Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Monitoring the use of the Mental Health Act in 2009 - 2010

This is the first annual report by Healthcare Inspectorate Wales of its activities and findings in relation to its monitoring of the operation of the Mental Health Act in Wales

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Foreword

It gives me great pleasure to present Healthcare Inspectorate Wales's first annual report on our work in relation to the monitoring of the use of the Mental Health Act across Wales in 2009-10.

Generally, it is estimated that one in four of us living in Wales will at some point in time be affected by mental health problems. A small percentage of those who suffer a mental problem will go on to experience a period of acute mental illness which may require a period of hospital admission. Sometimes, it will be in an individual's best interest to admit them to hospital and administer care and treatment even if they do not agree to being admitted.

The Mental Health Act 1983 and the accompanying Code of Practice was introduced to protect those who become vulnerable due to mental impairment. It does so by ensuring that any decision made to admit them to hospital and therefore deprive them of their liberty and enforce treatment is properly justified, is in the individual's best interest and that care is planned so that the least restrictions are placed on the individual.

On 1 April 2009, following the dissolution of the Mental Health Act Commission, we took on responsibility on behalf of Welsh Ministers for the monitoring of the use of the Mental Health Act in Wales. Our monitoring role in relation to the implementation and application of the Act is fundamental to our commitment to protecting those who are most vulnerable. Our overall aim is to ensure that those detained under the Mental Health Act have a voice and are supported and empowered as far as possible to make decisions over their care and treatment.

The findings set out in this report are based on our analysis of data collected by the Welsh Assembly Government and the work taken forward by our Mental Health Act Reviewers and Second Opinion Appointed Doctors. Where appropriate, we have also made reference to the outcomes of our routine inspection work and investigations.

The information in this report will be of interest not only to those responsible for implementing and monitoring the Act, but also to individuals and their families who are or could be subject to detention under the powers of the Act.

Peter Higson

Chief Executive

Healthcare Inspectorate Wales

Executive Summary

Each year Healthcare Inspectorate Wales is required to prepare an annual report that gives an account of the work we have undertaken to meet our Mental Health Act monitoring responsibilities and which sets out the findings from our work.

In this our first annual report we provide an overview of key figures and trends and the findings of the work undertaken in 2009-2010 by our Reviewers and Second Opinion Approved Doctors (SOADs).

Our first annual report also covers the period when Community Treatment Orders (CTOs) were introduced: their use during the first 18 months of their introduction has far exceeded the estimates made originally. There is wide variation in the use of the CTO powers across Wales and over the months ahead we need to ensure that the power is being used appropriately and that community teams are equipped to provide the necessary levels of care and support to those individuals.

During the year we saw a substantial increase in requests for a SOAD visit with the use of CTO powers impacting significantly on the level of demand. As a result, there were times when we did not meet the timescales we have set for such visits. Following our appointment of additional SOADs performance levels improved, which we will keep under close review in the coming months.

While in general detained patients are looked after in environments of care that are appropriate to their needs and are cared for and treated by staff who have the necessary knowledge and skills, there are some gaps in provision. We are particularly concerned that care plans do not always meet the holistic needs of the patient. We also have concerns about how well the needs of patients' with a mental health issue who also have a co-existing physical health problem are being met. We have taken forward a separate review of these matters and will be reporting on our findings later this year.

The lack of activities and therapeutic input that was evident in many settings needs to be addressed and we will be focusing on this matter in the year ahead.

The information that we have pulled together for this our first annual report provides a baseline of where mental health services in Wales are in relation to compliance with the requirements of the Act and its accompanying Code.

It is our usual practice to make a number of recommendations in our reports aimed at extending noteworthy practice and addressing the issues and shortcomings identified. However, many of the recommendations we would wish to make have already been made in previous years by the Mental Health Act Commission.

We will therefore be working with health boards and independent healthcare organisations over the coming year to ensure that noteworthy practice is shared across Wales and to better understand why the issues and shortcomings we have identified have not previously been addressed so that we can help them develop solutions that fit with their organisations particular circumstances.

Our intention is where necessary to develop realistic, achievable and timely action plans with individual organisations. These will be published on our website and we will monitor and follow up on progress as part of our routine programme of visits. We will, where necessary use our powers under the Health and Social Care Act 2003 to put organisations on special measures where we consider the necessary improvements are not being made.

Over the coming months we will also use the findings set out in this report to better focus our work and further develop our approaches to monitoring and review, ensuring that we look across pathways of care and that there is equal focus on those patients detained in a hospital setting or subject to a Community Treatment Order.

Chapter 1: The Mental Health Act and our Role in Monitoring its Use

The role and purpose of the Mental Health Act

1.1 The majority of people receiving care and treatment from mental health services across Wales do so voluntarily and are known as **informal** patients. Informal patients have exactly the same rights as patients who have a medical or physical problem. However, sometimes an individual may experience a period of acute mental illness that requires them to be detained for care and treatment to which they have not agreed. Patients who are detained are known as **formal** patients and such patients account for around 25% of all patients receiving care and treatment from mental health services.

1.2 The main purpose of the Mental Health Act 1983[1] (the Act) is to allow compulsory care treatment and action to be taken, where necessary, to ensure that an individual with a mental disorder gets the care and treatment they need for their own health and safety or for the protection of other people.

1.3 Under the Act individuals can be detained in hospital or be required to live in the community, subject to certain conditions as set out in a Community Treatment Order (CTO) or under Guardianship. In some circumstances they can be given treatment to which they have not consented or do not have the capacity to consent. For some people detention under the Act can last for significant periods of time.

[1] 2007 amendments to the 1983 Act, http://www.legislation.gov.uk/ukpga/2007/12/contents

1.4 The Act gives powers to and places responsibilities on a wide range of organisations and individuals, including:

- officers and staff of health boards, independent hospitals and social services departments, whether or not they work in mental health services;
- police officers;
- courts;
- advocates;
- Welsh Ministers; and
- the relatives of individuals who may be subject to the Act.

1.5 The Act is used in many environments, such as:

- hospitals;
    - mental health wards;
    - general medical wards for patients of all ages;
    - accident and emergency departments;
- nursing homes;
- patients' homes;
- courts; and
- public places.

1.6 The Act has serious consequences for the human rights of individuals who are subject to its powers. It is therefore clear as to the processes that must be followed when consideration is being given to detaining an individual, and for when an individual is subject to a detention or restrictions. The Act, together with the accompanying Code of Practice[2] sets out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

[2] Mental Health Act 1983 Code of Practice for Wales. http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=104742

1.7 Further, the UK is a signatory to the UN Optional Protocol to the Convention against Torture. Our role in relation to patients detained under the Act and the Mental Capacity Act Deprivation of Liberty Safeguards[3] is part of the UK's National Preventive Mechanism under this protocol. The protocol requires a system of regular visits to places of detention by independent expert bodies, to prevent torture and other forms of ill treatment.

How the use of the Mental Health Act is monitored in Wales

1.8 The Mental Health Act 1983 places a duty on Welsh Ministers to ensure that the Act is properly administered in Wales and measures are in place to properly safeguard those who become subject to the Act. Welsh Ministers are required to monitor how services exercise their powers and discharge their duties in relation to patients who are detained in hospital, or subject to community treatment orders (CTOs) or guardianship under the Act. Specifically they are required to:

- keep under review the exercise of powers under the Act in respect of:
    - detained patients;
    - patients liable to be detained;
- investigate certain types of complaints relating to the application of the Act;
- produce an annual report ; and
- provide a registered medical practitioner to authorise treatment in certain circumstances.

[3] HIW Deprivation of Liberty Safeguards Annual Report 2009-10. http://www.hiw.org.uk/Documents/477/HIW%20%20DoLS%20%202009%2D10%20v4%20MP%20FINAL.pdf

1.9 Since April 2009 Healthcare Inspectorate Wales (HIW)[4] has undertaken the monitoring of the Act on behalf of Welsh Ministers. In taking forward these responsibilities HIW has established the Review Service for Mental Health which involves:

- visits to patients subject to the powers of the Mental Health Act; and
- the provision of a Second Opinion Appointed Doctor (SOAD) service which appoints independent doctors to give a second opinion as a safeguard for patients who either refuse to give consent for certain treatments or are incapable of giving such consent.

1.10 The focus of the Review Service for Mental Health is on ensuring that everyone receiving care and treatment in Wales who is subject to the provisions of the Mental Health Act 1983:

- is treated with dignity and respect;
- receives ethical and lawful treatment;
- receives the care and treatment that is appropriate to his or her needs; and
- is enabled to lead as fulfilled a life as possible.

Mental Health Act Reviewers

1.11 Our Mental Health Act Reviewers (Reviewers) visit and talk to individuals who are subject to restrictions made under the powers of the Act. These discussions are held in private and only take place when the individual consents. The Reviewer will explore the individual's views on their care and treatment and will ensure that they understand their rights and the reasons for the restrictions placed on them. In addition, Reviewers will check all records and paperwork related to the restrictions

[4] Prior to this date the responsibilities had been taken forward by the Mental Health Act Commission who fulfilled the role on an England and Wales basis. Background information in relation to the circumstances of this transfer of responsibilities can be found in **Appendix 1**.

placed on the individual and ensure that the requirements set out in the Act and the Code have been met. Any concerns are escalated immediately and are followed up in writing.

1.12 Our Reviewers will visit any ward on which a patient is detained. A rolling programme of unannounced and announced visits is also in place to ensure that every psychiatric ward in Wales, where the majority of individuals are detained, is visited at least once every 18 months. Where we have concerns or need to follow-up on issues identified we will visit more frequently.

Second Opinion Appointed Doctor Service (SOAD)

1.13 The Act requires the appointment of a registered medical practitioner to authorise the treatment of patients subject to the Act in certain circumstances. These practitioners are known as second opinion appointed doctors or SOADs.

1.14 The role of the SOAD is to safeguard the rights of individuals detained under the Mental Health Act who either refuse treatment or who are considered to be incapable of consenting. Despite the name, the role of the SOAD is not to give a second clinical opinion about a patient's condition or diagnosis, but to decide whether the rights and views of the individual have been fully taken account of by clinicians and whether the treatment proposed is in line with guidelines and is appropriate.

1.15 SOADs are required to authorise treatment plans for:

- patients of any age who have capacity to consent to medical treatment and have refused to give consent;
- patients of any age who lack the capacity to consent to medical treatment;
- patients over 18 who lack the capacity to consent to electroconvulsive therapy (ECT);
- informal or detained patients under 18 for whom ECT is proposed, whether consenting or lacking capacity to consent;

- all patients on supervised community treatment; and
- formal and informal patients for whom certain very serious and invasive treatments are being considered (see discussion of section 57 treatments later in this report)[5].

1.16 If the SOAD agrees with the treatment to be prescribed and is content that the rights and views of the individual have been taken into account he/she will issue a certificate to authorise the treatment plan. Alternatively, SOADs may only approve part of the proposed treatment plan or place conditions on the treatment, for example they may place a limit on the number of ECT treatments permitted or set a maximum dose level on medication.

Investigation of complaints

1.17 The Mental Health Act places a duty on Welsh Ministers to make arrangements for the investigation of complaints relating to the exercise of powers and discharge of duties under the Act.

1.18 In 2009–10 we received 53 contacts by letter, email or post raising concerns with us. The majority of concerns raised related to:

- patients not believing that they should be detained;
- leave, transfers and other legal issues;
- communication and attitude of staff;
- medication; and
- privacy, dignity and cleanliness issues.

[5] The first two requirements come into force after the first three months of treatment, whilst the ECT requirements are in place immediately. It should be noted that since November 2008 it is not possible to administer ECT to patients who have the capacity to refuse to consent to it, except in an emergency as defined in Section 62 of the Act.

1.19 Many of these issues were outside of our remit and the powers delegated to us, such as requests from patients to have leave granted, their medication changed or to be released from detention. In such cases we provided information on the options available to patients and their representatives or signposted individuals to organisations who can help them with such matters, such as the Mental Health Review Tribunal or advocacy services.

1.20 Where possible we have supported patients to take advantage of local complaints processes, although where issues have arisen in relation to the interpretation or application of the Act we have taken action, as in the case outlined below.

The relative of a patient contacted us with concerns in relation to the response she had received from a hospital when she had attempted to exercise her right as nearest relative to discharge a patient from his CTO.

The hospital had used its powers to stop this move; however there was a dispute over the timing of the receipt of the request from the relative, which meant the hospital may not have had the power to do this.

We followed the issue up with the hospital to ensure they were aware of recent change in regulations which clearly defined when a letter of discharge was deemed to have been received.

The hospital revisited the matter and concluded that they had stopped the nearest relative's discharge request outside of the time period allowed by law. As a consequence the patient was discharged from his CTO.

1.21 We use the information from all complaints/concerns raised with us to guide our Mental Health Review Service inspection programme.

Review of deaths

1.22 Although not a statutory requirement for NHS hospitals, we are notified by all hospitals across Wales of the deaths of patients subject to the Act. In 2009–10 we received 23 such notifications; with a further four cases being transferred to us from the Mental Health Act Commission.

1.23 Our review of the circumstances of the 27 deaths has identified that six were due to the actions of the patient. One death was as a result of an accident that occurred when a patient was on home leave and the remainder were due to *'natural causes.'* The majority of the natural cause deaths were linked to pneumonia, respiratory infections, possible cardiac arrests or strokes.

1.24 We are currently reviewing our processes for the review of deaths and hope to provide more detailed information in our 2010-11 annual monitoring report.

Working with others

1.25 In addition to our inspection and review work described in this report, we also undertake a variety of other activities related to our responsibilities under the Act, including the hosting of workshops and conferences to ensure that the knowledge we share is up to date and accurate.

1.26 The Mental Health Act lays powers and duties on organisations that lie beyond our normal remit. Therefore, although we lead on the monitoring of the implementation and use of the Act, we work very closely with other inspection and review bodies, such as the Care and Social Services Inspectorate Wales (CSSIW).

1.27 We also work with other UK inspectorates and organisations who undertake a similar role, including the Care Quality Commission[6] and the Mental Welfare Commission Scotland.

Annual reporting

1.28 Each year we are required to prepare an annual report that gives an account of the work we have undertaken to meet our Mental Health Act monitoring responsibilities and which sets out the findings from our work.

[6] The Care Quality Commission (CQC) is the independent regulator of health care and adult social care services in England.

1.29 In this our first annual report we provide in the following chapters an overview of key figures and trends and the findings of the work undertaken in 2009-2010 by our Reviewers and SOADs.

1.30 During the coming months we will use the findings set out in this report to better focus our work and further develop our approaches to monitoring and review, ensuring that we look across pathways of care and that there is equal focus on those patients detained in a hospital setting or subject to a Community Treatment Order.

Chapter 2: Facts, Figures and Trends

In Wales during 2009-10:

- **1,453 people were detained in hospital under the powers of the Mental Health Act;**
- **12.8% of people admitted to NHS mental health facilities were the subject of a formal admission (detention);**
- **93% of all formal admissions were made to a NHS hospital;**
- **576 place of safety detentions took place in a hospital setting; and**
- **261 people were made the subject of a Community Treatment Order.**

Detention and admission to hospital under the Mental Health Act

2.1 During 2009-2010, **1,453**[7] people were admitted to hospital under the Mental Health Act for assessment and treatment across Wales compared to 1,673 in 2008-09.

2.2 As can be seen from **Table 1** the number of people admitted to hospital under the Act (formal admissions) accounted for 12.8% of all inpatient admissions to NHS mental health facilities.

Table 1: Number of inpatient admissions to mental health facilities

	All admissions to mental health facilities	Admissions under the Mental Health Act 1983[8]	Percentage of admissions that were under made the Mental Health Act 1983
2006-2007	11,017	1,310	11.9%
2007-2008	10,854	1,467	13.5%
2008-2009	11,101	1,673	15.1%
2009–2010	11,356	1,452	12.8%

Figures produced by Welsh Assembly Government

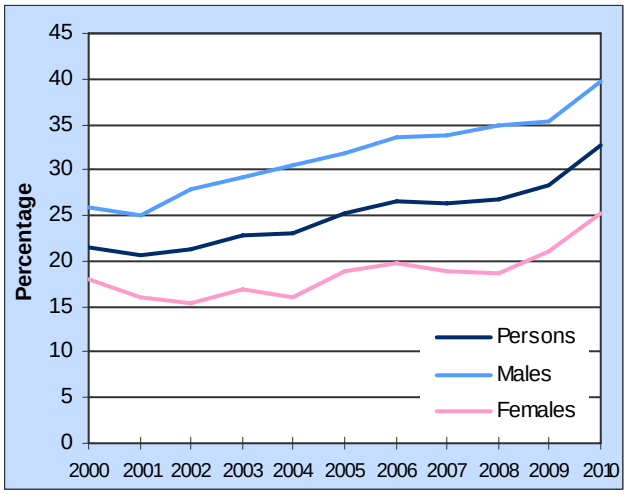
[7] Figure excludes place of safety detentions and detentions made under other legislation.
[8] Excluding place of safety detentions under part X of the Act – where police use powers to remove a person who appears to be mentally disordered to a place of safety for assessment.

2.3 While formal admissions accounted for 12.8% of all admissions to NHS mental health services they accounted for 84% of all admissions to independent mental health hospitals. Some 93% of formal admissions in 2009-10 were to NHS hospitals.

2.4 A census of patients resident in NHS mental health and learning disability units is undertaken by the Welsh Assembly Government on 31 March each year. The census data for 2009-10 highlights that there has been a downward trend in the number of people being treated as inpatients in such units since 2000, with a 16% decrease in the number of people being cared for on mental health wards and a much more significant decrease of 70% in the number of people being cared for on learning disability units. These figures demonstrate that with the introduction of improved mechanisms to support and care for people in the community the number of psychiatric beds have been reduced, as have the numbers of hospital admissions. In addition, since 2006 a detailed mental health and learning disability ethnicity census, known as *'Count Me In,'* has been taken in NHS and independent hospitals across England and Wales on 31 March of each year. The full data from the 2010 census is due to be published later in 2011.

2.5 Information and data collected indicates that the number of people subject to detention under the powers of the Act has risen each year since 2000 and they are an increasing percentage of the inpatient population (**see Chart 1)**. Only those with more complex and challenging needs are being admitted to hospital with individuals suffering from dementia, depression or a learning disability being in the main more appropriately cared for at home or in a non-hospital setting.

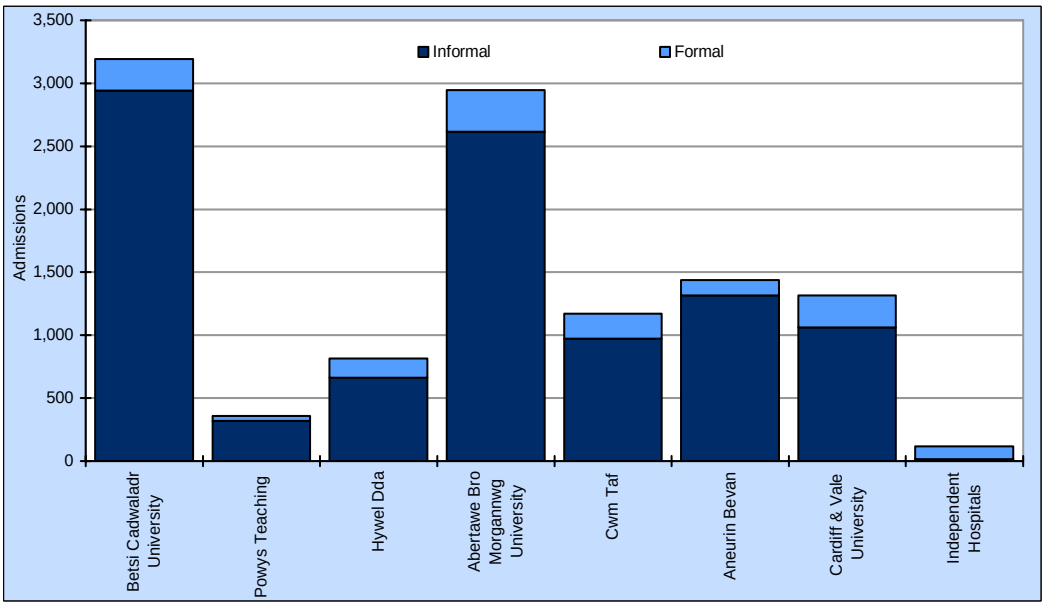
Chart 1: Percentage of people subject to detention in a Welsh mental health or learning disability facility in March of each year since 2000



Figures produced by Welsh Assembly Government

2.6 Of the seven Welsh health boards, Abertawe Bro Morgannwg University health board had the highest number of formal admissions, 334 or 25% of all admissions. Powys Teaching health board had the lowest number of both informal and formal admissions (317 and 41 respectively). As can be seen from **Chart 2** below most admissions to independent hospitals were formal admissions.

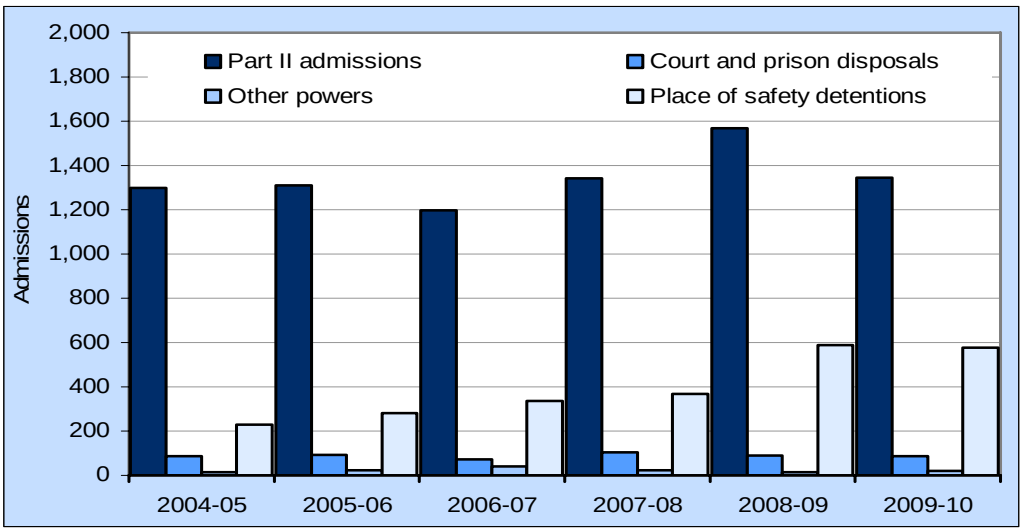
Chart 2: Admissions to mental health services (excluding place of safety detentions) by health board and independent hospitals, 2009-10



Figures produced by Welsh Assembly Government

2.7 As can be seen from **Chart 3** below, the majority of people (93%) detained under the Act are admitted to hospital under civil powers (known as *'part II admissions'*). Two thirds (66%) of part II admissions were for assessment, with or without treatment (Section 2 of the Mental Health Act 1983). A detailed table of admissions by legal status can be found at **Appendix 2**.

Chart 3: Number of detentions by type since 2004- 05



Figures produced by Welsh Assembly Government

2.8 The patient mix in inpatient facilities has tended, over the last ten years to move more towards people with psychotic (and dual diagnosis substance misuse) disorders, who are more likely to be detained. The chart above shows that the number of place of safety detentions[9] has grown and this supports the view that those being admitted to inpatient facilities are likely to be more severely ill.

Use of Section 135 and 136 powers – removal of an individual to a place of safety

2.9 Sections 135 and 136 of the Mental Health Act give police officers powers with respect to individuals who are or appear to be mentally disordered. Using a warrant from a Justice of the Peace, a police officer may use powers of entry under

[9] See section on use of Sections 135 and 136 for explanation of a place of safety.

section 135 of the Act when they need to gain access to a mentally disordered person who is not in a public place and, if necessary, remove them to a place of safety. Section 136 allows police to detain someone they find in a public place who appears to be suffering from mental disorder and to be in immediate need of care or control. Under section 136 an individual can be detained in a place of safety for up to 72 hours to allow for an assessment to determine whether hospital admission, or any form of help, is required. They can also be transferred between places of safety.

2.10 A place of safety may be a police cell, a hospital based facility, or *'any other suitable place, the occupier of which is willing temporarily to receive the patient*.' At present the only data available regarding occasions when these sections are used comes from hospitals which have been the first or subsequent place of safety. Should an individual be taken to any other form of place of safety and subsequently released their experiences are not necessarily systematically recorded. **Table 2** shows the figures for occasions where hospitals have been used as a place of safety and demonstrates the regular use of police stations as places of safety.

Table 2: Transfers whilst still subject to Section 135 and 136, 2009-10

Persons

	Transferred from			Transferred to		
Section	Hospital	Police Station	Other (a)	Hospital	Police Station	Other (a)
Section 135 - first place of safety	.	.	.	8	0	0
Section 135 - subsequent place of safety	0	3	0	0	0	0
Section 136 - first place of safety	.	.	.	51	5	3
Section 136 - subsequent place of safety	9	317	3	65	8	1
Total	**9**	**320**	**3**	**124**	**13**	**4**

(a) Includes Local social services accomodation (LSSA) and Independent Hospital / Care Homes.
. The data item is not applicable.

2.11 In recognition of the fact that a police cell is not really the most appropriate place of safety for most patients detained under section 135 or 136, a number of hospital based *'place of safety'* facilities have recently been put in place by health boards. As a result the number of place of safety detentions that occurred in a hospital based facility in 2009-10 was **576**[10] compared to 229 in 2004-05; a rise of some 60%.

[10] Police place of safety figures are not included in tables 2 and 3.

2.12 As can be seen from **Table 3** below, of the 490 notified *'place of safety detentions'* 358 resulted in a hospital admission. 150 (42%) of the 358 individuals were admitted to hospital under the powers of the Act.

Table 3: Outcomes of the use of Section 135 and 136 in 2009-10

Persons

	Discharged from place of safety			Admitted to hospital			
	Released	Transferred	Total	Informal	Section 2	Section 3	Total
Section 135 - first place of safety	0	0	0	1	13	6	20
Section 135 - subsequent place of safety	0	0	0	1	0	1	2
Section 136 - first place of safety	385	45	430	183	102	14	299
Section 136 - subsequent place of safety	59	1	60	23	13	1	37

2.13 Currently there is no consistent approach in place for the capture of information in relation to how often section 136 powers are used in non-hospital settings. That said our predecessor body, the Mental Health Act Commission, made an explicit recommendation in its final report to Parliament[11] regarding the need for such data to be collected. We are pleased that police authorities have accepted the need for this information to be collected and we will work with police forces and health boards across Wales to collate and analyse the results for our future annual reports.

2.14 The standardisation of section 136 records will in future enable us to monitor and report on this area in far more detail and will allow us to work with the police and health services to ensure that the power is used only when appropriate. Greater information will also allow us to ensure the adequacy and appropriateness of designated places of safety.

Recent reviews of the use of section 136 powers

2.15 Two key national organisations have published reports on the use of section 136 powers. The Independent Police Complaints Commission[12] and the Royal College of Psychiatrists[13] both made a series of recommendations to establish

[11] MHAC Biennial Report 2009, Chapter 2.140.
http://www.cqc.org.uk/_db/_documents/MHAC_Biennial_Report_0709_final.pdf
[12] Police Custody as a Place of Safety published 2008
http://www.ipcc.gov.uk/Documents/section_136.pdf
[13] Royal College of Psychiatrists http://www.rcpsych.ac.uk/files/pdfversion/CR149.pdf

standards on the use of section 136 powers. In particular, the College's report makes recommendations in respect of the choice of venue for places of safety; staffing of such facilities; transporting patients; and future monitoring and oversight of practice. The College's report only covered England but is due to be revised to take into account guidance in Wales.

2.16 In Wales, the Minister for Health and Social Services established a task and finish group to consider the findings and recommendations of both reports and it has been agreed that:

- specific guidance relating to the operation of section 136 would be developed for Wales;
- a centralised approach to the collection of section 136 data would be put in place; and
- each health board would identify a lead with responsibility for the oversight of the application of section 136 powers in their area.

2.17 As referred to earlier we will be working with the Welsh Assembly Government and police and health bodies over the coming months to ensure a focus on the improvement and consistency in the collection of section 136 data across Wales.

Community Treatment Orders

2.18 Community Treatment Orders (CTOs) were introduced in November 2008 as a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.

2.19 CTOs always contain two standard statutory conditions that are related to the individual making themselves available for examination. Other conditions can also be included in the CTO. While adherence to these conditions is not mandatory they are seen as an indicator of compliance and a trigger for consideration of recall or revocation.

2.20 During 2009-10, **261** people were made the subject of a CTO, with a total of **426** orders being issued in the 17 months since their introduction in November 2008. See **Table 4** below. This is an average of 25 each month.

Table 4: Number of patients discharged from hospital on a CTO and number of discharges from CTO, recalls and revocations.

	Discharge from hospital on CTO	Discharges from CTO	Recall	Revocations
November 08 – March 2009	165	7	11	8
April 2009 – March 2010	261	52	106	64

Figures produced by Welsh Assembly Government

2.21 The number of individuals placed on a CTO in 2009-10 is far higher than was forecast during the legislative process that introduced supervised community treatment. The number of people discharged from a Welsh hospital on a CTO during 2009 -10 was in excess of the total number expected to be discharged on a CTO during the four and half years between November 2008 and March 2013 (see **Table 5**).

Table 5: Estimated percentages and numbers of patients that would be placed on a CTO each year between 2008-09 and 2012-13

	Estimated % of patients transferring to CTO in England and Wales	Estimated number of patients transferring to a CTO in Wales
2008 – 09	2%	17
2009 – 10	4%	34
2010 – 11	6%	57
2011 – 12	8%	67
2012 – 13	10%	84
Total		**259**

Figures produced by Department of Health

2.22 The reasons why CTOs have proved so popular with clinicians is unclear. Our counterparts in England, the Care Quality Commission (CQC), have undertaken a clinical study[14] of the presenting histories of a sample of patients on a CTO, which identified that 30% of patients sampled, did not have the reported history of non-compliance or disengagement with services which would be expected of the group of patients for which CTOs were designed.

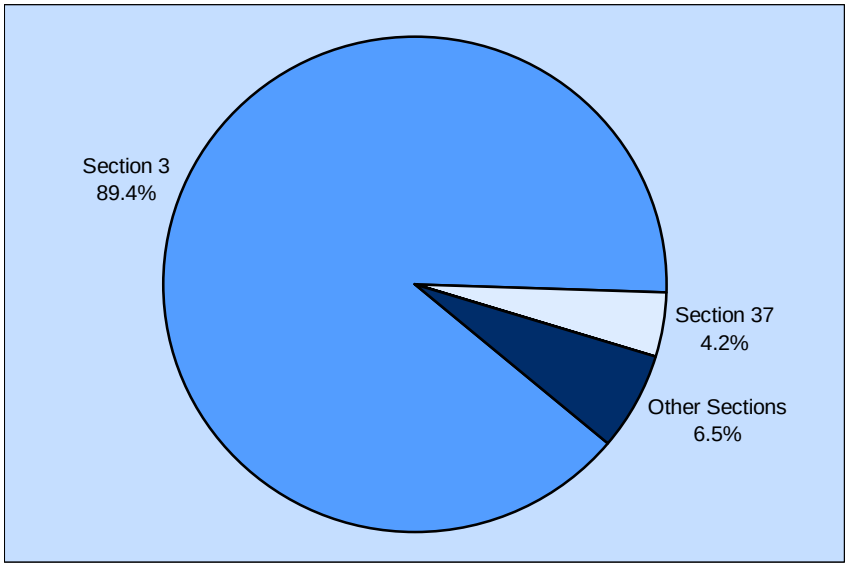
2.23 The recall power was used **106** times in 2009-10 and 117 times since the introduction of the power. Therefore, approximately 25% of patients placed under a CTO have been recalled at some point[15]. Of the 261 CTOs implemented up to the end of March 2010, **52** patients (20%) were discharged from CTO during the year, **106** (37%) patients were recalled back to hospital and **63** (24%) patients had their CTO revoked.

[14] Monitoring the Use of the Mental Health Act in 2009/10: CQC November 2010. http://www.cqc.org.uk/mentalhealthactannualreport2009-10.cfm

[15] We cannot be more precise as some patients may have been recalled more than once.

2.24 As can be seen from **Chart 5** below 89.4% of patients discharged under a CTO in 2009 -10 had been admitted to hospital under Section 3[16] of the Act. A further 4.2% had been admitted under Section 37[17] and 6.5% were admitted under other sections of the Mental Health Act.

Chart 4: Legal Status of patients before being discharged under supervised community treatment, 2009-10



Figures produced by Welsh Assembly Government

2.25 Analysis of data relating to the use of CTOs highlights that there is some variation in their use as well as recall and revocation powers across the seven Welsh health boards. As can be seen from **Table 6,** Abertawe Bro Morgannwg University Health Board placed 56 people on a CTO while Powys Health Board only used the CTO powers 15 times.

[16] Section three allows compulsory admission for treatment. It can be for up to six months and may be renewed for a further six months, and after that 12 monthly.
[17] Section 37 gives the court power to send a person to hospital for treatment instead of prison.

Table 6: Supervised community treatment related activity, 2009-10 (a)

Persons

Local Health Board	SCT related activity				
	Recall	Revocation	Discharge	Assignment to the hospital of a SCT patient	Assignment from the hospital of a SCT patient
Betsi Cadwaladr University	34	21	17	5	*
Powys Teaching	0	0	*	*	*
Hywel Dda	12	11	8	*	3
Abertawe Bro Morgannwg University	19	11	10	*	*
Cwm Taf	10	10	*	*	5
Aneurin Bevan	18	0	8	*	*
Cardiff & Vale University	13 (r)	10	8	*	*
Wales (a)	**106** (r)	**63**	**52**	**9**	**12**

(a) Wales totals in this table do not include 2 patients in independent hospitals with supervised community treatment related activity.
* Figures have been suppressed to avoid the risk of disclosing information about individuals.
(r) Revised on 29th November 2010

2.26 The work of our Reviewers and SOADs has highlighted a number of concerns in relation to the knowledge and understanding of the CTO process by some practitioners, particularly amongst staff working as part of community teams who may not have had experience in working within the framework and restrictions of the Mental Health Act. Specifically, they have identified occasions when:

- there has been a lack of communication and coordination between GP and community mental health teams leading to fragmented care being provided;
- there has been poor patient engagement with the CTO process, leading to their non attendance for SOAD visits and Tribunals; care planning has not been properly aligned with relapse signatures[18], the need to ensure compliance with CTO conditions and triggers for recall and revocation;
- shortcomings in arrangements for the transfer of care of patients subject to a CTO to other teams and areas. For example we were made aware of a patient who was made subject to a CTO while residing in North Wales and then moved to the Midlands to be nearer his family. His local community mental health service in the Midlands would not accept the transfer of his care so he had to travel regularly back to North Wales for reviews and to receive his medication. This is unacceptable;
- occasions when due to a lack of understanding of the CTO process and powers health care staff have acted outside of their powers, for example:

[18] These are signs and/or symptoms that may indicate that an individual could be heading to a relapse of his/her mental illness.

The experience of Patient A

Patient A, a patient subject to a CTO, was admitted to hospital informally for treatment of physical ill health issues connected to her long term mental disorder.

When she attempted to leave she was detained under a holding power of the Act, and then placed on Section 2 for assessment. She was moved from the general hospital to a specialist psychiatric unit. As she was subject to a CTO none of these actions should have been taken.

The experience of patient B

Patient B was subject to a CTO and had an approved plan of treatment for her schizophrenia. During a review meeting it became apparent that her GP had changed one of the medicines prescribed for her without seeking authorisation from a SOAD.

Fortunately, in this case the medicine prescribed belonged to the same category of medicine as allowed by the patient's SOAD certificate, so there were no legal issues. Nevertheless, this GP should have been aware of the fact that he/she could not change the patient's medicine without proper consultation with the patients approved clinician.

2.27 Over the coming months we will be undertaking a piece of focused review work that will look more closely at how the CTO powers and processes are being applied across Wales to ensure the appropriateness of their application.

Hospital care of children and adolescents

2.28 The Mental Health Act does not have age restrictions on its use, so could in theory be applied to very young children. From our visits to children and adult wards, and SOAD visits, we are aware of six young people who were subject to the Act in Wales during 2009-10. These young people were aged between 14 to 17 years of age and a few of the six had been detained on an adult mental health ward.

2.29 Organisations need to remain aware that use of adult services for young people is to be an exception and not a planned part of service delivery. Specifically, the Code states that in only exceptional circumstances should a young person be admitted to an adult ward and in such circumstances '*discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the child's needs'* must be put in place.

2.30 Children and adolescents requiring admission to a mental health facility are extremely vulnerable and are sometime, due to a lack of suitable facilities, admitted to an adult mental health ward or to a general paediatric ward which may not have the skills or facilities to manage such patients safely[19]. In acknowledgement of this, as of April 2010, a requirement was placed on hospital managers to have measures in place to ensure that any psychiatric patient under the age of 18 is accommodated (whether or not they are otherwise subject to MHA powers) in a '*suitable'* environment, *'having regard to his age (subject to his needs)'* (section 131A).

2.31 Chapter three of the Code of Practice defines age appropriate services as being those that have:

- the facilitates to allow for as normally as appropriate physical activities;
- staff with the right training to understand and address their specific needs as children; and
- a hospital routine that will allow their personal, social and educational development.

2.32 There are two specialist inpatient units for children and young people in Wales; The North Wales Adolescent Unit in Abergele and the Hafod Newydd Unit near Bridgend. The North Wales Adolescent Unit opened in July 2009 so that young people can be cared for as near to home as possible in a setting able to meet their needs. Unlike the setting it replaced, the new unit is able to admit patients subject to the Act.

[19] In 2009 we, along with the Wales Audit Office, CSSIW and Estyn, published a report of the findings of a review of child and adolescent mental health services (CAMHS). The review identified a number of concerns across Wales and in particular highlighted that young people with mental health problems were being inappropriately admitted to adult psychiatric wards and paediatric wards.

2.33 We visited the North Wales Adolescent Unit twice during 2009-10 and found it to provide good services to its residents, with a very well respected education provision playing an integral part in care plans. However, we have raised concerns with Betsi Cadwaladr University health board regarding the preparedness and understanding of staff in relation to the requirements of the Act. Further, it is of concern to us that neither of the two adolescent units has the level of acute/emergency provision originally envisaged. This raises concerns about the availability of appropriate services for those young people who may need detention. In addition, intensive community support services similar to those teams for adults described later in this report which help avoid admission, are not planned to be developed across Wales at the present time.

Chapter summary

2.34 The work we have taken forward in 2009-10 has highlighted that over the coming year we need to have a greater focus on CTO processes. We need to better understand the apparent variations in the use of the powers across Wales. Also, as the current numbers of individuals subject to a CTO are far higher than the numbers estimated prior to their introduction we need to ensure that the power is being used appropriately and that community teams are equipped to provide the necessary levels of care and support to those individuals.

2.35 As highlighted in this Chapter we will also be working with health and police agencies to improve the information collected in relation to *'place of safety detentions.'*

2.36 We look forward to being able to provide more detailed reports on these areas in our next annual report.

Chapter 3: Detained Patients and Consent to Treatment

In Wales during 2009-10:

- **There were 811 requests for a visit by a Second Opinion Appointed Doctor (SOAD);**
- **754 SOAD requests related to the certification of medication;**
- **68 SOAD requests related to the certification of ECT;**
- **356 SOAD requests related to Community Treatment Orders; and**
- **One request was made for a Section 57 authorisation.**

3.1 Any individual detained under the Mental Health Act may be given treatment and medication with or without consent for a period of up to three months of their detention[20]. The treatment is given under the authority of the approved clinician responsible for their care.

3.2 After the three months has passed, unless an emergency situation arises, treatment can only be given under certain conditions and the authority for that treatment must be formally certified.

The role of the SOAD

3.3 In circumstances where the patient is happy to consent to the treatment, and has the capacity to consent, either the patient's approved clinician or a second opinion appointed doctor (SOAD) may certify the patient's consent. Where a patient lacks capacity to consent or refuses to consent, the treatment may only be given following certification by a SOAD that the treatment prescribed is appropriate.

3.4 As described in chapter one of this report, SOADs are required to authorise treatment plans for:

- patients of any age who have capacity to consent to medical treatment and have refused to give consent;

[20] This three month period does not apply to electro-convulsive therapy (ECT).

- patients of any age who lack the capacity to consent to medical treatment;
- patients over 18 who lack the capacity to consent to Electroconvulsive Therapy (ECT);
- informal or detained patients under 18 for whom ECT is proposed whether consenting or lacking capacity to consent;
- all patients on supervised community treatment; and
- formal and informal patients for whom certain very serious and invasive treatments are being considered (see discussion of section 57 treatments later in this report).

3.5 Before a SOAD certifies the treatment he/she visits the patient and discusses his/her case with the Approved Clinician and two other statutory consultees, such as nurse and social workers[21]. Where necessary and appropriate the SOAD will consult with more people, including advocates, relatives or carers. A decision to certify treatment in full or in part, or alternatively not at all is only made when all necessary information has been collected and assessed. In certifying treatment the SOAD will clearly define the maximum dosages of medication and routes of administration to be used.

3.6 SOADs are key to ensuring that the human rights of individuals are safeguarded as far as possible while they are subject to a detention under the powers of the Act and that the treatment they are prescribed is ethical and in line with national guidelines and best practice, for example:

The experience of patient C

During 2009-10 a SOAD visit was undertaken to a detained patient (patient C) for whom a course of ECT was proposed. After consideration of the lady's diagnosis and history the SOAD declined to authorise this treatment as the patient did not meet the requirements set out in NICE guidance for the use of ECT.

[21] Both statutory consultees must have been professionally concerned with the patient's medical treatment, and neither may be the clinician in charge of the proposed treatment or the responsible clinician.

Requests for SOAD visits received during 2009-10

3.7 As can be seen from **Table 7** below there has been a marked increase in the number of requests for a SOAD visit over the two years, particularly since the introduction of CTOs in November 2008.

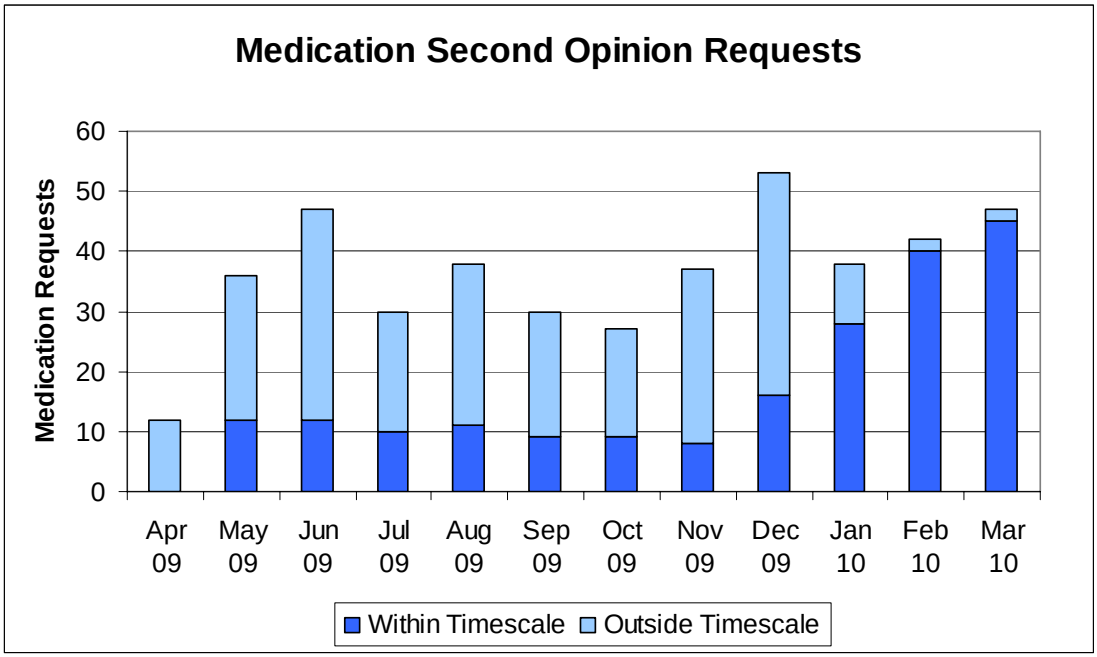
Table 7: SOAD requests for certification by type of request

	Request received for certification of:			
	Medication	**ECT**	**Both**	**Total**
2006 – 07	428	106	3	537
2007 – 08	427	79	5	511
2008 – 09	545	60	2	607
2009 – 10	743	57	11	811

3.8 Given the important role that the SOAD plays in ensuring that the treatment individuals, detained under the Act, are prescribed is ethical and in line with national guidelines and best practice, we have set very tight timescales for the visits. Upon receipt of a SOAD request we aim to ensure that it takes place within:

- two working days for a ECT request;
- five working days for an inpatient medication request; and
- 10 working days for a CTO request.

3.9 During the year we experienced a number of problems meeting these timescales particularly in certain areas of Wales and during certain months. There were two noticeable periods when the time between receipt of request and the SOAD visit taking place was much longer than they should have been (June/July and November 2009). These peaks coincided with periods when SOADs were unavailable due to holidays, sickness or other calls on their time.


Medication Second Opinion Requests
Medication Requests
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50
40
30
20
10
0
Apr 09
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Jun 09
Jul 09
Aug 09
Sep 09
Oct 09
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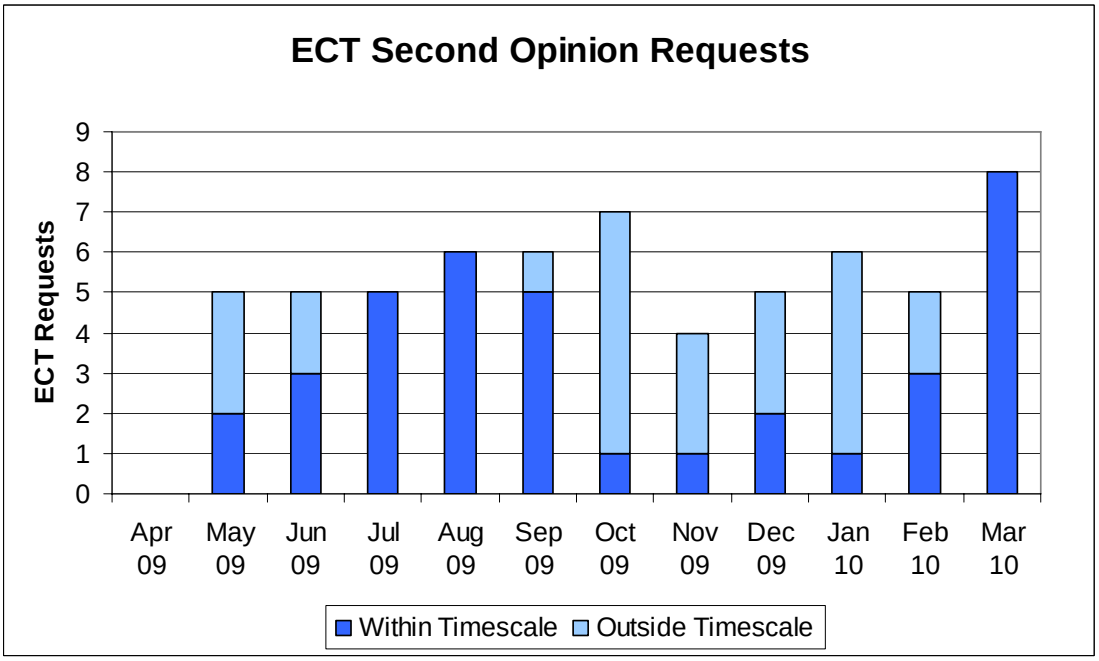
ECT Second Opinion Requests
ECT Requests
9
8
7
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5
4
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2
1
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Apr 09
May 09
Jun 09
Jul 09
Aug 09
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Nov 09
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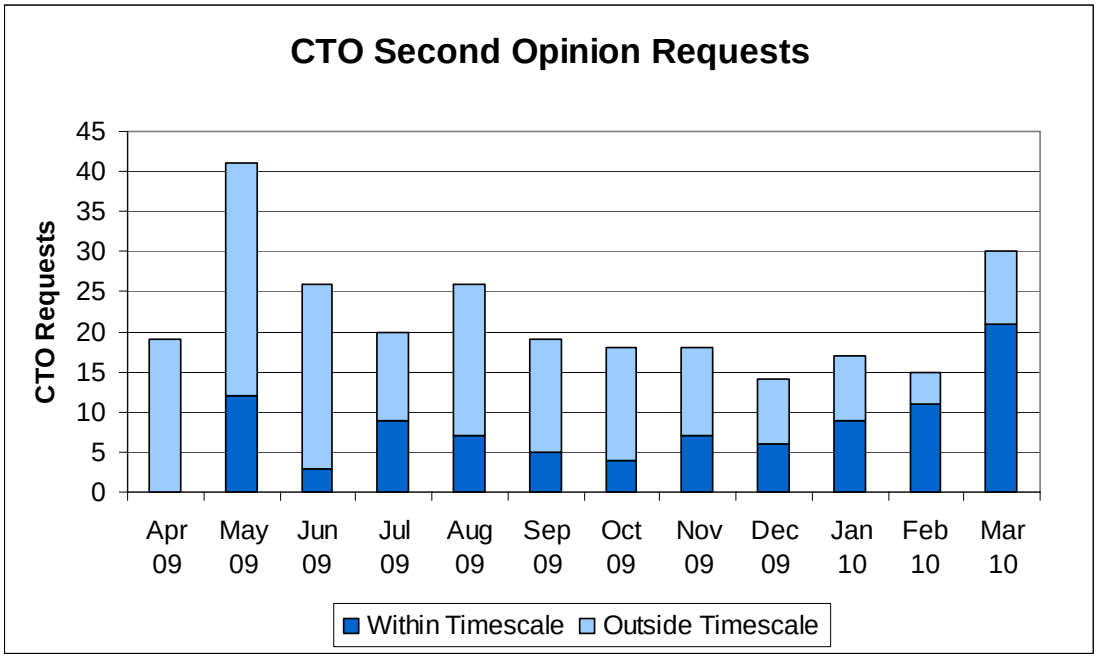

3.10 To avoid such a situation occurring again we have recruited a number of additional SOADs, who, following induction training, started work in December 2009. We specifically focused on recruiting SOADs to cover those areas of Wales, particularly the West and North, where we have previously had problems in relation to delays in visits. We have already seen a positive impact and the time between receipt of a request and a visit taken place has reduced significantly.

Community Treatment Orders

3.11 Every patient placed on a CTO is required to be seen by a SOAD to authorise the treatment they will receive in the community. The SOAD can also approve treatment to be given if the patient has to be recalled to hospital.

3.12 It is a mandatory condition of all CTOs that the patient makes his/herself available to be seen by the SOAD; they can be recalled to hospital to facilitate this.

3.13 Beyond the general impact of increased demands for SOADs described above, our performance in meeting requests for CTO visits has been affected by the experience of our SOADs in undertaking these visits, which include:

- **Location of visits**: Our SOADs are lone workers and as they cover wide geographical areas they are often required to undertake visits to unknown locations. We expect the team responsible for the care of the individual to arrange for the SOAD visit to take place in a suitable location. This can be an outpatient or Community Mental Health Team clinic, nursing home, other staffed residential settings or a GP surgery. However, our SOADs have sometimes found themselves in situations where they have been alone with a patient in an unattended clinic building.

  We do not expect a SOAD to visit a patient in a private house, except perhaps when there are very exceptional circumstances and even then the visit would only be undertaken at the discretion of the individual SOAD. In such circumstances we would expect a member of the local team to accompany the SOAD.

- **Access to patient records and notes:** SOADs have often experienced difficulties accessing staff and notes. For example, one SOAD reported that it took him six weeks to complete a certificate following a CTO visit as, despite making many attempts; he was unable to access all records or arrange a meeting with one of the individuals that he needed to consult with. An alternative person with sufficient knowledge of the patient could not be identified.

- **Patients not attending SOAD appointments:** on numerous occasions patients have not turned up for their SOAD appointment. A number of patients have missed more than one appointment. Community teams should be supporting patients to ensure that they understand the importance of the SOAD visit and to ensure that they attend their appointment. Clinical teams should consider whether those who repeatedly miss their SOAD appointment are really suitable to be placed on a CTO.

3.14 The experience of our SOADs is not dissimilar to that of SOADs in England. We consider that many of the issues arise because of insufficient understanding of the importance and reasons for the SOAD visits by mental health staff working in the

community, whose experience of working with mental health legislation may be limited. This is supported by our experiences in relation to the administrative processes that some health boards have in place. In particular we have found that:

- there is an expectation that SOADs or HIW, neither of whom is known to the patient or the area, will make all the arrangements for a visit;
- there is a lack of clarity within organisations as to whether administrators or care teams, especially care co-ordinators will lead on making appropriate arrangements;
- administrative staff are not always informed that visits have been made or cancelled; and
- copies of the statutory forms given to community staff by the SOADs are not being sent to central teams so that legal records are kept up to date.

3.15 The Code of Practice makes it clear that health boards are responsible for making arrangements for SOAD visits. There should be agreement with individuals regarding the location of a CTO visit and they should be given access to the help they need to be able to comply with the conditions of their CTO.

3.16 We will continue to work with health boards to address these issues, for example by helping them to arrange *'CTO clinics'* where arrangements are made for a number of patients to attend a location during one session, and relevant staff and notes are to hand as well. We have already participated in a number of CTO training events for staff.

3.17 In relation to 287 of the 351 requests received for a CTO visit, the individual had the capacity to consent to treatment and was consenting to treatment. The need for SOAD visits to be undertaken in such circumstances has been questioned by many clinicians. In this regard it should be noted that the Health and Social Care Bill published in January 2011 contains proposals to bring the requirement for certification by a SOAD in line with the practice currently in place for patients detained as an inpatient; that is approved clinicians will be able to certify treatment for those patients subject to a CTO who have capacity and are consenting to treatment.

Section 57- treatments requiring consent and a second opinion

3.18 The safeguards set out in Section 57 of the Act are there to ensure that certain of the most serious forms of medical treatment for mental disorder can **only** be provided if the patient consents to the treatment **and** three independent people appointed by HIW – one being a SOAD – have certified that the patient understands the treatment, has consented to it and that the treatment is appropriate. If the patient does not or cannot consent the treatment cannot proceed. Section 57 is one of the few sections of the Act that applies to informal patients as well as those subject to the longer-term sections of the Act.

3.19 The forms of treatment for mental disorder to which the safeguards apply are currently:

- any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue, this is commonly referred to as *'psychosurgery'* or *'neurosurgery for mental disorde*;' and
- the surgical implantation of hormones for the purpose of reducing the male sexual drive.

3.20 Such treatments are rarely prescribed. A request to authorise the surgical implantation of hormones has not been made for approximately 20 years; this is believed to be due to such treatment having been superseded by non-invasive alternatives.

3.21 Psychosurgery is also very unusual and the number of people undergoing such procedures has declined, with normally around only one or two procedures being undertaken each year across the UK. Until 2010 the University of Wales (UHW) Hospital in Cardiff, part of the Cardiff and Vale University health board was the only hospital in England or Wales to have undertaken such procedures in recent years

3.22 In 2009-10 we received one request for us to certify psychosurgery for an informal patient referred for treatment from England. This referral was not progressed and so we were not required to consider the patient's case in detail. We have been working with the Cardiff and Vale University health board to clarify procedures, expectations and governance arrangements. In this respect we are grateful for the advice and information we have received from our counterparts in the Mental Welfare Commission Scotland. They have had a higher number of requests for such certifications and their legislation has been recently amended to bring newer neurosurgical techniques which are invasive but less destructive of tissue, such as Deep Brain Stimulation (DBS).

3.23 We have received representations from clinicians who suggest that DBS and other similar treatments should fall within the remit of section 57 in England and Wales, as it has a similar impact on brain function if not its structure as more invasive techniques. We hope that Ministers will give consideration to extending the current scope of section 57 and associated legislation to bring it in line with contemporary clinical practice.

Chapter summary

3.24 During the year there was a substantial increase in requests for a SOAD visit. As a result there were times when we did not meet the timescales that we have set for such visits. Following the appointment of additional SOADs we saw an improvement in performance which we will keep under close review in the coming months.

3.25 We will also continue to work with health boards to improve CTO visit processes and governance arrangements relating to section 57 safeguards.

Chapter 4: Patient Experience

The visits we have undertaken during 2009-10 identified issues in relation to:

- **The recording of consent and capacity assessments;**
- **Mixed sex wards and the need for staff to be aware of how to manage the tensions that can arise;**
- **The lack of knowledge and skills of mental health staff to enable them to manage patients with co-existing physical or medical needs;**
- **The need for care planning to be improved; and**
- **Shortcomings in the provision of activities and therapies.**

4.1 When an individual is detained under the Mental Health Act they are very ill and by the very nature of their illness, extremely vulnerable. It is a very distressing time for the individual subject to the detention and his or her family. In recognition of this our Reviewers undertake visits to hospitals and wards where someone may be detained to ensure that the Act is being administered and used appropriately and the human rights of patients protected. Further, in line with the requirements of the Code of Practice they ensure that the Act is operated with a view to promoting recovery by maximising the mental and physical wellbeing of patients and protecting them and others from harm, while keeping restrictions on liberty to a minimum.

4.2 During 2009-10 we undertook 91 visits to hospitals across Wales. These visits were made to 51 hospitals that care for and treat individuals detained under the powers of the Act. Our Reviewers provide the organisation with feedback on the day of the visit and this is followed up with a Management letter that is sent to the Chief Executive or Responsible Manager[22].

[22] Management letters are not published on our website because the content relates, in the main, to individual patients and we have a responsibility to safeguard their identity and privacy.

4.3 Our visits were focused on ensuring that any individual who is subject to a detention under the powers of the Act: is treated with dignity and respect, is made aware of their rights, is cared for in a suitable environment, is given care and treatment that is in line with relevant guidelines and is as far a possible given the opportunity to influence his/her care plan. We assess whether services strike an appropriate balance between the needs of security and the need to provide a relatively normal, *'homely,'* environment for patients detained in hospital.

4.4 As part of these visits our Reviewer will:

- examine legal papers, care plans and risk assessments to assess how the Act's requirements have been complied with and managed, and the adequacy and appropriateness of care given to the individual;
- hold discussions with staff in order to develop a picture of their knowledge, understanding and attitudes;
- talk with service users and their families to test how organisations have met their responsibilities in relation to ensuring that their rights are explained to them, involving them in care planning as well as to gain a picture of their experiences of care and treatment;
- assess the environment of care to ensure it is appropriate, clean and affords the individual privacy and dignity; and
- check to ensure that policies and procedures are in place, and that powers have been delegated appropriately.

4.5 During the year our reviewers spoke to over 200 detained patients, either informally in private interviews or during group discussions. They also met with relatives, carers and friends who were visiting at the time when the Reviewer was on the ward. Reviewers also examined the records of around 200 patients.

4.6 The remainder of this Chapter provides an overview of the findings from these visits. For ease of reference we have set out our findings under the key questions that our Reviewers sought to answer as part of their visits.

Have the correct legal processes been followed?

4.7 Generally we found that the correct legal processes had been followed. However, it is clear that professionals differ in their views as to the circumstances when it is appropriate to use the Act. While we understand the desire to avoid placing the potential stigma of *'a section'* on a patient when it can be avoided, we have been told by some informal patients (i.e. who are not detained under the Act) that they feel coerced into accepting treatment or staying in hospital informally through being told that they would otherwise be detained.

4.8 We also identified a small number of people who had been informal patients for a long period of time. We are concerned that patients in such a position are not afforded the same rights and safeguards as detained patients. We believe that the appropriateness of the status of any long term patient as an informal patient should be reviewed.

Are adequate records kept?

4.9 A number of the queries raised by our Reviewers in relation to the legality of a detention were due to poor record keeping and management. For example, on a number of occasions there was some inconsistency between legal documentation held on the ward and that held centrally, making it difficult for staff to have a clear and correct picture of a patient's legal status.

4.10 We found that staff did not always follow the Code of Practice's guidance and record certain actions and activities relating to the Act in patient notes. One common example is that staff do not always record the fact that they have acted as a statutory consultee during discussions to authorise treatment.

Where appropriate has consent been obtained and the assessments of capacity undertaken?

4.11 As discussed in chapter three of this report, the Act has strict procedures relating to the authorisation of the administration of treatment. Reviewers found that the quality of records kept in relation to the assessment of an individual's capacity to make a decision about their treatment to be variable and often did not contain adequate detail. The documentation of discussions held with individuals with capacity in order to establish whether they consented to treatment were equally variable. There were particular issues in relation to situations where an individual's capacity to consent to treatment fluctuated over time.

4.12 Of particular concern was that some of the staff spoken to did not always seem to appreciate the consequences of not following due process and ensuring the proper documentation of discussions. Such shortcomings could result in legal action being taken against the organisation and professional consequences for individual staff members if they are seen to oversee or administer treatment that is not lawfully authorised. The experiences of patients set out below provide examples of the concerns our reviews have highlighted:

The experience of patient D

Patient D was seen during a visit to her ward. Her patient notes indicated that she was judged to have capacity to consent to her treatment and that she had consented to it; having a full understanding of the side effects and implications.

When our Reviewer discussed her treatment and medication regime with Patient D she appeared to have a poor understanding of what she was taking and why. Further examination of Patient D's notes highlighted that discussions had been held by the team caring for her about administering her medication covertly, as there had been recent difficulties getting her to accept it.

Professional guidance is clear that covert administration of medication should not be considered in circumstances when a patient has capacity.

The experiences of patients E, F and G

Patients E, F and G were under the care of the same Responsible Clinician. All three individuals had been detained sufficiently long for the consent to treatment provisions of the Act to come into force. However, despite reminders from administrative staff, it appeared from the patients' record that the Responsible Clinician had not taken action to gain informed consent from the patients or the required authorisation for treatment where they did not or could not consent.

Our Reviewer queried this with the administration office, in case there was a mismatch between ward and central records. It became clear that the necessary action to gain consent had not been taken and so the safeguards set out in the Act were not put in place for theses individuals, for periods between two weeks and three months.

On checking the prescription and medication charts for these patients it was evident that nursing staff had continued to administer medication to them despite there being no record of the consents or authorisations required by law being in place.

4.13 It is of concern that staff do not always comply with or understand capacity and consent requirements. Similar issues have been highlighted by our Deprivation of Liberty Safeguards[23] monitoring work. Clinicians and nursing staff have a professional responsibility to ensure they are acting lawfully and following the appropriate frameworks and processes when assessing capacity and gaining consent.

4.14 On a positive note some organisations have put arrangements in place to remind staff of the need to ensure that consent has been sought. Some practices that are worthy of note include:

When the Mental Health Act administration team in one Health Board sends out notification that authorisation is required, along with the relevant forms, they provide a pro forma for recording an assessment of capacity.

In parts of Abertawe Bro Morgannwg University Health Board, yellow alert stickers are in use on prescription charts which alert both the prescriber and administrator of the consent to treatment provisions.

[23] Further DoLS information can be found on www.hiw.org.uk/page.cfm?orgid=477&pid=36825.

Are individuals detained under the Act aware of their rights and do they have access to an advocate?

Is the right information made available to patients?

4.15 Most hospitals take particular care to ensure that patients understand the implications of their detention and are clear about their rights, particularly in relation to their right of appeal to Hospital Managers hearings[24] or the Mental Health Review Tribunal[25].

4.16 In most hospitals visited the patients we spoke to were are able to describe what they can and cannot do as a result of being subject to the Act, who can help them and their right of access to records, interpreter services and information in their language of choice. However in some hospitals or wards we found that there was a *'tick box'* approach in place, although we were showed forms indicating that the patient had received a leaflet or a member of staff had '*read their rights'* to them, the patients we spoke to could not demonstrate that they were aware of or understand their rights. This is of concern and we will be following this matter up with the individual organisations as a priority.

Do patients have access to an advocate?

4.17 Changes made to the Act in 2008 included the introduction of the Independent Mental Health Advocacy (IMHA) service, to provide independent support to patients subject to the Act to ensure that they understand their rights and are able to express their opinions and concerns. IMHA services are commissioned through contracts setup by the 22 former local health boards, often in consortia, which have been

[24] Hearings held by a committee formed by the hospital responsible for the use of the Act on a patient which can decide to use the hospital's powers to discharge certain patients from detention or supervised community treatment.
[25] A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge in the Act.

inherited by the new health boards following the NHS reorganisation of October 2009. An IMHA service should be available for all qualifying patients subject to the Act, whether or not they are under the care of an NHS or non-NHS provider.

4.18 We identified some inequalities in access to IMHAs across Wales. As stated above health boards are required to commission IMHA services for any patient detained in their area, and all have done so. However we have found that some registered independent hospitals are not aware who provides their local statutory IMHA service and neither do they have regular contact with their IMHA service, unlike in neighbouring NHS facilities where IMHA services make scheduled visits in addition to responding to individual referrals for support.

4.19 In addition, some concerns were raised with us about IMHA services as some staff and patients felt that on occasion IMHAs possibly overstepped the boundaries of their role. For example there have been instances when they have spoken to a newly detained patient whether or not that patient had requested to see an advocate. They have also been known to make an application for a tribunal for patients who have subsequently told hospital staff that they had not wished to make an appeal.

4.20 The Code of Practice clearly sets out the role of the IMHA; health boards as commissioners need to ensure that the requirements set out in the Code are being met by all IMHAs. They need to monitor the level and approach to provision and ensure the equity and appropriateness of provision. As part of monitoring, health boards must ensure that IMHAs are fully engaging with independent healthcare organisations.

4.21 There is also a second type of statutory advocacy service, the Independent Mental Capacity Advocates (IMCAs) who have a specific role under the Mental Capacity Act when decisions need to be made for patients who lack capacity. IMCAs cover both formal and informal patients.

4.22 In addition, some hospitals and wards have arrangements in place for the provision of general advocacy services. Such services are usually provided by third sector organisations or service user groups. While such advocacy services provide

good support to their clients they do not necessarily have the detailed understanding of the Act required to provide adequate support to detained patients and neither do they have the same rights as IMHAs, for example around access to patient records.

4.23 We have found that when advocacy services are provided by various agencies confusion can arise, for example when we asked about IMHA services many of the staff and patients we talked to referred to the general advocacy services provided by third sector organisations. Staff need to ensure that detained patients have access to an advocate who has the necessary skills and knowledge to fully support them and ensure they are properly represented, and they therefore need to ensure that detained patients have access to an IMHA.

4.24 Given that the Mental Health Measure[26] will extend statutory access to advocacy services to all inpatients with a mental disorder in Wales, there is scope for further confusion and therefore health boards need to ensure that appropriate processes and guidelines for staff are in place.

4.25 Overall we found staff to work appropriately with advocates. However we have been made aware of some difficulties that are experienced in relation to the attitudes of some staff, for example not letting advocates accompany and support patients during ward rounds or informing patients that issues should be raised directly with a member of staff rather than through an advocate. Staff need to be reminded of the importance of the role of the advocate in ensuring that the human rights of the patient are maintained as far as possible. They should see the advocate as a safeguard not just for the patient but also for them, as a skilled advocate will highlight risks and issues in relation to non compliance with the Act and human rights requirements at the earliest opportunity.

[26] A Measure of the National Assembly for Wales to make provision about primary mental health support services; the coordination of and planning for secondary mental health services; assessments of the needs of former users of secondary mental health services; independent advocacy for persons detained under the Mental Health Act 1983 and other persons who are receiving in-patient hospital treatment for mental health; and for connected purposes. This Measure was passed by the National Assembly for Wales on 2 November 2010 and approved by Her Majesty in Council on 15 December 2010.

Is the environment of care appropriate and conducive to recovery?

4.26 An individual detained under the powers of the Act can spend many weeks and months in an inpatient environment and often because of the severity of their illness they cannot leave the ward on which they are being cared for. Therefore the appropriateness of the environment of care is extremely important because it can have an influence on the mood and behaviour of the individual and either help or hinder a speedy recovery.

4.27 The majority of settings we visited were found to be clean, comfortable and in good decorative order. Many wards had access to gardens and/or conservatories and smoking rooms. We considered environments that were comfortable, less clinical and promoted social interaction and communal activities to be more conducive to a relaxed environment where recovery could be supported.

Is the environment of care safe?

4.28 Ligature points were still evident on several of the wards/units visited. While the staff that we spoke to were aware of the risks posed by these and were able to clearly demonstrate how best to manage them, organisations need to ensure that ward designs and fixtures and fittings are appropriate to the client group.

4.29 We were also concerned that sometimes staff were not alert to some issues that could impact on the safety of patients who may, due to the nature and severity of their illness, attempt to take their own life. For example, the appropriateness of leaving large plastic bin bags in patients' bedrooms. Often where wards/units are in need of updating or were designed originally for a different use, there are inherent risks to confused patients that need to be properly managed, such as in the case set out below.

A ward at Hospital A was designed as a general medical ward, but is now used for elderly patients with mental illnesses. As a consequence it is fitted with medical equipment such as pipes to carry oxygen in which confused patients can become entangled.

There is a low desk at the nurses' station, which can be reached over by a patient. We observed confused patients removing items from the desk, including a set of patient notes that were later found in an empty bedroom that the patient had managed to lock from outside by use of an external over-ride mechanism.

Are patients afforded privacy and dignity?

4.30 A number of issues that impact on the privacy and dignity of patients were highlighted by our reviews. While many mental health units/wards have single bedrooms, others have bays or dormitories of varying capacity, which reduces the level of privacy and dignity afforded to patients.

4.31 Single rooms can raise issues in relation to safe observation and we noted that on some wards curtains had been removed from glass panels so that anyone passing could see straight into the room; this is unacceptable.

Unit B is a newly refurbished facility, which cares in the main for older people with continuing healthcare needs and cognitive disorders.

Many of the windows of patient rooms and communal areas have vertical slat blinds, which have over time been interfered with by the patients, leaving gaps in the slats or blinds that cannot be closed, compromising patients' privacy.

4.32 We were also told by patients, particularly on elderly care wards that staff did not always knock before entering their rooms. Staff should afford all patients respect and ensure that they always knock before entering a room.

4.33 Another key issue for patients was the fact that they could not always lock their rooms to safeguard their personal possessions, and a number of wards did not have lockable cupboards or units in which patients could keep their possessions.

Is gender appropriately managed?

4.34 It is inevitable that some wards admit both sexes, particularly those managing the most acutely ill patients where there is insufficient need to justify single sex wards. However, the Code of Practice highlights the need for mixed sex wards to have appropriate gender separation, including quiet spaces. Most wards visited had sufficient separation of bed spaces, but with a few there were issues in relation to the appropriateness of communal and toilet/bathroom areas. For example, some bathrooms opened directly onto communal areas and there was often poor signage making it difficult for patients to differentiate between male and female facilities.

4.35 Often female patients raised concerns with us about mixed sex arrangements and the behaviour of other patients; the nature of their illnesses can mean some patients behave out of character or become very dis-inhibited. They felt that staff did not always appear to fully appreciate the impact of such behaviour on others, who may be particularly sensitive to some behaviour due to their past experiences.

The experiences of patients H and I

Two elderly female patients (patients H and I) on one ward we visited told us that they had asked staff to lock them in to their bay to prevent a disruptive male patient from entering the area.

The experience of patient J

We were informed of an incident on a ward where a male Patient J had a bedroom near the toilet facilities. He had been observed using the female toilets and so was moved to another room. However, a few days later he was moved again back to a room near the toilets. Following this move he was accused of assaulting a female patient in the toilets.

Are bathroom and toilet facilities adequate?

4.36 We identified a number of issues in relation to bathroom facilities, either due to limited access or poor maintenance. Issues we highlighted included:

- one ward having only one bathroom for the use of 18 patients;

- leaking and slippery shower rooms;
- wards needing to use the bathroom facilities on adjacent wards;
- specialist lifting equipment not being available as it was awaiting repair, meaning that patients could not have a bath; and
- bathrooms being cluttered with equipment as they were being used as storage rooms.

4.37 Some wards had been awaiting a visit from maintenance for many months, despite staff raising issues regularly.

Do patients have access to phones and rooms for private conversations?

4.38 Access to phones or rooms for private conversations was a key issue for patients. Many patients and their relatives felt that they had little opportunity to have private discussions or quiet time with their loved ones.

4.39 There were particular issues where community teams have been co-located on inpatient wards. While such arrangements have the benefit of facilitating continuity of care before admission and after discharge, and improving information sharing and communication, in some locations there has been an impact on patients with the loss of communal rooms, interview rooms or bedrooms. Also, some arrangements can cause privacy issues, for example in one organisation community staff have to pass through a patient dormitory to access their offices.

4.40 Often organisations will say that they cannot do anything about the environment of care because the building is ageing and does not support current models of care or standards of privacy and dignity. They also say that they have development plans in place and cannot justify the expenditure needed as an interim measure. Organisations need to be aware of the huge impact poor environments of care can have on a patient's wellbeing and it is their responsibility to ensure that their facilities are as fit for purpose as is possible.

4.41 The Cardiff and Vale University Health Board is an example of an organisation that has been very proactive in taking steps to improve the environment of care for its patients despite delays in taking forward the plans for Whitchurch hospital.

Whitchurch Hospital is an ageing facility which has been the subject of closure and redevelopment plans for many years. Cardiff & Vale Trust (now University Health Board) have either moved patients into newer more suitable units, such as the Iorwerth Jones unit, or have invested in refurbishing and remodelling existing wards.

One example is Ward East 2, where we noted the very obvious change in atmosphere on this ward, which has been redesigned to make it more soothing and calming and it now provides much improved living facilities.

Staff told us that the need for high levels of observation had decreased significantly since these changes

Do patients have access to regular activities and the therapies they need?

Are adequate activities provided?

4.42 Research and experience has shown that varied programmes of activity and therapy can have a very positive impact on patients and patient outcomes. However, a recurrent theme raised with us by the patients we have spoken to is the lack of provision of meaningful activities. In particular they told us that activities are rarely available at weekends or evenings and they can therefore be left just sitting around getting very bored. Their illness often means that they cannot sit and read or watch television for periods of time because they are unable to concentrate and focus.

4.43 Some patients have significant restrictions placed on them as part of their detention, and are unable to leave a ward even to visit another area of the hospital such as a shop or café. Sufficient activities that meet the varied needs and interests of patients within the framework of their detention are vital to promote recovery.

4.44 A further concern often raised with us by patients was that planned escorted leave or trips were often cancelled due to the unavailability of staff. The reasons given for the cancellation were usually related to unavailability due to staff sickness or shortages or staff being required to undertake other duties at short notice, such as enhanced levels of observation for a patient whose risk level has intensified. Escorted leave and trips are a key part of the patients' steps to recovery. Such cancellations often lead to disappointment and frustration, which in turn can lead to increased tensions.

Do patients have access to therapies including psychologists?

4.45 We have found very variable access to therapeutic input beyond medication. Access to occupational therapy, physiotherapy, speech and language therapy, dietetics and in particular psychological therapies varies markedly, even between wards in the same hospital. Often we found that staff could not provide an explanation for the variations, although in some cases we were told it was because the patients were outside the therapy services' eligibility criteria, for example they may have a co-existing learning disability.

4.46 The lack of access to psychological therapies is of particular concern and has been a recurrent issue raised with us this year. Many of the detained patients we spoke to have had mental health issues for many years and told us that when they had received psychology input in the past they found it helpful and felt that it aided a quicker recovery. We are concerned that the lack of access to appropriate therapies leads to a slower recovery and unnecessarily longer periods of detention.

4.47 Our visits also identified a lack of facilities on many wards for the provision of therapeutic activities and assessments which are often essential to promote continued independence or assessing a patient's capacity to care for themselves prior to discharge. On some wards patient kitchens and exercise facilities were not being used due to health and safety or staff training issues, and in others lack of

space led to occupational therapists and physiotherapists undertaking one to one work with patients in a corner of a day room in front of the other residents, which gives rise to privacy and dignity issues.

Is the approach to care planning appropriate and are well developed care plans in place?

Are care plans detailed and appropriate?

4.48 The Code of Practice provides clear guidance on the planning of the care and treatment of patients subject to the Act. The Code's aim is to ensure that the recovery of an individual subject to detention and the re-establishment of their independence takes placed as soon as is safely practicable.

4.49 A key principle of the Code is that patients should be involved in the development of their care plans. In Wales, the Care Programme Approach (CPA[27]) has been adopted. While we have seen some highly innovative and detailed care plans, we are concerned that generally plans are of a poor quality. Overall, plans lack detail and clear objectives, they are rarely reviewed and we found that patients and their relatives had little or no knowledge of their content.

4.50 In 2009, the Delivery Support Unit[28] (DSU) and National Leadership and Innovation Agency for Health[29] (NLIAH) produced a report of a detailed review of the implementation of CPA across the NHS in Wales[30], which demonstrated that our findings are not unusual.

[27] Care Programme Approach is concerned with identifying and recording outcomes from the care provided and the time scales within which it is hoped that the outcomes will be achieved.
[28] The Delivery and Support Unit (DSU) was formed in 2005 to assist NHS Wales organisations to continually improve and sustain their performance against the national access targets set by the Minister for Health and Social Services.
[29] The National Leadership and Innovation Agency for Healthcare (NLIAH) was launched in March 2005. Its purpose is to provide a national strategic resource to support NHS Wales in delivering the Designed for Life agenda by building leadership capacity and capability to secure continuous service improvement underpinned by technology, innovation, leading-edge thinking and best practice.
[30] Review of the Care Programme Approach 2009 Joint publication by DSU and NLIAH. http://www.wales.nhs.uk/sites3/Documents/438/Review%20of%20CPA%20in%20Wales%202009.pdf.

4.51 In response to concerns raised about care planning in July 2010 the Welsh Assembly Government published revised interim CPA guidance and we have had the opportunity to feed the outcomes and findings of our visits into this.

4.52 Over the coming months we will continue to look at care plans to assess and evaluate their quality and adequacy.

Are adequate risk management and safeguarding arrangements in place?

4.53 The assessment of risks and developing plans to mitigate and manage these is an important part of care planning. We found considerable variation in the detail and quality of risk assessments and how they were linked to the safeguarding agendas. Generally, there was a lack of engagement with patients, carers, relatives or other significant people in identifying possible risks and in developing plans for their mitigation and management. Further information on this issue can be found in our reports on safeguarding and protecting children and safeguarding and protecting vulnerable adults[31].

The experience of patient K

We were contacted by the wife of a confused, detained older gentleman (patient K) who told us of her experiences.

She told us that she had wished to assist with her husband's care while he was an inpatient, including the intimate washing of her husband, as she felt that he was far less likely to become agitated if she did this rather than care staff that he did not know.

Staff would not let her help because, she claimed, they said she might abuse him.

[31] Safeguarding and Protecting Children in Wales published October 2009
Safeguarding and Protecting Vulnerable Adults in Wales published March 2010
www.hiw.org.uk

4.54 We were particularly concerned that staff working in adult mental health services often did not recognise the risks to children, whether as visitors to wards or as part of the patient's life in the community. This was more noticeable amongst older people's services, despite the possibilities of aggression or inappropriate behaviour caused by a patient's illness.

4.55 It is important that children and young people are able to maintain contact with parents, carers and relatives who require hospital admission. The Code of Practice gives clear guidance regarding the development of policies for the planning of visits by children, including the need for appropriate facilities and multi-disciplinary agreement following a risk assessment that visits are in the child's best interest. We are concerned that this guidance is not being followed by all organisations. On a number of occasions we have observed young children being allowed onto acute admission wards to visit patients in the main day room where some patients were displaying disturbed behaviour: we saw no evidence of a private space or activities to distract the child being offered.

4.56 In this regard we welcome the publication this year by the National Patient Safety Agency of a Rapid Response Report: '*Preventing harm to children from parents with mental health needs*'[32] and recommend that staff take note of its recommendations.

Are the physical health needs of patients being met?

4.57 Care plans should be holistic, addressing not only the mental health of patients, but also other aspects including their physical health. Detained patients in hospital can have additional physical health problems, whether chronic conditions such as diabetes or acute illnesses that develop during their admission. Further, recent research has identified the possibility of higher risks of pneumonia, clots or strokes for those on anti-psychotic medications for long periods.

[32] http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59898.

4.58 We have had concerns about the adequacy of the arrangements to provide care and treatment of patients with a mental disorder and a co-existing physical health issue for some time. As a consequence we have undertaken a special review across Wales into this issue, following which a report is due to published later in 2011.

4.59 During our visits we have come across some good examples of joint care between teams and input from specialist services, such as palliative care services. However, we have also come across a number of areas of concern and particular cases where care has been sub-optimal, including:

- inadequate arrangements for providing support to patients who need investigative procedures for a medical or physical complaint. We noted a number of cases where appropriate investigations had not been taken because medical staff felt that they could not manage the patient;
- mental health ward staff focusing on treating the manifestations of the mental disorder, but not delivering the fundamentals of care expected from care staff on general wards. In particular we were concerned that when caring for frail and elderly patients they do not follow the expected practice of regularly monitoring weight, nutrition and fluid intake;
- inadequate access to medical support out of hours, particularly in smaller community based units (whether NHS or independent settings) which rely on GP or occasional junior doctor input;
- poor access to primary care services, for example dentistry. As an example a medium secure hospital that detains a number or patients subject to restrictions, which means they will rarely be able to leave the ward, did not have arrangements in place for its long term patients to have routine dental checks;
- poor communication between mental health services and other services leading to a lack of understanding of the skills and expertise of mental health staff. For example, staff working in general medical services believe that mental health wards have access to the same skills and facilities as acute wards, and so do not understand that patients who have a serious medical condition cannot be managed on mental health wards;

- staff on general medical wards often require patients transferred from mental health wards to be placed on one to one observation at all times by staff from the home ward. This requirement is often stipulated, even when risk assessments highlight that they do not require any more observation than any other patient on that ward. This often leads to inter-departmental arguments regarding the responsibility for providing staff or agency cover to undertake these observations; and
- when a patient is discharged from a medical ward back to a mental health ward, discharge letters and follow-up appointment letters are still sent to the GP. As a result important information is often received by the mental health ward late or not at all.

The experience of patient L

Patient L had been detained on an acute admission ward for many years and his physical health deteriorated rapidly over a period of time. It was considered this might be a manifestation of his illness or may be due to a specific condition related to medication.

Patient L lacked capacity to consent to treatment. As his frailty increased there were long discussions over seven months as to whether he required a CT scan and how and when to undertake this, in association with other trials of medication.

Referrals were made between consultants but when no action arose there was no timely follow-up.

The experience of patient M

Patient M developed urological problems. He was transferred from his ward to the nearby but separate general hospital, where his symptoms were diagnosed as being due to the medication he was receiving for his mental disorder.

When he was discharged back to the mental health unit, the discharge letter outlining his medication and ongoing care was sent to his GP, with suggestions as to stopping or changing his medication. Fortunately the GP was aware of his admission and passed it on to the ward.

Follow up appointments were required but again were sent home not to the ward. Urology staff showed no willingness to assess him on the mental health ward.

4.60 Promoting physical well being is also important, particularly as certain medication regularly used for mental disorder can have a considerable impact on physical well being. In particular some can cause significant levels of weight gain, with the consequent risk for heart disease, diabetes and so forth. The provision of healthy lifestyles and weight management techniques is important, as is the ability to undertake physical exercise, which can be difficult given the issues mentioned earlier about access to leisure facilities on and off wards.

Can the ward/unit deal with the number of patients and their various needs safely and appropriately?

4.61 In recent years there have been major developments in the provision of extended and intensive community services, such as assertive outreach teams, crisis resolution and home treatment services and early intervention teams. Such services aim to manage patients safely in the community, avoiding admission or facilitating early discharge and we have certainly seen an impact on bed occupancy levels. We found fewer patients *'sleeping out'* on other wards or being sent on '*home leave'* to free up beds.

4.62 What we have found is that as a consequence of the improvement and development of community mental health services, when patients **do** require admission it is because they are acutely ill with distressing symptoms, high risk levels and/or a higher level of challenging behaviours. This is reflected in the statistics quoted in Chapter two with numbers of admissions dropping and the proportion of detained patients increasing. However, we saw little evidence of staffing levels and skills being reviewed in light of this change in patient mix.

4.63 Further, some wards do not have access to seclusion or low stimulus areas to aid the safe management of patients with very challenging behaviour; neither do they have access to an intensive care ward. In one rural setting where we raised such concerns the health board told us that additional staff could be sent from their intensive care unit 50 miles away if required; we were not satisfied that such an arrangement supported good care.

4.64 In some instances due to a lack of on-site facilities the police have been called and the patient has been removed to a police cell for his/her safety. Such action can be very disturbing and upsetting for the patient.

The experience of patient N

Patient N became very disturbed and aggressive. Staff had no access to a safe facility in which to care for the patient and to de-escalate the situation. As a consequence the police were called. The patient was removed to a police cell, with a nurse accompanying him, who was required to administer a sedative injection to him in the cell.

4.65 Some wards or settings admit patients with a wide variety of needs and behaviours, which do not always fit well together and can cause tensions. A particular concern is wards for elderly patients where individuals with organic illnesses and cognitive problems such as dementia are often cared for alongside others with what are referred to as functional disorders, for example severe depression or schizophrenia. The former Audit Commission in Wales raised concerns about such practice as far back as 2002 and it is of great concern that such arrangements are still in place in many organisations.

The experience of patient O

Patient O contacted us with concerns about the ward on which she was being cared for. We found that some patients had been admitted for rehabilitation while others on the ward had a learning disability or challenging behaviour.

Patient O told us how one patient, on occasions, required four staff to observe her and keep her safe. At such times the other patients had to be kept together in the day room so that the remaining staff could care for them all. During such times patients had little access to activities resulting in them becoming frustrated, tense and resentful.

Do patients have access to appropriate and timely care?

4.66 During our visits we came across a number of patients who were being cared for in inappropriate settings. This was due to a lack of appropriate services to meet their needs or delays in agreement being reached as to who should fund the individual's next stage of care and treatment, whether it be a move to a low or medium secure setting, specialist nursing homes, rehabilitation unit or supported housing.

4.67 We are concerned that shortfalls in local services and delays in agreeing funding result in patients being detained for longer than necessary and them not receiving the care and treatment they require. The following patient experiences highlight the issues we have identified:

The experiences of patients P, Q and R

Several patients in one setting were experiencing delays in transfer to a more appropriate setting care setting. Some had been waiting in excess of twelve months. Suitable placements had been identified for some patients but agreements about funding had not been reached.

The experience of patient S

Patient S had complex physical needs as well as challenging behaviour. He had been cared for on a mental health assessment unit for over two years because of difficulties finding an appropriate placement for him in the local area.

The experience of patient T

Patient T was frail with deteriorating physical health. He was cared for on an acute mental health admission ward, normally used for short term admissions of seriously ill people, for over seven years.

He was unable to walk, spent most of his time in bed mainly in the foetal position, was doubly incontinent and required feeding and careful management to ensure pressure sores did not develop.

The experience of patient U

Patient U required specialist care and as this could not be provided locally she was therefore moved many miles away from her family and friends. Despite being able to access the care she needed Patient U became very stressed due to the lack of regular contact with her family.

4.68 Some of the issues highlighted above are partly due to the eligibility criteria established by organisations restricting access to particular services. For example, detained patients denied access to speech and language therapy services because they have a learning disability.

4.69 Another issue is the boundaries between adult and older peoples' services. We have noted situations where staff on an older people's ward had sought advice about a functional condition of which they had little experience from adult services, but this had not been provided because the patient was over 65.

4.70 Alternatively some younger adults develop Alzheimer's or a similar cognitive or degenerative condition and find that they can only receive services from older peoples' services.

Is Section 17 leave managed appropriately?

4.71 Section 17 of the Act allows the patient's Responsible Clinician to grant leave of absence from the hospital, this can be for short or longer periods of time and the patient may be escorted or unescorted within or near the hospital, or for be allowed overnight or longer stays at home or alternative accommodation. Such leave is important in ensuring that the recovering patient's confidence and independence is built up again before they move on from the inpatient environment. When subject to Section 17 a patient can be recalled to hospital should they become unwell again.

4.72 We found there to be many examples of noteworthy practice in place in relation to the granting of Section 17 leave, with mechanisms for ensuring that there were clearly defined boundaries and timescales put in place and that these were agreed with the patient and their families, as appropriate. Where such practices

were in place we also found that the reasons for granting or indeed refusing Section 17 leave were clearly outlined within the context of the individual patient's care plan and were supported by clear assessments of risks. Details of monitoring mechanisms and an evaluation of the efficacy of leave were also documented.

4.73 However we also came across examples where the details and circumstances of Section 17 leave were less well set out, for example one record only read *'leave to be given at nurse's discretion*.' We found a number of examples where there was no evidence of the patient being consulted about Section 17 leave or overnight leave being granted with no indication as to where the patient was going to be staying. Such practice leaves both patients and staff unclear as to what is or is not permitted and can in some circumstances lead to the inadvertent breaching of conditions.

4.74 We also found that some wards do not monitor Section 17 leave or evaluate whether it is proving of benefit to the patient. While some wards kept a log of patients on Section 17 leave others did not and hence, when we asked about a patient's whereabouts they were unsure where they were and were unclear as to whether they had the right to be off the ward. This was particularly an issue where patients had regular periods of unescorted leave, for example two hours leave taken every afternoon; staff assumed that the patient had gone on their two hours unescorted leave rather than actually knowing they had; this is a real safety issue. A patient could be missing because they have become unwell or had an accident and in such circumstances staff may not raise the alarm until it was too late to help the individual.

Are staff aware of their responsibilities and are there sufficient staff in place to manage the case mix?

4.75 During the majority of visits it was noted that staff interacted well with the patients and appeared attentive to the patient needs. Staff interacted with patients in a caring, respectful and sensitive manner. Many wards/units showed evidence of strong clinical governance and leadership; there was also evidence of open communication with both families and carers.

4.76 A multi-disciplinary team approach is proven to be the most effective in meeting patient needs; those units which had had good access to occupational therapists, physiotherapists, rehabilitation and medical staff demonstrated the best outcomes for patients. However, our visits highlighted a number of training and skills issues that we believe are at the root of some of the concerns we have raised in this report. These include:

- a lack of understanding by some staff of the Mental Health Act and the Code of Practice, particularly those working on general wards;
- mental health nurses lacking the necessary skills and training to deal with patients' physical health needs, for example administration of intravenous fluids or PEG feeding[33]; and
- staff on older peoples wards having high level of skills and experience in managing patients with cognitive conditions, but not the functional disorders their ward also occasionally admitted.

[33] PEG feeding is used to provide nutrition to patients, who cannot obtain nutrition by swallowing, by the insertion of a tube into the stomach.

Are Approved Clinicians (ACs) aware of their role and are there sufficient ACs in place?

4.77 An Approved Clinician (AC) is a mental health professional who has been approved by Welsh Ministers to fulfil certain actions and carry out the role as defined by the Act. Certain decisions under the Act can only be taken by an AC. Betsi Cadwaladr University Health Board undertakes the approval of ACs across Wales.

4.78 When revisions to the Act came into force in November 2008 the role of AC replaced that of the Responsible Medical Officer (RMO) and the range of professions eligible to undertake this role was widened beyond medical practitioners. The first Approved Clinician in Wales not to be a medical practitioner, a nurse consultant, was appointed this year.

4.79 When these changes came into effect transitional arrangements were put in place that enabled doctors who held RMO status to immediately become approved clinicians without the need to go through the full appointment process. We were disappointed to find that not all organisations had taken advantage of these arrangements and hence there were issues in relation to capacity to cover the full range of services that they are required to provide.

4.80 During our visits we came across problems that can occur when the AC on the team is on holiday or on sick leave. As the AC is the only person able to make certain decisions delays and problems for detained patients often occur, unless there is a locum in place who is also an approved AC.

4.81 Organisations have told us that it can be difficult to obtain locums who have AC status in Wales from agencies. While a fast track process is in place to grant AC status in Wales for ACs approved in England further work is needed to improve the availability of locums able to act as ACs in Wales.

The experience of patient V

A Reviewer highlighted concerns with the medication that a patient had been prescribed, as the prescribed levels were above recommended maximums.

We requested that the patient's AC review this plan. However, we were informed that this could not happen for a further for six weeks as the AC was on sick leave and then would be on holiday.

The experience of patient W

We received a request for a Second Opinion Appointed Doctor to authorise treatment for a patient who was unable to consent.

The request was made three days prior to the deadline for authorisation. Our SOAD needed to speak to the AC as part of the process, however the AC went on leave for two weeks the day the request was submitted and no one else was able to take on this role.

Are section 12 doctors fulfilling their roles appropriately?

4.82 Section 12 doctors are approved by Welsh Ministers and have special experience in the diagnosis or treatment of mental disorder. Section 12 status enables doctors to make certain medical recommendations or provide medical evidence to courts under the Act.

4.83 The availability of Section 12 doctors has not been identified as an issue this year, although we are aware of problems in the past. The main concern that has been raised with us this year has been the variation in arrangements for paying doctors. Such arrangements may depend on locality or status, with some being paid additional fees whilst others are expected to give opinions as part of their employment, even when it involves a patient or location outside of the health board area. Betsi Cadwaladr University Health Board, which approves all section 12 doctors in Wales on behalf of Welsh Ministers, is to report to the Minister for Health and Social Services on payment arrangements which may lead to further guidance on this.

Have the findings and recommendation of our previous visit been acted upon?

4.84 When we identify a concern regarding the lawfulness of an action or the upholding of patients rights, we request confirmation from an organisation in relation to action taken, including confirmation that a patient has been told that a problem has been identified and informed of what their rights are to challenge or seek rectification. Unfortunately we have found that organisations are not always proactive in putting things right. Furthermore, the level of information and support provided to patients can be inadequate. We hope that the introduction of the NHS Redress process will drive improvement in this area and health boards need to consider how they will tackle such mistakes within this system.

The experience of patient X

We identified that patient X was treated for several months without the consent to treatment provisions being followed. We asked the health board to confirm that he had been informed of the lapse and his rights to follow up this issue through legal channels. We were provided with a copy of a letter that the patient had been sent by his Approved Clinician[34], which did not clearly explain the legal issues or the patient's rights as a consequence.

Following our further intervention the health board addressed this with the individual clinician and has now developed a process and standard letters for informing patients should such a situation arise again.

4.85 We have also found, particularly in relation to environment of care issues, that the same issues have repeatedly been raised with organisations by our predecessor organisation, the Mental Health Act Commission. We will be taking steps over the coming year to ensure that such issues are being addressed and improvements are taking place.

[34] The mental health professional, approved by Welsh Ministers to undertake certain decisions under the Act, who has overall responsibility for the patient's case.

Chapter summary

4.86 Our review work during 2009-10 has highlighted that while, in general, detained patients are cared for in environments of care that are appropriate to their needs and looked after and treated by staff who have the necessary knowledge and skills, there are some gaps in provision.

4.87 We are particularly concerned about the overall quality of care plans in meeting the holistic needs of the patient. As referred to earlier in this chapter we have taken forward a separate review of these matters and will be reporting on our findings later in 2011.

4.88 The lack of activities and therapeutic input that was evident in many settings needs to be addressed and we will be focusing on this matter in the year ahead.

Chapter 5: Conclusion and Next Steps

5.1 The figures, trend and findings set out in this report highlight the importance of our role in monitoring the use of the Mental Health Act in Wales. They demonstrate that the roles fulfilled by our Mental Health Reviewers and SOADs are fundamental to ensure that the human rights of those most vulnerable are safeguarded and that when issues are highlighted steps are taken to put matters right.

5.2 The information that we have pulled together for this our first annual report provides a baseline of where mental health services are in relation to compliance with the requirements of the Act and its accompanying Code. A number of issues and shortcomings have been identified along with particular areas of noteworthy practice and we will be working with health boards and independent healthcare organisations over the coming year to ensure that noteworthy practice is shared across Wales and shortcomings are addressed.

5.3 It would be normal practice for us to make a number of recommendations in our reports aimed at addressing any issues and shortcomings identified. However, many of the recommendations we would wish to make have already been made by the Mental Health Act Commission in previous years. We therefore intend to work with individual organisations to better understand why some actions have not been taken forward and help them to develop recommendations that fit with their organisation's particular circumstances. As noted earlier in this report they have all received individual management letters and we are already monitoring the implementation of any improvements that have been recommenced.

5.4 Our intention is to develop realistic, achievable and timely action plans with individual organisations. These will be published on our website and we will monitor and follow up on progress as part of our routine programme of visits.

Appendix A

Transfer of Responsibilities to Healthcare Inspectorate Wales

The Mental Health Act Commission (MHAC) was established in 1983 to undertake the monitoring duties in England and Wales laid out in the Mental Health Act. When these monitoring duties were devolved to the National Assembly for Wales (later transferred to Welsh Ministers) MHAC continued to undertake its work on their behalf. On 1 April 2009, as a consequence of reorganisation and mergers of inspection and review bodies in England, MHAC was subsumed into the Care Quality Commission (CQC), a new body with responsibilities across health and social care but with a purely England only remit. The Welsh Ministers decided that this would be an appropriate point in time to make new arrangements for fulfilling its duties and as a consequence Healthcare Inspectorate Wales (HIW) took on these responsibilities on behalf of Welsh Ministers from that date.

Although HIW is part of the Welsh Assembly Government we have functional independence from the Department of Health and Social Services, which develops mental health policy and oversees NHS mental health services. As such we are part of the National Preventative Mechanism under the Optional Convention against Torture, a way for the UK government to demonstrate independent scrutiny of activities where people are deprived of their liberty through legal structures.

Prior to 1 April 2009 a project was put in place to oversee the smooth transfer of responsibilities from MHAC to HIW, including the transfer of electronic and paper records and putting in place contracts with reviewers and doctors who had been working for MHAC in Wales.

Our activities and responsibilities under the Act

We have a number of roles under the Act, including:

- the duty to keep under review the exercise of powers under the Act in respect of:
  - detained patients
  - patients liable to be detained

- the duty to investigate certain complaints relating to the application of the Act
- the duty to produce an annual report
- the provision of registered medical practitioners (known as second opinion appointed doctors or SOADs) to authorise treatment of patients subject to the Act in certain circumstances

Appendix B

Number of Admissions by Legal Status

Persons

Legal status (b)	2005-06	2006-07	2007-08	2008-09 (e)	2009-10 (e)
Formal admissions:					
Part II:					
2 (assessment with or without treatment)	836	722	824	954	883
2 (from ACUS)	.	.	.	0	1
3 (to hospital for treatment)	397	402	435	547	415
3 (from supervised discharge)	10	9	17	.	.
3 (from ACUS)	.	.	.	11	6
4 (for assessment in emergency)	67	63	66	56	40
Total	**1,310**	**1,196**	**1,342**	**1,568**	**1,345**
Court and prison disposals:					
35 (remanded to hospital for report)	7	4	4	6	7
36 (remanded to hospital for treatment)	0	1	0	0	1
37 (convicted person sent to hospital for treatment with section 41 restriction)	33	22	39	34	28
37 (convicted person sent to hospital for treatment without section 41 restriction)	21	18	28	17	28
47 & 48 (prisoner transferred to hospital with section 49 restriction)	27	23	26	31	20
47 & 48 (prisoner transferred to hospital without section 49 restriction)	6	3	6	3	3
Total	**94**	**71**	**103**	**91**	**87**
Other powers (c)	22	43	22	14	20
Formal admissions Total	**1,426**	**1,310**	**1,467**	**1,673**	**1,452**
Informal admissions	12,033	9,717	9,387	9,428	9,904
All admissions	**13,459**	**11,027**	**10,854**	**11,101**	**11,356**
of which were first admissions (d)	3,097	*2,585*	*1,820*	*3,022*	*2,633*
Place of safety detentions					
135 (warrant to remove to a place of safety)	18	21	12	29	21
136 (removal by police from a public place to a place of safety)	263	316	355	558	555
Total	**281**	**337**	**367**	**587**	**576**

(a) NHS and independent hospitals

(b) See notes at end of Release for details

(c) Other sections of the Mental Health Act 1983 and other Acts.

(d) Data not available for all hospitals / units in Wales.

(e) Changes to the KP90 data collection form and guidance were made for 2008-09 to take into account changes to the Mental Health Act 1983 made by the Mental Health Act 2007. These changes may affect comparisons with data for previous years.

Appendix C

Glossary for MHA Report

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also '*independent mental health advocate.'*
After-care	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients, as well as those who have been absolutely discharged.
Appropriate medical treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Approved Mental Health Professional	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the Mental Capacity Act 2005.
Care Programme Approach (CPA)	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.

Carer	Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs.
Child and Adolescent Mental Health Services (CAMHS)	Specialist mental health services for children and adolescents. CAMHS covers all types of provision and intervention - from mental health promotion and primary prevention and specialist community-based services through to very specialist care, such as that provided by inpatient units for children and young people with mental disorder.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Compulsory treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you; particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as 'sectioning' or 'sectioned.'
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Doctor approved under section 12 (also 'section 12 doctor')	A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers.

	Some medical recommendations and medical evidence to courts under the Act can only be made by a doctor who is approved under section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under section 12.
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
GP	A patient's general practitioner (or *'family doctor'*).
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of all health.care in Wales.
Holding powers	The powers in section 5 of the Act which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS trust). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Hospital order	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under section 37 of the Act.
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.

Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'section 17 leave.'*
Local Social Services Authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental disorder	Any disorder or disability of the mind. As well as mental illness, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities.
Mental Health Act Commission (MHAC)	The independent body which was responsible for monitoring the operation of the Act. The Health and Social Care Act 2008 abolished the MHAC. Its functions in relation to Wales transferred to the Welsh Ministers who delegated them to Healthcare Inspectorate Wales (HIW).
Mental Health Review Tribunal for Wales (MHRT for Wales)	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Nearest relative	A person defined by section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.
Part 2	The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients.

	Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.
Part 3	The Part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for Treatment.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other terms such as *'service user,' 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, to a limitation direction under section 45A or to a restriction direction under section 49 The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.

Revocation (and revoke)	Term used in the Act to describe the rescinding of a community treatment order (CTO) when a supervised community treatment patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made.
SCT patient	A patient who is on supervised community treatment.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Healthcare Inspectorate Wales who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 12 doctor	See doctor approved under section 12.
Section 57 treatment	A form of medical treatment for mental disorder to which the special rules in section 57 of the Act apply, especially neurosurgery for mental disorder (sometimes called psychosurgery).
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Supervised Community Treatment (SCT)	Arrangements under which patients can be discharged from detention in hospital under the Act but remain subject to the Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again.
Three month period	The period of three months from when treatments to which section 58 of the Act would apply are first administered.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Assembly Government.