

Monitoring the use of the Mental Health Act in 2009/10

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

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One of the most serious acts that the state can ever undertake is the deprivation or restriction of an individual's liberty on account of their mental disorder. How the state arranges for such acts to be kept under review is equally important, as is how such review activity is accounted for both to Parliament and the public more generally. In as far as the *Mental Health Act 1983* is concerned, principal responsibility for undertaking this function passed on April 1st 2009 from the Mental Health Act Commission (MHAC) to the Care Quality Commission (CQC) which published its first annual report about its monitoring of the Mental Health Act in October 2010.

This document is therefore the direct successor of thirteen Mental Health Act Commission biennial reports. The first looked a bit like a statutory instrument printed on what might be described as old fashioned HMSO paper using two colours only. It was comparatively brief, subtly written and sophisticated in its conclusions. The thirteenth biennial report was magisterial in its length, content and recommendations, professional in its presentation and generally regarded as not only being extremely helpful but also striking a suitable valedictory note for the MHAC. In between, biennial reports grew in size, topics covered, number of references to other publications in the text and the sophistication with which a national picture was painted, against which the activities and findings of the MHAC were set.

The statutory audience for both Commissions' reports remains the same, but beyond that and looking back over the 27 years since the MHAC was established, the audience has always been a bit of a moving target. At the outset practitioners and those with a particular interest in the operation of the Mental Health Act have been the primary target; after all they are the people who have to be influenced to put right concerns identified by the Commission. Early biennial reports were not good at extracting from the text recommendations and grouping them together in a way that made it easier for service providers,

practitioners and commissioners to act upon them. As the years went by, the scope of the reports expanded to include extensive summaries of relevant legal developments, discussion of potential relevant legal and policy development as well as the concerns identified by the everyday visiting activities of Commissioners. There is little doubt that future academics researching the compulsory mental health system in England and Wales in the last seventeen years of the 20th century and the first nine of the 21st will make much resort to the MHAC's biennial reports, especially the latter ones.

This is therefore part of the context into which arrives the CQC's first Mental Health Act annual report. Inevitably it will be used as evidence as to whether the transfer of visiting and monitoring responsibilities for the Act to the CQC (not universally welcomed) has led to the enhancement or diminution of the undertaking of this role. It is of course only part of the evidence and it is for the reader to come to their own conclusion.

The report is divided into two parts, *Detention under the Mental Health Act* and *Key areas of special focus*. Each part is subdivided into three subsections. Unlike its predecessors there is less discussion of legal developments relevant to the remit and there is very little if anything about Part 3 of the Act – Patients concerned in criminal proceedings or under sentence.

Inevitably there are also matters that if you closed your eyes and willed yourself back 15 years would read substantially the same. The discussion about police use of the Mental Health Act, notwithstanding that fewer people appear to be taken to police stations as a place of safety and that at a local level there is clearly a more sophisticated understanding of what is going on, raises issues that were current concerns more than a decade ago. Really basic requirements such as the standardization of section 136 records are still to be realized. The police are key players in responding to, amongst other things, psychiatric emergencies in public places and it is dispiriting that we do not know more about how this role is undertaken. Similarly the discussion about detained patients and consent and the finding that “in a large number of visits, we find that patients have been certified as consenting when they were in fact refusing or lacked the capacity to give it” identifies an issue that was the subject of comment 20 years ago.

Appropriately the report commences with an analysis of the trends in the use of Mental Health Act detention. The overall picture is presented clearly, especially diagrammatically and records a steady year on year increase in admissions under the Act as well as an increasing proportion of in-patient beds occupied by detained patients. The nature of those receiving care as in-patients is changing: not only are many more detained, the patient mix is shifting towards those with psychotic disorders and dual diagnosis substance misuse; and an increasing number of so called Part 3 patients have been admitted. The first chapter then goes onto a detailed analysis of the admission of children and adolescents to adult wards (CQC demonstrating how it monitors one of the brand new provisions of the Act), the extensive and very welcome discussion about police use of the Act referred to above, and it culminates with an examination of various aspects of assessments for detention under the Act. Other than the fact that the general regulatory regime for all healthcare facilities has developed dramatically over the last 20 years, the discussion under the latter heading of the use of the Act in acute hospitals could have been written at any time during that period. This section concludes with five succinct recommendations to a range of providers, CAMHS commissioners and the police.

The second subsection of Part 1 focuses on the experience of detained patients and in particular how services make the trade off between the needs of security and the provision of a relatively normal “homely” environment. The issues that arise from Commissioners' observations in this regard lie at the heart of the reality of detention and again, because human nature does not change, it is perhaps

unsurprising that none will come as a surprise. It is disturbing that in an in-patient service increasingly focused on caring for psychotically ill detained patients, the majority of wards visited in 2009/10 “were either over-occupied or running at full capacity”. Acquiring accurate occupancy level information as an outsider can at times be difficult – there can be a range of motives for sometimes pulling the wool over various external eyes as this author discovered back in the 1990s. Having said that, the Commissioners’ sophistication at analyzing such data is now no doubt considerably greater and their concern is a worry, as is their finding that “Over the last five years, there has been no significant change in the proportion of trained staff to untrained staff, or agency staff to permanent staff when we visit”.

Running alongside these observations is a reported perception amongst Commissioners and patients (especially those who experienced hospital many years ago) of an increasing emphasis on rules, especially about security including outside the secure sector. Reported are an increasing number of locked acute admission wards (caring also for informal patients), very different approaches to security evident in the low secure sector and the increasingly observed impact of a more blanket approach to security and safety on the delivery of privacy and dignity tailored to the needs of individuals. This age old conflict is perhaps exemplified by the concluding discussion about the impact of the restrictions on smoking in hospitals in force since July 2008.

Part 1 of the report concludes with observations about detained patient involvement and aspects of the protection of their rights. How service providers cope with implementing the guiding principles behind the Act and in particular those that can be seen at times to compete – for example aiming to restore autonomy through “recovery” whilst at the same time maintaining the safety of the patient and others – lies at the very heart of the experience of both patients and those who care for them. It is the reason why it was essential that the operation of the Act was monitored under the new regime by continuing to visit detained patients. Delivering choice and participation and meaningful involvement within a legal framework that is potentially very coercive is demanding but essential: in the end some kind of reasonably acceptable ‘deal’ between the patient and their care team is the quickest road to effective and successful care and treatment. The report can only provide the sum of some individual snapshots including observations on the implementation of the Care Program Approach and the involvement of independent mental health advocates as well as families and carers. The picture is inevitably mixed but some services clearly know how to do it. This section concludes with observations about the Mental Health Tribunal.

In its early days the MHAC forbore from commenting on tribunals but this policy changed in the early 1990s. In what is proportionately (in relation to the document as a whole) a relatively lengthy but welcome and robust discussion of the tribunal and its activity, a number of what might be termed on-going important challenges are identified: delays, the desirability of improving the range of administrative data to be collected not least in relation to ensuring compliance with the Equality Act 2010, the continuing problem of inadequate social circumstances reports and the possible impact of Legal Aid changes on the way some legal representatives contribute to tribunal hearings as well as the overall quality of some representatives. It is good to read that CQC have established a joint project with the Administrative Justice and Tribunals Council to examine patients’ experience of Mental Health Tribunals.

The second part of the report turns to three key areas of special focus: the use of control, restraint and seclusion; consent to treatment; and community treatment orders. Of these three the latter is of particular novelty and importance, reporting as it does on the first full financial year that community treatment orders (CTOs) were in force, having been introduced in November 2008.

The touchstone for the report's observations about control, restraint and seclusion remains the Code of Practice and meeting all aspects of its guidance obviously remains a challenge. Enabling patients to write their own account of an incident of their disturbed behavior (that led to restraint) to be filed in their own notes; providing personal or quiet space for patients and ensuring that they have access to activities and are able to go outside; the use of various forms of mechanical restraint especially in non-acute mental health settings and learning disability services; and aspects of the use of seclusion and long term seclusion are all perhaps unsurprisingly identified as issues worthy of further attention and development. Recommendations include a national notification or data collection process for the use of mechanical restraints; a review of restraints and seclusion recording practices to include a record of any de-escalating steps taken; and the desirability of reviewing the access of patients in seclusion to basic provisions to meet their needs and ensure their dignity. To paraphrase the old saying "the price of good practice is eternal vigilance" – nowhere do Mental Health Act Commissioners continue to contribute more to that vigilance than when observing these areas of practice on their visits.

The penultimate subsection of the report concerns detained patients and consent to treatment. Part 4 and 4A of the Act are central protections: the former was amended in important ways in 2007 and the latter is a new regime accompanying the introduction of community treatment orders and is dealt with in the concluding subsection of the report along with other aspects of CTOs. The key conclusion from Commissioners' observations is that the assessment of capacity and consent and the recording of related discussions is an area in which services need to improve significantly. As noted above, this has been identified in numerous previous biennial reports. What is perhaps new and a reflection of the "teeth" possessed by the CQC and the absence of which was much lamented by many commissioners throughout the life of the MHAC, is what CQC has done about this. Using the registration regime for providers operated by the Commission, they have placed conditions on the registration of three NHS specialist mental health providers requiring them to improve their performance in this area. Observation of the initial consequences of such conditions, are positive. The report's analysis of the work of the SOAD service provides amongst other things an interesting commentary on the changing nature of those subject to detention including a steady increase in the proportion of detained patients deemed incapable of consent. Is this the consequence of greater severity of illness amongst detained patients or that clinicians are more alert to, and better at, assessing incapacity? The substantially increased use of urgent treatment powers both in relation to medication and ECT are noted, not all of which can be explained by the extreme difficulties (and embarrassment) experienced by the CQC in administering the SOAD service and consequential on the far higher than anticipated number of community treatment orders.

The concluding subsection of the report provides a particularly valuable insight into something that is really new: the community treatment order. This is the aspect of the report that attracted external attention and coverage, and not surprisingly, given that throughout almost the entire life of the MHAC the debate lasted as to whether compulsory powers in relation to mental disorder should be changed so as to reflect better that the care and treatment of even those with severe and enduring mental illness was no longer necessarily solely hospital-centered. Obtaining a reliable and external view about this important and still controversial provision is actually operating, is important. It is still early days but over and above the fact that the number of orders made is way above the predictions of the Department of Health before introduction, the following important observations are made:

- Good beginnings have been made in building a profile of those subject to CTOs. A disproportionate number are black and minority ethnic patients; most had a diagnosis of schizophrenia and other psychotic disorders; almost all were prescribed some form of psychotropic

medication; and 35% were prescribed medication above BNF recommended limits. In addition preliminary research indicates that possibly 30% in the sample under review had no reported history of non-compliance or disengagement with services after discharge.

- A range of what might be termed administrative and interpretation difficulties have been identified, including some misunderstanding about the role of the SOAD in CTO cases, difficulties with implementing the recall powers, some examples of lack of communication between hospital and community teams and some challenges experienced in the undertaking of the role of the Approved Mental Health Act Professional as a safeguard in the use of the CTO.
- Patient involvement is one of the keys to successful CTO interventions.

The central role that Mental Health Act Commissioners and SOADs must play in ensuring the proper implementation of these powers is a critical challenge for the CQC.

In the overview of the CQC's findings that accompanied the report three priority areas for improvement are identified: involving detained patients in their care and treatment; practice relating to patients capacity and consent; and unnecessary restrictions and blanket security measures. This document concludes with the re-assertion that the failure to address any systemic problems may result in conditions being imposed on a provider's registration.

At a number of levels it is unfair to contrast and compare this report with its predecessors. For one thing it is an annual report which may well explain the fact that it deals with far fewer topics than some of its biennial predecessors. In addition the responsibilities of the CQC do not extend to Wales. What is absolutely clear is that as the health service (and in particular commissioning arrangements) undergo the most radical restructuring in its history, alongside the implementation over the next four years of the most substantial savings program ever attempted, the interests of those detained under the Act, their families and carers and society at large must not be overlooked. The monitoring of the Act by the CQC is going to be central to ensuring that outcome and the importance of its annual reports can only grow in the coming years.

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