet the criteria for detention, for example to ‘game’ the system to obtain a bed for the patient.

We think it is unlikely that reform of mental health legislation on its own will reduce the rate of detention. There must also be action to address the underlying problems that almost certainly contribute to the rise this decade.

The pattern of change in rates of detention over the previous 25 years (figure 1, page 16) supports our conclusion that changes in mental health law need to happen alongside action to address wider problems. Following year-on-year increases during the 1990s, the rate of detention fell from 2000 to 2009 before starting to rise again. After publication of the mental health National Service Framework in 1999, the decade that followed was a time of significant investment in new community teams, whose purpose was to act as alternatives to hospital admission.

This information is an extract of our full report, *The rise in the use of the MHA to detain people in England*.

### Bed availability and MHA assessments

Under section 140 of the MHA, clinical commissioning groups have a legal duty to 'give notice' to local authorities 'specifying the hospital or hospitals that have made arrangements to receive patients in cases of special urgency' (and also to receive patients aged under 18). This legal duty may not be sufficient, as it only requires that commissioners name a hospital that will take urgent admissions in theory. Such hospitals are not required to take a particular urgent admission, and there is not a requirement for them to

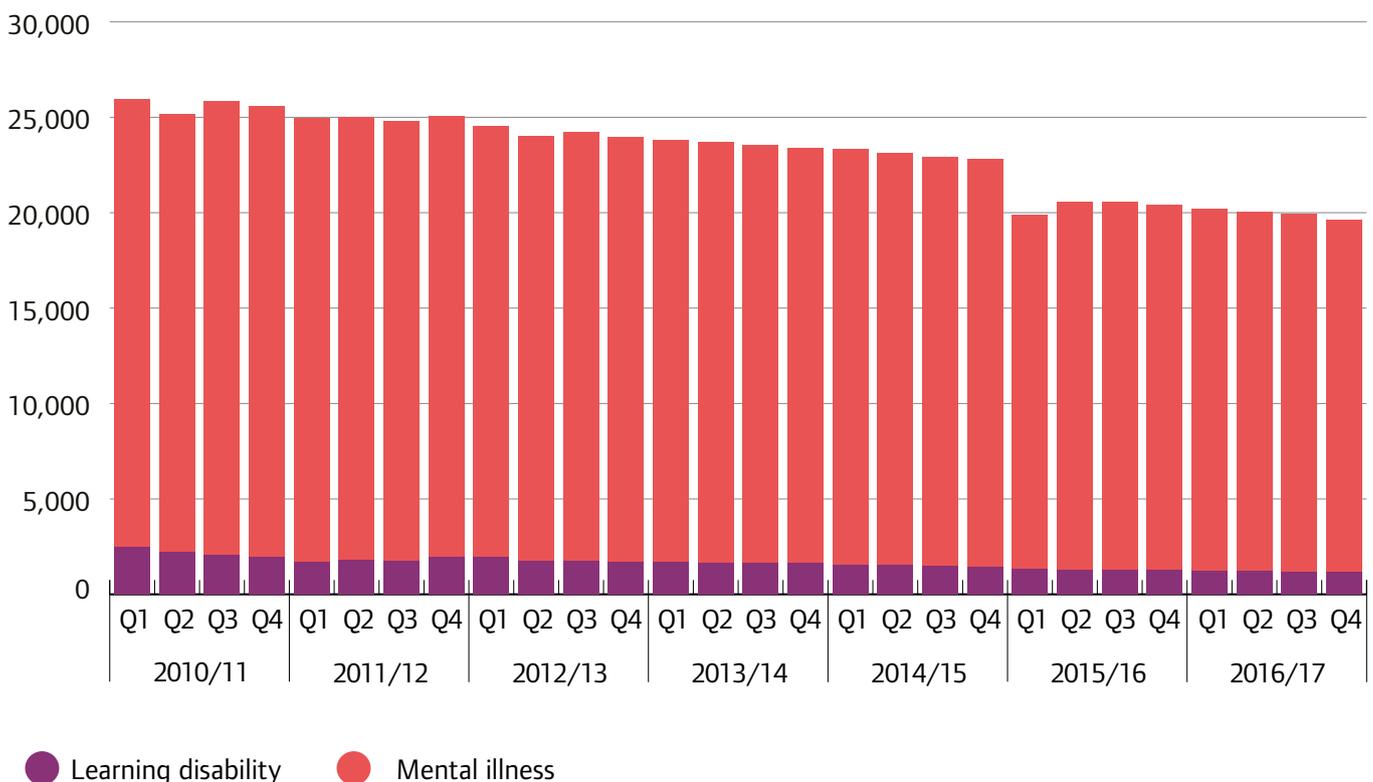
maintain the capacity to take such admissions when they occur.

Although bed numbers have fallen in recent years (figure 2), the number of admissions and lengths of stay in hospital have not.<sup>3</sup> This is a problem for all services, leading to difficulties in

There has been no increase in the provision of community mental health services to offset the reduction in bed availability in the last five years. Generic community mental health team provision fell slightly during this period.

**Centre for Mental Health (2017)**

**Figure 2** Mental illness and learning disability NHS beds open overnight, 2010/11 to 2016/17, England



Data source: NHS England, Bed Availability and Occupancy Data – Overnight, KH03 quarterly data collection<sup>d</sup>

Footnote:

<sup>d</sup> There is not a comparable database of wards available for the same period so this information cannot be contextualised against reductions in ward.

finding a timely hospital bed in many areas. This means that some services are finding it difficult to access appropriate support to prevent a patient's admission, and patients are not receiving the mental health care they need when they need it from specialist children and young people's mental health services. We are carrying out a separate review into children and young people's mental health services in 2017/18.

In 2017, we carried out a programme of work to review Approved Mental Health Professionals (AMHP) services in England. AMHPs play a key role under the MHA. They decide whether to apply to have someone detained in hospital when two medical recommendations for this have been made. Our review included national engagement with specialists and national bodies to review the way AMHP services are being delivered and site visits with 23 local authorities in England in March to July 2017. AMHPs across the country reported that a reduction in beds nationally was having an effect on their ability to complete assessments in a timely manner, particularly when patients needed specialist beds.

In our meetings with AMHPs, they recognised community provision and alternatives to admission as useful tools to manage people's crisis at home, and were keen to share positive examples of how improved access to crisis services could support them to deliver a least restrictive alternative to detention. However, there was general concern about the limited ability to offer patients' support to prevent a crisis occurring, particularly across social work and social care. Typically, social workers stated that they were unable to engage with people until they were in crisis, because they were expected to prioritise their casework. Some areas reported limited funding across adult social care commissioned services, and cuts to budgets, which had an effect on detention levels.

We will publish a separate report on our meetings with AMHPs and local authority representatives in early 2018.

In August 2017, the Association of Police and Crime Commissioners wrote to the Secretary of State for Health for England expressing concern over delays in locating mental health beds for people in need of mental health assessments after police had arrested them for a criminal offence. The Police and Criminal Evidence Act (PACE) rules limit the time that police can lawfully detain such a person without charge to a period not normally exceeding 24 hours. After this time expires, there is no legal authority for custody officers to detain individuals pending continued efforts to complete a mental health assessment or identify a bed. As a result, custody officers often have the dilemma of holding a detainee without legal grounds to do so, or releasing the detainee with potential risk to themselves or the public.

Police sources have suggested that these situations appear to be common. In part, this may be because police may be the first, or only, responders in domestic situations involving a person with mental disorder, and there are no readily available MHA powers that they can rely on in these situations. For some forces, the number of requests they make for MHA assessments following arrests under criminal justice powers exceeds the number of detentions they initiate under section 136 of the MHA. NHS England and NHS Improvement highlighted this as a concern as part of their joint letter to all NHS regions, commissioners and providers on 31 October 2017.

From December 2017, the period of lawful detention under sections 135 and 136 has been limited to 24 hours. This creates a similar risk if a bed is not found for the person that needs it, and it would be unsafe to allow the person to leave.

The concern highlighted by the police is a variation of a more general problem. This is the issue of what to do with a person who urgently needs admitting under the MHA for their own safety or for the safety of other people, but there is no bed available. These situations happen

regularly in the community, where people are left either on their own, or with relatives or carers, or in some cases with an AMHP or other professional. Many AMHPs that we talk with have discussed the ethical and practical dilemma of whether to arrange an MHA assessment of someone if you know that there is no available bed, if one is needed, or delay the assessment until a bed becomes available. Neither option provides a meaningful intervention when the patient needs it. There is also a risk that, if assessments only take place when a bed has been found, there could be pressure to resolve matters while that window of opportunity is open, leading to alternative to hospital not being considered as much.

### **Delays in admission of women to appropriate secure beds**

During the year, we saw particular pressures on high secure hospital placements for women. Rampton Hospital, which houses the 50 commissioned high secure beds for women, has been running at 100% occupancy with a waiting list of several patients. At the time of our comprehensive inspection of Rampton Hospital in March 2017, the longest wait had been nine months for a placement, and we have continued to monitor the position in MHA visits across many women's services.<sup>4</sup> By the time of writing this report, one patient had been in conditions of long-term segregation for over a year while awaiting access to a Rampton Hospital bed. Medium secure services are also operating at full capacity, which has an effect on the efforts of high secure services to step patients down. This does not follow the principle in the Code of using the least restrictive hospital setting possible. It suggests that lack of appropriate placements is leading to patients being admitted to, or retained in, higher levels of physical security than is appropriate for their overall care.

We have raised concerns with NHS England (NHSE). NHSE have assured us that they recognise these significant pressures, both in demand for access to high secure placements, and in difficulty in discharging existing patients, and have instigated a capacity and model review of these services.

NHSE have assured us that its review will address the demands for access to high secure placements; review and implement the most effective pathways; and review the women's strategy to make sure women are receiving care in the least restrictive environment. This includes developing new models of care to reduce reliance on low and medium secure beds and supporting providers to develop less restrictive care and treatment options that are nearer to the patients' homes. NHSE hope that these initiatives will reduce the pressure on medium secure beds and have a positive effect on the overall pathway management to high secure care.

## **1.2 An equality and human rights focus in mental health care**

### **Black and minority ethnic overrepresentation in the use of the MHA**

The government has said that its wish to tackle inequality in the use of the MHA between population groups is a main motivation behind commissioning the MHA review. Detention rates for the 'Black or Black British' population group are more than four times that for the White population group (figure 3). Detention rates for the Black and minority ethnic (BME) category 'any other Black background', including Black European or Black American, are over 10 times the rate of the White population group.<sup>5</sup>

It is not widely understood why the MHA is used more for people in some BME groups. The Lammy Review, an independent review of the treatment of, and outcomes for people from BME groups in the justice system published in 2017. This review said the causes of similar problems in the justice system lie outside the system and start long before a young man or woman ever enters that system. This is likely to be true for mental health services and national and local initiatives to improve will need to apply a broad scope to identify and implement solutions.

One national response is the specific commitment in the MHA review, and in the Five Year Forward View for Mental Health, to give greater priority to tackling inequalities. In last year's report, we highlighted that

practical guidance in addressing inequalities has been available for commissioners of mental health services since April 2014.<sup>6</sup>

We are also aware that some providers have helped to develop the British Institute of Human Rights' guides on human rights, mental health and mental capacity. The guides are part of a project funded by the Department of Health and Social Care to place human rights at the heart of mental health and mental capacity services. The guides aim to make sure that frontline staff have the knowledge and skills to fulfil the vital role they can play in upholding the dignity and human rights of the people using their service.<sup>7</sup> There are also factsheets for people who use services and other resources.<sup>8</sup>

In 2017, we co-published the equality and human rights good practice resource *Equally outstanding*.<sup>9</sup> This explores how a focus on equality and human rights can improve the quality of care in times of financial constraint. The report provides examples of organisations rated as outstanding that have engaged with equality and human rights

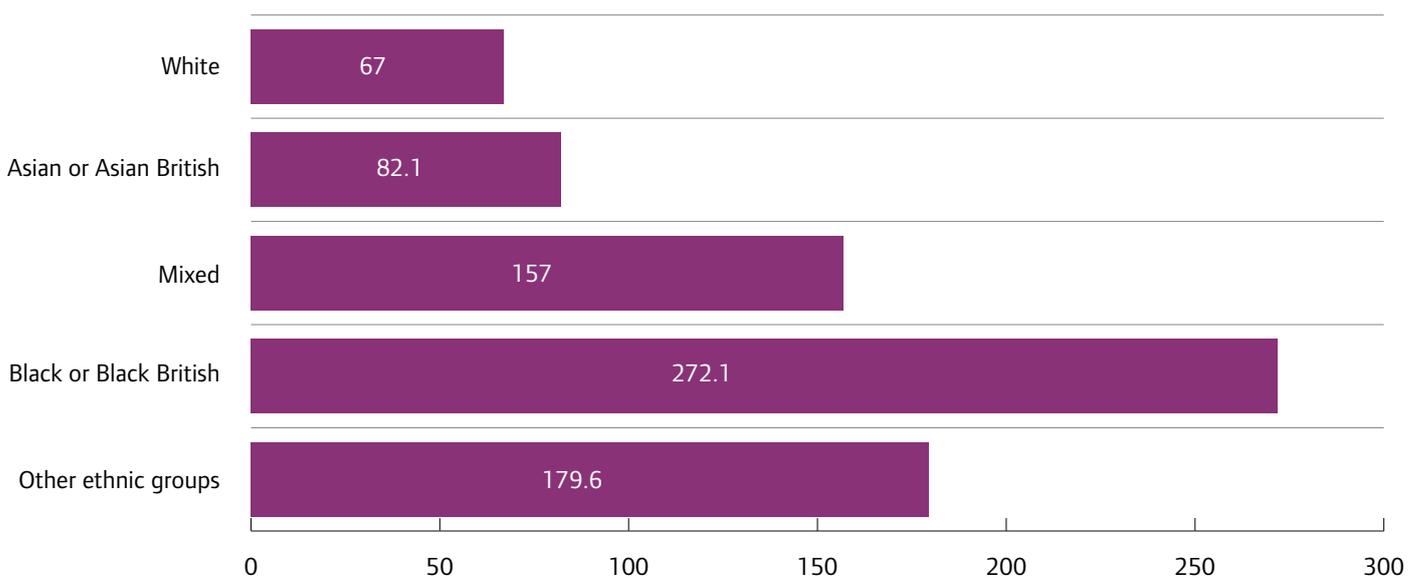
approaches. It summarises the factors common to those examples, showing that none take large resources – they take shifts in thinking and in behaviours.

### 1.3 Protecting patients' rights and autonomy

This section looks at the way services support detained patients to be involved in their care and treatment, understand their rights and exercise their autonomy. The MHA and Code of Practice

People from a Black background are more than twice as likely to live in poverty than those from a white background. Black children are more than twice as likely to grow up in a lone parent family. Black and Mixed ethnic boys are more likely than White boys to be permanently excluded from school and to be arrested as a teenager.<sup>10</sup>

**Figure 3** Standardised rates of detention under the MHA per 1,000 population, 2016/17



Source: NHS Digital, MHSDS

require services to provide patients (as well as carers and relatives where appropriate) with information and opportunities to be consulted and involved in treatment.

### Information for patients

Under the MHA, providers need to give patients information about their rights, verbally and in writing, as soon as possible after the start of their detention or community treatment order. This allows patients to understand how the MHA will affect them, be involved in their care and treatment and discuss any concerns with staff. It also gives them the opportunity to exercise their rights if they wish to do so, for example by requesting their discharge through an appeal to the tribunal or hospital managers.

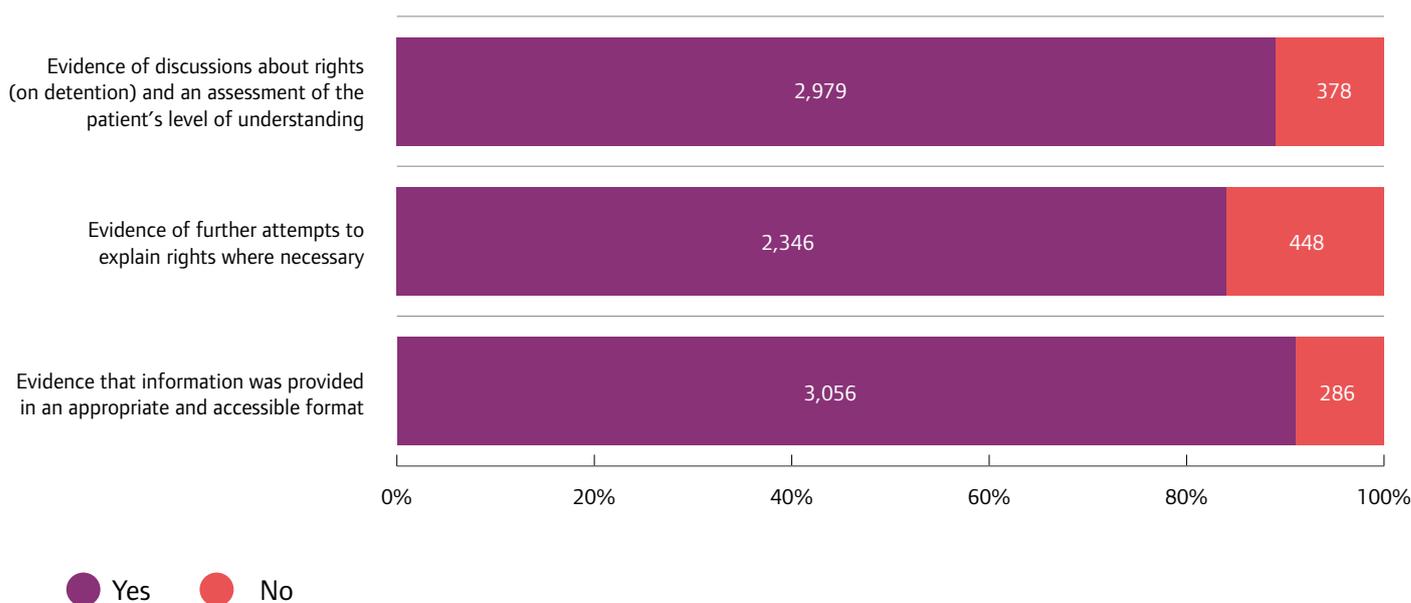
Our visits throughout 2016/17 found no real difference from the previous year in the proportion of services meeting their duties. After continuous improvement from 2010/11 to 2014/15, it seems that there are still services that continue to fail these legal duties, or with

recording systems that inadequately capture staff attempts to meet it.

There was no evidence that staff had discussed rights with the patient on admission in 11% (378) of patient records that we checked. In a further 9% (286) of records, there was no evidence that patients received the information in an accessible format. The Code requires staff to remind patients of their rights and of the effects of the MHA from time to time, to check the hospital is meeting its legal duties. However, there was no evidence of this happening in 16% (448) of records that we checked (figure 4).

It is important that the duties under the MHA to provide information to detained patients are not read too narrowly by services. As stated in our previous report, we sometimes hear these duties referred to as ‘reading the patient their rights’, which has unhelpful echoes of police procedure. It is not enough to focus on rights to appeal detention. The duty under the MHA should enable patients to understand and engage

**Figure 4** Evidence of discussions of rights in examined records 2016/17



Source: CQC

with staff and others in exercising agency over their immediate and longer-term involvement with services. We would like to see the MHA review emphasise and strengthen these duties. This should include a clear statement that services should not overly rely on advocacy services to provide information to patients on their statutory position and rights.

### Independent Mental Health Advocacy

Under the MHA, providers are required to take practicable steps to make sure that patients subject to the MHA are aware of the help that is available from Independent Mental Health Advocates (IMHAs). On almost every ward we visited throughout 2016/17, patients stated that they had some degree of access to IMHAs. Where this is not the case, this could be a reflection in breakdowns in provision during retendering contracts for advocacy services, or handovers from one provider to another when contracts change.

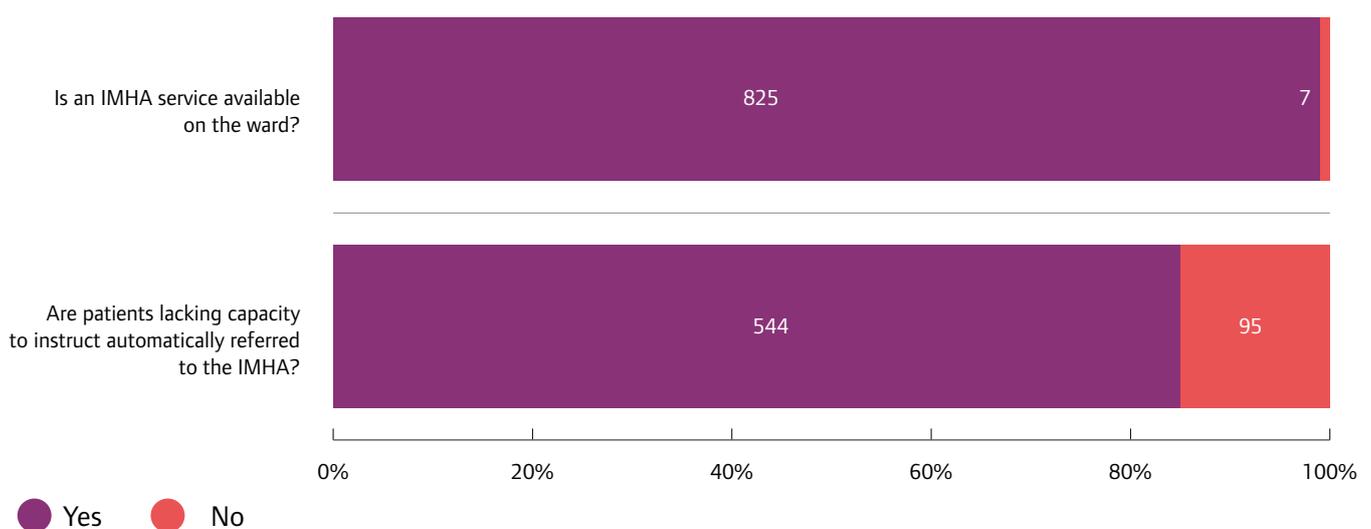
By law, local authorities are responsible for commissioning IMHA services. Some specialist and independent hospitals have found it difficult

to access local authority commissioned IMHA services and, as a result, have commissioned their own services. Some national services and independent hospitals find it difficult to persuade their local authority to meet its responsibilities for commissioning IMHA services, despite the Health and Social Care Act 2012 clarifying the legal responsibilities involved (see section 130 (4A) of the MHA 1983). In other cases, it seems that local authority provision of advocacy services has not met the needs of the hospital and so the hospital has taken up the commissioning role to remedy this. These arrangements do raise the question of the practical independence of the advocacy service.

Where hospitals have had to become the commissioning body for advocacy, we suggest that they look at their own governance arrangements to avoid compromising their practical independence. This could be a matter of separating mechanisms for commissioning the service and those that exist for engaging with the advocates on a day-to-day level in the course of their work.

If advocacy is to be effective, it must reach out to patients who are unable or unwilling to ask

**Figure 5** Evidence of IMHA service provision, 2016/17



Source: CQC

for help. Under the current legislation, IMHA services rely on hospital services to inform them of any patient who is eligible for help. The Code recommends that hospital managers should arrange for an IMHA to visit any patient who lacks capacity to decide whether to request help from an advocate, to explain directly what the IMHA service can offer (paragraphs 4.23 and 6.16). We found evidence that this was happening on 85% of wards (544) where we asked this question.

We welcome the government's proposals to consider changing regulations to make sure that advocacy services are more formally provided on an opt-out (rather than opt-in) basis for patients who lack such mental capacity.<sup>11</sup> We expect that the MHA review will consider this area, and identify if there are other ways to strengthen the statute and support advocacy services to develop.

## 1.4 Care, support and treatment in hospital

The MHA Code of Practice's chapters on medical treatment and care in hospital emphasise how important it is for services to offer patients appropriate treatment. To determine if treatment is appropriate, staff need to consider whether the patient has consented to or refused treatment, whether the patient has the capacity to consent, and if they need to use the powers given under the MHA to impose treatment without consent. Chapters 23 and 24 of the Code also expects services to promote good physical health care and healthy living for detained patients, assess individual needs and have clear processes for managing behavioural disturbance in a safe and therapeutic way.

### Promoting good physical health

In last year's report, we highlighted the importance of improving the physical assessment, treatment and healthy living of patients, in line with the *Five Year Forward View for Mental Health*.<sup>12</sup> Work to improve this has continued nationally, for example NHS England have

recently published guidance on physical health of people with serious mental illness.<sup>13</sup> This includes information for inpatient care and details of collaboration between commissioners and providers to improve physical health to reduce premature mortality.

We continue to see examples of good practice. Our *State of Care* report for 2016/17 highlights some excellent examples of staff enabling patients to access GP services, dentists and healthcare clinics, and promoting physical exercise and healthy eating. Many services have arranged for regular GP clinics on inpatient wards. We have seen a decrease in the percentage of wards that have had problems in accessing GP services. In 2012/13, we reported that a quarter of wards we visited did not have ready access to GP services. In 2014/15 and 2015/16, it was around 10% of wards. In 2016/17 it was 7% (figure 6).

We continue to find problems with adequately monitoring detained patients' physical health. In 2016/17, we looked at the care records of 2,303 patients who had been detained for less than a year in hospital. Of these, there was no evidence in 8% (193) of records that a health assessment had been carried out at admission. This is a worse result than the previous two years.

"Physical health reviews are usually very basic on admission – just questions and a quick physical examination by a junior doctor. Most hospitals will use a scoring system (completed by nursing staff) to raise concerns about physical health. However, these are often poorly completed. During a visit I will look at the initial interview, the first ward round, the scoring charts and talk to patients about whether they feel their physical health is being monitored. This means where we report no record of an assessment of physical health on admission, we believe it is very likely that the assessment was not completed at all."

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We will continue to strengthen our assessment of physical health care when carrying out our regulatory inspections of services. This includes looking at physical health monitoring of people on psychotropic medication, rapid tranquillisation, and high dose antipsychotic therapy.

### Consent to treatment

Under the MHA, services have legal powers to give psychiatric care and treatment without consent to some detained patients.<sup>e</sup> For the first three months of treatment with psychiatric medication, and for the range of nursing and other interventions that can fall in the broad category of treatment for mental disorder, the statute simply states that the consent of a patient is 'not required' (see section 63 of the MHA 1983).

Where the MHA allows providers to give treatment without consent, paragraph 24.41 of the Code is clear that providers should seek the patient's consent wherever practicable. Consent, refusal to consent, or a lack of capacity to consent need to be recorded. Providers should consider carefully whether to go ahead with treatment if the patient refuses or is unable to give consent.

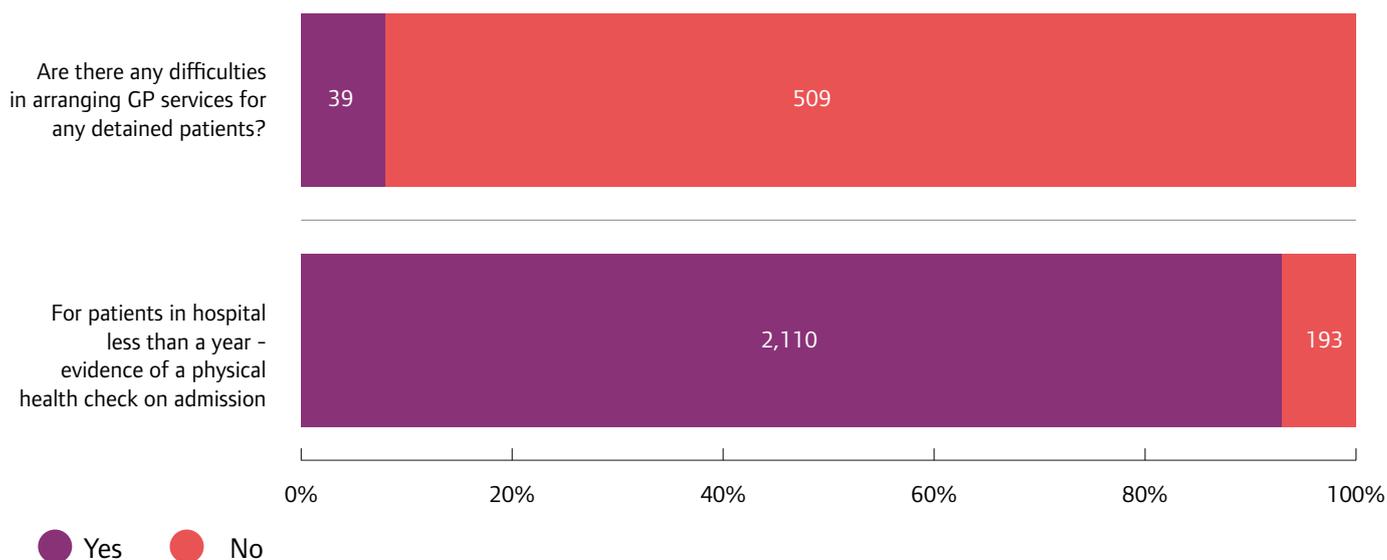
During visits, we frequently raise concerns over whether clinicians have recorded evidence of their conversations with detained patients over their proposed treatment, and recorded the patients' views on that treatment. We also have concerns about whether the patient consents, refuses consent, or is incapable of consent. If a patient is recorded to be incapable of consent, we expect to see a capacity assessment to support this view and, unless it would clearly be inappropriate to expect this, evidence that staff have considered ways in which they could help the patient gain or regain capacity.

In general medicine, the Supreme Court has set a high bar in terms of the legal standard required to advise patients about their options and give

Footnote:

e The treatment provisions of the MHA (and therefore the authority to treat without consent) apply to patients detained under s. 2, 3, 17A, 36, 37, 38, 44, 45A, 46, 47, 48 and 49 of the MHA. They do not apply to patients held under short-term holding powers such as s.5, 135 or 136, or conditionally discharged or CTO patients who have not been recalled to hospital, who are in the same position as informal patients about treatment without consent.

**Figure 6** Physical health care of detained patients, 2016/17



Source: CQC

effect to patient preferences in their choice of treatment.<sup>14</sup> The test of duty of care set out in the Montgomery ruling<sup>15</sup> marks a shift from the clinician's interpretation about what would be best for patients to a more balanced appreciation of what matters to a particular patient, taking into account that patient's values and priorities.<sup>16</sup> The MHA review is an opportunity to reflect these developments even where treatment can be given without consent.

### **The safe and effective management of behavioural disturbance**

Paragraph 26.4 in the Code emphasises that the best way to manage behavioural disturbance is prevention, with a focus on a positive and therapeutic culture over using restrictive interventions such as seclusion or restraint. The Code advises services to establish restrictive intervention reduction programmes, supported at Board level, to help focus on reducing the use of physical interventions in hospitals.

We are concerned about the wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. In our 2016/17 State of Care report, we report that wards where the level of physical restraint was low had staff trained in the specialised skills needed to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.<sup>17</sup>

We are also concerned that services hold varying definitions and reporting thresholds of physical restraint, and that there is no quality assurance of physical restraint training programmes. The Mental Health Units (Use of Force) Bill may address this. Parliament is currently considering this bill, after Steve Reed MP introduced it in response to the death of his constituent Olaseni Lewis.

In December 2017, we published a guide to help mental healthcare providers, building on the standards set in the MHA Code of Practice to give appropriate support to people whose behaviour might endanger themselves or others.

The guide, *A focus on restrictive intervention reduction programmes in inpatient mental health services*, highlighted good practice by NHS mental health services that has led to fewer incidents of staff having to use physical restraint.<sup>18</sup> In previous MHA reports and our *State of care in mental health services 2014 to 2017* published in 2017, we have highlighted concerns that care for some people is overly restrictive and in response, we challenged services to commit to reducing restrictive interventions.<sup>19</sup>

The guide represents the output of work completed in 2017, when we asked five NHS trusts to say what they were doing to reduce the use of restrictive interventions and what was working well for their staff and the people who use their services. The examples show that a positive and therapeutic culture across a mental health ward can reduce the need for restrictive interventions.

NHS England has set up a Restrictive Practices Expert Reference Group. This group will help identify how cross-organisational work can be

“The ability to impose medication is unique to the Mental Health Act and is always a priority area for review and assessment when I am meeting with patients, reviewing records or speaking with staff. Medication discussions are a critical part of the patient experience and ability to be involved during detention. From my experience, a supportive and meaningful discussion about the treatment options, implications and choices can make a big difference to patient recovery. This can be a positive one, helping them to understand what to expect and how the consultant's proposed treatment plan has been decided, but we also want to highlight when there isn't a record of a discussion and the potential negative impacts when preferences or previous experience with medication is not sought.”

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delivered to improve the national tools, guidance and oversight for restrictive practices in England.

### **Concerns over care in Rampton and Broadmoor high secure hospitals**

During the year, we told the Secretary of State about a shortage of nurses at Rampton and Broadmoor hospitals. These staff shortages restricted patients' access to therapies and leisure activities during the day and, in the case of Broadmoor Hospital, could in our view have put patients at risk.<sup>20</sup> Both hospitals applied 'night time confinement' (a decision to lock patients in their room overnight unrelated to the patient's behaviour or risk assessment). The combination of night-time confinement and restriction on day-time activities is unacceptable – the 2013 guidance to the security directions sets out arrangements for general night-time confinement that "should only be put in place where it is considered that this will maximise therapeutic benefit for patients, as a whole, in the hospital. For example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day".

We will monitor the response of the trusts that manage Broadmoor Hospital and Rampton Hospital closely. We have shared our concerns with the Secretary of State and discussed our findings with NHS England Specialised Commissioning and the National Oversight Group for high secure services. We have recommended that all three high secure hospitals work more closely to share best practice and to address our concerns.

### **Long-term segregation**

In 2017, we produced guidance for our MHA reviewers and inspectors on how to assess and report concerns about the management of patients in long-term segregation, taking into account the duties of CQC as a National Preventive Mechanism against inhuman and degrading treatment.<sup>21</sup>

The Committee for the Prevention of Torture stated in its UK visit report that it "understands that seclusion followed by Long-Term Segregation is supposed to be an extreme measure for patients who are considered to be a threat to themselves and/or to others", but that "in certain cases, the impact of LTS on patients amounts to inhuman and degrading treatment".<sup>22</sup>

CQC's guidance sets out expectations in line with the Code, the committee report on the UK visit, and the National Preventive Mechanism guidance on monitoring Isolation in detention.<sup>23</sup>

We take the view that long-term segregation does have the potential to amount to inhuman and degrading treatment if:

- it is applied when it is not necessary (whether from the beginning or if it continued beyond the point where it is justified)
- if it is applied in such a way as to be inhuman or degrading (for example extended isolation from any human contact; lack of appropriate activity or diversion; being spoken to or fed only through a door hatch that is also used for slopping out; and lack of access to fresh air).

There is a particular risk that the restrictions of long-term segregation worsen the behaviour that it is designed to contain. This could lead to a cyclical effect, where providers use the patient's worsened behaviour to justify the person staying in segregation.

We are particularly concerned that delays in transferring a patient to a more appropriate level of security, due to a bed not being available, leads to them spending extended time in long-term segregation. Such situations might meet the threshold of inhuman and degrading treatment.<sup>f</sup> We continue to work with services to identify and address concerns over this intervention.

Footnote:

f See MS v UK [2012] for a possible precedent case.

## 1.5 Leaving hospital

In its chapters on leaving hospital, the Code provides guidance on care planning in the context of the Care Programme Approach, including aftercare planning and individualised risk-assessment.

On our MHA review visits, we found that some services' care planning is detailed, comprehensive and developed with patients and carers being involved. However, a substantial proportion of the care plans of detained patients that we have examined are of a poor quality.

### Patient involvement in care planning

Although the MHA provides authority for treatment without consent, the principles that should underpin its use require a person-centred care planning approach, consistent with the legislative and international conventions set out in chapter 3 of the Code of Practice. This is to make sure that individuals are fully supported to be involved in decision-making as much as is appropriate. Chapters 1.8 to 1.10 of the Code state that views on proposed treatment should be considered and fully documented in care plans, as well as the reasons why professionals take any decision that is contrary to the patient's preferences.

In our 2012/13 report,<sup>24</sup> we recommended that services draw on good practice such as the *4Pi National Involvement Standards* to assess the quality of co-production in individual care planning, involving carers and working in partnership with communities to develop and improve mental health services.<sup>25</sup> These standards were produced in 2013 as a part of a National Survivor User Network (NSUN) hosted project, aimed to strengthen and 'hard-wire' people who use services in to planning, delivering and evaluating mental health services, including individual care planning and involvement. *The Five Year Forward View for Mental Health* also recommends the standards.<sup>26</sup>

During our visits in 2016/17, MHA reviewers found no evidence of patient involvement in 32% (1,034) of the care plans they reviewed (figure 7). This was three percentage points worse than the previous year, and a further fall in quality of care from the year before (figure 8).

We collected less data this year on the question of whether there was evidence in the plans that the patients' views about treatment had been considered, but of the 1,788 plans for which we have this data, 31% (550) recorded that there was no such evidence. This was five percentage points worse than the previous year.

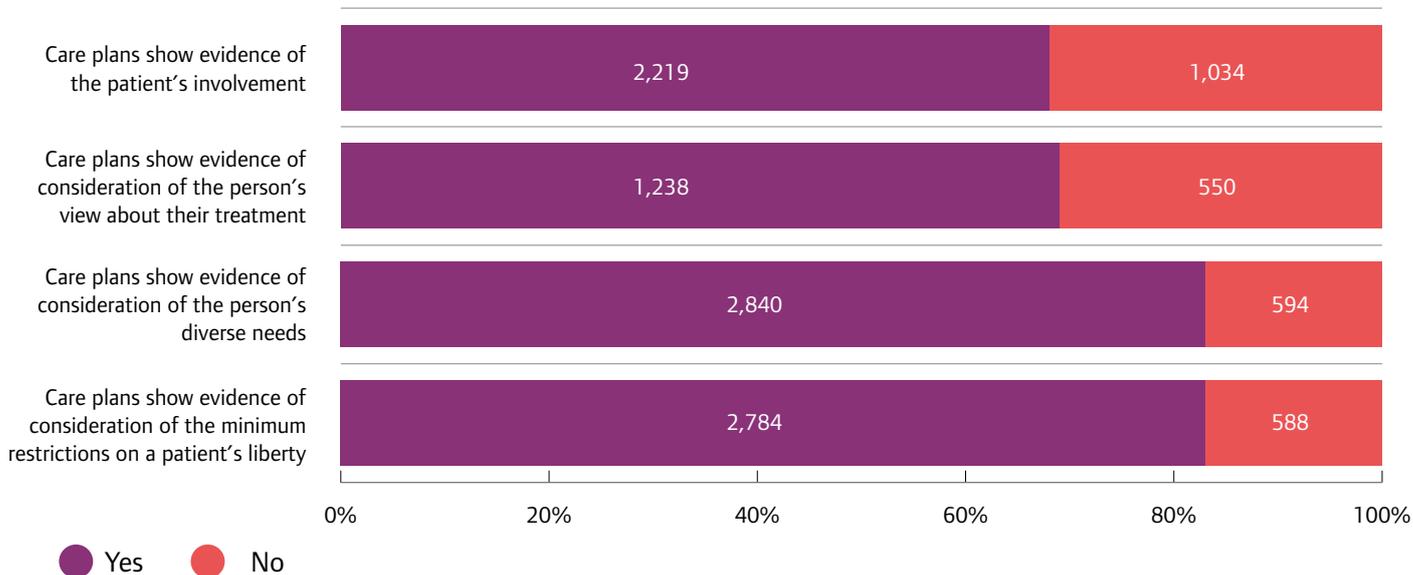
There are more worrying indicators about lack of patient involvement, in that 17% (594) of care plans did not give evidence that the patient's diverse needs had been considered, and in 17% (588) there was no evidence that the least restrictive options for care had been considered (figure 7). Both of these are seven percentage points lower than in 2015/16.

We will work to identify and explore the local reasons for this lack of progress through our activities and evidence gathering in 2018. Our conversations with staff and experts suggest that this is likely to include staffing pressures, with staff feeling that they do not have enough

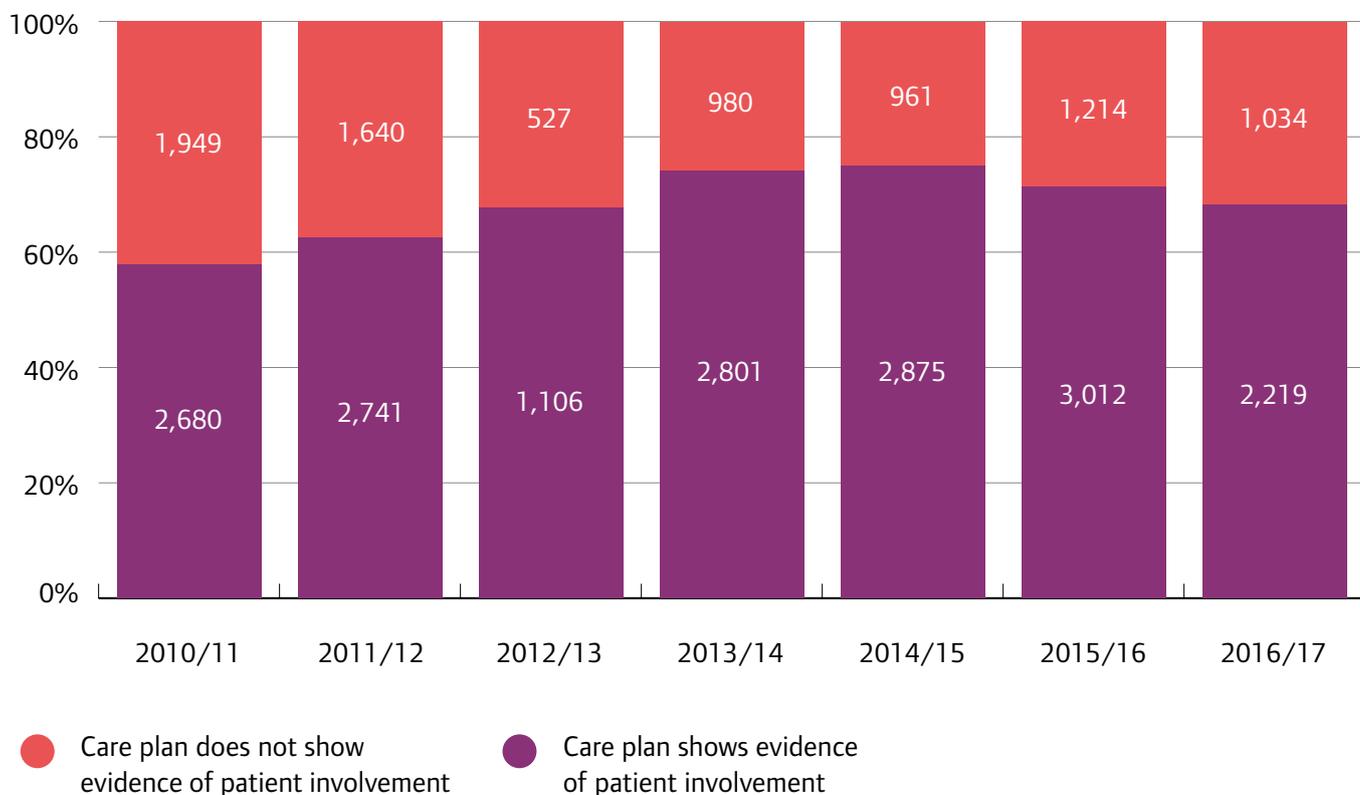
"Our records check will ask 'are the patient's views recorded?' and they are either there or they are not on the care planning tools. There are often issues about quality of recording and whether they are truly the patient's views or the nurse's aspiration for the patient. I always speak to patients first during my visit so then I'm looking to hear their voice as I've heard it in interviews when I examine the records and I will have asked the person in charge what to expect in terms of involvement and how records are captured in that service."

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**Figure 7** Evidence of patient involvement in care planning in examined records 2016/17



**Figure 8** Examined care plans showing evidence of patient involvement, 2010/11 to 2016/17



Source: CQC

one-to-one time with individual patients. It may also be related to the patterns of inpatient care – in particular shorter admissions, during which patients remain relatively unwell. These factors make it difficult for patients’ engagement with the care planning process, but they are not an excuse for the ongoing failure of some services to address the problem. We continue to expect all services to carry out and document measures to support patients’ engagement with the care planning process, including building patients’ capacity to engage, for example by providing advocacy support.

### Discharge planning

The Code and Care Programme Approach expect providers to begin discharge planning as soon as the patient is admitted. Services also need to make sure that patients are clear about plans and goals for their recovery and discharge. Chapter 33.4 of the Code provides a broad definition of aftercare services. This should include health care, social care and employment services, supported accommodation and services to meet the patient’s wider social, cultural and spiritual needs, to the

extent that they meet a need arising from or related to that person’s mental disorder and could help recovery.

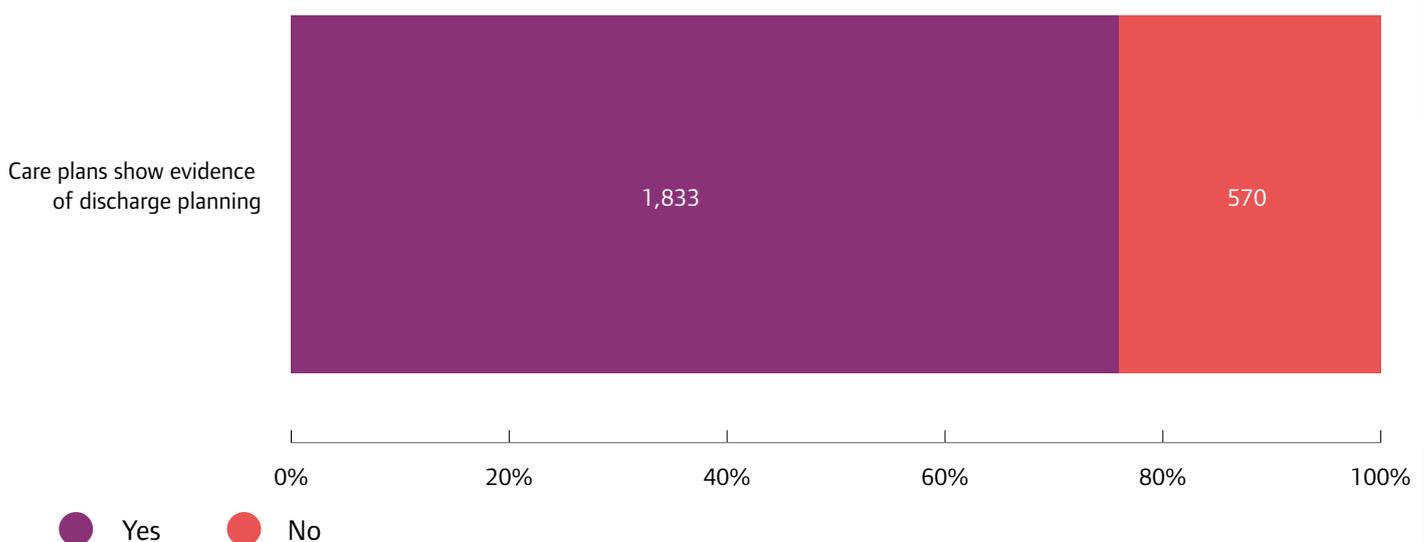
In 2016/17, 76% (1,833) of care plans examined showed evidence of aftercare planning. This is a higher percentage than the previous year (68%), but we continue to expect providers to review aftercare planning regularly from the point of admission, and fully document this in care plans.

### Advance statements and decisions

The Code offers guidance on the practical use of patients’ advance decisions (refusing treatment) and advance statements (expressing wishes for care and treatment more generally) for clinicians and professionals. The use of advance statements and decisions, defined in the Mental Capacity Act, is a tool that strengthens patients’ participation in their treatment and recovery, and helps them to feel more empowered about their future care and treatment.

As the use of advance statements can be a positive way of engaging patients in future planning, the National Institute for Health and Care Excellence

**Figure 9** Examined care plans showing evidence of discharge planning, 2016/17



Source: CQC

(NICE) supports this in quality standards and guidance for mental health services. This includes recognising the use of advance statements in crisis planning, particularly when people have had more than one admission to hospital, and care plans to manage disturbed behaviour.

We reviewed 49 visit issues raised by our MHA reviewers about the use of advance decisions or statements during April to December 2017. We raised concerns that providers were not recording advance decisions and statements in care plans. It was also not always clear whether staff would record a patient's advance statement on an electronic patient information system, or retrieve it from the system. This is a relatively small sample, and we did not routinely ask about advance decisions or statements on all our visits. However, it does show that some providers are not having conversations with patients during their time as an inpatient about making advance statements. Not all providers we reviewed had a formal process in place to support staff or patients to make advanced statements.

These findings warrant further review in 2018. This will form part of our work programme to evaluate the implementation of the MHA Code of Practice (2015). We will also look at the different ways providers are supporting the advance decision and advance statement process. Services responded to the visits we reviewed. This included:

- refresher training for staff on advance statements and advance decisions
- audit of patient records to determine if, over the previous six months, patients had an advance statement on admission, or whether advance statements were discussed with them during the course of their admission, with gaps for current patients addressed through discussion by nursing staff
- discussing advance statements as part of the recovery and discharge planning and included in these plans
- adding prompts to the electronic records to remind staff to discuss this with patients.

## Individualised risk assessments

MHA reviewers check care plans for individualised risk assessments that are updated as a patient's circumstances change. The 2016/17 findings of our MHA reviewers suggest that practice has not improved from the previous year, and may have got worse (figure 10):

- In 2015/16, 10% (409) of records did not include appropriate care plans for identified risks. In 2016/17, we found 15% (502) of records lacked such care plans.
- In 2015/16, we found that 14% (562) of care plans had not been re-evaluated and updated following a change in circumstances. In 2016/17, this was 17% (566) of care plans.

## Mental Health rehabilitation units

In *The state of care in mental health services 2014 to 2017*, we expressed concern at whether locked rehabilitation wards provide the right model of care for our mental health service in the 21st century. We think it possible that a number of patients in locked rehabilitation wards have the capacity to live in a setting of lower dependency and with fewer restrictions – provided there was suitable accommodation and intensive community support available in their local area to meet their needs.

### NICE Guideline - Transition between inpatient mental health settings and community or care home settings

#### Crisis plans 1.2.9

Support people who have had more than one admission to develop a crisis plan as part of their care planning process. This should include:

- relapse indicators and plans
- who to contact in a crisis
- coping strategies preferences for treatment and specific interventions
- advance decisions.

This support should include access to drug and alcohol services if needed. However, this is an area where many local authorities have reduced provision in recent years.

Rehabilitation units provide nearly 5,000 beds in England. Many of these accommodate patients who are a long distance from their home area. We are also concerned that some patients may be staying too long in these units.

We have worked with providers to find out how long patients have been resident on rehabilitation wards, where their home area is, and who commissions their placement. We expect to publish our findings from this work in early 2018.

### Delays in restricted cases handled by Ministry of Justice

Clinicians and patients have told us about delays in obtaining permission for leave or transfer for restricted patients from the Ministry of Justice, given its current staffing shortages in its casework section. We are particularly concerned that these delays could cause patients to remain in hospital or at particular levels of hospital security for longer than is clinically necessary.

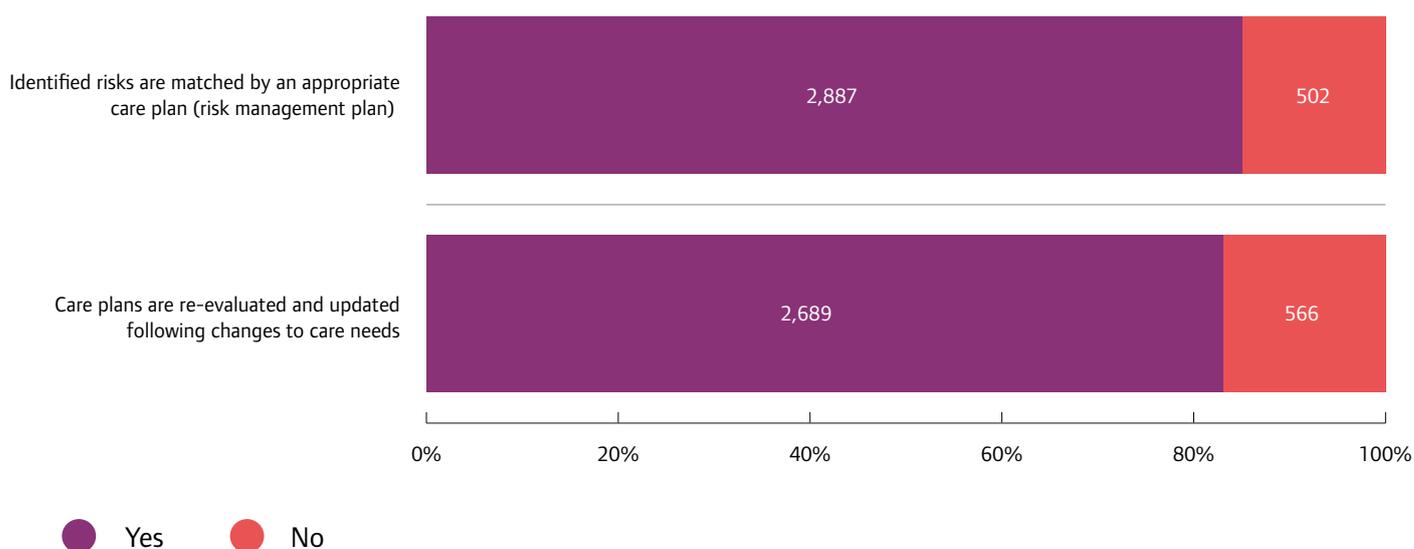
One solution is for the Secretary of State to issue a notice of blanket permission for certain types of leave (for example escorted leave and compassionate leave), to be taken at the discretion of the responsible clinician in any individual case. This would reduce the administrative burden of the system, while retaining a certain level of decision-making with the Secretary of State.

### The First-Tier Tribunal (Mental Health)

The number of patient applications and referrals to the Tribunal Service continues to increase and this is placing the administration of the Tribunal under pressure (figure 11). As a result, the Tribunal has to impose hearing dates on hospitals. This can add to pressures on clinical and social work teams to produce reports, or result in less time for patients to have access to their reports and prepare with their representatives in advance of a hearing.

While we are not responsible for monitoring or regulating the work of the Tribunal, we will engage with representatives from the Tribunal Service throughout the year and seek to identify how our work to offer safeguards and protect patients may impact or support each other. This year the Tribunal

**Figure 10** Evidence of risk assessments in examined records 2016/17



Source: CQC

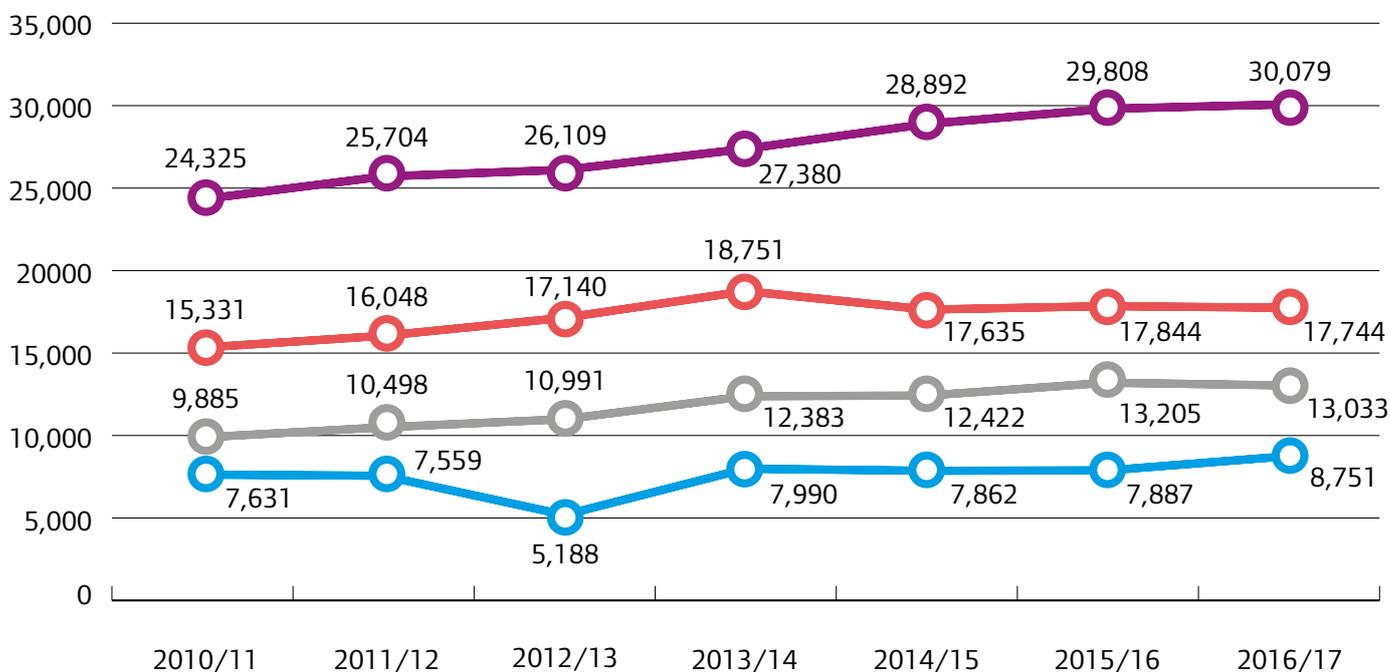
have carried out analysis of its workload from May to August 2017, reporting that 85-90% of applications are direct appeals against the use of the MHA by the patient (or, in what is likely to be a small proportion of these, the patient's Nearest Relative). The remainder are referrals of cases to the Tribunal where neither the patient nor (if there is one) the Nearest Relative have contested the use of the MHA themselves.

Not all applications to the Tribunal result in a hearing. Some are withdrawn by the patient or their representative before the hearing takes place. Other applications do not proceed to hearing because the patient is discharged from the powers of the MHA before it can be held. In many cases, especially for patients detained under the short-term section 2 power, this is to be expected and may show timely and appropriate review to end coercive powers as

soon as possible. However, the Tribunal service have expressed concern at the number of patients discharged by their responsible clinician in the 48 hours before hearings for patients on section 3 and 37 or CTO.

It seems unlikely that patients have suddenly improved enough to warrant such a late discharge before the Tribunal hearing. We look at this because it may indicate wider problems in bed management, discharge planning, or adherence to the principle of least restriction in holding timely case reviews. We will be working with the Tribunal Service and our operational staff to consider how we could follow up individual cases during our routine visits in 2018.

**Figure 11** First-Tier Tribunal (Mental Health) activity, 2010/11 to 2016/17



Source: Tribunal Secretariat, as published in past QOC 'monitoring the MHA' reports

- Total applications against detention
- Total hearings
- Total discharged before hearing
- Total detentions upheld by hearing

**Figure 12** Outcomes of applications against detention to the First-Tier Tribunal (Mental Health), 2016/17

		Section 2	Other unrestricted	Restricted	All detained patients
<b>Applications and hearings</b>	Applications	10,534	16,139	3,406	30,079
	Withdrawn applications	980	3,499	1,169	5,648
	Discharges by clinician prior to hearing	3,509	5,176	66	8,751
	Hearings <sup>g</sup>	6,833	8,353	2,558	17,744
<b>Decision of Tribunal</b>	Absolute discharge	442	354	48	844
	Delayed discharge	193	185	0	378
	Conditional discharge	0	0	374	374
	Deferred conditional discharge	0	0	153	153
	Total discharge by Tribunal	635	539	575	1,749
	No discharge	5,167	6,402	1,464	13,033

Source: Tribunal Secretariat

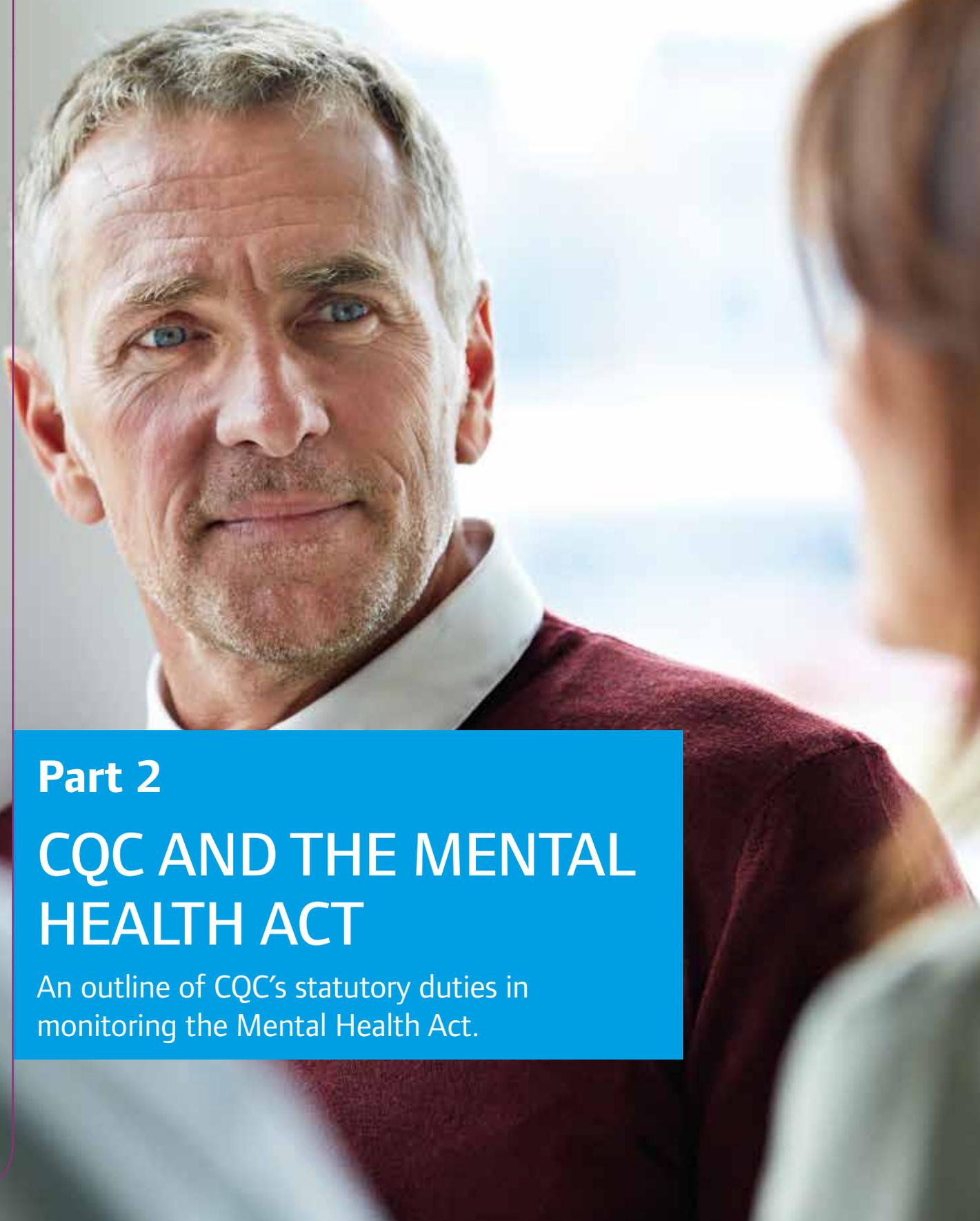
**Figure 13** Outcomes of applications against CTOs to the First-Tier Tribunal (Mental Health), 2016/17

	Number
Applications	4,645
Withdrawn applications	928
Full hearings (with patient present)	4,008
'Paper' hearings (without patient present)	520
Discharges by Tribunal	156
No discharge by Tribunal	3,326

Source: Tribunal Secretariat

Footnote:

g The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.



## Part 2

# CQC AND THE MENTAL HEALTH ACT

An outline of CQC's statutory duties in monitoring the Mental Health Act.

## Key points

In 2016/17:

- We carried out 1,368 visits, met with 4,114 patients and required 6,475 actions from providers.
- Our Second Opinion Appointed Doctor service carried out 14,594 visits to review patient treatment plans, and changed treatment plans in 26% of their visits.
- We received 2,353 complaints and enquiries about the way the MHA was applied to patients.
- We were notified of 186 deaths of detained patients by natural causes, 54 deaths by unnatural causes and 7 yet to be determined verdicts.
- We were notified of 642 absences without leave from secure hospitals.

1,368 

We carried out 1,368 visits

4,114 

We met with 4,114 patients

6,475 

There were 6,475 actions required from providers

14,594 

Our Second Opinion Appointed Doctor service carried out 14,594 visits to review patient treatment plans

26% 

and in 26% of their visits they changed treatment plans

2,353 

We received 2,353 complaints and enquiries about the way the MHA was applied to patients

186

We were notified of 186 deaths of detained patients by natural causes, 54 deaths by unnatural causes and seven yet to be determined verdicts

642

We were notified of 642 absences without leave from secure hospitals

### 2.1 Monitoring visits

We carry out monitoring visits to all mental health services registered to assess and treat people subject to the MHA. Over 95% of monitoring visits are unannounced and focus on the experiences and concerns of the detained patients we meet. We also speak with staff, advocates and any other relevant people, examine records, and look at the environment of the unit.

In 2016/17, our MHA reviewers carried out 1,368 MHA monitoring visits to 1,319 wards and met with 4,114 detained patients. The number of patients detained in hospital at any time can be as high as 20,000. The number of visits and meetings with patients we report this year is lower than previous years. We believe that this is because the interviews, focus groups and visits completed as part of an inspection, instead of a MHA visit, have not been recorded in the same way. To improve this, we have

changed our recording system for 2018 and we expect next year's figures to be higher as a result.

### Impacts and improvements

At the end of visits, we meet with local teams and explain what we saw and heard during the day. This can include general observations about how the provider applies the MHA, examples of good practice, and where we think the provider needs to take action to improve care. After the visit, we set out our findings in a report, and request an action plan to address all the concerns raised by our MHA reviewers.

In 2016/17, we recorded 6,475 separate concerns raised with provider services through this process. Of these, 19% (1,207) were specific to an individual patient's care. From 2016, we have categorised concerns against the chapters and grouping in the MHA Code of Practice. Improvements required by our staff and linked to the Code accounted for 75% (4,840) of the total.

Figure 15 shows the most frequently referenced chapters of the Code (see part 1 for more information).

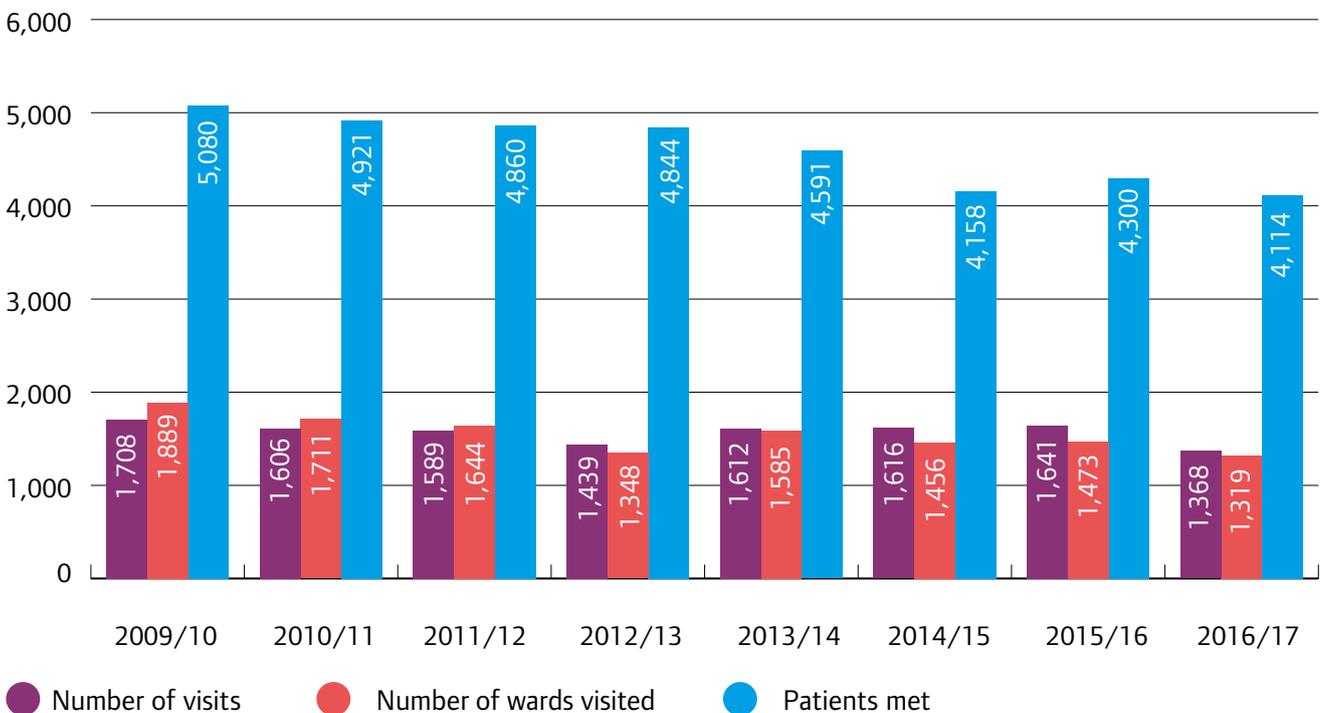
## 2.2 The administration of the Second Opinion Appointed Doctor service

The Second Opinion Appointed Doctor (SOAD) service is an additional safeguard for patients detained under the MHA, providing an independent medical opinion to state whether certain treatments are appropriate.

Providers request for a SOAD visit to approve the following treatments in the absence of consent, except in an emergency:

- medication for mental disorder after three months from first administration when a patient is detained under the MHA
- medication for mental disorder after the

**Figure 14** MHA monitoring visits and patient meetings, 2009/10 to 2016/17



Source: CQC

first month of a patient being subject to a community treatment order (CTO)<sup>h</sup>

- electroconvulsive therapy (ECT), at any point during the patient’s detention.

CQC is responsible for the administration of the SOAD service, but SOADs are independent and reach their own conclusions by using their clinical judgment.

When we receive a request from the provider caring for the patient, we have a duty to appoint a SOAD to visit the hospital, to assess and discuss the proposed treatment with a minimum

of two professionals involved in the patient’s care. SOADs can issue certificates to approve treatment plans in whole, in part, or not at all depending on their assessment of the treatment plan in an individual case.

In 2016/17, SOADs carried out 14,594 visits. This is only slightly less than the 14,601 we

Footnote:

- h Or the expiry of the original three month period applicable from the start of treatment under detention, if the CTO was instigated when this still had more than a month to run (see paragraph 25.31 in the Code).

**Figure 15** Code of Practice issues referenced in visit feedback, 2016/17

Type of issue	Number of CoP issues 16/17	% of total (4,840)
CoP Chapter 4: Information for patients, nearest relatives, carers and others	700	14.5%
CoP Chapter 1: (b) Empowerment and involvement	555	11.5%
CoP Chapter 8: Privacy, dignity and safety	537	11.1%
CoP Chapter 27: Leave of absence	444	9.2%
CoP Chapter 24: Medical treatment	372	7.7%
CoP Chapter 26: Safe and therapeutic responses to behavioural disturbance	350	7.2%
CoP Chapter 25: Treatments subject to special rules and procedures	293	6.1%
CoP Chapter 13: Mental capacity and deprivation of liberty	191	3.9%
CoP Chapter 1: (a) Least restrictive option and maximising independence	158	3.3%
CoP Chapter 14: Applications for detention in hospital	158	3.3%
CoP Chapter 6: Independent mental health advocates	145	3.0%
CoP Chapter 1: (d) Purpose and effectiveness	123	2.5%
CoP Chapter 1: (c) Respect and dignity	105	2.2%
CoP Chapter 35: Receipt and scrutiny of documents	91	1.9%
CoP Chapter 34: Care programme approach	72	1.5%
<i>All other CoP chapters</i>	546	11.3%
<b>Total</b>	<b>4,840</b>	<b>100.0%</b>

Source: CQC

completed in 2015/16. Eighty-three per cent (12,081) were to look at proposed medication treatment plans for patients who were subject to the MHA in hospital. This is a small increase from the 11,991 visits carried out last year and the highest number of medication visits since the SOAD service began in 1985. The number of visits to inpatients to consider ECT (1,637) remained similar to the previous two years (1,627 and 1,631 visits respectively). However, the number of visits (1,128) to consider treatment plans for patients on CTOs continued to decline with 8% fewer visits taking place than last year.

### Outcome of SOAD visits in 2016/17

In 2016/17, 26% of all SOAD visits resulted in changes to the patient's treatment plans (figure 16). This percentage has not changed markedly for a number of years (see figure 17 as an example of the changes made to medication plans over the last eight years). Changes to a

treatment plan range from minor adjustments to dosages or numbers of drugs prescribed, to major changes to the proposed treatment.

The MHA can provide authority to give a patient medication (but not ECT) for mental disorder, even where a detained patient retains capacity to give or refuse consent, and is refusing. SOAD visits appear to be marginally more likely to change treatment proposals where the patient is refusing to give consent. In 2016/17, 32% of visits to consider medication for patients who were refusing consent resulted in a change to the proposed treatment, compared with 27% in the case of patients who were incapable of consenting. This is consistent with previous years' findings.

### Neurosurgery for mental disorder

Before any patient can undergo neurosurgery for mental disorder (NMD), a CQC-appointed panel must approve the treatment. NMD is a surgical operation that destroys brain tissue, or

**Figure 16a** Second opinion appointed doctor visits, 2014/15 to 2016/17

SOAD visits over time		
2014/15	2015/16	2016/17
14,375	14,601	14,594

**Figure 16b** Outcomes of second opinion visits, 2016/17

Outcome	ECT (detained)		Medication (detained)		Community Treatment Orders	
Number of visits	1,637	100%	12,081	100%	1,128	100%
Plan not changed	1,269	78%	8,625	71%	901	80%
Plan changed	348	21%	3,367	28%	215	19%
Missing data	20	1%	89	1%	12	1%

Source: CQC

Note: the numbers of visits in figure 16b amount to more than the total number of visits as a small number related to both ECT and medication.

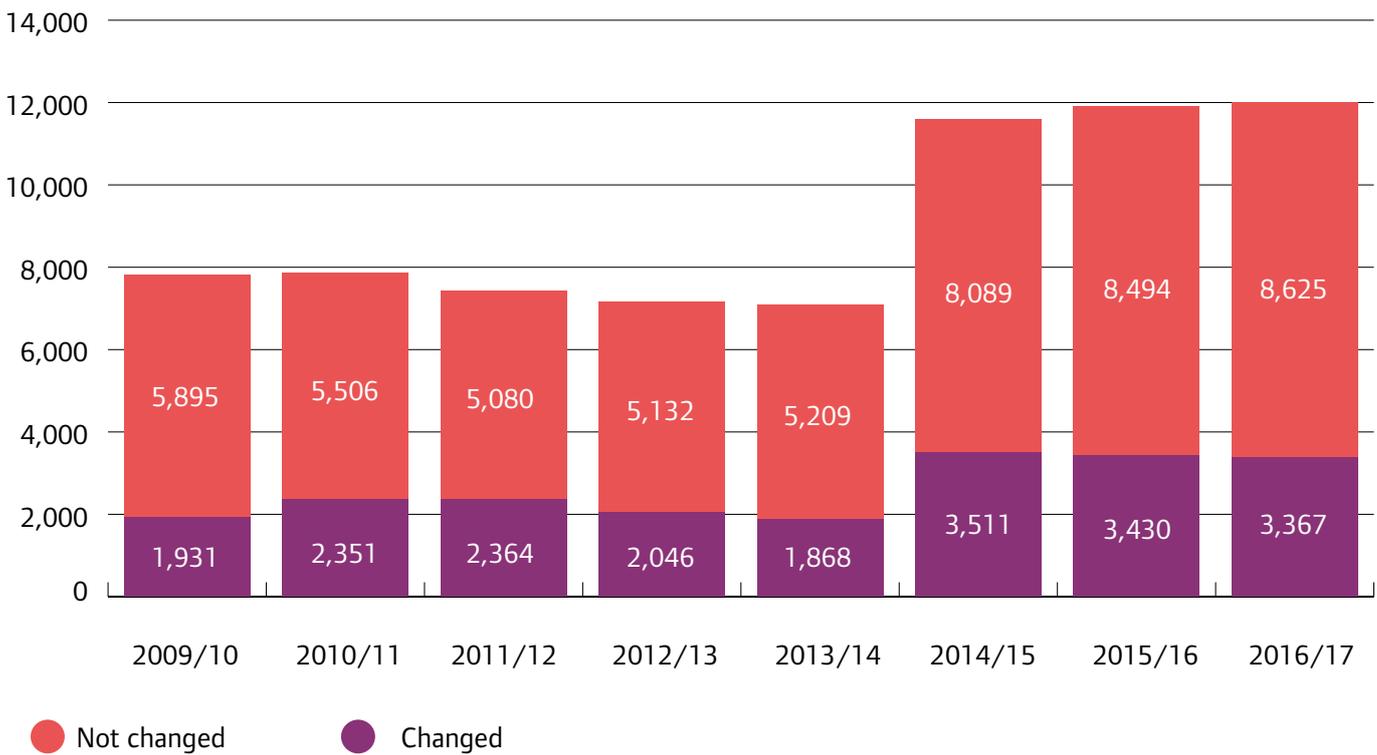
the function of brain tissue, for the treatment of a mental disorder.

In 2016/17, the CQC panel received three requests to consider proposals for NMD. One request was withdrawn, one is still under discussion, and one subcaudate tractotomy

operation was certified and went ahead. The recipient of that operation had previously undergone Deep Brain Stimulation (DBS) procedures, but without benefit.

In previous reports, we have called for DBS to be regulated when used as a treatment for

**Figure 17** Outcomes of second opinion visits for medication, 2009/10 to 2016/17



Source: CQC

**Figure 18** Outcomes of second opinion visits for medication, by patient consent status, 2016/17

Medication		Patient capacity	
		Incapable	Refusing
Outcome	Plan changed	2,769	598
	Plan not changed	7,345	1,280
<b>Total</b>		<b>10,114</b>	<b>1,878</b>

Source: CQC

mental disorder. However, there is still no specific regulation of DBS in England, in contrast to the statutory safeguards for other forms of NMD. This is also in contrast with the situation in Scotland, where the government took clinical advice and consequently brought DBS into the scope of its equivalent statutory safeguard to MHA section 57. This regulatory gap in England will form part of the discussions and evidence gathering with the MHA review. We will work together to seek solutions that recognise the need for safeguards over the use of DBS equivalent to those for other, older types of NMD.

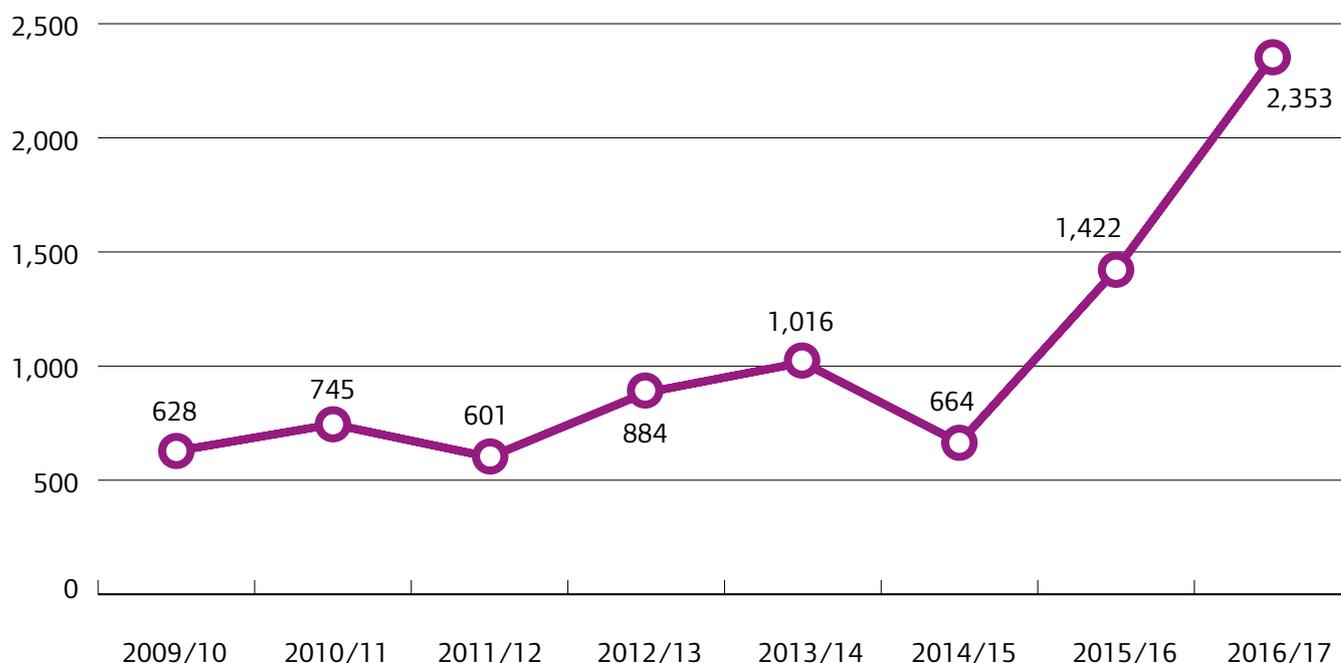
## 2.3 Complaints and enquiries

We review all complaints made to us about the way providers exercise their powers and duties under the MHA, and investigate if appropriate. All providers must inform patients of our complaints role and enable them to contact us as part of the information on patients' rights.

In 2016/17, we received 2,353 complaints and enquiries. This continues the sharp increase noted in last year's report (figure 19). The increase reflects changes in the way we receive and record the contacts from patients over the last two years. In 2016/17, over 81% (1,925 of 2,353) were raised by telephone contact to our call centre. To make sure we are capturing this contact from patients, responsibility for triaging and recording contacts transferred from our operational teams to our contact centre staff and a new recording system in 2016.

Our priority is to make sure that all patients have an opportunity for their voice to be heard. We work with patients to make sure the right people address their concerns locally and in a timely way. In 2016/17, we were able to make sure that for the majority of concerns, there was a resolution that met the person's need, either at the initial triage stage or with additional support from our MHA reviewers. This meant that 16

**Figure 19** Complaints and enquiries received, 2009/10 to 2016/17



Source: CQC

complaints had to be escalated for investigation in the year, and five remain ongoing at the time of this report. In the concluded cases, one was withdrawn by the complainant, one was deemed as outside of our remit, four were not upheld and five were partially upheld.

Where we uphold or partially uphold complaints, we can make recommendations to the provider. Our recommendations included asking services to review processes about the provision of agreed section 17 leave; to review and improve privacy in patient telephone access; to respond to issues with more clarity or to address areas that the hospital complaints process had missed; to review complaints investigations and processes; and to make sure duty of candour is adhered to when responding to complaints.

## 2.4 Withheld mail and telephone monitoring in high security hospitals

Under the MHA, most hospitals have very limited powers to withhold mail from detained patients. However, the three high security hospitals are empowered by the MHA to withhold outgoing or incoming mail if it is likely to cause distress to the intended recipient, or could be considered a danger to any person (see section 134 of the MHA 1983). These hospitals also have powers to monitor telephone calls.

The MHA states that if an item of mail is withheld by any of the high security hospitals, the patient (or the sender of any incoming mail) may appeal to us, and we will review the decision and can require the hospital to release the item (see section 13 (4A) of the MHA 1983). In 2016/17, we dealt with 14 appeals relating to withheld mail; this is an increase from the seven appeals received in 2015/16. Two appeals were resolved before our review (in one case by the hospital releasing the item itself), and in another, we instructed the hospital to release the item concerned. In the remaining 11 cases, we agreed the item should continue to be withheld. We also received one appeal against telephone monitoring which was not upheld following our review.

## 2.5 Notifications of absence without leave

The law requires secure hospitals to notify CQC of the absence without leave of any detained patient, if that absence extends over midnight on the day the patient goes missing. In 2016/17 we were notified of 642 absences. Four hundred and sixty-eight (73%) were from low secure wards, and 174 (27%) from medium secure wards. There were no absences without leave from high security hospitals. Men accounted for 78% of notifications, and 29% of patients recorded were

**Figure 20** Absences without leave – means of absence 2016/17

Type of absence	Number	%
Failed to return from authorised leave	326	51%
Absented him or herself during escorted leave	211	33%
Absented him or herself from hospital	97	15%
Not known	8	1%
<b>Total</b>	<b>642</b>	<b>100%</b>

Source: CQC

**Figure 21** Absences without leave – means of return 2016/17

Return method	Number	%
Returned by police	221	34%
Returned voluntarily	216	34%
Returned by hospital or other staff	88	14%
Not specified	82	13%
Returned by family member(s)	19	3%
Other	16	2%
<b>Total</b>	<b>642</b>	<b>100%</b>

Source: CQC

from BME groups. Although this demographic data on patients who go absent without leave is probably no more than a reflection of the population profile in the hospital, this highlights the overrepresentation of people from BME groups in secure services. We were notified of 598 absences in 2015/16 and 703 in 2014/15.

Just over half of all of these notified absences without leave occurred when patients failed to return on time from authorised leave (figure 20). A third occurred when patients absconded while on escorted leave. Granting patients leave is an important part of a hospital's discharge

planning, and involves a certain amount of positive risk taking.

Over a third of absent patients return to hospital by themselves (figure 21). A third are returned by the police and return with hospital staff accounts for 14% of returns.

## 2.6 Deaths in detention

All providers registered under the Health and Social Care Act 2008 must notify us about the deaths of people who are detained, or liable to be detained under the MHA.<sup>j</sup> In 2016/17, providers

**Figure 22** Cause of death of detained patients, 2012/13 to 2016/17

Type	2012/13	2013/14	2014/15	2015/16	2016/17
Natural causes <sup>i</sup>	200	126	182	201	186
Unnatural causes	48	36	34	46	54
Undetermined	27	36	11	19	7
<b>Total</b>	<b>275</b>	<b>198</b>	<b>227</b>	<b>266</b>	<b>247</b>

Source: CQC

notified us of 247 deaths of detained inpatients (figure 22). Although not required by regulation, we ask providers to inform us when patients die while subject to community treatment orders (CTO). We were notified of 42 deaths of CTO patients in 2016/17. Full details of the notifications we received are in appendix B.

### **Deaths where restraint had been used within seven days of death**

Twelve deaths were recorded within seven days of the use of restraint during 2016/17. Sixteen deaths were recorded in 2015/16. This year's reported deaths included two people age 70 and over and 10 aged 54 and under. Three confirmed causes of death have been returned by the providers; none are reported as being related to the restraint that occurred. Our review of the details given to us by providers at the time of all other deaths of patients has not identified any deaths during or immediately (within 24 hours) following restraint by staff. Our inspection teams complete further reviews once the full details are available from the coroners investigating the deaths.

### **Reporting deaths to the coroner**

It is a legal requirement under the Coroners and Justice Act 2009 for a coroner to investigate any death of a detained patient. This is the only current mechanism to meet the state's duty to ensure independent investigation of the circumstances of a death in its custody. In our 2015/16 report, we noted two deaths reported in that period where the coroner had not been informed, and reminded providers of the necessity to do this in all cases, even where the death appears to be from natural causes. All of the deaths notified to us in 2016/17 (both detained and CTO patients) appear to have been reported to the coroner.

Footnote:

- i We use the term 'natural causes' in the sense that coroners use it on death certificates and associated documents. It is used when a person has died from an illness or an internal malfunction of the body not directly influenced by external forces. This does not assume that the death was unavoidable.
- j Patients 'liable to be detained' include detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. For the purposes of deaths notifications, 'detained patients' include patients subject to holding powers such as s.4, 5, 135, or 136, and patients recalled to hospital from CTO.

# Appendix A: Involving people

## Involving people who have experience of the MHA

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.

### Service User Reference Panel

The Service User Reference Panel gives us helpful information on conducting visits and helps to steer different projects in the right direction. The panel is made up of people who are, or have been, detained under the Mental Health Act 1983 (MHA). Each member is encouraged to share their views on our work and advise us about how we can involve more members of the public.

Some of the members of Service User Reference Panel also attend our MHA monitoring visits and inspections of health and social care services as 'Experts by Experience'. Their main role is to talk to people who use services and tell us what they say. They can also talk to carers and staff, and can observe the care being delivered.

We have found many people find it easier to talk to an Expert by Experience rather than an inspector. This is just one of the benefits of including an Expert by Experience in our visiting and inspection programme, and we include an Expert by Experience on all of our regulatory inspections.

## Mental Health Act External Advisory Group

An external advisory group provided experience and expertise on our Mental Health Act monitoring role. The group meets twice annually, and is in regular email contact between meetings.

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

- Association of Directors of Adult Social Services
- Birmingham Mental Health NHS Trust
- Black Mental Health UK
- British Association and College of Occupational Therapists
- British Institute of Human Rights
- Central and North West London NHS Foundation Trust
- Department of Health
- East London NHS Trust
- Human Rights Implementation Centre, Bristol University
- Mental Health Alliance
- Mental Health Provider Forum
- National Survivor User Network for Mental Health
- NHS Confederation
- NHS Digital
- NHS England
- NHS Providers (Foundation Trust Network)
- Royal College of Nursing
- Royal College of Psychiatrists
- Service User Reference Panel Representative (CQC)

Find the terms of reference for the advisory group at: [www.cqc.org/advisorygroups](http://www.cqc.org/advisorygroups).

## Appendix B: Deaths of detained patients and people subject to community treatment orders

### CQC data from notifications 2011/12 to 2016/17

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. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness also collects data about suicides from national statistics.

In previous reports, we have highlighted that more work is needed to improve the accuracy and detail of the national data on deaths. As a result, please read all the figures on deaths with the awareness that they may change depending on future information or review. This is because we extract the figures

from a live database, at a specific point in time, and the data input will change when we receive further information from providers, our reviews, inquests and other investigations.

We have taken the data used to produce the tables in this appendix from the notification forms that providers return to us. Find the notification form on our website at:  
[www.cqc.org.uk/mentalhealthnotifications](http://www.cqc.org.uk/mentalhealthnotifications).

We also submit data on a quarterly basis to the Independent Advisory Panel on Deaths in Custody. The statistical reports produced by the panel can be accessed on their website:  
<http://iapdeathsincustody.independent.gov.uk/>.

### Detained patients

**Figure 23** Cause of death of detained patients, 2012/13 to 2016/17

Type	2012/13	2013/14	2014/15	2015/16	2016/17
Natural causes	200	126	182	201	186
Unnatural causes	48	36	34	46	54
Undetermined	27	36	11	19	7
<b>Total</b>	<b>275</b>	<b>198</b>	<b>227</b>	<b>266</b>	<b>247</b>

Source: CQC

**Figure 24** Cause of death of detained patients (natural causes), 2012/13 to 2016/17

Cause of death	2012/13	2013/14	2014/15	2015/16	2016/17
Aspiration pneumonia	11	5	13	6	4
Cancer	12	4	13	14	11
Chronic obstructive pulmonary disease	3	4	8	9	6
Heart disease	17	21	24	49	29
Myocardial infarction	11	7	19	14	4
Pneumonia	33	24	35	34	36
Pulmonary embolism	16	13	21	19	26
Respiratory problems	2	5	6	7	1
Unknown	44	9	5	0	29
Other	51	34	38	49	40
<b>Total</b>	<b>200</b>	<b>126</b>	<b>182</b>	<b>201</b>	<b>186</b>

**Figure 25** Age at death of detained patients (natural causes), 2013/14 to 2016/17

Age range	2013/14	2014/15	2015/16	2016/17
20 and under	0	0	0	0
21 to 30	3	3	7	7
31 to 40	6	5	9	10
41 to 50	15	8	14	16
51 to 60	21	19	29	24
61 to 70	29	36	38	27
71 to 80	27	49	46	55
81 to 90	20	52	48	34
91 and over	5	8	8	7
Unknown date of birth	0	2	2	6
<b>Total</b>	<b>126</b>	<b>182</b>	<b>201</b>	<b>186</b>

Source: CQC

**Figure 26** Cause of death of detained patients (unnatural causes), 2012/13 to 2016/17

Cause of Death	2012/13	2013/14	2014/15	2015/16	2016/17
Hanging	14	16	9	6	12
Jumped in front of vehicle/train	6	1	1	3	3
Jumped from building	5	4	3	5	0
Self-poisoning	0	2	5	7	1
Drowning	4	2	4	0	0
Self-strangulation/suffocation	10	4	2	12	8
Method unclear	3	0	0	1	1
Unsure suicide/accident	2	4	5	8	21
Accidental	0	3	3	4	7
Another person	3	0	0	0	0
Iatrogenic	1	0	1	0	1
Fire	0	0	1	0	0
<b>Total</b>	<b>48</b>	<b>36</b>	<b>34</b>	<b>46</b>	<b>54</b>

**Figure 27** Age at death of detained patients (unnatural causes), 2013/14 to 2016/17

Age range	2013/14	2014/15	2015/16	2016/17
20 and under	3	2	1	7
21 to 30	7	9	16	12
31 to 40	11	9	13	17
41 to 50	5	5	11	7
51 to 60	5	6	1	5
61 to 70	0	0	2	3
71 to 80	3	1	1	2
81 to 90	2	0	0	1
91 and over	0	0	0	0
Unknown date of birth	0	2	1	0
<b>Total</b>	<b>36</b>	<b>34</b>	<b>46</b>	<b>54</b>

Source: CQC

**Figure 28** Deaths of detained patients by ethnicity, 2016/17

Ethnicity	Natural causes	Unnatural causes	Undetermined	Total	%
White	122	33	6	161	65%
BME	21	3	1	25	10%
Unknown/other	43	18	0	61	25%
<b>Total</b>	<b>186</b>	<b>54</b>	<b>7</b>	<b>247</b>	<b>100%</b>

Source: CQC

### Patients on community treatment orders to CQC

While not included in regulations, we ask providers to tell us about the deaths of patients subject to community treatment orders. This means the data may not be a complete picture of all deaths that occur for patients subject to a community treatment order.

**Figure 29** Cause of death of CTO patients, 2012/13 to 2016/17

Type	2012/13	2013/14	2014/15	2015/16	2016/17
Natural causes	26	21	29	27	29
Unnatural causes	9	7	15	11	12
Undetermined	10	6	2	2	1
<b>Total</b>	<b>45</b>	<b>34</b>	<b>46</b>	<b>40</b>	<b>42</b>

Source: CQC

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## How to contact us

Call us on > 03000 616161

Email us at > [enquiries@cqcc.org.uk](mailto:enquiries@cqcc.org.uk)

Look at our website > [www.cqc.org.uk](http://www.cqc.org.uk)

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