



Monitoring the Mental Health Act in 2018/19







Care Quality Commission

Monitoring the Mental Health Act in 2018/19

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of the Mental Health Act 1983.





OGI

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Foreword	5
Summary	6
Introduction	9
Part 1: Human rights and the use of the MHA	11
Overseeing the implementation of the MHA at board level, including human rights and equalities issues	13
Understanding why Black and minority ethnic groups are disproportionately detained under the MHA	13
Information for patients	14
Independent Mental Health Advocacy	16
Involving patients in care planning	18
Promoting the principle of least restriction	23
Delays in admission and/or assessment	25
Use of police powers	26
Community treatment orders	31
The interface between the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards	32
First Tier Tribunal (Mental Health)	33
The Second Opinion Appointed Doctor service	35
Part 2: CQC activity in monitoring the MHA	38
Mental Health Act visits	39
Notifications of child admissions to adult wards	41
Notifications of absence without leave	41
Notifications of deaths of patients subject to the MHA	42
Appendix A: Deaths of detained patients detained under the MHA or subject to a community treatment order	44
Appendix B: Involving people	50
References	52



A personal experience of being detained

I once had two friends who, like me, were detained under the Mental Health Act. My friend, Leanne, bereaved and severely depressed, and Clive, a lorry driver who by the time he was discharged had lost not only his job but his home as well. They both told me that they could never, would never go back into hospital. Back in the community, they did their best to manage, but in the end they lost their lives. I also remember two ladies I shared a ward with, they were stuck in the secure system – gentle, vulnerable people who happened to suffer periods of psychosis, and whose wishes were overruled for decisions as trivial as which shower gel or biscuits they could buy. They rarely complained and often spent days at a time never leaving the sterile air-conditioned ward, seven locked doors away from the world outside.

I guess it's easy to have preconceptions about people who have been sectioned – it's the stuff of whispered conversations and horrified fascination, that even a growing acceptance of mental illness can't wash away. But the reality is of course much more mundane, more messy and human than any comic-book characterisation can ever be.

During my years of acute illness, I met so many people, like me, just trying to survive. I spent the best part of six and a half years away from my partner and two young children, on various wards – acute, rehab and secure rehab – and the care I received ranged from the excellent to the abusive. I was detained under an array of sections, by the police, while restrained on the floor in A&E, and many times in hospital. I've been shipped out of area by ambulance, sedated and mute with fear, and transported more than once locked in the back of a police van, handcuffed, my legs held together with Velcro tape.

When asked why I do the work I do, I always say that I want people detained in hospital, people like those I met who were my friends, to be given a voice, to be valued and respected and supported to build or rebuild fulfilling lives. The 1959 Mental Health Act was intended to restrict the reasons for which people could be detained. It was revolutionary but hidden within its heart was an assumption that patients lacked capacity to make almost any decision. Previous amendments have failed to address this fundamental wrong and so we continue to live within a culture that fails to respect us, where we can be treated as though we are ill because of a lack of will or effort, or through some strange lifestyle choice. We may receive good care from dedicated staff, but too often we really struggle to endure the bad.

Autonomy is not about prioritising the will of patients over safety, it's a recognition that those most likely to come to harm in the current system are the patients themselves and that it's better for everyone if consensus can be found and decisions shared. There are often real solvable reasons why people are judged as 'failing to engage'; why they stop taking their medication; why they are 'difficult'. Why they end up being detained often over and over again.

Kate King MBE

Adviser on Lived Experience, FMHC; Working Group member of Mental Health Act Review 2018 (see page 50)



Foreword

The human rights of people detained under the Mental Health Act 1983 (MHA) are of critical concern to us as we review what we have found through our monitoring of the MHA in the last year. Taking away a person's liberty so that they can be treated in hospital has a major impact on that person's life, work and family and it is therefore essential that this is carried out in a manner that respects their fundamental rights. The reality is that this is frequently not the case.

The impact of being detained is particularly acute when people have to go far from home to receive the treatment they need. When a person is admitted to hospital under the MHA, this should be to a location as close as possible to their normal place of residence, their families and other support systems. Unfortunately, patients continue to be hospitalised out-of-area, sometimes over a hundred miles from home, usually because there are no beds in the local hospital. Worryingly, this is frequently being accepted without challenge.

People from Black and minority ethnic (BME) groups experience a higher use of the MHA. There have been many attempts to explain this and the reasons why this is happening are not completely understood. A person from a BME group who has been subject to the powers of the MHA is likely to experience this as a discriminatory act. There is little evidence that this situation is improving or that there is a system-wide commitment to effect change.

Our most vulnerable patients need the greatest protection. The reality is that this is not always how the system responds. In the last year, some horrific human rights abuses have been revealed for people with a learning disability and autistic people. These patients have found themselves in care settings far from home, hidden from view and experiencing few of the protections they should receive as detained patients, breaching the MHA Code of Practice principles of respect and dignity.

We have commissioned two separate reviews of our regulation of Whorlton Hall, which will include recommendations for how regulation of similar

services can be improved. We will use the outcomes of these reviews to further develop our approach to MHA monitoring visits. An innovative approach to how we communicate with non-verbal patients to understand their experience and concerns is required, and we will be considering how we improve our approach to this in the upcoming year.

There is little point in monitoring the MHA if there is no action taken to highlight concerning issues and to drive improvements. We continue to integrate the regulatory work we undertake as CQC and the work of our MHA monitoring functions, allowing us to take enforcement action where we find concerns. We intend to focus more clearly on the human rights aspects of the working of the MHA during MHA monitoring visits, particularly in services where there is a risk of a closed culture developing. Information gained from our MHA monitoring visits is always used to inform our regulatory hospital inspections and to hold the system to account.

A white paper detailing future reform of the MHA is due to be released this year. This is a real opportunity for a more human rights-based approach to the use of the MHA. We are working with our partners to inform the development of the new MHA, to ensure that future legislation and practice supports people to have a real say in their care, that they are treated equitably, and that their rights are protected.

Kevin Cleary

Deputy Chief Inspector of Hospitals and
lead for mental health

Summary

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a serious mental disorder and who need protection for their own health or safety, or for the safety of other people. The MHA also provides more limited community-based powers, called community treatment orders (CTOs) and guardianship. These interventions engage with and potentially infringe fundamental human rights, and as a result human rights need to be the focus of all parts of the system in which they operate.

An independent review of the MHA, led by Sir Simon Wessely, took place throughout 2017 and a final report was published in December 2018 setting out 154 recommendations for government on how the MHA and associated practice needs to change.¹ The independent review concluded:

“There is a clear case for change: the rate of detention is rising; the patient’s voice is lost within processes that are out-of-date and can be uncaring; there is unacceptable overrepresentation of people from Black and minority ethnic groups amongst people detained; and people with learning disabilities and/or autism are at a particular disadvantage. We are also concerned that we are out-of-step with our human rights obligations.”

We will be using the findings from our activities to influence future reform of the MHA and improvements in practice. We welcome proposals for reform to increase patient safeguards and autonomy, and to strengthen how organisations work together to improve people’s experience.

Over the last year, we have seen a continued improvement in the number of people being given information about their rights, and being offered the support of an Independent Mental Health Advocate (IMHA). However, we remain concerned that people detained under the MHA are still not receiving

the care and treatment they require, in a way that respects their human rights.

Through our MHA monitoring visits in 2018/19 we found:

1. The use of human rights principles and frameworks must be applied and their impact on people continuously reviewed and updated to improve people’s experience and make sure they are protected and respected.

Throughout this report, we have considered how agreed human rights principles – Fairness, Respect, Equality, Dignity and Autonomy (FREDA) – are applied to people affected by the MHA.² These principles are considered to underpin all international human rights treaties, incorporating articles used in the Human Rights Act 1998. Our analysis of findings from our MHA monitoring activity in 2018/19 suggest that these principles are not always being applied to the care and treatment of detained patients. More needs to be done to understand and address issues of inequality, both for people in Black and minority ethnic (BME) groups, and people in other equality groups. Oversight of the MHA at board level must include how human rights and equality issues for all patients will be monitored and addressed, as well as ensuring that care and treatment is given in the least restrictive way, through the implementation of a reducing restrictive interventions programme.

2. People must be supported to give their views and offer their expertise when decisions are being made in their care and treatment. Providers must take this seriously and look for evidence that this is being done across their service.

Following an MHA monitoring visit, we most often reference the empowerment and involvement principle when we ask a provider to take action to improve. In 2018/19 we recommended that patient

involvement still needed to improve in 26% of care plans that we reviewed. In 11% of care plans we reviewed, there was no evidence of patient involvement at all. How providers encourage people to make decisions in advance also needs to improve. However, we have found over the last three years that people in nearly all the wards we visited (99%) have the opportunity to access to Independent Mental Health Advocacy (IMHA) services.

While it is positive to see that there has been improvement in access to IMHAs, we would welcome consideration of more formal roles for, and expectations of, IMHA services in any future revisions to the MHA.

3. People who are in long-term segregation can experience more restrictions than necessary and delays in receiving independent reviews. This is particularly true for people with a learning disability and autistic people.

Through our thematic review of restraint, seclusion and segregation as well as our MHA monitoring activities, we have found that too many people with a learning disability and autistic people are in hospital because of a lack of local, intensive community services. A better system of care is needed for people with a learning disability and autistic people who are, or are at risk of, being hospitalised, segregated and placed in overly restrictive environments. All patients who are segregated from their peers must be safeguarded through regular and independent reviews of their situation. This is one of the key safeguards in the Code of Practice that allows the principle of least restriction to be applied more robustly.

4. People are not always receiving the care and treatment they need, with services struggling to offer appropriate options, both in the community and in hospital.

We are seeing issues with the availability of care overall. There has been a 14% fall in the number of mental health beds from 2014/15 to 2018/19. While this is in line with the national policy

commitment to support people in the community, reductions in community care services means that people are not always getting the help they need to avoid crisis situations and hospital admissions, leading to detention under the MHA. Between June 2018 and March 2019, coroners made us aware of at least seven deaths of people who were assessed as requiring admission, but for whom no mental health bed was available.³

5. It is difficult for patients, families/ carers and professionals to navigate the complexity of the interface between the MHA, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

In England, we have a complex legal framework, which continues to change and evolve through case law. People are unlikely to be clear on what safeguards and rights they have under each of these frameworks, especially if they are being used concurrently or if patients are being deprived of their liberty by one legal framework and then another within a short time-frame. Professionals have to work within these complex legal frameworks and have the additional challenge of needing to keep up-to-date with case law that redefines legislation.

As a matter of urgency in current reforms to law, the codes of practice for the MHA, the Mental Capacity Act and Deprivation of Liberty Safeguards must be updated and provide clear guidance on these complex interface issues. How this guidance can be updated quickly to reflect evolving case law needs to be considered.

Many of the issues raised in this report are system-wide issues that will need to be addressed through national reform. To make sure that people can get the right care and to reduce the need for detention, the provision and consistency of community services needs to improve and people should also be able to access an inpatient bed when it is needed. The quality of care that detained patients receive also depends heavily on the staff working in services.

Over the last five years, the total number of mental health nurses has continued to fall, with 2% fewer mental health nurses in April 2019 than in April 2014. For detained patients to be empowered and involved in decisions about their care and treatment in therapeutic environments that are least restrictive, the national workforce challenges in mental health services need to be resolved. We welcome commitments made in the NHS Long Term Plan to address these issues as well as the findings from the independent review of the MHA, which have demonstrated the urgency for these issues to be addressed.⁴ However, there are actions that providers can take forward locally to improve experiences and outcomes for detained patients.

These include making sure that there are effective working relationships with partner organisations in local areas to support people to access the right care when they need it, and overseeing how the MHA is working at a local level. This includes what

impact the MHA is having on people's human rights and people in equality groups. Providers have the primary responsibility for making sure that people receiving care are free from abuse and that they have their human rights upheld. Leaders are responsible for creating a culture that consistently respects human rights, and this culture must be consistent from leadership through to frontline practice. For detained patients, building this culture in services is particularly important as they are deprived of their liberty against their will in a setting that is unlikely to be of their choice.

Finally, we recognise that, as the regulator, we need to support any improvements and make sure that we are continually reviewing and improving our regulatory and monitoring approach. In particular, the independent review recommended that we improve how we assess the social and physical environments of wards, and strengthen how we assess whether a provider is meeting the needs of people in different equalities groups. It also recommended that we consider how we might extend our MHA monitoring role to look at how the MHA and Code of Practice is working in local areas. Taking such a system-wide approach would enable us to identify issues in patient pathways, as well as improve how we monitor the effectiveness of joint working between organisations.

In 2018/19

- We carried out 1,190 visits, met with 4,436 detained patients, spoke with 179 carers, and required 4,477 actions from providers.
- Our Second Opinion Appointed Doctor service carried out 14,354 visits to review patient treatment plans. This changed treatment plans in: 22% of visits to detained patients to consider electroconvulsive therapy (ECT) treatment; 31% of visits to consider medication for detained patients; and 18% of visits to consider medication treatment for patients on community treatment orders (CTO).
- We received 2,276 enquiries about the way the Mental Health Act was applied to patients and investigated complaints from six people.
- We were notified of 195 deaths of detained patients, of which 136 were known to be of natural causes, and 16 deaths of patients on CTO, of which nine were known to be of natural causes. A total of 39 deaths were known to be of unnatural causes for both detained patients and CTO patients.
- We were notified of 923 absences without leave from secure hospitals.

Introduction

This report sets out the Care Quality Commission's (CQC) activity and findings from our engagement with people subject to the MHA and our 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 that 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

The Mental Health Act 1983 (MHA) is the legal framework that provides authority 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 (CTOs) 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 human rights when they are being

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 MHA Code of Practice 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 people are detained in hospital or are subject to community treatment orders or guardianship. We carry out, mainly unannounced, visits to meet people who are currently detained in hospital under the MHA in private and ask them about their experience. We will 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, to review or investigate MHA complaints, and to make proposals for changes to the MHA Code of Practice.

The UK is a signatory of the international human rights treaty Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). As a result, we have a duty to provide a National Preventive Mechanism (NPM) system of independent, regular visits to all places of detention to monitor the treatment of and conditions for people deprived of their liberty. We are one of the 21 statutory bodies that form the UK's NPM.⁵ Our MHA monitoring visits seek to prevent inhuman or degrading treatment through highlighting and seeking action when we find practices that could be in breach of human rights standards.



Our data

To prepare this report, we analyse data from our work with patients and local services throughout the year, including our MHA activities and our inspections of mental health services. We also analyse statutory notifications data submitted by providers, including data on the deaths of patients detained under the MHA, children who have been placed in out-of-area placements, and patients who are absent without leave. Finally, we analyse information from other national agencies including NHS Digital, NHS England and the Tribunal Service.





Part 1: Human rights and the use of the MHA



Part 1: Human rights and the use of the MHA

When a person is detained in hospital under the Mental Health Act 1983 (MHA), whether this is necessary for their health or to protect themselves or others from harm, it is a serious interference with some of their basic human rights. It is essential that services make sure that people receiving treatment feel safe, that they are treated with dignity and that their human rights are respected.

While the FREDA principles are useful in making human rights understandable, providers need to use the tighter framework of the articles in the European Convention on Human Rights (ECHR). For example, providers need to check that any proposed restrictions on a patient that might interfere with rights to a private life covered under Article 8 are lawful, are for a legitimate aim and are the least restrictive way of meeting that aim. Other key articles in the ECHR that are at risk of being infringed for people detained under the MHA are the right to life (Article 2), the right to freedom from torture and inhuman or degrading treatment (Article 3) and the right to liberty and security (Article 5).

The final report of the independent review of the MHA made a clear case for change, highlighting that current processes are out of step with the modern mental health care system and made several recommendations for reform.⁶ In particular, the report recognised that a person-centred approach and involving people better in decisions about their care are key to developing legal and practical support for a human rights-based system.

The Committee on the Rights of Persons with Disabilities (CRPD) has raised concerns about the compulsory treatment and detention of people with disabilities. While we have seen some improvement in services complying with their human rights duties, more improvement is needed. In May 2019, BBC Panorama exposed the culture of abuse and human

rights breaches of people with a learning disability at Whorlton Hall. It reinforced how important it is for everyone involved in the care of people with a learning disability and autistic people to identify closed cultures, where abuse and human rights breaches may be taking place.

Providers have the primary responsibility for making sure that people with a learning disability and autistic people receiving care are free from abuse and that they have their human rights upheld. As the regulator we monitor, inspect and regulate these services to ensure this is happening. In services where abuse and breaches of rights are deliberately concealed by managers or groups of staff there are additional challenges in identifying these.

We have acknowledged that we need to change the way we assess mental health and learning disability wards so that we can better understand their safety and quality, and the experiences of people who use them. We have started a programme of work to strengthen our approach and to make better use of the information that people share with us. This includes consulting with people who use services and their families, as well as strengthening our guidance for providers and inspectors. In addition, we have commissioned Professor Glynis Murphy to carry out an independent review into how our regulation of services like Whorlton Hall can be improved.

We recognise that services face challenges in providing care for people detained under the MHA. Issues with the availability and quality of community care, challenges with people being placed far from home, as well as the decline in the number of inpatient mental health nurses and other clinical staff, can all have an impact on people's experience of care. In part 1 of this report, we report on the key findings from our MHA visits, focusing on the implications for and impact on people's human rights.

Overseeing the implementation of the MHA at board level, including human rights and equality issues

When the MHA Code of Practice was revised in 2015, one key aim was to make sure that it adequately addressed and protected human rights and equality issues. Embedding the new guiding principles, explained in chapter 1 of the Code, was intended to help achieve this. The introduction of the guiding principle of respect and dignity, and the addition of chapter 3 of the Code about human rights and equalities, were intended to strengthen the equalities and human rights approach.

Chapter 3 aims to make sure that all commissioners and providers understand what is required of them in relation to Equality Act 2010 and human rights legislation, including the need for public bodies, including providers, to comply with the public sector equality duty.^a

Paragraph 3.15 of the Code outlines the specific duty on commissioners and providers to have a human rights and equalities policy in place. This policy needs to set out how relevant legislation will be complied with, how use of the MHA will be monitored to understand how people in equality groups are affected, and what training will be provided to staff on human rights and equalities.

At CQC, we carry out trust-wide well-led inspections. This includes a focus on how providers are

overseeing the implementation of the MHA and how human rights and equality issues are addressed at board level. The Code expects that providers will put in place appropriate governance arrangements to do this and suggests that organisations should establish a MHA steering group to effectively do this.⁷ In our June 2019 report *Mental Health Act Code of Practice 2015: An evaluation of how the Code is being used*, we included a good practice example from the South London and Maudsley NHS Foundation Trust that had agreed a new approach to the oversight and monitoring of the MHA. The trust board approved a new Mental Health Law Committee terms of reference with the aim of making sure that high-quality and least restrictive care was delivered, that had a focus on promoting equalities and human rights.⁸

Providers must make sure that they are overseeing how the MHA is working at a local level, including any impacts on human rights and equality issues, to improve people's experience. Providers should consider how they will review the culture of wards to make sure that environments are therapeutic and that patients are treated with dignity and respect, as well as seeking out and acting on feedback from all patients, including people in equality groups, to improve the experience of detained patients locally.

Understanding why Black and minority ethnic groups are disproportionately detained under the MHA

From 2016/17 the Mental Health Services Dataset (MHSDS) became the official source of national statistics on the use of the MHA. The use of the MHA continues to rise with 49,988 new detentions under the MHA being recorded for 2018/19.^b The overrepresentation of some Black and minority ethnic (BME) groups who are detained under the MHA continues to be a particular cause for concern.

National data from the 2018/19 MHSDS shows that:

- Known rates of detention for Black or Black British people in 2018/19 (306.8 detentions per 100,000 population) were over four times higher than for White British people (72.9 per 100,000 population).

^a The public sector equality duty is a duty on public authorities to consider or think about how their policies or decisions affect people who are protected under the Equality Act.

^b Overall national trends will be higher as not all providers submitted data, and some submitted incomplete data. Trend comparisons are also affected by changes in data quality. For the subset of providers that submitted good quality detentions data in each of the last three years, NHS Digital estimates there was an increase in detentions of 2% from last year.

- Known rates of use of community treatment orders (CTOs) have continued to be higher in 2018/19 for Black or Black British people group, with 53.8 uses per 100,000 population compared with 6.4 uses per 100,000 population for White British people.⁹

The inequality in the use of the MHA for people from BME groups is complex and not well understood. As evidence used by the independent review of the MHA acknowledges, only “well-designed longitudinal studies and multisectoral, intersectional approaches will be able to untangle the causes of health care inequality in BME groups and inform practice”.¹⁰

The All-Party Parliamentary Group on Social Work has called for a national data set to be established alongside the MHSDS that would collate the number of MHA assessments (not just admissions) with outcomes, and with the age and ethnicity of people assessed.¹¹ This would provide a vital tool to begin to understand and address issues of inequality and the rising use of coercion.

Previous reports have looked at the relationship between mental health services and people from BME groups. Possible causes of inequality include structural or institutional racism, in both health services and wider society. For example, it may be that people from BME groups face stereotyping or prejudice in assessments or, at a basic level, that mental health services are not accessible, welcoming or responsive to people from BME groups. *Breaking the Circles of Fear*, which looked at the relationship between mental health services and African and Caribbean communities, made a

number of recommendations that could help to address these issues if implemented effectively.¹² The independent review of the MHA also made some recommendations for improving how people from BME groups access care and their experiences of being detained. This includes, for example, the development of a patient and carer experience tool, and the provision of culturally appropriate advocacy. The Equality and Human Rights Commission have recently called for the public sector equality duty (PSED) to be strengthened and for public bodies to take firm action to address challenges in achieving equality. Guidance on the PSED is included in Chapter 3 of the Code and providers should make sure that, in their oversight of how the MHA is working locally, they are considering how the MHA is affecting people from BME and other equality groups. We focus on whether providers are doing this through our well-led inspections.

In June 2019, we published CQC’s Equality Objectives for 2019 to 2021.¹³ These complement our longer term strategy for looking at equality and human rights in our regulation of services. Equality objective 4 aims to promote equal access of care and equity of outcomes in local areas, and we will be encouraging local areas to consider the needs of people in different equality groups through our work at a local area level. For example, we would expect providers, in partnership with commissioners and other system partners, to look at how they can improve access and outcomes for people from BME groups using mental health services, with a focus on providing care that reduces the likelihood of being detained under the MHA.

Information for patients

This is the most common issue raised by MHA reviewers during monitoring visits. The MHA Code of Practice is clear that people should be given information about their rights, verbally and in writing, as soon as possible after their admission or detention starts, or they are placed on a community treatment order (CTO). This helps people 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, for example by requesting to be discharged

from hospital, either through hospital managers or through an appeal to the First Tier Tribunal. The person’s nearest relatives should also be given this information. Giving people information about their detention, how it affects them and how they can appeal supports them to be more autonomous, which is a key human rights principle. Making sure that people know how to challenge their detention under the MHA also supports the human rights principle of fairness.

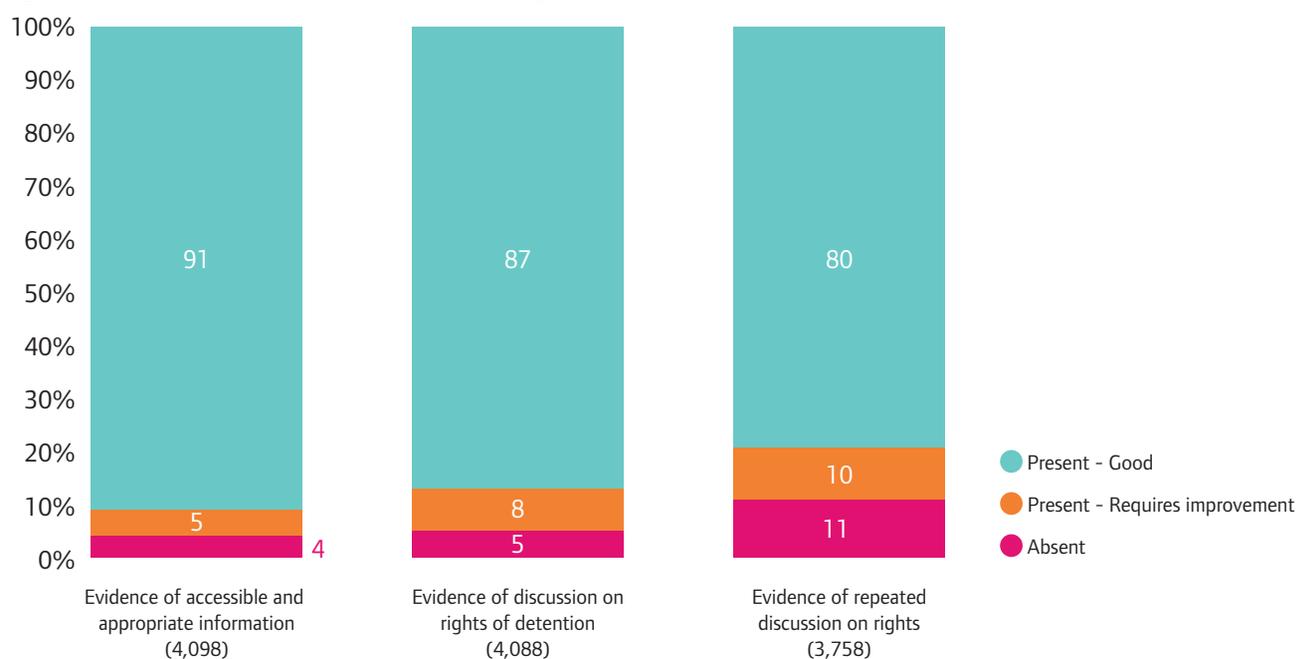
The Code of Practice also provides guidance on the need to inform patients about their rights at particular points during their detention following admission. It highlights that professionals should be aware that a patient who is unwell is likely to require this information when their condition has improved, and that providers need to make sure that information is provided in an appropriate and accessible format.

Over the last four years, we have seen a continued improvement in the number of people being

given information about their rights, as evidenced in patient records. In 2018/19, we found good evidence of accessible and appropriate information in 91% of all records, initial discussions about rights in 87% of all records and repeated discussions about rights in 80% of all records (figure 1).

However, we are concerned that there are still people who do not understand their legal rights as they are not having meaningful discussions or being given this information in a format they can understand (figure 1).

Figure 1: **Examined records showing evidence of provision of information, 2018/19**



Source: CQC

Information for patients: personal experience of an informal patient

I very rarely get admitted to hospital as an informal patient because when I am unwell, to the point of professionals wanting to admit me to hospital, I am no longer able to consent. However, on this occasion, I was admitted informally late at night. The following morning, I said to the nurse that I was going to have breakfast with a friend. The nurse said I couldn't, despite me explaining that I was an informal patient.

I persisted in saying that I was going off the ward for breakfast and the nurse said that if I asked again he would put me on a section 5(4) (power of nurses to prevent informal patients leaving hospital). When I asked again, he then did. I thought this was unfair, if they were always going to prevent me leaving they should have told me when I was admitted.

Catherine El-Houdaigui (see page 50)

Information for informal patients includes their right to leave the ward and arrangements for moving around the hospital and its grounds. This information needs to be provided in a format and language the patient understands, to avoid people mistakenly believing that they are not allowed to leave hospital, which could result in them being unlawfully deprived of their liberty and their human rights being breached.

In 2018/19, almost all (94%) of the wards we visited were locked on the days of our visits, including wards where patients may be admitted on an informal basis. In 7% of visits (86 wards), we raised concerns about whether informal patients were free to leave the ward at will.

Staff may be concerned about how safe it is to allow informal patients to move freely around the hospital grounds or to leave the hospital. As a result, they may be reluctant to fully explain their rights to them or feel like they must take a risk averse approach and use the section 5 holding powers under the MHA to stop the person leaving when they request to do so.

To avoid unlawful detention, when a person is admitted as an informal patient, there should be an agreement between the provider and the person about positive and managed risk taking, so that they understand that while they do have the right to leave, the provider also has a duty to make sure they come to no harm. This means that a risk assessment will be carried out if the person does try to leave the ward.

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).¹⁵ Access to an IMHA can enable patients to be more autonomous and support them to make choices about their care and treatment, which is a key human rights principle.

Over the last three years, we have found that patients in nearly all wards visited (99%) have had access to an IMHA service. While this shows access to IMHAs, there is no nationally available evidence to show the effectiveness of IMHA services. The independent review of the MHA recommended that

a full consultation should take place to consider the standardisation, accountability and regulation of advocates that would enable national reporting on impact and outcomes for patients using IMHA services. We are also concerned that the levels of engagement and visibility of IMHA services varies, and that some mental health professionals do not fully understand or appreciate the role of IMHAs, which may distort the way in which they explain the role to patients.

People who lack capacity to make decisions when they are admitted to hospital could be helped to be more autonomous with the support of an IMHA. In 2015, the revised MHA Code of Practice

Giving people a voice: the importance of IMHAs

Often my clients don't understand their rights under the Mental Health Act until they have seen an Independent Mental Health Advocate (IMHA). They can't get their voice heard as they aren't go into ward rounds alone, because they feel intimidated at the thought of walking into a room full of doctors, nurses, and often a variety of other faces they don't recognise. They need help when their property is lost. They need toiletries because they weren't given chance to

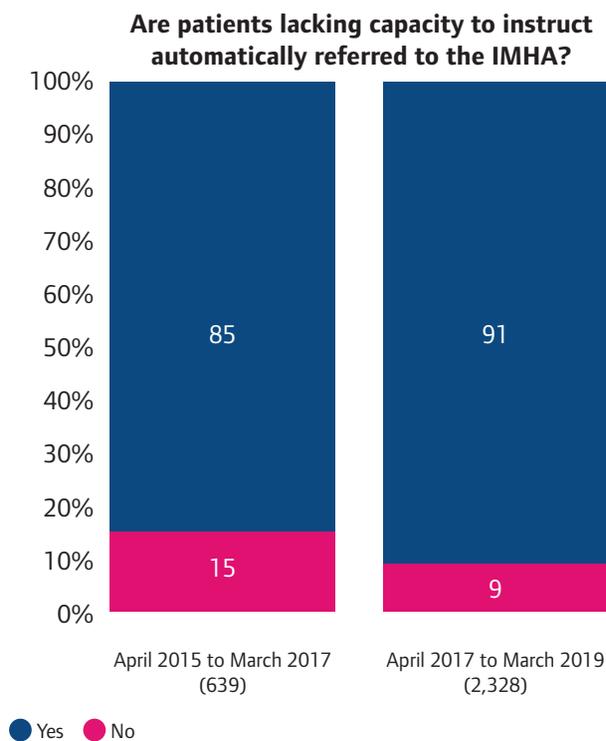
pack before they were hauled into hospital, and don't know what to do. They want to leave, but don't know who to ask. They want to complain about the way in which a member of staff has spoken to them. All of these things make a real difference to a person's experience of inpatient settings.

The importance of 'I' in IMHA.
Peter Edwards Law Blog, 21 October 2019¹⁴

recommended that hospital managers should routinely refer patients who lack capacity to do so themselves to IMHA services. Since its introduction, there has been a six-percentage point rise in the number of wards automatically referring patients who lack capacity to instruct to an IMHA. Over the last two years, 91% of wards visited have automatically referred patients to an IMHA (figure 2).

IMHAs play a crucial role in giving patients a voice and making sure that their human rights are being upheld. While it is positive to see that there has been some improvement in access to IMHAs, we would welcome consideration of more formal roles for, and expectations of, IMHA services in any future revisions to the MHA.

Figure 2: Wards that automatically refer patients lacking capacity to instruct to the IMHA, 2015 to 2017 and 2017 to 2019



Source: CQC

Putting people first: role of the IMHA

“I have been asked on numerous occasions what my view is in relation to someone’s treatment, or asked to attend professionals’ meetings without the service user present. I am always staggered at the lack of understanding by some professionals as to my role as an independent advocate and their surprise that I do not hold a clinical view on their required treatment.

I was asked by a social worker/care coordinator to contribute towards a social circumstances

report for a client’s forthcoming Tribunal hearing. The social worker was genuinely surprised when I politely declined and explained that providing information to strengthen an argument in favour of my client’s ongoing detention was definitely not part of my role as an IMHA.”

View of an IMHA taken from *The importance of ‘I’ in IMHA.*

Peter Edwards Law Blog, 21 October 2019¹⁶

Involving patients in care planning

Listening to me and involving me in decisions about my care

I often do not see the point of care plans. There is certainly no point to a care plan unless staff say what they are going to do and then do it. Most of the time I am presented with a care plan that has been cut and pasted from some very old care plans. Staff often give me a completed care plan, ask me to add my comments and then sign it. When I am not involved in drawing up my care plans they do not help me get better.

Fortunately, I have some better experiences of how nurses develop my care plans with me. Some nurses will give me a blank care plan document and ask me to write what I can in

it, they then arrange a time to sit down with me and complete the plan. Other nurses will sit down with me and say let's do this together. Care plans, when they are written like this have more detail about me, include my wishes and views, are more understanding of me, and have more information about how to help me recover.

When a mental health professional takes the time to really understand me, it makes me feel amazing because so few people understand me. It is important that people understand what I am thinking and feeling.

Catherine El-Houdaigui (see page 50)

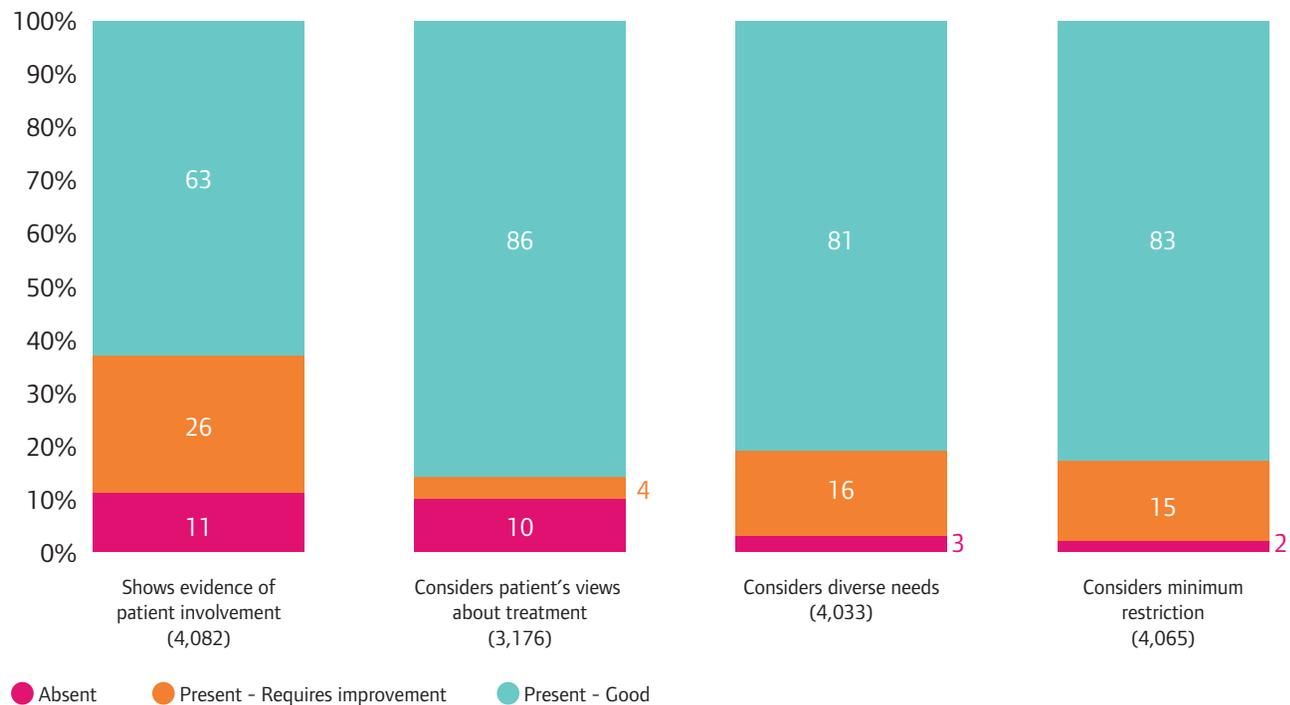
Although the MHA provides authority for people to be detained and treated without consent in some circumstances, the principles that should underpin its use require a person-centred approach to care planning, that is consistent with the legislative and international conventions set out in Chapter 3 of the Code of Practice on equality and human rights. The MHA Code of Practice is clear that patients should be fully involved in decisions about their care, support and treatment under the guiding principle of empowerment and involvement. Involving patients in their care planning enables them to be more autonomous and make decisions about their care and recovery journey.

Findings from our visits suggest that since 2015 the number of services meeting the basic expectations of the Code have improved, although this is still not good enough. In 2018/19, we recommended that patient involvement was absent or needed to improve in 37% of care plans that we reviewed. Nineteen per cent of care plans showed insufficient or no evidence that a person's diverse needs were considered, and 17% showed insufficient or no evidence that the service had considered the

minimum restriction on a patient's liberty (figure 3). In 11% of care plans we reviewed, we found no evidence of patient involvement at all.

MHA reviewers also look at patient records for evidence of that carers have been involved appropriately. In 2018/19, 12% (369 out of 3,177 records) showed no such evidence, 20% (633) showed some evidence but required improvement, and 68% (2,175) showed good evidence of carer involvement.

Figure 3: Examined care plans showing evidence of patient involvement, views, diverse needs and minimum restriction, 2018/19



Source: CQC

Advance statements and care planning

Advance statements and decision-making strengthen people's participation in their treatment and recovery, and help them to feel more empowered about what may happen to them should they lack mental capacity to make decisions about their care and treatment in the future. The recommendations made by the independent review of the MHA assume a much greater future role for advance decisions and advance statements.

We encourage services to reflect people's broader wishes and preferences as to their current and future position in their care plans. In our ongoing thematic

review of restraint, seclusion and segregation, we have noted that the care plans of patients from learning disability units who had been held in long-term segregation did not include future-orientated thinking that would help to prevent or manage a crisis situation in a more personalised way.

On our MHA reviewer visits we check that services have the mechanisms in place to store and check for advance decision documentation. While 68% (1,192 out of 1,761) of records checked in 2018/19 showed services had good mechanisms in place, we are concerned that 22% of records checked (389 out of 1,761) showed that there were no such mechanisms in place.

Examples of good practice of advance decisions

In response to our visit reports, the **Langford Clinic, Bexhill** have introduced a *wishes expressed in advance* statement for each person and review this regularly during care programme approach/discharge meetings. The statement is written by each person with help from staff. This helps to make sure that staff seek the person's views, wishes and feelings regarding their care and treatment. With the patient's permission, any such wishes and feelings recorded were also copied to the nearest relative or carer.

At **Livewell Southwest**, there is a dedicated responsible clinician from the Cotehele Unit for

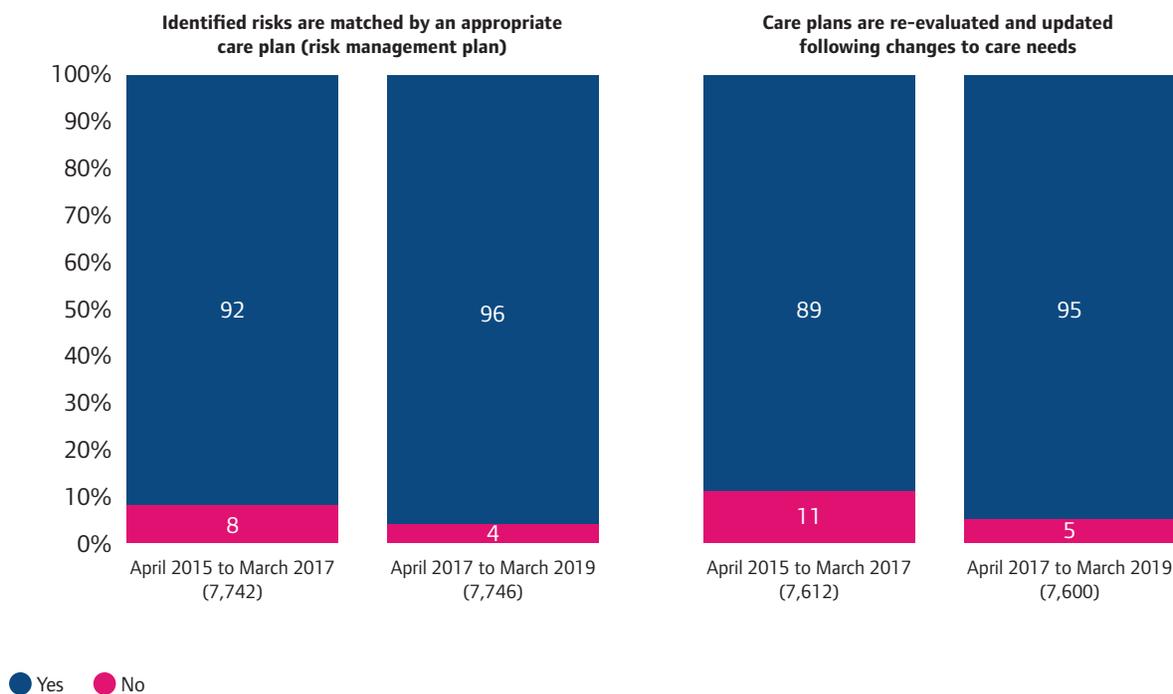
older patients with functional mental illness. Advanced decisions were checked on admission and people were invited to express wishes in advance about their care and treatment. We saw that one detained patient had an advanced statement that included refusing certain treatments for mental illness. We spoke with the person who confirmed that staff were accommodating to their wishes. We saw that the responsible clinician had spent a lot of time with them to discuss how to safely accommodate his advanced statement of wishes, that staff were aware of them, and that they were reflected in his care plan.

Risk assessment and care planning

MHA reviewers check care plans for individualised risk assessments that are updated as a person's circumstances change. Appropriately personalised risk assessments, undertaken jointly with patients where possible, should help to avoid the use of

unnecessary blanket rules and allow for positive risk management. While we have found evidence that services have continued to improve how they identify and manage risk, there is some evidence that a small number of services remain risk averse (figure 4). This also came through in the independent review of the MHA.

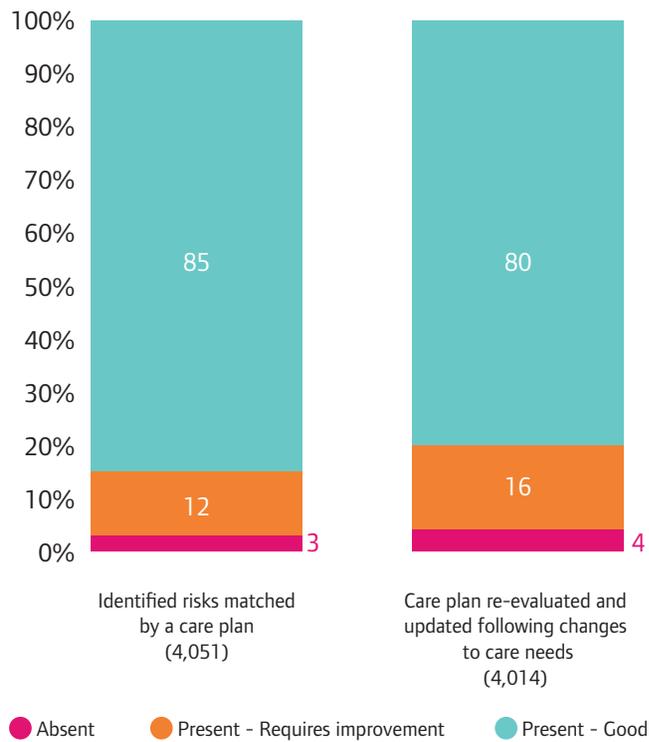
Figure 4: Evidence of risk assessments and care plan re-evaluation following changes to care needs, in examined records 2015 to 2017 and 2017 to 2019



Source: CQC

In 2018/19, 15% of reviewed care plans showed insufficient or no evidence of being based on identified individual risk assessments. Twenty per cent showed insufficient or no evidence of some re-evaluation after a person’s care needs had changed (figure 5).

Figure 5: Evidence of risks managed by a live care plan, in examined records, 2018/19



Source: CQC

Example of a risk assessment screening tool

On a visit to an acute admission ward for men, staff were told to complete a written risk screening assessment tool before any detained patient went off the ward on leave, or any informal patient went off the ward. It had about 20 questions, including some whose appropriateness we questioned relating to

self-reported ‘good’ behaviour. People told us that it was delaying them going out as they had to sit with a staff member to complete the checklist, even if they had done so the day before. Following our visit use of the checklist was discontinued.

The care of detained patients' physical health

Providers must give equal priority to physical health conditions as they do to mental health under the guiding principle of efficiency and equity.¹⁷ Providers also have a duty to promote good physical health for detained patients. Details of how any physical conditions are managed should be planned for and recorded in the person's care plan. This is especially important as people with long-term mental health conditions are more likely than others to have physical health problems, for example due to the side-effects of medicines.¹⁸

Through our visits, we have found that most detained patients receive a physical health check on admission. In 2017/18, 98% (2,579 of 2,644) records checked showed evidence of this. However, we are concerned that some people are not getting access to a GP while detained. Although there has been a slight improvement in services arranging GP appointments, 5% (61 out of 1,192) wards visited in 2018/19 had difficulties in arranging GP appointments for detained patients.

Discharge planning

The MHA Code of Practice provides a broad definition of aftercare services following discharge from detention. This should include health care, social care and employment services, and supported accommodation. It also incorporates services that meet the patient's wider social, cultural and spiritual needs, including any needs arising from, or related to, that person's mental disorder that could help recovery. Discharge planning should begin as soon as a person is admitted to hospital, so that they are clear about their care plans and goals for recovery and discharge.

In terms of the quality of discharge plans, in the last two years MHA reviewers have found that roughly a quarter of all the records show some evidence that discharge planning requires improvement. Of the 3,198 records noted by MHA reviewers to show some evidence of discharge planning on their visits in 2018/19, 2,456 were judged by the reviewer to be good or adequate, with the remaining 742 present but requiring improvement (figure 6).

Figure 6: **Examined care plans showing evidence of discharge planning, 2017/18 and 2018/19**



To make sure the human rights principles of fairness and equality are promoted, we would expect to see less variation in the quality of discharge planning. We continue to expect providers to review aftercare planning regularly from the point of admission, and fully document this in care plans.

Visit to a child and adolescent mental health service eating disorder ward, 2019

People on an eating disorder ward complained to us that they were only allowed to use their mobile phones in their bedrooms, where Wi-Fi reception was very poor. We asked a number of staff why this restriction was in place and everyone said that it was because of the risk of confidential images of patients and staff being posted online.

We pointed out that people on another child and adolescent mental health ward in the hospital were not asked to restrict phone use to bedrooms. Instead, they were asked to sign a mobile phone contract undertaking to use their phones according to unit rules.

People and their families also believed that visits could not take place in a person's room. In addition, some parts of the ward were locked without any clinical rationale, including the art room and outdoor area.

In response to our visit, the ward managers revised the mobile phone policy to allow phones to be used throughout the ward, except during mealtimes and clinical interventions. They also reassured us that visits would be allowed in people's rooms, and that parts of the ward would be unlocked to allow freer access. These changes were to be reflected in a revised ward pack for patients' information.

Promoting the principle of least restriction

Chapter 8 of the Code of Practice emphasises that services should avoid the use of blanket restrictions, which it defines as rules that restrict patients' liberty or other rights, and that are routinely applied to all patients without individual risk assessment (paragraph 8.5). A restrictive intervention may breach a person's rights under Article 8 of the European Convention on Human Rights if it has a sufficiently adverse effect on the patient's right to private life.

A key focus of our MHA reviewer visits is to challenge the use of blanket rules and restrictions. Restrictions on people being able to use their mobile phones, or having restricted access to the internet, are commonplace on our visits (figure 7).

Figure 7: **Access to internet and mobile phones on wards visited 2018/19**

2018/19	No	%	Yes	%
Patients able to access internet	261	23%	891	77%
Patients able to access mobile phones	181	16%	971	84%

Source: CQC (excludes visits to high secure hospital wards)

All services are expected to have a programme in place to reduce the use of restrictive practices, and to be able to demonstrate a year-on-year reduction in restrictive practices. As well as blanket restrictions, this should include the use of restraint, seclusion and rapid tranquilisation. In our briefing on restrictive

intervention reduction programmes in inpatient mental health services, published in December 2017, we included good practice examples from five trusts that showed that a positive and therapeutic culture across the whole organisation can reduce the need for restrictive interventions.¹⁹

Long-term segregation

Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, the patient is not allowed to mix freely with other patients on the ward or unit on a long-term basis.²⁰

In December 2018, we were commissioned by the Secretary of State for Health and Social Care to review the use of restraint, prolonged seclusion and segregation for people with mental health problems and/or a learning disability, and autistic people. Our interim report, published in May 2019, found that:

- Many people we visited had been communicating their distress and needs in a way that people may find challenging since childhood, and services were unable to meet their needs.
- A high proportion of people in segregation were autistic.
- Some of the wards did not have a built environment that was suitable for autistic people.
- Many staff lacked the necessary training and skills to care for their client group.
- Several people we visited were not receiving high-quality care and treatment.
- In the case of 26 of the 39 people, staff had stopped attempting to reintegrate them back onto the main ward. This was usually because of concerns about violence and aggression.
- Some people were experiencing delayed discharge from hospital, and so prolonged time in segregation, due to there being no suitable package of care available in a non-hospital setting.

Our interim report emphasised how important it is to consider the human rights of people in segregation. We highlighted that staff in services must only impose such restrictions on people after careful thought as to whether they are for a legitimate aim and are the least restrictive option available. Once in place, staff must review them regularly to check whether they are still necessary and that they remain a proportionate response to the risk.²¹

Before and during the thematic review, MHA reviewers raised concerns with providers about a number of patients who were being kept in situations that clearly met the description of long-term segregation but were not being recognised as such. Some patients who are isolated from their peers were not recognised as being in long-term segregation because they were being isolated for their own safety, rather than them being a risk to the safety of others. We encourage services to make sure that all patients who are separated from their peers, in any circumstances, should have appropriately expert-led assessments and reviews, using external advice as required.

We have also seen other cases where patients (who are often autistic) are segregated because that is what they 'prefer'. In these situations, we encourage services who care for patients who self-isolate to assess whether these patients are being helped to build skills or tolerance for being around people, or are potentially reinforcing what could be a negative path of behaviour.

Delays in admission and/or assessment

Visit to an acute ward for adults, 2019

One person told us that during her current admission she had been asked to move bedrooms five times. She found this unsettling, depressing and distressing. She was currently sleeping on a different ward to the one she had been admitted to, in a bedroom off the male corridor. She told us that she felt uncomfortable but not unsafe. She told us that during this time her observations were increased from hourly to every 15 minutes.

She also told us that she had been previously been out on extended section 17 leave and that although she needed to come back into hospital, there was no bed available and she was discharged from detention and had to return home. A few days later she was again detained under the MHA. She felt that if a bed had been available initially, her mental health would not have deteriorated to the point where she needed to be detained.

In our report on how the MHA Code of Practice is being used, we raised concerns about how local areas were discharging their responsibilities under Section 140 of the MHA. This places a duty on commissioners to notify local authorities in their areas of arrangements for admitting people in need of urgent care. Despite the revised guidance in chapter 14 of the MHA Code of Practice, commissioners are still not doing enough to make sure they are meeting their statutory responsibilities under this section.²² Our report recommended that:

“Local areas, including commissioners, local authorities, police and providers, should work together better to make sure that people receive the right care across organisations, including making sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the MHA.”

In October 2019, we reiterated our concerns in our State of Care report that people were at risk because they were not getting the help they needed when they needed it – this includes making sure there is adequate community provision to prevent admission to hospital as well as making sure urgent inpatient care is available when needed, as close to home as possible. We also highlighted that between June

2018 and March 2019, coroners made us aware of at least seven deaths of people who were assessed as requiring admission to hospital, including under the MHA, but for whom no mental health bed was available.

In our 2018/19 State of Care report, we reported that from 2014/15 to 2018/19 there was a 14% fall in the number of mental health beds, with facilities in some areas operating at or near 100% bed occupancy. We expect providers to have robust escalation, oversight and monitoring structures in place that have been agreed with system partners, including commissioners, local authorities and police and ambulance services, to make sure that people can access the right care they need when they need it.

However, making sure inpatient services are available is not enough and we remain concerned that community mental health provision is not compensating for the reduction in inpatient beds.²³ The commitment in the NHS Mental Health Implementation Plan to increase funding into community mental health services is particularly welcome as is the commitment to eliminate all inappropriate adult out-of-area placements by 2020/21.

The Department of Health and Social Care is currently developing a practical briefing to support how the system implements section 140.

A personal experience of being detained in a hospital far from home

One day, at a meeting with my care coordinator, who was an approved mental health professional (AMHP), he asked me if I would meet with a doctor as he was worried about me. When I arrived at this meeting I found out that it was actually an MHA assessment, which I felt was a bit cheeky of my care coordinator. I was persuaded to stay for this assessment even though I knew that legally that they could not keep me there. They would only come around to my house later with a warrant if I didn't.

Once the assessment had been completed, we had to wait many hours for a bed and when one was found it was at a hospital in a different area from my home. I was in this

hospital for two weeks before I was transferred to my local hospital. While I was waiting to be transferred I could not start to get better or build relationships with staff because I knew I would be leaving soon, I just didn't know when. I felt in limbo for those two weeks as I could not put my energy into my recovery. The distance also mattered to my family as they could only visit once a week. When I was in my local hospital, they could see me every day.

Relationships with staff are very important to me. While I sometimes find it difficult to get on with the staff at my local hospital, at least my husband brings me dinner every night!

Catherine El-Houdaigui (see page 50)

Use of police powers

Under section 136 of the MHA, a police officer may remove from any place other than private domestic property any person who appears to be suffering from a mental disorder and 'in need of care or control'. That person should be taken to a place of safety, where they can be detained for up to 24 hours to be assessed by doctors and an approved mental health professional (AMHP), so that any further arrangements needed can be made.

Choice of places of safety

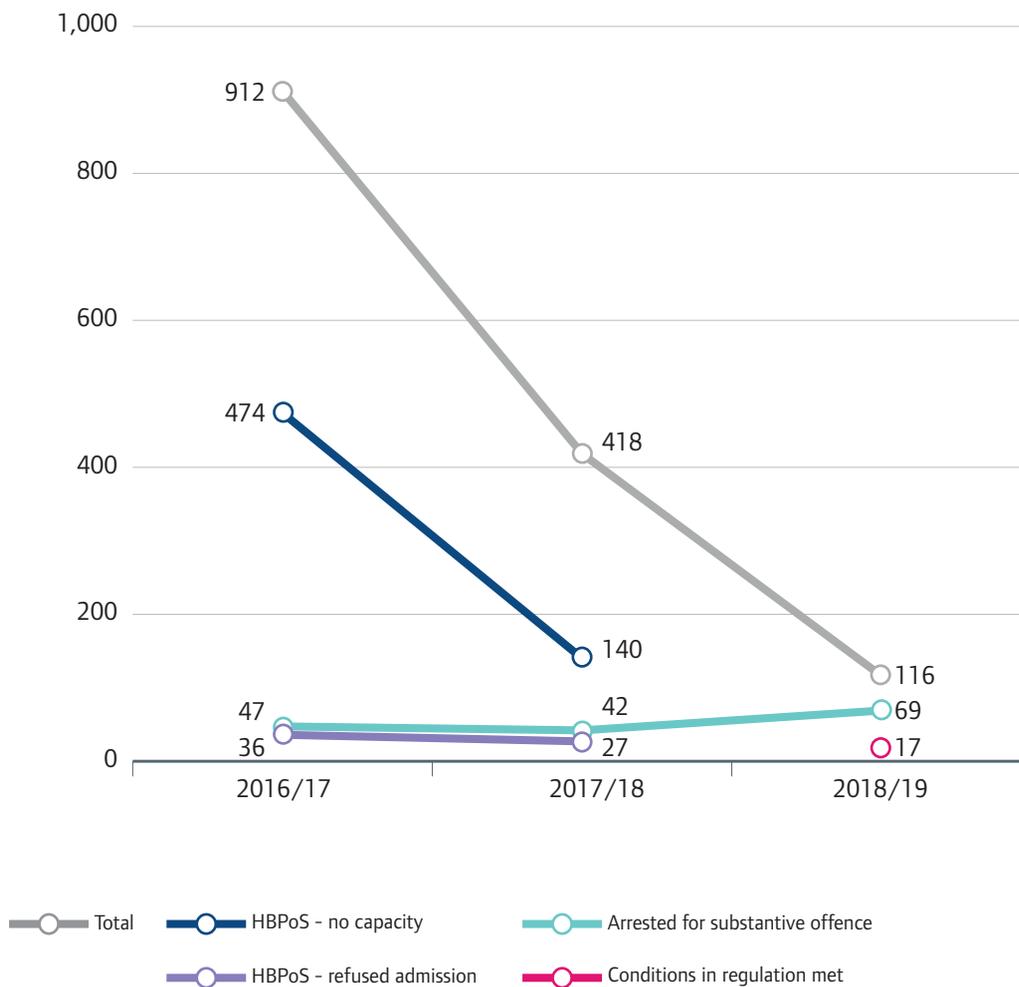
From 2017, it has been unlawful to use a police station as a place of safety for people who are under 18 years old. Regulations that came into force in December 2017 set out specific criteria that should be met if a police station is to be used as a place of safety for adults.²⁴ Using a police station as a place of safety, rather than a health-based place of safety (HBPoS), compromises the basic human rights principles of fairness and equality, and in some cases compromises a person's dignity.

Over the last three years there has been a sharp fall in the use of a police station following a section 136 detention, from 912 in 2016/17 to just 116 in 2018/19 (an 87% reduction, figure 8). For the first two years of this period, the lack of capacity in HBPoS remained a substantial reason for using a police station, although it fell both absolutely (from 474 to 140) and as a proportion of all uses of a police station (from 52% to 34%). In 2018/19, the Home Office amended its reporting categories, in line with the Policing and Crime Act 2017 and the MHA (Places of Safety) Regulations 2017, which placed strict conditions on the circumstances in which a police station could be used as a place of safety. Use of a police station when conditions in the regulations were met was recorded 17 times that year (15% of the total).

Over the three-year period the number of times a police station was used because the person was arrested for a substantive offence has risen both absolutely (from 47 to 69) and very sharply as a proportion of all uses of a police station (from 5% to 59%). Underneath the national trend it is worth noting that 50 out of 116 uses of a police station in 2018/19 were accounted for by just two

of the 39 police force areas (North Yorkshire and Leicestershire), and arrest for a substantive offence was the reason given in the vast majority of these cases (24 out of 28 and 21 out of 22 respectively). In comparison, the Metropolitan Police area reported only one police station being used following section 136 detention during the whole year.

Figure 8: Use of a police station as a place of safety following a section 136 detention, and key reasons, 2016/17 to 2018/19



Source: Detentions under the MHA – police powers and procedures, 2018/19, Home Office

Conveying patients to places of safety

When people have to be taken to a HBPOS, the MHA Code of Practice is clear that an ambulance or similar vehicle should be used. There is widespread failure to meet this expectation. Where the method of transport was recorded in 2018/19, in 40% of cases (13,162) people were taken to a place of safety in a police vehicle (figure 9).

While the use of police cars varies across the country, the most common reason for ambulances not being used is because an ambulance was not available within 30 minutes. This, or the fact that the ambulance had been re-tasked to a higher priority call, was cited as the reason in 44% (5,138) of incidents in 2018/19 (figure 10).

A personal experience of being conveyed under section 136

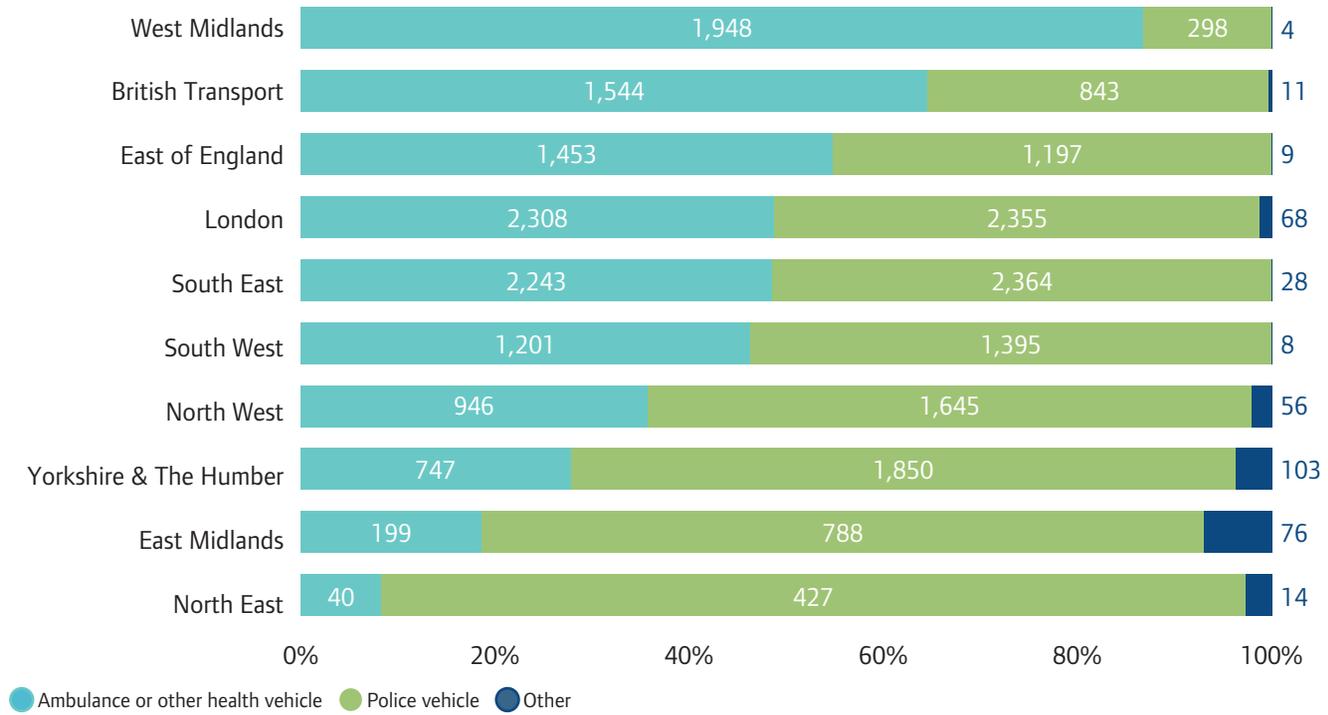
Once, while I was detained in hospital under section 2 of the MHA, I told my doctor that I wanted to prove to people that I would live forever and that if I jumped off a bridge I would survive. He didn't want to grant me any leave. However, in the ward round the nurse persuaded him to give me 15 minutes unescorted leave. I took myself off to a bridge over a dual carriageway, which I had visited before. I was not thinking of suicide but wanted to prove I would live forever.

A couple of passers-by talked to me and soon the police arrived. The police quickly detained me, but that was the first time a police officer had explained what they were doing and told me that they were detaining me under section 136 of the MHA. They handcuffed me and when I asked why, they said it was for my own safety until they got me off the bridge, even though I was not resisting them or being aggressive. They placed me in the police car while they found a place of safety for me.

I did not tell them that I was already a detained patient. They were going to take me to a place of safety in another hospital because I was not in my home area, but they soon found out that I was detained in a different hospital. They didn't call an ambulance to take me back, which they should have done. They put me in the cage in the back of a police van. When I asked why I needed to go into the cage, they said it was for my own safety. I had been calm all the time so didn't understand what they were concerned about. The cage was horrible and there was a camera in there. Being taken to hospital in the cage in the back of a police van made me feel like a criminal, that I had done something wrong, rather than someone who was ill.

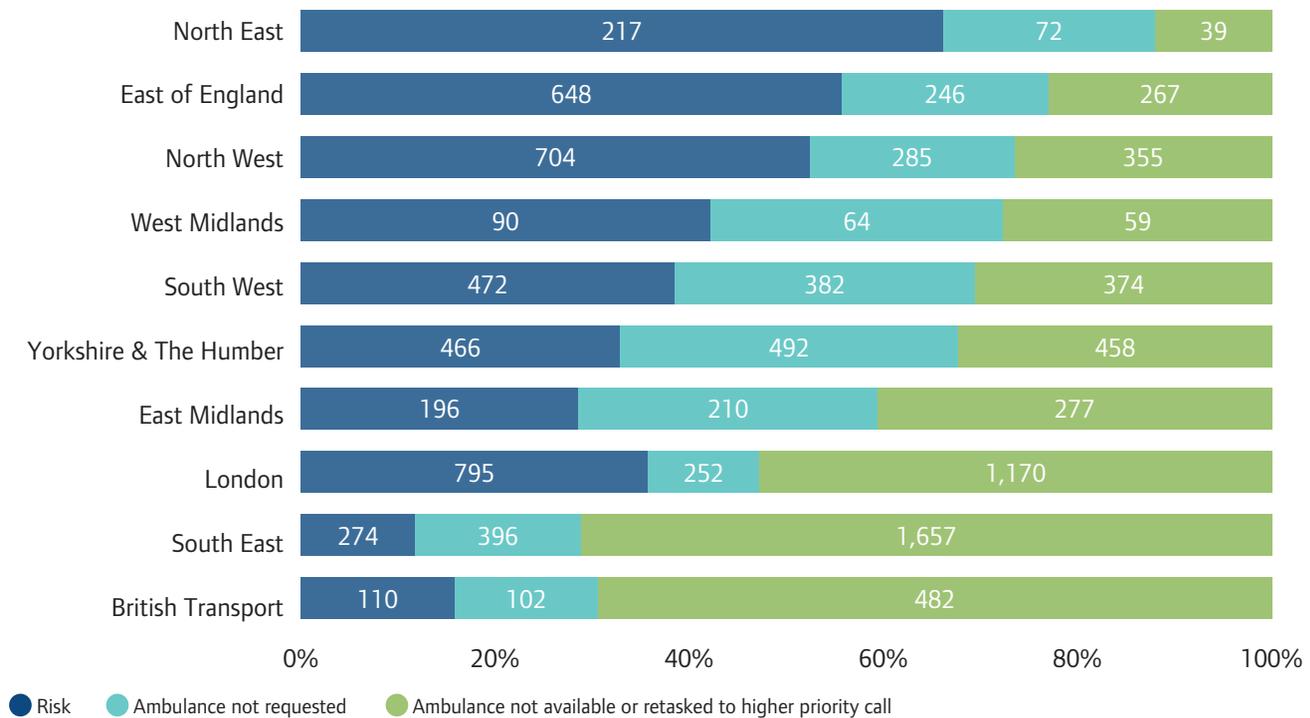
Catherine El-Houdaigui (see page 50)

Figure 9: Method of conveyance to initial place of safety, where known, by police region, 2018/19



*Data from British Transport Police covers England and Wales. Excludes 513 records where section 136 instigated at a place of safety (presumably A&E departments) requiring no conveyance.
 Source: Detentions under the MHA – police powers and procedures, 2018/19, Home Office

Figure 10: Reasons recorded, where known, for not using ambulance conveyance to initial place of safety, by police region, 2018/19



*Data from British Transport Police covers England and Wales.
 Source: Detentions under the MHA – police powers and procedures, 2018/19, Home Office

The regional variation in the use of ambulances is likely to reflect how independent ambulance services, which provide secure transport, operate locally. In 2015, we recommended that clinical commissioning groups should make sure that arrangements for conveying people subject to section 136 to hospital by ambulance are appropriate and timely.²⁵ Some specialist services use 'caged vans', which may avoid the stigma of transport in a similarly-built vehicle with police markings, but otherwise do not provide a substantially different experience for the person being conveyed. While such secure vehicles may well be needed in individual cases, we would be concerned if independent ambulance fleets consist only of secure 'cage' vehicles that could compromise the principle of least restriction, as well as the principle of respect and dignity.

NHS ambulance services must prioritise their calls across all types of mental and physical health needs. As many NHS ambulances are effectively mobile

intensive care units, it is unsurprising that there are delays and diversions when answering mental health requests, and that there are intense pressures to deal with mental health calls as quickly as possible after the ambulance attends. This could be a barrier to positive risk taking, leading to more patients being taken to emergency departments. Emergency departments are rarely suitable environments for the effective assessment of patients in mental distress and are often associated with extremely long lengths of stay and escalation of the person's presenting condition. This may increase the likelihood of inpatient admission and use of the MHA.

Some ambulance services recognise this and release funding to provide staffed crisis cars and similarly designated mental health transport, as the good practice example below demonstrates.

We welcome the commitment in the NHS Long Term Plan to introduce new mental health transport to reduce inappropriate ambulance and police conveyance to places of safety.

Example of a mental health crisis car

London Ambulance Service established a Mental Health Joint Response Car (MHJRC), which was piloted in South East London in 2018. The car is staffed by a paramedic and mental health nurse. The team provide an enhanced assessment and

ensure patients access the right care, in the right place, first time and can help avoid unnecessary and often stressful trips to Emergency Departments.

Length of detention under section 136

We are concerned about the amount of time people are spending in a HBPOs. After the introduction of the Policing and Crime Act 2017, the amount of time that a person can be detained in a place of safety under section 136 has decreased from 72 hours to 24 hours. However, as we raised in our 2018/19 State of Care report, we are concerned that people are being held for over 24 hours and would question the lawful basis for detaining people under these circumstances.

Some services have created dedicated section 136 suites, which are often self-contained units adjoining and sharing staff with acute admission wards. In some cases, services have also designated

these facilities as a 'swing-bed' for the admissions wards, meaning that the suite is an additional bed in times of emergency. This means that when the time limit for holding a person in a HBPOs expires, the patient can be admitted under section 2 or section 3 without moving, and they continue to be detained legally.

We suggest that trusts that use swing beds should closely monitor how it is working and try to make sure that there are contingency plans for what happens if the police announce they are bringing in another person under section 136 when the suite is already in use.

MHA assessments for people arrested by police

MHA assessments may be required for people who have been arrested and taken to a police cell.

Under the Police and Criminal Evidence Act 1984 (PACE), people can be held for up to 24 hours under arrest, just as is now the case under section 136 of the MHA. Police are left in a difficult situation when this 24-hour time limit expires, and a bed still has not been found so that an MHA application can be made. While people in these situations cannot be legally detained in a police station, they or someone else could come to significant harm if they are released. Police have told us that delays in completing assessments in police stations does

happen, but more often the delay is caused because of difficulties in finding an available bed when a person needs to be admitted to hospital.

One potential solution would be a wider use of the 'swing-bed' approach to hospital-based places of safety discussed above, as these could provide a temporary place that enables the MHA admission to be made. However, some police forces, such as Norfolk, already find that they are frequently unable to take a person held under section 136 to such places of safety because they are still occupied by someone else, suggesting that more places of safety are still needed.

Community treatment orders

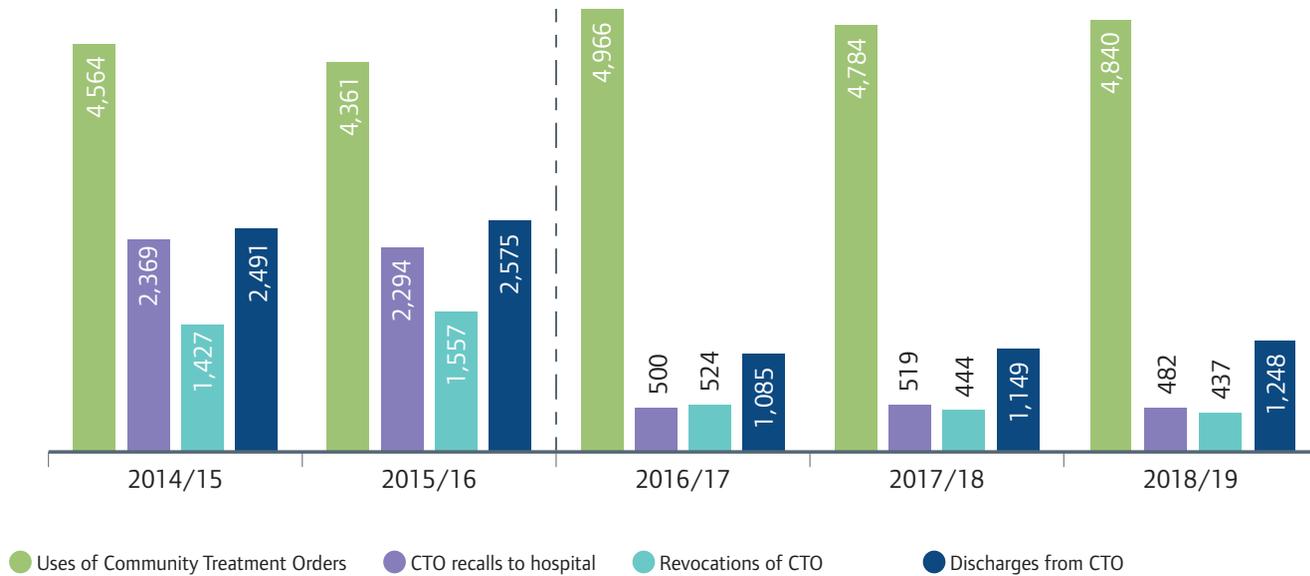
The purpose of a community treatment order (CTO) is to allow people to be safely treated in the community rather than under detention in hospital, where appropriate, and to provide a way to help prevent relapse and any harm. They are intended to help people to maintain stable mental health outside hospital and to promote recovery. The principles of treating people using the least restrictive option and maximising their independence, and that of purpose and effectiveness should always be considered.²⁶

It is important to note that the national picture on the use of CTOs (figure 11) is not reliable, with some services not providing accurate data, and others not providing any data to the national mental health services dataset collection. Figure 11 shows a notable difference in volumes reported between the previous KP90 collection running up to 2015/16, and the mental health services data set that replaced it in 2016/17. Services should look at local data on their use of CTOs to identify local trends.

We are concerned that the use of CTOs varies between different demographic groups. While it needs to be explored further, we are concerned about the higher use of CTOs among men (11.2 per 100,000 population) compared to women (6.1 per 100,000 population), and the particularly high use for BME groups. We have also expressed concern in the past that many CTO patients are not appropriately informed of the exact legal powers held over them and believe, in consequence, that they are legally obliged to comply with taking their medicine, when this is not a requirement under the MHA.

CQC is carrying out several CTO-focused visits over 2019/20 to get a better sense of issues in practice, and to inform future MHA reform. We will report on our findings from these visits next year in our MHA annual report.

Figure 11: CTO uses, recalls revocations and discharges, 2014/15 to 2018/19



Source: KP90 (2014-15 to 2015-16), MHSDS/MHA Acute (2016-17 to 2018-19) - NHS Digital
 The vertical dotted line represents the change in the data source. NHS Digital state that "Data about uses of CTOs are incomplete in the MHSDS and should not be compared to data from the KP90 data source".

The interface between the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards

When CTOs were introduced in 2007, Parliament ruled that they would not provide powers to force people to receive treatment. However, in July 2018, an unreported High Court judgement ruled that the Court of Protection could authorise the restraint and forcible administration of depot medication under the Mental Capacity Act 2005 (MCA), even though the two patients concerned in the case would be subject to CTOs at the time.²⁷

The High Court considered that using the MCA alongside the CTO in these circumstances was the least restrictive option and would prevent the need for the patient to be re-admitted to hospital to receive treatment. Although the patient concerned in this case was treated in the least restrictive way, this case demonstrates the complexity of the interface between the MHA and the MCA and indicates the need for clear updated guidance for professionals working within these two frameworks. The need for professionals to understand this

complex interface is important so that they can explain to patients what rights, safeguards and protections patients have under each framework.

Patients detained in hospital on powers relating to criminal proceedings may be subject to a restriction order. Discharge into the community from detention for a restricted patient may be absolute or conditional. As of the 31 December 2018, there were approximately 4,800 restricted patients in hospitals across England and Wales, and 2,700 conditionally discharged patients in the community.²⁸

In November 2018, the Supreme Court ruled that conditional discharge cannot be used to discharge a patient from hospital into conditions that amount to a deprivation of liberty elsewhere, for example, to a care home in cases where patients have the capacity to agree to their community placement. For patients who lack capacity to agree to their community

placement, the Deprivation of Liberty Safeguards (DoLS) or the Court of Protection can authorise a deprivation of liberty in the community.

Guidance from Her Majesty's Prison and Probation Service in January 2019 advised that long-term escorted leave of absence under section 17(3) of the MHA should be used instead of conditional discharge for those patients still detained in hospital.²⁹ For the significant number of patients already on conditional discharge, a variation could be made to their conditions of discharge so that they do not amount to deprivation of liberty. Otherwise, the patient might be recalled with or without instantaneous grant of escorted leave to the current placement, or the patient may be absolutely discharged or referred to the tribunal.

In a separate judgement, the Supreme Court has ruled that there is no power to authorise deprivation of liberty under the conditions of a CTO. However, through the DoLS or the Court of Protection it is possible to apply for authority to deprive a person of their liberty while also subject to a CTO.³⁰

The immediate impact of the above case law is that there are challenges to transferring patients to community settings. This has led to delayed

discharges and challenged the legality of some existing placements. Also, the use of section 17 leave as a replacement for conditional discharge has potential disadvantages for the patients concerned. These patients would, for example, be technically subject to the consent to treatment provisions of the MHA that allow enforced treatment. Whether these patients are eligible to apply to the tribunal if they are technically on section 17 leave is also not clear.

The interface between the MHA, the MCA and DoLS is an area that is constantly evolving. Patients are unlikely to be clear on what safeguards and rights they have under each of these frameworks, especially if they are being used at the same time, or if patients are being deprived of their liberty by one legal framework and then another within a short time-frame. Professionals are working within complex legal frameworks and have the additional challenge of needing to keep up-to-date with case law that redefines legislation. As a matter of urgency in current reforms to law, the codes of practice for the MHA, the MCA and DoLS must be updated and provide clear guidance for professionals on these complex interface issues. The way in which this guidance can be updated quickly to reflect evolving case law needs to be considered.

First-Tier Tribunal (Mental Health)

The First-Tier Tribunal (Mental Health) is an independent judicial body that reviews cases of detained and conditionally discharged patients, and patients subject to community treatment orders (CTOs) under the MHA.

It is unsurprising, given the key role that the tribunal has in deciding if restricted patients can be discharged, that the success rate for applications involving restricted patients is higher than average at 33%. Although concerns have been raised that applications against section 2 detention may often be futile, 11% are successful. However, it is likely that the rate of success depends on whether the appeal is initiated in the first or second week of the application window (with later applications being the more likely to succeed). The lowest overall successful rate was for all other unrestricted detention powers, at 8%.

The success rate of applications against CTO that proceed to a hearing is 5% (figure 13). The tribunal discharged 178 people from CTO in 2018/19, which would be 14% of the total discharges from CTO (1,248) recorded by official statistics on use of the MHA.³¹

Figure 12: **Outcomes of applications against detention to the First-Tier Tribunal (mental health), 2018/19**

		Section 2	Other	Restricted	All detained
Applications and hearings	Applications	9,939	15,477	3,173	28,589
	Withdrawn applications	1,154	3,493	1,172	5,819
	Discharges by clinician prior to hearing	3,853	5,157	43	9,053
	Clearing at hearing ^{c,d}	6,736	11,982	2,465	21,183
	Heard ^e	6,449	8,684	2,469	17,602
Decision of Tribunal	Total discharge by Tribunal	613	502	624	1,739
	Of which:				
	Absolute discharge	393	367	79	839
	Delayed discharge	220	135	0	355
	Conditional discharge	0	0	359	359
	Deferred conditional discharge	0	0	186	186
	No Discharge	4,723	5,637	1,295	11,655

Source: HM Courts & Tribunal Service

Figure 13: **Applications against community treatment orders to the First-Tier Tribunal (Mental Health), 2018/19**

	2018/19
Applications	4,429
Withdrawn applications	897
Hearings	4,183
Oral Hearings ^f	3,600
Paper Reviews (considered on papers and therefore patient not present)	583
Discharges by Tribunal	178
No discharge by Tribunal	3,364

Source: HM Courts & Tribunal Service

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

d We are unable to distinguish CTO hearings disposed from the total number of other unrestricted hearing disposals.

e Includes all cases heard irrespective of outcome in the reporting period.

f Oral hearings is based upon the total number of hearings less the manual count of paper reviews

Supporting patients to appeal to the tribunal

A recent case has provided clarity on what information patients need to understand in order to make a decision to apply to the tribunal.³² Prior to this case, case law had established that an application made by a patient to the tribunal without capacity was invalid. In this case, it was held that in order to make a valid application to the tribunal the person simply needs to be able to

understand that they are being detained against their wishes and that the tribunal is a body that will be able to decide whether they should be released.³³

This is a low threshold and professionals should support patients to make direct applications to the tribunal themselves if patients understand these points, rather than carrying out formal capacity assessments based on doubts over capacity and then requesting the Secretary of State to make a referral to the tribunal on the patient's behalf under section 67 of the MHA.

The Second Opinion Appointed Doctor service

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

A SOAD visit would be needed to allow the following treatments where consent is not given, 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 first month of a patient being subject to a community treatment order (CTO)^g
- electroconvulsive therapy (ECT), at any point during the person'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 2018/19:

- SOADs carried out 14,354 visits. Numbers of second opinion visits have been relatively constant for over five years (figure 14).
- Of these visits, 82% (11,731) were to consider proposed medication treatment plans for patients who were detained in hospital under the MHA.
- The number of visits to consider ECT treatment increased by 10% from 1,697 in 2017/18 to 1,859.
- The number of visits (1,060) to consider treatment plans for patients on CTOs continued to decline with 5% fewer visits taking place than last year.

^g 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 MHA Code of Practice, paragraph 25.31.

Figure 14: **All SOAD visits, 2014/15 to 2018/19**



Source: CQC

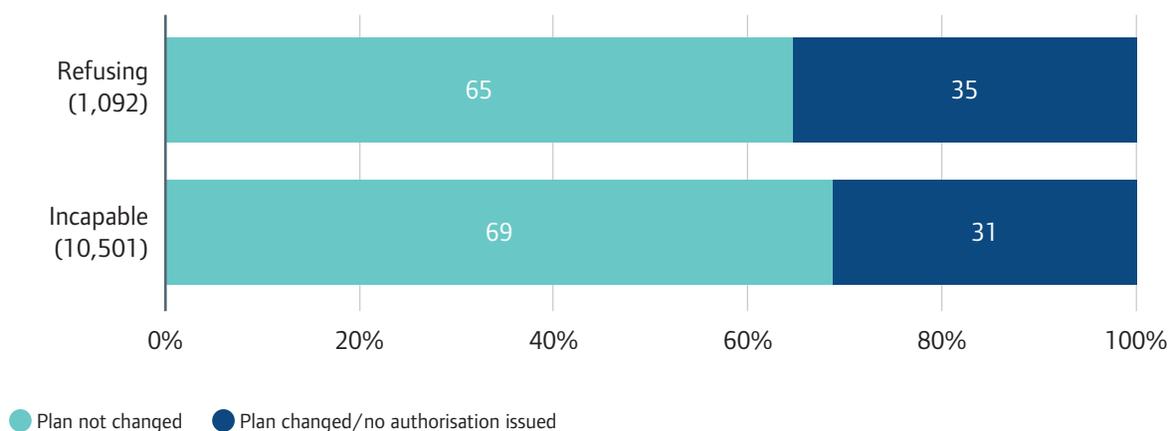
In our last report, we acknowledged the MHA independent review’s recommendation to reduce the three-month period (the ‘three-month rule’) during which medicines may be given to a detained patient without consent or a second opinion. This is something we called for in the debates leading to the last review of the MHA in 2007 and continue to support. We acknowledge that there are resource questions to resolve to achieve this, in part due to the availability of consultant psychiatrists. We have been in discussion with Department of Health and Social Care over some of these challenges, which include contractual limitations on full-time consultant psychiatrists undertaking work outside their NHS trust employers.

Outcomes of SOAD visits

In 2018/19, SOAD reviews resulted in 29% of all treatment plans considered being changed. Overall, a change of treatment plan or no authorisation was given in:

- 31% of visits to consider medication for detained patients
- 22% of visits to consider ECT
- 18% of visits to consider medication treatment for CTO patients.

Figure 15: **Outcomes of Second Opinion visits, medication for detained patients, by capacity assessment, 2018/19**



Source: CQC

Section 61 of the MHA requires that, where a patient has received treatment certified by a panel under Section 57 or a SOAD under sections 58 or 62A, the approved clinician in charge of the patient's treatment must give CQC a report on the treatment and the patient's condition. This is known as a section 61 review of treatment form. These section 61 reports are generally required when a patient's detention is renewed, except in the case of CTOs where the report is only required at the renewal of the order if the patient has been recalled and received treatment certified by a SOAD. SOADs can, at the time they issue a certificate authorising treatment, stipulate a specific time when the approved clinician should complete a section 61 review of treatment form.

In 2018/19, our panel of additionally trained SOADs acting as independent scrutineers examined 4,468 section 61 review of treatment forms. Providers were asked for further information in 529 instances, to justify continuing treatment in 428 instances, and we withdrew the authorisation and/or required that a further second opinion be arranged in 66 instances.

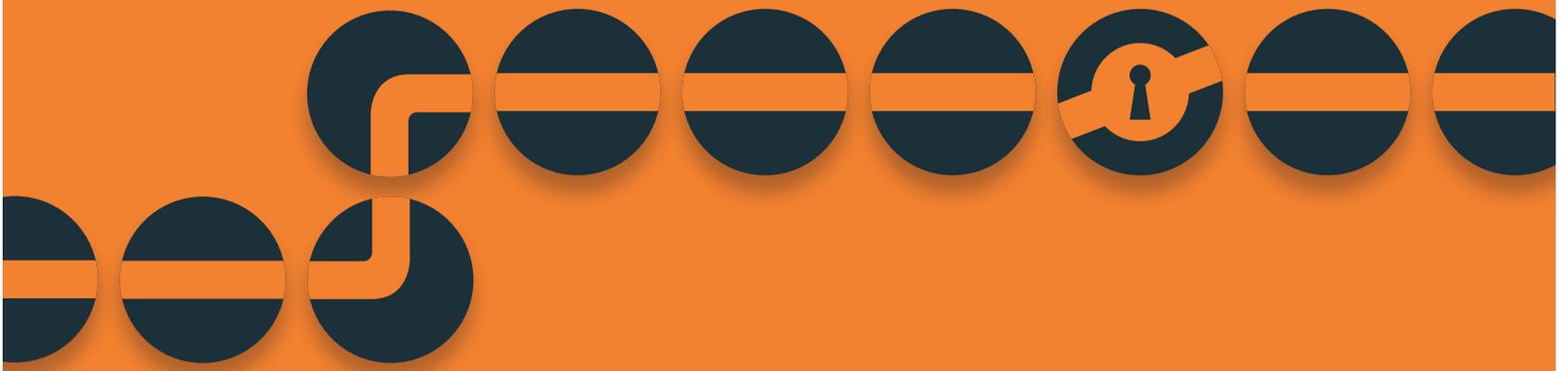
A common issue that arises is the availability of statutory consultees to speak to SOADs when they visit services. Statutory consultees are qualified professionals who ideally know the patient well so that they can best inform the SOAD's decision as to the appropriateness of the proposed treatment and

whether the patient has the capacity to consent to that treatment. SOADs not being able to speak to statutory consultees on the day they visit results in a delay in proposed treatment plans being agreed as they will often have to follow up with statutory consultees by telephone after they have left the service.

Neurosurgery for mental disorder

Neurosurgery for mental disorder (NMD) is a surgical operation that destroys brain tissue, or its function, to treat mental disorder. Before any patient can undergo NMD, a CQC-appointed panel must certify that the treatment would be appropriate and that the person really does give informed and valid consent to it.

In 2018/19, CQC received referrals to consider NMD in three separate cases. One treatment proposal was not authorised; the other two remain under consideration at the time of writing. The small number of treatment referrals is such that a more detailed discussion in this report would be inappropriate as it could inadvertently lead to individuals being identified.



Part 2: CQC activity in monitoring the MHA



Part 2: CQC activity in monitoring the MHA

Mental Health Act visits

We aim to visit every psychiatric hospital ward that is registered with us for the care and treatment of patients detained under the Mental Health Act 1983 (MHA) at no more than two-yearly intervals. We prioritise visits within this timescale based on types of ward and acuity of patients, locally-known risks, previous visit findings and the frequency of admission to the ward type.

In 2018/19, we made 1,190 MHA visits (figure 16), crossing the threshold of 1,199 wards in total. We visited a small number of wards more than once.

The most common types of ward visited were forensic wards, acute admission wards, and rehabilitation wards (figure 17). On our visits, we met with 4,436 people in private and interviewed 179 carers.

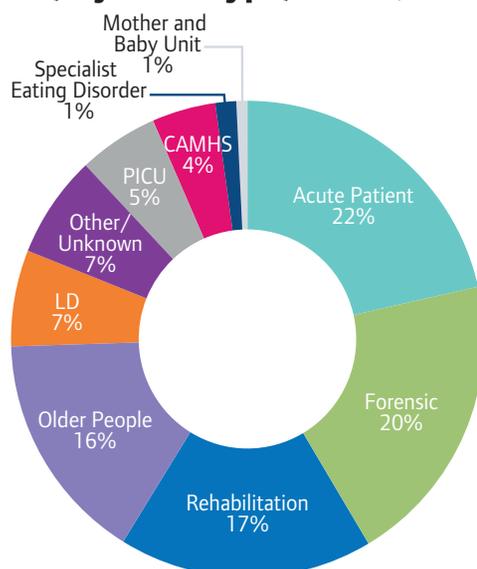
The most frequently visited hospitals will always include the three high secure psychiatric hospitals – Ashworth, Broadmoor and Rampton Hospitals – partly because of their scale, but also because such hospitals are, in principle, the most restrictive environments in which people may be detained and therefore warrant close scrutiny.

Figure 16: MHA monitoring visits, 2014/15 to 2018/19



Source: CQC

Figure 17: MHA visits, by ward type, 2018/19



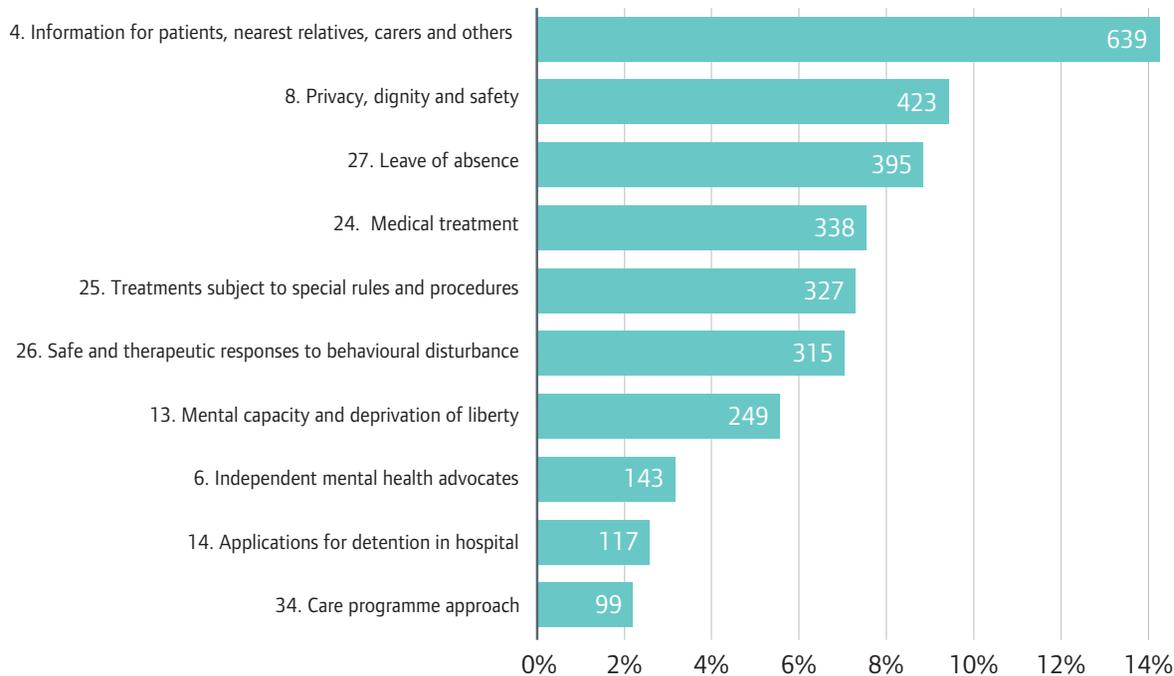
Source: CQC

Types of issues raised on MHA monitoring visits

Monitoring visits by MHA reviewers are a separate but complementary process to CQC’s regulatory inspection work. The findings of MHA reviewers are fed into the regulatory process, and an MHA visit may trigger regulatory action. At the end of every visit, MHA reviewers provide verbal feedback on their observations and any urgent matters. This is followed by a written report setting out action points to which we require a written statement about the action that hospital managers propose to take.³⁴

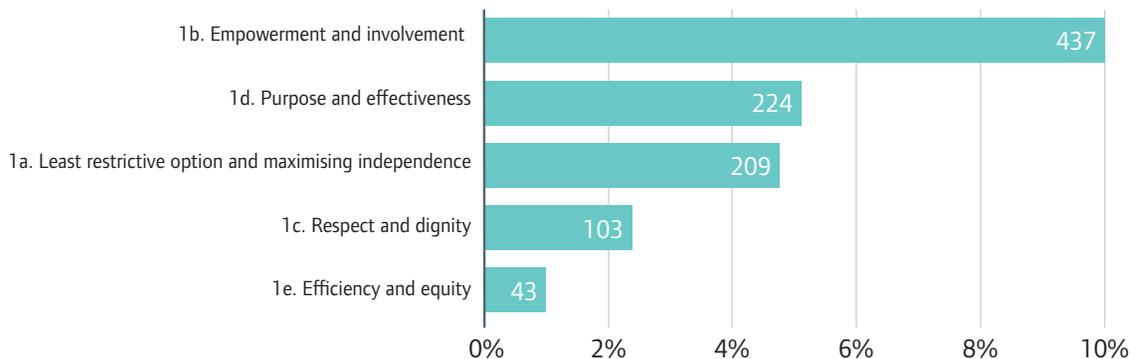
When suggesting an action point, MHA reviewers usually indicate either a specific reference to a chapter of the MHA Code of Practice, or state the relevant principle of the Code of Practice. Figures 18 and 19 show the most commonly used categories of either type in the 4,477 action points during 2018/19. As in 2017/18, ‘information for patients, nearest relatives, carers’ and others was the most commonly selected category referring to a chapter of the MHA Code of Practice, and ‘empowerment and involvement’ the most common principle invoked.

Figure 18: MHA Code of Practice references in MHA reviewer action points, 2018/19



Source: CQC

Figure 19: MHA Code of Practice principles referenced in MHA reviewer action points, 2018/19



Source: CQC

Notifications of child admissions to adult wards

Services are required to notify CQC when a person under 18 years old is placed in a psychiatric ward or unit intended for adults, where the placement lasts for a continuous period of more than 48 hours. Although not a significant change statistically, it is

encouraging to see that the number of notifications received to inform us that a child has been placed in an adult psychiatric ward in 2018/19 has decreased.

Figure 20: **Notifications of child admissions to adult psychiatric wards, 2014/15 to 2018/19**

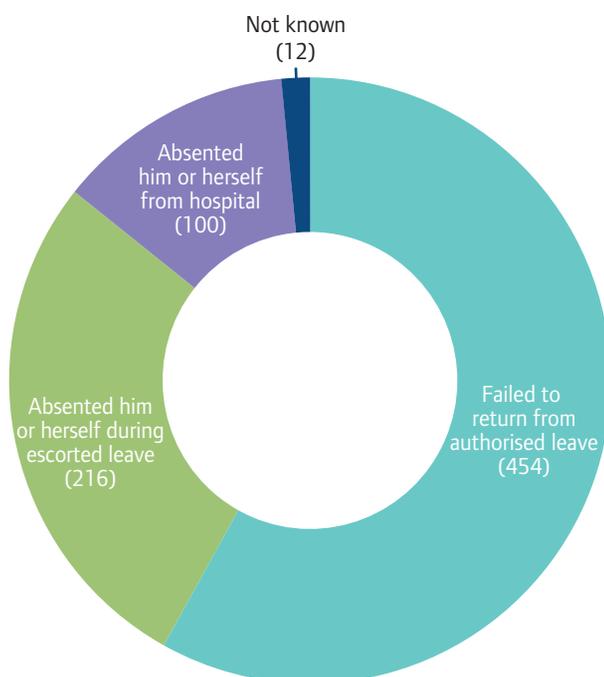
	Number of notifications received of admission of child to adult psychiatric wards
2014/15	233
2015/16	241
2016/17	260
2017/18	200
2018/19	152

Notifications of absence without leave

Hospitals designated as low or medium security must notify us when any patient liable to be detained under the MHA is absent without leave, if that absence continues past midnight on the day it began. In 2018/19, we received 782 separate absent without leave notifications from

low and medium secure facilities, 68 more than were recorded in 2017/18 (714). Over half of such absences (58%) occurred when patients stayed away longer than had been authorised: such cases may reflect positive risk taking by providers (figure 21).

Figure 21: **Absences without leave reported to CQC, 2018/19**

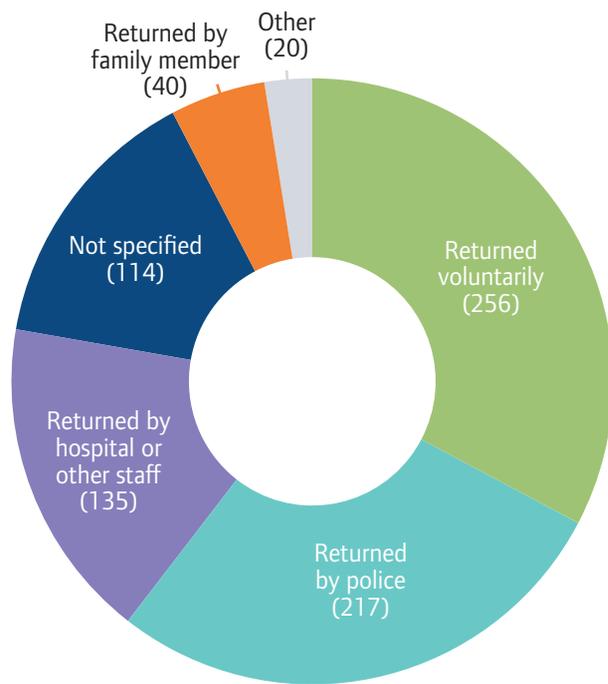


Source: CQC

We do not have complete data on how patients who went absent without leave were returned to detention. Of the data available, the larger proportion (roughly a third of patients) returned to the ward by themselves, with a small number (40) being recorded as having been returned by a relative (figure 22). As with the previous year, patients

appear more likely to be returned by the police than through the action of hospital staff or other mental health professionals. This is of potential concern, given that the MHA provides such staff with equivalent powers to the police to take patients who are absent without leave into custody and convey them back to hospital.³⁵

Figure 22: **Absences without leave reported to CQC - data on how patient returned, 2018/19**



Source: CQC

Notifications of deaths of patients subject to the MHA

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. In 2018/19, providers notified us of 195 deaths of detained inpatients. We were also notified of 16 deaths of patients subject to community treatment orders (CTOs). Full details of the notifications are available at appendix A. The information we receive is reported to our inspection teams for local review and action, including enforcement action where this may be necessary in the Health and Social Care Act 2012.

We also report the collective data quarterly to the Ministerial Board on Deaths in Custody and the Independent Advisory Panel on Deaths in

Custody who lead on the collection, analysis and dissemination of relevant information and lessons that can be learned from all deaths in detention in England and Wales.³⁶ The statistical reports produced by the panel can be accessed on their website: <http://iapdeathsincustody.independent.gov.uk/>

The deaths data we report on includes information on deaths known to be of natural causes, deaths of unnatural causes and deaths for which the cause is currently undetermined while a coroner's verdict is reached. This year, we will be having discussions with key stakeholders including the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) to consider how we can better report on



deaths in detention in the future. This may include, for example, a stronger focus on qualitative data to understand the circumstances surrounding a death to enhance our understanding of the current quantitative datasets we report on.

Deaths of patients where availability of a mental health bed was a factor

When people reach crisis but are not able to access inpatient care because a bed is not available, the consequences can be devastating. Between June 2018 and March 2019, coroners made us aware of at least seven deaths of people who were assessed as requiring admission, but for whom no mental health bed was available. We have written to NHS England to alert them to this finding and other areas of concern including:

- people being held for a prolonged period (over 24 hours) in a health-based place of safety – we question the lawful basis for detaining people under these circumstances
- people being accommodated for a prolonged period in a mental health decision unit – it is unacceptable that people in a state of distress are held for days in a facility that has no beds and which provides no privacy
- the unavailability of a mental health bed, which is one of the most common reasons for patients waiting longer than 12 hours from decision to admit to transfer to inpatient bed.

We will continue to raise awareness of our concerns with local services and, where necessary, with national agencies.

Appendix A: Deaths of patients detained under the MHA or subject to a community treatment order

Deaths of detained patients

Figure 23: Deaths in detention by natural/unnatural causes, 2014/15 to 2018/19

	2014/15	2015/16	2016/17	2017/18	2018/19
Natural causes	182	201	186	189	136
Unnatural causes	34	46	54	48	34
Undetermined	11	19	7	10	25
Total	227	266	247	247	195

Source: CQC

Figure 24: Natural causes of deaths in detention, 2014/15 to 2018/19

Cause of death	2014/15	2015/16	2016/17	2017/18	2018/19
Aspiration pneumonia	13	6	4	0	1
Cancer	13	14	11	14	11
Chronic Obstructive Pulmonary Disease	8	9	6	8	6
Heart disease	24	49	29	45	20
Myocardial infarction	19	14	4	6	8
Pneumonia	35	34	36	23	22
Pulmonary embolism	21	19	26	14	5
Respiratory problems	6	7	1	12	5
Unknown	5	0	29	28	24
Other	38	49	40	39	34
Total	182	201	186	189	136

Source: CQC

Figure 25: **Deaths in detention by natural causes; age at time of death, 2014/15 to 2018/19**

Age range	2014/15	2015/16	2016/17	2017/18	2018/19
20 and under	0	0	0	0	0
21 to 30	3	7	7	5	5
31 to 40	5	9	10	7	2
41 to 50	8	14	16	11	8
51 to 60	19	29	24	35	20
61 to 70	36	38	27	37	32
71 to 80	49	46	55	38	31
81 to 90	52	48	34	36	21
91 and over	8	8	7	4	3
Unknown date of birth	2	2	6	16	14
Total	182	201	186	189	136

Source: CQC

Figure 26: **Unnatural causes of deaths in detention, 2014/15 to 2018/19**

Cause of death	2014/15	2015/16	2016/17	2017/18	2018/19
Hanging	9	6	12	12	4
Jumped in front of vehicle/train	1	3	3	2	3
Jumped from building	3	5	0	1	2
Self-poisoning	5	7	1	5	0
Drowning	4	0	0	0	0
Self-strangulation/suffocation	2	12	8	4	3
Method unclear	0	1	1	0	1
Unsure suicide/accident	5	8	21	10	19
Accidental	3	4	7	11	2
Another person	0	0	0	0	0
Iatrogenic	1	0	1	2	0
Fire	1	0	0	1	0
Total	34	46	54	48	34

Source: CQC

Figure 27: **Deaths in detention by unnatural causes; age at time of death, 2014/15 to 2018/19**

Age range	2014/15	2015/16	2016/17	2017/18	2018/19
20 and under	2	1	7	1	2
21 to 30	9	16	12	7	5
31 to 40	9	13	17	13	8
41 to 50	5	11	7	13	2
51 to 60	6	1	5	8	2
61 to 70	0	2	3	2	6
71 to 80	1	1	2	0	3
81 to 90	0	0	1	0	0
91 and over	0	0	0	0	0
Unknown date of birth	2	1	0	4	6
Total	34	46	54	48	34

Source: CQC

Figure 28: **Regional distribution of deaths in detention, 2018/19**

Region	Natural causes	Unnatural causes	Undetermined	Total
East Midlands	13	1	1	15
East of England	7	6	2	15
London	13	4	3	20
North East	18	2	4	24
North West	32	2	5	39
South East	21	8	5	34
South West	8	2	1	11
West Midlands	8	2	1	11
Yorkshire & Humberside	16	7	3	26
Total	136	34	25	195

Source: CQC

Deaths of patients subject to community treatment orders

Figure 29: **CTO deaths by natural/unnatural causes, 2014/15 to 2018/19**

Type	2014/15	2015/16	2016/17	2017/18	2018/19
Natural causes	29	27	29	23	9
Unnatural causes	15	11	12	7	5
Undetermined	2	2	1	4	2
Total	46	40	42	34	16

Source: CQC

Figure 30: **Natural causes of CTO deaths, 2014/15 to 2018/19**

Cause of death	2014/15	2015/16	2016/17	2017/18	2018/19
Aspiration pneumonia	0	2	0	0	0
Cancer	1	5	2	5	2
Chronic Obstructive Pulmonary Disease	4	2	2	0	1
Heart disease	4	5	8	5	2
Myocardial infarction	3	2	1	0	0
Pneumonia	5	3	7	3	0
Pulmonary embolism	3	1	1	1	0
Respiratory problems	2	2	0	2	0
Unknown	1	0	3	4	2
Other	6	5	5	3	2
Total	29	27	29	23	9

Source: CQC

Figure 31: **Unnatural causes of CTO deaths, 2014/15 to 2018/19**

Cause of death	2014/15	2015/16	2016/17	2017/18	2018/19
Hanging	5	3	2	1	1
Jumped in front of vehicle/train	2	1	3	1	0
Jumped from building	1	2	0	1	0
Self-poisoning	1	1	1	1	1
Drowning	2	0	0	0	0
Self-strangulation/suffocation	1	0	0	0	0
Method unclear	1	0	0	0	0
Accidental	1	0	2	0	1
Another person	0	1	0	0	0
Unsure suicide/accident	1	3	4	3	2
Total	15	11	12	7	5

Source: CQC

Figure 32: **CTO deaths; age at time of death, 2018/19**

Age range	Natural causes	Unnatural causes	Undetermined	Total
21 to 30	0	1	0	1
31 to 40	0	0	0	0
41 to 50	2	2	0	4
51 to 60	2	1	1	4
61 to 70	3	1	0	4
71 to 80	0	0	1	1
81 to 90	1	0	0	1
91 and over	0	0	0	0
Unknown date of birth	1	0	0	1
Total	9	5	2	16

Source: CQC

Figure 33: **Regional distribution of CTO deaths, 2018/19**

Region	Natural causes	Unnatural causes	Undetermined	Total
East Midlands	0	0	1	1
East of England	0	0	0	0
London	1	2	0	3
North East	1	0	0	1
North West	2	2	0	4
South East	1	0	1	2
South West	1	0	0	1
West Midlands	1	0	0	1
Yorkshire & Humberside	2	1	0	3
Total	9	5	2	16

Source: CQC

Figure 34: **Ethnicity data on deaths, 2018/19**

Detained

Ethnicity	Natural causes	Unnatural causes	Undetermined	Total	%
White	84	12	16	112	57%
BME	9	2	0	11	6%
Unknown/Other	43	20	9	72	37%
Total	136	34	25	195	100%

CTO

Ethnicity	Natural causes	Unnatural causes	Undetermined	Total	%
White	6	4	2	12	75%
BME	0	0	0	0	0%
Unknown/Other	3	1	0	4	25%
Total	9	5	2	16	100%

Source: CQC



Appendix B: Involving people

We are grateful to two of our colleagues in mental health services who have given permission for their words to be reproduced in this report.

Catherine El-Houdaigui

I have been using mental health services for 26 years and experienced detention under the Mental Health Act (MHA) over the last 15 years. I have been diagnosed with bi-polar disorder, emotionally unstable personality disorder and chronic fatigue syndrome. I agree with my diagnoses, including the personality disorder one. I spent a year in a therapeutic community several years ago, which was both the worst year and the best year of my life. Since then, my personality disorder has been in remission.

I work part time as a healthy lifestyle advisor and as a trainer in Mental Health First Aid, Suicide First Aid, Knowledge and Understanding Framework for personality disorder and Deaf Awareness. I am also an Expert by Experience for CQC, taking part in inspection and MHA monitoring visits. I use my lived experience of mental health conditions to enhance learning and encourage services to improve.

Kate King BSc, BA, MBE

Adviser on Lived Experience, FMHC; Working group member of the Mental Health Act Review 2018

I have lived with recurrent depression since my teens and use my experience of this, of numerous detentions under the MHA, and of inpatient treatment in various settings, to contribute critically and constructively to debate on ways to improve the quality and nature of care and treatment. An intrinsic part of this is to recognise and promote the experiences and opinions of all patients, with the aim of ensuring that they will be believed, respected for their knowledge, and empowered to make decisions about their care and treatment.

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 our regulatory inspections.

MHA External Advisory Group

An external advisory group provided experience and expertise on our Mental Health Act monitoring role.

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

Anthony Beschizza, Central and North West London NHS Foundation Trust

Nick Brindle, Leeds and York Partnership NHS Foundation Trust

Steve Chamberlain, National Approved Mental Health Practitioner Leads Network

Deborah Cohen, Association of Directors of Adult Social Services

Guy Davis, East London NHS Trust

Max Edelstyn, Equality & Human Rights Commission

Paul Farrimond, NHS Providers

Dorothy Gould, National Survivor User Network

Sandra Hudson, Bipolar UK

Ian Hulatt, Royal College of Nursing

Brenda Jones, Service User Reference Panel, CQC

Viral Kantaria, NHS England

Judy Laing, Bristol University

Matthew Lees, Department of Health

Clementine Maddock, Royal College of Psychiatrists

Louise McLanachan, Birmingham and Solihull Mental Health NHS Foundation Trust

Ramesh Notra, NHS Digital

Kathy Roberts Association of Mental Health Providers

Jane Shears, St Andrew's Hospital

Geraldine Strathdee, NHS England

Emma Tilley, Independent Police Complaints Commission,

Hazel Watson, British Institute for Human Rights,

Cathie Williams, Association of Directors of Social Services,

Sarah Yiannoullou, National Survivor User Network

Find the terms of reference for the advisory group at:
<http://www.cqc.org.uk/content/advisory-groups#tabs-2>.

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