Arolygiaeth Gofal Iechyd Cymru

Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Monitoring the use of the Mental Health Act in 2010 - 2011

This is the second 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.

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

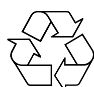
Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications and Facilities Manager
Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Or via

Phone: 029 20 928850
Email: hiw@wales.gsi.gov.uk
Fax: 029 20 928877
Website: www.hiw.org.uk



Printed on recycled paper

Print ISBN 978 0 7504 7629 4
Digital ISBN 978 0 7504 7630 0

© Crown copyright 2012

WG 15787

Contents

Foreword 1

Executive Summary 3

Chapter 1: The Mental Health Act and our Role in Monitoring its Use 5

The role and purpose of the Mental Health Act 5

How the use of the Mental Health Act is monitored in Wales 7

Mental Health Act Reviewers 8

Second Opinion Appointed Doctor Service (SOAD) 8

Investigation of complaints 10

Review of deaths 10

Working with others 11

Annual reporting 11

Chapter 2: Facts, Figures and Trends 13

Detention and admission to hospital under the Mental Health Act 13

Use of Section 135 and136 powers – removal of an individual to a place of safety 17

Community Treatment Orders 19

Chapter summary 23

Chapter 3: Detained Patients and Consent to Treatment 25

The role of the SOAD 25

Requests for SOAD visits received during 2010-11 26

Community Treatment Orders 29

Chapter summary 32

Chapter 4: Patient Experience 33

Have the correct legal processes been followed? 34

Are adequate records kept? 35

Where appropriate has consent been obtained and the assessments of capacity undertaken? 36

Are individuals detained under the Act aware of their rights and do they have access to an advocate? 40

Is the right information made available to patients? 40

Do patients have access to an advocate? 41

Is the environment of care appropriate and conducive to recovery? 43

Is the environment of care safe? 44

Are patients afforded privacy and dignity? 45

Is gender appropriately managed? 47

Are bathroom and toilet facilities adequate? 47

Do patients have access to regular activities and the therapies they need? 48

Are adequate activities provided? 48

Do patients have access to therapies including psychologists? 49

Is the approach to care planning appropriate and are well developed care plans in place? 50

Are care plans detailed and appropriate? 50

Is Section 17 leave managed appropriately? 51

Are staff aware of their responsibilities and are there sufficient staff in place to manage the case mix? 52

Are Approved Clinicians (ACs) aware of their role and are there sufficient ACs in place? 53

Are Section 12 doctors fulfilling their roles appropriately? 54

Have the findings and recommendation of our previous visit been acted upon? 54

Chapter summary 55

Chapter 5: Conclusion and Next Steps 57

Appendix A: Number of Admissions by Legal Status 59

Appendix B: Glossary for MHA Report 61

Foreword

I am pleased to introduce the second annual report of Healthcare Inspectorate Wales' work in relation to the monitoring of the use of the Mental Health Act across Wales in 2010-11.

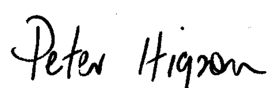
The Mental Health Act 1983 and the accompanying Code of Practice was introduced to protect those who become vulnerable due to mental impairment. It does so by ensuring that any decision made to compulsorily admit an individual to hospital and therefore deprive them of their liberty and enforce treatment 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.

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 Government and the work taken forward by our Mental Health Act Reviewers and Second Opinion Appointed Doctors during 2010-11. Where appropriate, we have also made reference to the outcomes of our routine inspection work and investigations.

We hope that the information in this report will be of interest and helpful to 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 second annual report we provide an overview of key figures and trends and the findings of the work undertaken in 2010-2011 by our Reviewers and Second Opinion Appointed Doctors (SOADs).

During the year we again saw an increase in requests for a SOAD visit. Requests relating to CTO powers accounted for a large number of these requests. There were periods during 2010-11 where delays in SOAD visits were experienced and more SOADs were recruited in the summer of 2011. We will keep performance levels under review.

We generally found detained patients to be cared for and treated by staff who have the necessary knowledge and skills, however, there were gaps in provision. We are particularly concerned that record keeping in relation to consent to treatment was not always appropriately followed. As the Act allows for some medical treatment for mental disorder to be given without an individual's consent it is important the correct procedures are followed by organisations. We are also concerned that patients were not always being made aware of their rights in a timely manner.

The lack of activities and therapeutic input that was evident in many settings needs to be addressed and we will continue to focus on this matter in the year ahead. Access to therapies including psychologists was found to be variable between organisations. This is concerning as such therapeutic input can assist in recovery and lead to shorter periods of detention.

We continue to work with health boards and independent healthcare organisations to ensure compliance against the Act and that the care provided to patients is suitable, appropriate and conducive to each individual's needs. We will also continue to share

noteworthy practice across Wales and look to further understand why the issues and gaps in provision highlighted in this report have not been addressed previously.

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 to receive care and treatment to which they have not agreed. Patients who are detained are known as **formal** patients.

1.2 The main purpose of the Mental Health Act 1983[1] (the Act) is to allow for 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.

1.4 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.

[1] 2007 amendments to the 1983 Act, http://www.legislation.gov.uk/ukpga/2007/12/contents
[2] Mental Health Act 1983 Code of Practice for Wales. http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=104742

1.5 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.

1.6 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.

1.7 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.

---

[3] Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2010-2011 http://www.hiw.org.uk/docopen.cfm?orgid=477&id=186190

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 lawfully 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.

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.

[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.

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 explores 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 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[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.

---

[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.

Investigation of complaints

1.17 The Mental Health Act also 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 2010-11 we received 25 contacts by letter, email or post raising concerns with us. We also received concerns by telephone. The majority of concerns raised related to:

- patients feeling that that they were being wrongly detained;
- leave, transfers and other legal issues;
- communication and attitude of staff;
- medication; and
- privacy, dignity and cleanliness issues.

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

Review of deaths

1.21 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 2010-11 we received 23 such notifications.

1.22 Our review of the circumstances of the 23 deaths has identified that three were due to the actions of the patient 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.

Working with others

1.23 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.

1.24 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).

1.25 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

1.26 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.

1.27 In this our second annual report we provide in the following chapters an overview of key figures and trends and the findings of the work undertaken in 2010-11 by our Reviewers and SOADs.

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

Chapter 2: Facts, Figures and Trends

In Wales during 2010-11:

- **1,717 people were detained in hospital under the powers of the Mental Health Act;**
- **13.8% of individuals admitted to NHS mental health facilities were the subject of a formal admission (detention);**
- **88.3% of all formal admissions were made to a NHS hospital;**
- **697 place of safety detentions took place in a hospital setting; and**
- **233 people were made the subject of a Community Treatment Order.**

Detention and admission to hospital under the Mental Health Act

2.1 During 2010-11, **1,717**[7] people were admitted to a Welsh hospital under the Mental Health Act for assessment and treatment. This represents an increase of 18.3% when compared to admissions (1,452) in 2009-10.

2.2 As can be seen from **Table 1** the number of people admitted to hospital under the Act (formal admissions) accounted for 15.3% 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	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%
2010–2011	11,198	1,717	15.3%

Figures produced by Welsh Government

[7] Figure excludes place of safety detentions and detentions made under other legislation.

2.3 While formal admissions accounted for 13.8% of all admissions to NHS mental health services they accounted for 88.3% of all admissions to independent mental health hospitals. Figures for the total admissions to NHS and independent settings are demonstrated below in Table 2

Table 2: Number of inpatient admissions to mental health facilities by setting (NHS and Independent Mental Health Hospitals) in 2010-11

	Admissions	Informal Admissions	Formal Admissions that were made under the Mental Health Act 1983	Percentage of admissions that were made under the Mental Health Act 1983
NHS Mental Health services	10,976	9,460	1,516	13.8%
Independent Mental Health Hospitals	222	21	201	88.3%
Total	11,198	9,481	1,717	15.3%

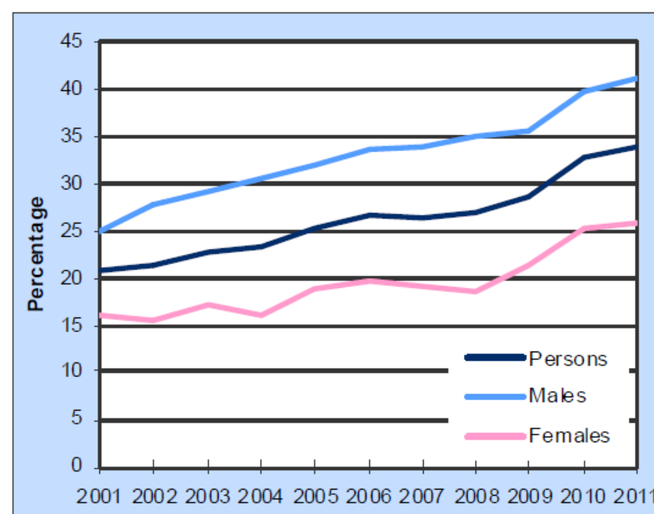
Figures produced by Welsh Government

2.4 A census[8] of patients resident in NHS mental health and learning disability units is undertaken by the Welsh Government on 31 March each year. On the day of the 2010-11 census 1,764 individuals were cared for on a mental health ward. The census data for 2010-11 highlighted that when compared to the first census undertaken in 2001 there had been a 19% decrease (a fall of 421 patients) in the number of individuals being cared for on mental health wards and a decrease of 56 patients since 2010.

[8] The census covers patients in mental health hospitals and mental health units in hospitals which may have other specialties. The census does not include Welsh residents who are patients in hospitals outside Wales. Mental health hospitals and units include those for patients with learning disabilities as well as those with mental illness.

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)**. At the time of the census 594 patients (34%) were detained under the Act, this is compared with 442 patients in 2001, which represented 20% of the patient population. 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.

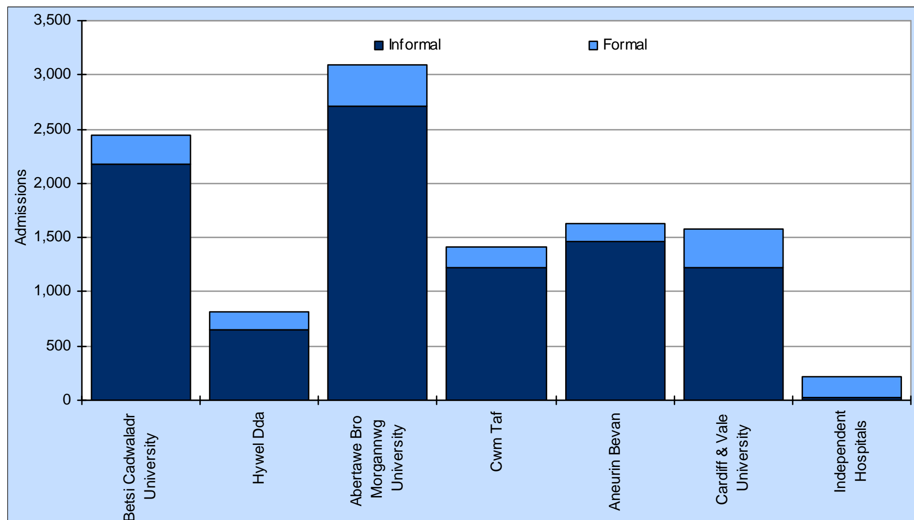
Chart 1: Percentage of people subject to detention in a Welsh mental health or learning disability facility in March of each year since 2000



Figures produced by Welsh Government

2.6 For NHS providers in Wales in 2010-11, Abertawe Bro Morgannwg University Health Board had the highest number of formal admissions, 383 or 25% of all admissions to Welsh Hospitals. Abertawe Bro Morgannwg University Health Board also had the highest number of informal admissions in Wales (2,713 or 29%). Hywel Dda Health Board had the lowest number of both informal and formal admissions (654 and 160 respectively). As can be seen from **Chart 2** below most admissions to independent hospitals were formal.

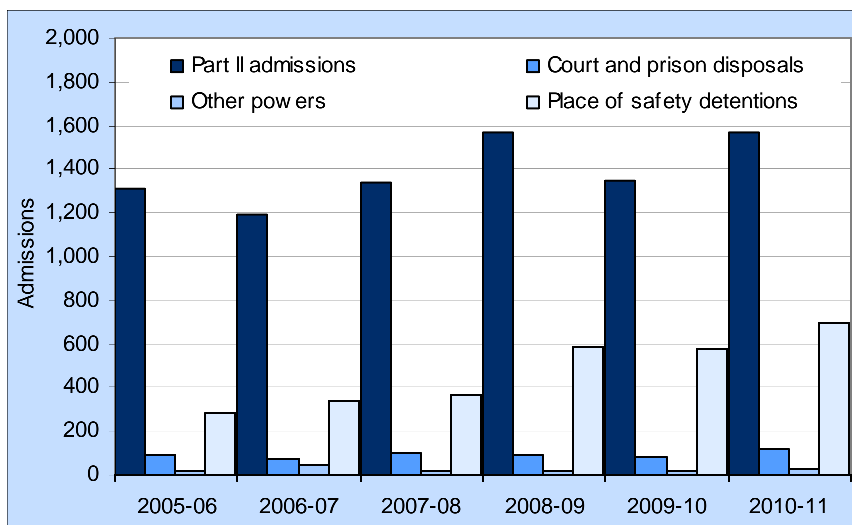
Chart 2: Admissions to mental health services (excluding place of safety detentions) by health board and independent hospitals, 2010-11



Figures produced by Welsh Government

2.7 As can be seen from **Chart 3** below, the majority of people (92%) detained under the Act are admitted to hospital under civil powers (known as *'part II admissions'*[9]). Nearly two thirds (65%) 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 1**.

Chart 3: Number of detentions by type since 2005- 06



Figures produced by Welsh Government

[9] The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients.

2.8 The patient mix in inpatient facilities has generally, over the last ten years, moved 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[10] has more than doubled from 281 in 2005-06 to 697 in 2010-11. This is discussed further below.

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 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 be undertaken to determine whether hospital admission, or any form of help, is required.

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.

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

Table 2: Transfers whilst still subject to Section 135 and 136, 2010-11

Persons

Section	Transferred from			Transferred to		
	Hospital	Police Station	Other (a)	Hospital	Police Station	Other (a)
Section 135 - first place of safety	.	.	.	6	0	0
Section 135 - subsequent place of safety	0	4	0	0	0	0
Section 136 - first place of safety	.	.	.	38	8	81
Section 136 - subsequent place of safety	5	326	0	45	3	8
Total	**5**	**330**	**0**	**89**	**11**	**89**

(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 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 2010 -11 was **697**[11]. This represents a 21% increase in the number of place of safety detentions that took place in a hospital setting in 2009-10 (576) and a significant rise in hospital based place of safety detentions that took place in 2004-05 (229).

2.12 As can be seen from **Table 3** below, of the 697 notified *'place of safety detentions,'* 369 resulted in a hospital admission. 160 (43%) of the 369 individuals were admitted to hospital under the powers of the Act.

Table 3: Outcomes of the use of Section 135 and 136 in 2010-11

Persons

	Discharged from place of safety			Admitted to hospital			
	Released	Transferred	Total	Informal	Section 2	Section 3	Total
Section 135 - first place of safety	2	0	2	2	10	9	21
Section 135 - subsequent place of safety	0	0	0	0	2	0	2
Section 136 - first place of safety	377	47	424	154	112	13	279
Section 136 - subsequent place of safety	148	4	152	53	13	1	67

2.13 The standardisation of section 136 records and routine data collection 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

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

when appropriate. Greater information will also allow us to ensure the adequacy and appropriateness of designated places of safety.

Community Treatment Orders

2.14 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.

2.15 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.

2.16 During 2010-11, **233** people were made the subject of a CTO across Wales; this represents a 10.7% decrease in the use of CTOs when compared to 2009-10 (261). In total **659** CTOs have been issued since their introduction in November 2008; this is an average of 23 new CTOs each month. Of the 659 CTOs issued since November 2008 only 42.9% had ended by 31 March 2011 (either by discharge or by revocation). The number of discharges from CTOs since November 2008 is 137 (20.8%) with 146 (22.2%) being revoked. See **Table 4** below.

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
April 2010 – March 2011	233	78	87	74
Total	659	137	204	146

Figures produced by Welsh Government

2.17 The number of individuals placed on a CTO since their introduction in November 2008 has been far higher than was predicted during the legislative process that introduced supervised community treatment. The number of people discharged from a Welsh hospital on a CTO each year since their introduction has been near to or in excess of the total number originally expected to be discharged on a CTO during the entire four and half year period between November 2008 and March 2013. It was estimated that 259 patients would be placed on a CTO between November 2008 and 31 March 2013 (see table 5). To date 659 patients have been placed on a CTO. With a further two years left to run on the original forecast this figure will inevitably increase (see **Table 5**).

2.18 As can be seen from Table 4, the recall power was used **87** times in 2010-11 (down from 106 in 2009-10) and 204 times since the introduction of the power. Therefore, approximately 30% of patients placed under a CTO have been recalled at some point[12]. Of the 233 CTOs implemented between 1 April 2010 and 31 March 2011, **78** patients (20%) were discharged from CTO during the year, **87** (37%) patients were recalled back to hospital and **74** (24%) patients had their CTO revoked.

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

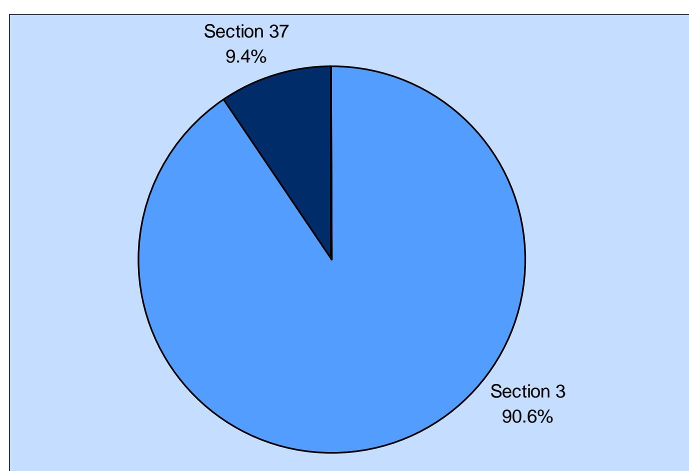
Table 5: Estimated percentages and numbers of patients that would be placed on a CTO each year between 2008 - 09 and 2012 - 13

	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

2.19 As can be seen from **Chart 4** below 90.6% of patients discharged under a CTO in 2010-11 had been admitted to hospital under Section 3[13] of the Act. A further 9.4% had been admitted under Section 37[14].

Chart 4: Legal Status of patients before being discharged under supervised community treatment, 2010-11



Figures produced by Welsh Government

[13] 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.
[14] Section 37 gives the court power to send a person to hospital for treatment instead of prison.

2.20 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.

Table 6: Supervised community treatment related activity, 2010 - 11 (a)

Persons

	SCT related activity				
Local Health Board	Recall	Revocation	Discharge	Assignment to the hospital of a SCT patient	Assignment from the hospital of a SCT patient
Betsi Cadwaladr University	32	20	20	3	*
Hywel Dda	13	10	11	*	*
Abertawe Bro Morgannwg University	14	8	9	*	*
Cwm Taf	*	7	16	*	4
Aneurin Bevan	*	15	6	*	*
Cardiff & Vale University	18	11	16	*	*
Wales (a)	**86**	**71**	**78**	**9**	**7**

(a) Wales totals in this table do not include 11 patients in independent hospitals with supervised community treatment related activity.
* Figures have been suppressed to avoid the risk of disclosing information about individuals.

2.21 In our annual report last year it was noted that the work of our Reviewers and SOADs had highlighted a number of concerns in relation to the knowledge and understanding of the CTO process. Whilst some of these issues have been addressed over the last year there are still many concerns that have been raised by our Reviewers and SOADs. 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 continued to be 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[15], the need to ensure compliance with CTO conditions and triggers for recall and revocation; and
- 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.

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

Chapter summary

2.22 The work we have taken forward in 2010-11 has highlighted that over the next year we need to have a greater focus on CTO processes. We need to work closely with organisations to set up regular SOAD clinics and ensure the growing number of CTO patients are seen by a SOAD as efficiently as possible (discussed further in next chapter). We also need to work closely with organisations to ensure that community teams are able to provide the necessary levels of care and support to individuals.

Chapter 3: Detained Patients and Consent to Treatment

In Wales during 2010-11:

- **There were 901 requests for a visit by a Second Opinion Appointed Doctor (SOAD); of these:**

  - 823 SOAD requests related to the certification of medication;
  - 78 SOAD requests related to the certification of ECT;
  - 297 SOAD requests related to Community Treatment Orders.

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[16]. 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;

[16] 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 nurses and social workers[17]. 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.

Requests for SOAD visits received during 2010-11

3.7 As can be seen from **Table 7** below there has been a significant increase in the number of requests for a SOAD over the last three years. This increase can be largely attributed to the introduction of CTOs in November 2008 as SOADs are required to visit patients on newly commenced CTOs and also for patients on existing CTOs where changes are made to the patient's treatment plan.

[17] 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.

Table 7: SOAD requests for certification by type of request

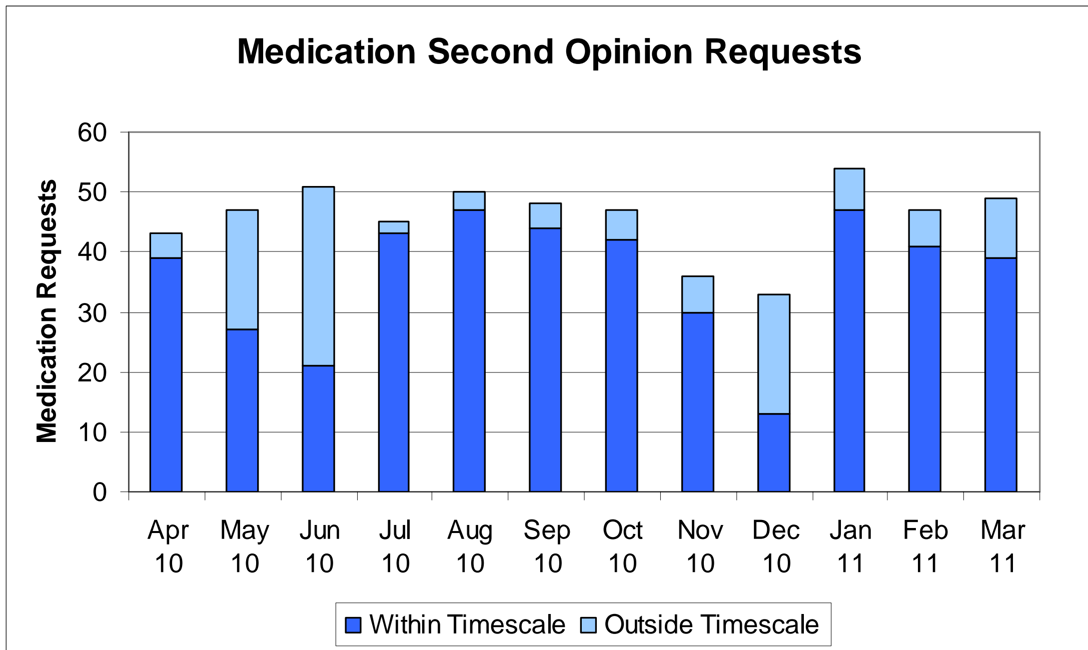
Request received for certification of:					
	Medication (inpatients)	**Medication** (CTO patients)	**ECT**	**Both** (ECT and Medication)	**Total**
2006 – 07	428	n/a	106	3	537
2007 – 08	427	n/a	79	5	511
2008 – 09	380	165	60	2	607
2009 – 10	387	356[18]	57	11	811
2010 – 11	526	297[18]	61	17	901

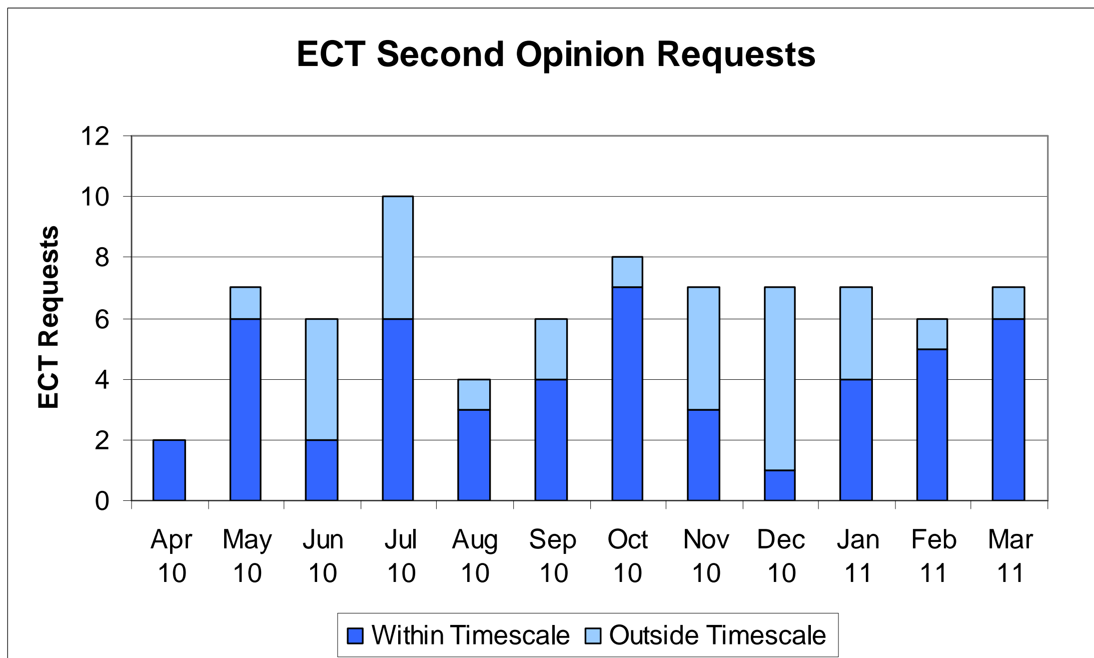
3.8 Given the important role that the SOAD plays in ensuring that the treatment individuals detained under the Act are prescribed is ethical and in line with national guidelines and best practice, we have set very tight timescales for the visits. Upon receipt of a SOAD request we aim to ensure that it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

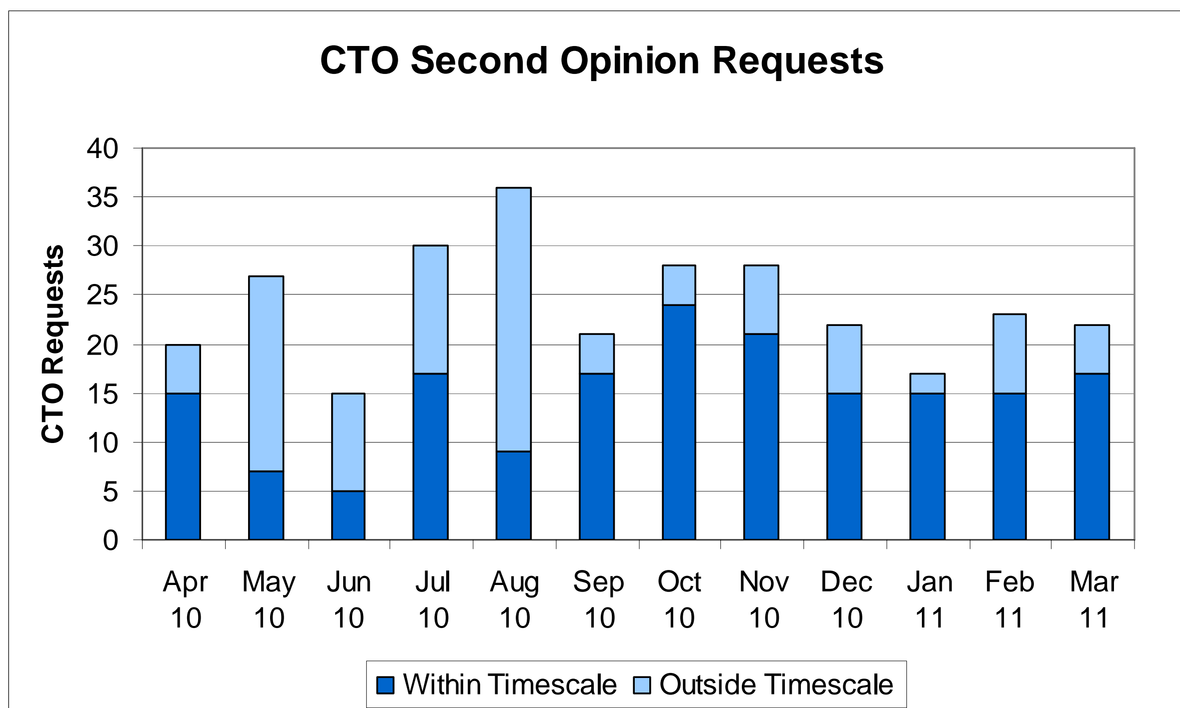
- two working days for a ECT request;
- five working days for an inpatient medication request; and
- 10 working days for a CTO request.

3.9 In last year's report we described experiencing a number of problems meeting these timescales. We recruited additional SOADs in December 2009 and this immediately had a positive impact on the timeliness of visits. This positive impact has largely continued throughout 2010-11. However, there were periods during May, June and December 2010 when delays in visits were experienced. These periods coincided with unavailability of SOADs due to annual leave, holidays, sickness or other calls on their time.

[18] This is the total amount of requests we received in relation to CTO patients and not the total number of new patients placed on a CTO during that period. If a patient on an existing CTO requires amendments to their current treatment plan SOAD authorisation is required.


Medication Second Opinion Requests
Medication Requests
60
50
40
30
20
10
0
Apr 10
May 10
Jun 10
Jul 10
Aug 10
Sep 10
Oct 10
Nov 10
Dec 10
Jan 11
Feb 11
Mar 11
Within Timescale
Outside Timescale


ECT Second Opinion Requests
ECT Requests
12
10
8
6
4
2
0
Apr 10
May 10
Jun 10
Jul 10
Aug 10
Sep 10
Oct 10
Nov 10
Dec 10
Jan 11
Feb 11
Mar 11
Within Timescale
Outside Timescale



3.10 To improve the situation further we recruited a number of additional SOADs, who, following induction training, commenced SOAD duties in the summer of 2011. We specifically focused on recruiting SOADs to cover those areas of Wales, particularly the West, where we had previously had problems in relation to delays in making visits. We recruit SOADs on an on-going basis and anticipate recruiting an additional five SOADs in the summer of 2011. It is hoped this will further strengthen our pool of SOADs and improve the timeliness of visits. We are continually looking for psychiatrists to strengthen our pool of SOADs and undertake recruitment on a rolling basis. Further information can be found on our website[19].

Community Treatment Orders

3.11 Every patient placed on a CTO is required to be seen by a SOAD who authorises 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.

[19] http://www.hiw.org.uk/page.cfm?orgid=477&pid=38396

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 a number of issues, including:

- **Patients not attending SOAD appointments:** on numerous occasions patients requiring a SOAD to authorise their community treatment have not turned up for their SOAD appointment. A significant number of patients have missed more than one appointment despite prior notification of the 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.
- **Responsible Clinicians on annual leave or sick leave:** numerous visits to patients have had to be cancelled by SOADs as the Responsible Clinician was not available to consult with due to annual leave or sick leave. In situations where the Responsible Clinician is not available for a prolonged period of time a contingency plan should be in place and an alternative clinician nominated to cover the leave of absence.
- **Requests made when a patient transfers to another Responsible Clinician or when the CTO is renewed (called extension in the Code):** SOADs have been requested to visit a patient when he/she transfers to another Responsible Clinician or when the CTO is renewed. SOADs are not required to visit patients under these circumstances and only need to see a patient within one month of the CTOs commencement or if the treatment plan changes.
- **Statutory Consultees:** Several CTO visits have had to be cancelled by our SOADs as they cannot access the statutory consultees, a suitable individual to act as a consultee were unable to be identified or the nominated consultee did not feel they have enough involvement with the patient to act as a consultee. It is the responsibility of the health board to ensure two consultees who have professional involvement with the patient can be accessed by a SOAD.

- **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 reported not having access to patient notes at the time of the visit which can lead to a request taking longer to complete than necessary.

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. 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 participated in a number of CTO training events for staff.

3.17 In relation to 241 of the 297 requests received for a CTO visit, the individual had the capacity to consent to treatment and had consented 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 inpatients; 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.

Chapter summary

3.18 During the year there was again 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. Following the appointment of additional SOADs we saw an improvement in performance which we will keep under close review in the coming months. We will also recruit additional SOADs to help with the timeliness of visits.

3.19 We will also continue to work with health boards to improve CTO visit processes and arrange more regular SOAD clinics.

Chapter 4: Patient Experience

The visits we have undertaken during 2010-11 identified issues in relation to:

- **The recording of consent and capacity assessments;**
- **Patients not being consistently informed of their rights;**
- **Privacy and dignity issues;**
- **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 2010 -11 we undertook 85 visits to hospitals across Wales. In total 47 different hospitals were visited that treat and care for individuals detained under the Act. During the course of the 85 visits undertaken by our Reviewers, 102 different wards were visited. We provide the organisation with feedback on the day of the visit and this was followed up with a Management letter sent to the Chief Executive or Responsible Manager[20].

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

[20] 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.

appropriate balance between the need for security and the need to provide a therapeutic, *'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 we spoke to 140 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 approximately 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 Poor record keeping and management was raised as an issue in several settings again this year. A number of these queries relate to the legality of a patient's detention. Generally, the correct documentation was accessible as the information was held centrally by Mental Health Act Administrators. However, such inconsistencies in record keeping can make it problematic for ward staff to have an accurate perception of a patient's legal status and we recommend that up to date and accurate notes are kept on the ward. We also observed in several settings that the physical condition of patients' files was poor and there was the possibility that important documentation could become detached from the files.

4.10 We found again this year that some staff are not always adhering to the Code of Practice's guidance in relation to the recording of certain actions and activities in patient notes that relate to the Act. One common example, which was reported last year, is that staff do not always record that they have acted as a statutory consultee during discussions to authorise treatment. Another common example is the recording of patients' rights (discussed further later in this chapter).

4.11 We highlighted the correct processes and frameworks in relation to patients consent to treatment provisions were not always being followed correctly.

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

4.12 The Act allows for some medical treatment for mental disorder to be given without an individual's consent (usually during the first three months of detention). The consent of the patient should, however where feasible be sought before treatment is administered and in every case adequate information must be given to ensure the patient understands the nature, likely effects and risks of treatment. For valid consent to be given an individual must have capacity to give such consent. It is vital that mental health practitioners have a good understanding and knowledge of the laws concerning mental capacity, the Code of Practice references these. The Code also states:

> *'the patient's consent or refusal should be recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent[21].'*

4.13 There were many positive examples identified during our visits which demonstrate that organisations have put arrangements in place to remind staff to make certain that consent has been sought from a patient or if consent has not been given that the relevant processes have been followed. Several health boards send out notifications from the Mental Health Act Administration department about the need to record assessments of capacity.

4.14 Last year the quality of records kept in relation to the assessment and recording of a detained individual's capacity to consent was found to be variable. We focus on this area during every visit and have reported examples of good practice. However, we raised issues of concern and areas where improvement needs to be made, specifically:

[21] Mental Health Act Code of Practice for Wales para 16.40.

- The quality of records kept in relation to the assessment of an individual's capacity to make decisions about their treatment were variable and often did not contain sufficient detail;
- The documentation of discussions held with individuals who had capacity to determine whether they consented to treatment were also variable;
- Issues were highlighted about situations where an individual's capacity to consent to treatment fluctuated over time;
- In some cases the decisions of the SOAD had not being communicated to the patient; and
- Discussions with patients about proposed treatment by Responsible Clinicians not being completed adequately

The experience of patient A

Patient A was seen by a SOAD. The Responsible Clinician completed the relevant pro-forma indicating the reasons for not communicating the SOAD's decision as follows: *'patient not present when notification received.'* This is an unsatisfactory reason and is not compliant with paragraph 18.30 of the Code of Practice for Wales, which states that the clinician in charge of the treatment is personally responsible for communicating the results of the SOAD visit to the patient. The only exception to this is if the clinician in charge considers the decision may cause serious harm to the patient's or anyone else's physical or mental health.

The experience of patient B

Patient B was subject to consent to treatment provisions. There was a CO2[22] certificate in place and the Responsible Clinician (RC) has completed the test of capacity pro-forma. However, in the box for recording the discussion with the patient about proposed treatment the RC had written *'see notes.'* The entry on the notes simply stated the patient had capacity to consent and did not detail the RC's discussion of the proposed treatment.

---

[22] A CO2 certificate is completed by a patient's responsible clinician and confirms that the patient has capacity and consented to the proposed medication for mental disorder when the three-month period ends.

The experience of patient C and D

In respect of patient C and patient D, both had a CO2 certificate in place, indicating that they had capacity and had consented to treatment. There was evidence that the RC had recorded a test of capacity. However, in both cases there was no record in the notes of discussions with the patient and their RC in relation to proposed treatment in terms of effects and side effects. This is contrary to paragraph 17.28 of the Code, and did not demonstrate that they had given informed consent.

The fact staff don't always comply with or understand capacity and consent requirements is a concern. There is a professional responsibility on clinicians and nursing staff to make certain they are acting lawfully and following the appropriate processes and frameworks when assessing capacity and gaining consent from patients.

In some cases we found a number of consent to treatment certificates were in excess of two years old, some being on the superseded form 38[23] (usually completed by the patients Responsible Clinician or in some instances a SOAD) and form 39[24] (completed by a SOAD).

- Prescribed medication not being documented on the patients CO2.

The experience of patient E

Patient E was subject to consent to treatment provisions and there was a CO2 certificate in place. However, our Reviewer noted that Diazepam was prescribed PRN but had not been authorised on CO2 certificate.

[23] A Form 38 use to be completed where a patient capable of consent had consented to medication for mental disorder. The Form 38 was replaced by the CO2 form/certificate when the functions of the Mental Health Act transferred to HIW on 1 April 2009.
[24] A Form 39 use to be completed by a SOAD to authorise treatment for mental disorder when a patient did not have capacity to consent to treatment or refused treatment but the SOAD considered treatment to be appropriate. The Form 39 was replaced by the CO3 form/certificate when the functions of the Mental Health Act transferred to HIW on [t] April 2009. .

All medication prescribed to detained patients, whether the patient has consented or not, need to be authorised on the relevant certificate.

- Similar to last year we found several occasions when staff had not recorded that they had acted as a statutory consultee during discussions to authorise treatment[25].

The experience of patient F and G

Patient F and patient G were receiving treatment as a result of a SOAD certificate (CO3[26]). The SOAD is required to consult with a nurse and another professional before issuing the certificate. The certificate was completed following the SOAD's discussions with the patients' statutory consultees. Those consulted by the SOAD should record their conversation with the SOAD, as guided in the Code paragraph 18.23, in the patients' notes. In addition, the Responsible Clinician is required to record that they have provided the patient with the reasons for the SOAD's decision or they have decided to withhold reasons because it was likely to cause serious harm to the patient or anyone else's physical or mental health (see 18.30 and 18.31 of the Code). Non-compliance with this guidance has been subject to high court action in the past, in the case of R (Wooder) v Fegetter and MHAC.

- Outdated consent to treatment certificates were found on patient files. Old certificates that no longer authorise treatment should be marked as cancelled and copies held in the patient's notes and medication chart should also be marked as cancelled as directed in the Code paragraph 17.72. Old certificates and their copies that no longer authorise treatment need to be marked as cancelled to avoid the possibility of confusion over the medication a patient is currently authorised to receive.
- In one case we found a CO3 certificate was not filed with the patient's prescription chart. Further, there was no alert on the medication chart to advise the patient was subject to a CO3 certificate. As a consequence staff

[25] Mental Health Act Code of Practice for Wales para 18.23 states all consultees should ensure they make a record of their consultation with the SOAD and place this in the patient's notes.
[26] A CO3 form is used by a SOAD to authorise medication for mental disorder that is considered appropriate for a patient who does not have the capacity to consent to treatment or refuses treatment.

would not be aware of what treatment was and was not approved for this patient and assure themselves they had sufficient authority to administer it.

- Staff interviewed did not always seem to understand the consequences of not following the correct processes and ensuring the discussions were properly documented. Discrepancies and inconsistencies in the proper documentation of discussions regarding patients' consent could result in legal action being taken against the organisation and result in professional consequences for the individual staff member if they are considered to have overseen or administered treatment that is not lawfully authorised.

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 Certain information must be given to all patients when they are detained under the Act, which explains the Act and their rights. In addition to this, individuals must be provided with all information relevant to their care and treatment. Such information must include details relevant to their detention, renewal and discharge, information concerning appeal against detention, information on consent to treatment and information about independent mental health advocates (IMHAs). Information should be provided to a patient as soon as practicable after the commencement of their detention and at regular intervals thereafter (for example when a renewal of detention is being considered). Paragraph 22.30 of the Code of Practice for Wales, states:

> *'Patients should regularly be given an explanation of their rights and restrictions…'*

4.16 We found most hospitals take thorough steps to make certain that patients understand the implications of being detained under the Act and are clear about their

rights, especially concerning their right of appeal to Hospital Managers' hearings[27] or the Mental Health Review Tribunal[28].

4.17 However, during the course of our visits it was evident that consistency around patients being notified of their rights varied. In the majority of 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. However in a small number of hospitals or wards we were concerned to note that patients had a poor understanding of their rights. In addition, in some cases it was not evident that patients had had their rights explained to them. It was also highlighted that there was no evidence in patients' files if rights had been read when a detention was renewed. We will be following these matters up with the individual organisations as a priority.

The experience of patient H

Patient H was initially detained in mid October 2010; however the provision of information under section 132 of the Mental Health Act was delayed until late December 2010

4.18 For all detained patients, but particularly those with fluctuating or limited capacity of understanding, it is important that their nearest relatives are informed of their rights, on behalf of the patient. We found this was not always happening in practice.

Do patients have access to an advocate?

4.19 Evidence suggests that advocacy can lead to improved experience of mental health services for patients. Advocacy can greatly aid patients by improving a patient's involvement in decision making, promote access to a range of different services and also help create more choice. Changes were made to the Act in 2008,

[27] 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.
[28] A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge in the Act.

which included the introduction of the Independent Mental Health Advocacy (IMHA) service. This service was established to provide independent support to patients under the Act to ensure that they understand their rights and are able to express their opinions and any concerns they may have. 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.

4.20 We identified some variation in access to IMHAs across Wales. Health boards are required to commission IMHA services for any patient detained in their area and all have done so. We found last year that not all registered independent hospitals were aware who provided their local statutory IMHA service. This has now generally improved.

4.21 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. We found when advocacy services are provided by various agencies, confusion could arise and IMHA services do get confused with general advocacy services provided by third sector organisations.

4.22 The Mental Health Measure[29] extends statutory access to advocacy services to all inpatients with a mental disorder in Wales. The Measure will establish statutory duties to ensure help and support is available to any patient receiving treatment and care for a mental health problem and not just those who are detained under the Act. This expansion of IMHA services will support inpatients in making decisions about their care and also enable their voices to be heard. However, there is the possibility that further confusion could arise and, therefore, health boards need to ensure that appropriate processes and guidelines for staff are in place. Currently the Act allows for patients subject to longer-term sections to receive help and support from an

[29] 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.

IMHA service. IMHAs are not currently available to patients on shorter-term sections of the Act and the Mental Health Measure will ensure these patients have access to an IMHA service. Many patients who receive care and treatment in hospital for a mental health problem are informal patients (and not detained under the Act) and such patients may require help and support from an advocate but this is not always available.

Is the environment of care appropriate and conducive to recovery?

4.23 An individual detained under the powers of the Act can spend extended periods of time in an inpatient environment. Frequently, patients are unable to leave the ward where they are being cared for due to the severity of their illness. Therefore it is crucial that the environment of care is appropriate as it can have a significant influence on the behaviour and mood of an individual and can help or hinder a timely recovery.

4.24 In most cases the settings we visited were found to be clean, comfortable and in a good decorative state. A homely therapeutic environment is something we look out for as it can again have an impact on the speediness of an individual's recovery. Environments that are comfortable, less clinical and encourage social interaction offer the most relaxing environment for patients and support recovery.

4.25 Many of the wards visited had access to outside areas including gardens, conservatories and smoking rooms or outdoor smoking areas. However, in some cases wards were found to be not clinical and in a poor decorative state with walls being marked or damaged. Some furniture on wards was found to be old and in poor condition with stains and rips. We fed this information back to the settings concerned and made recommendations about how the overall condition and atmosphere of the ward should be improved.

Is the environment of care safe?

4.26 Ligature points were still present on several of the wards/units visited. Generally, staff were aware of the risks posed by such ligature points and how to manage the risks associated with them. Some ligature points were observed in areas such as bathrooms and toilets, which could pose a considerable risk to patients who may attempt to take their own life. Such ligature points could be difficult for staff to monitor so awareness of the potential risk and how best to manage certain patients should be given careful consideration with all staff being fully aware of the risk associated with some patients. Organisations need to address ligature points where appropriate and ensure the layout and design of wards are suitable to maintaining the safety of the client group.

4.27 We were also concerned that security arrangements for wards were in some instances weak. This can put patients and staff at risk as well as visitors to the ward, such as in the case set out below.

An unannounced visit commenced at 08:30am. On arrival to the open-access ward at hospital A we were buzzed onto the locked ward without being asked for ID. Our Reviewer walked the length of Ward A corridor without challenge by staff. On arrival at the adjoining locked entrance to Ward B staff members were talking with the first door open, staff did not enquire who we were. The security arrangements of Ward B involve an '*airlock'* which should ensure that the adjoining door to Ward A is locked before the door to Ward B is unlocked. The deputy ward manager confirmed that this is the standard procedure. On this occasion both doors were unlocked at the same time and we were able to gain entry to Ward B unchallenged.

Are patients afforded privacy and dignity?

4.28 When an individual is detained under the Act it is important that their privacy and dignity is maintained. As part of our visits we assess if patients' privacy and dignity is being afforded. A number of issues that impact on the privacy and dignity of patients were highlighted during our visits.

4.29 Many mental health units/wards have single bedrooms; however, others have bays, dormitories or shared bedrooms which reduces the level of privacy and dignity afforded to patients.

4.30 Single rooms, however, can raise issues in relation to the safe observation of patients. We noted that on some wards curtains had been removed from glass panels so that anyone passing in the corridor could see straight into the room; this is unacceptable.

4.31 It was also noted on some wards that the windows in patient bedrooms and ward areas did not have curtains. In some instances these were adjacent to buildings and/or car parks. While we were aware that in some instances the curtains had been removed by service users, it is important that arrangements are in place to ensure patients' dignity and privacy.

4.32 Many wards used obscuring or opaque film on windows to protect the privacy and dignity of patients. It was noted on several of our visits that the film was: either deteriorating (and therefore not fit for purpose) or provided privacy by day but not by night.

4.33 Many patients reported that they are unable to lock their rooms to safeguard their personal possessions. This can cause patients unnecessary anxiety, especially at night. Some units also did not have viewing panels on the windows that patients could close themselves from inside their room.

4.34 Consideration should, therefore, be given to the allocation of staff for increased observation levels of patients where possible. However, this also needs to be gender sensitive.

The experience of patient I

Female patient I who was under 1:1 observation was unhappy that a male member of staff had been allocated to her for observation when she was in bed. She felt this was obtrusive and impeded in her dignity.

4.35 Consideration needs to be given to the privacy and dignity of patients when visitors are present on a ward. Clear monitoring of the number and gender of visitors to wards should be considered and appropriate observation maintained to ensure patient dignity is upheld.

At one point during a visit six male visitors were present on a ward. During this time a female patient with a history of disinhibited behaviour was lying on the floor in an in appropriate manner in full view of the visitors. Her privacy and dignity were not maintained.

4.36 Access to laundry facilities was raised as an issue by a number of patients during visits in terms of impacting on privacy and dignity. In some settings there was only one washing machine available to multiple patients and at times it was reported in some instances that this facility could be out of order for prolonged periods of time. While patients were able to access the hospital laundry it was reported to not be without problems, including damage to personal clothing and items of clothing being lost. It is important that patients have access to suitable laundry facilities on wards to support them in developing and maintaining daily living skills. Also, sufficient supplies of clean clothing are important to maintain patients' dignity.

Is gender appropriately managed?

4.37 It is unavoidable that some wards admit both sexes, especially those managing the most acutely ill patients where there may be insufficient need to justify single sex wards. We found most mixed sex wards had sufficient segregation in relation to bed spaces, however, some issues were highlighted about ward layouts. For example some bathrooms opened directly onto communal areas. The Code of Practice points out the need for mixed sex wards to have sufficient gender separation.

4.38 Some patients raised concerns about the gender of the staff member carrying out their increased observation levels. This was of particular concern to female patients.

4.39 We have consistently highlighted our concerns in relation to mixed gender facilities and are often informed by organisations that they cannot do anything about the layout and environment because the building is ageing or expenditure cannot be justified. Organisations need to be aware of the implications of mixed gender wards and make every effort to ensure mixed gender wards are appropriately managed and laid out both to alleviate patient anxieties and to maintain their dignity.

Are bathroom and toilet facilities adequate?

4.40 We found a number of issues surrounding bathroom and toilet facilities. Issues we highlighted included:

- one ward having only one bathroom for the use of 15 patients;
- poor drainage in *'wet rooms'* leading to pooling of water;
- leaking and slippery shower rooms;
- toilets and/or showers being out of order for prolonged periods; and
- bathrooms being cluttered with equipment as they were being used as storage rooms.

4.41 Some wards had raised issues with maintenance with a view to having problems repaired but had waited for many months, despite staff raising issues regularly.

4.42 We found the layout of some mixed gender wards did not afford patients privacy and dignity. It was evident in some wards that some bedrooms, shower rooms and toilets open directly into patient lounges which can affect the privacy and dignity of patients using the bathroom and facilities. This can impact of the patients in terms of adequate privacy, especially at times of distress.

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

Are adequate activities provided?

4.43 A common theme identified in last year's report was that patients reported a lack of activities and boredom. Patients again this year raised the same concerns. Patients reported that activities are rarely available at weekends or during the evening. In some settings patients reported a lack of activities generally; varied programmes of activity and therapy have been demonstrated by research to have a positive impact on patient outcomes.

4.44 The lack of activities is of particular concern to patients who may have significant restrictions placed on them as part of their detention. This can mean patients are unable to leave the ward and are therefore lacking stimulation; varied and regular activities can be conducive and vital in promoting recovery.

4.45 The reasons for a lack of activities, as reported by patients, was remarkably similar across most settings. Issues around a lack of staffing was the most common reason that patients felt activities were not taking place or being cancelled, sometimes at short notice. The health board or provider should ensure contingency plans are in place to make certain meaningful activities are consistently available to

patients and avoid long periods of boredom that are being experienced by many patients.

4.46 A further concern often raised by patients was that planned escorted leave or trips were often cancelled due to the unavailability of staff. This is a theme that was identified in last year's report and something that continues to be a concern. Patients stated a common reason for leave being cancelled related to unavailability of staff due to sickness, staff shortages or because staff were required to undertake other duties. These factors led to leave being cancelled, generally at short notice, as staff could be required to undertake enhanced observation levels for patients whose risk level had increased. In many cases patients complained that less trips, social events and less choice in their day could mean they were sat around on the ward with little to occupy their time. Escorted leave, trips and social events facilitated by staff can be key to the patient's pathway to recovery and reintegration into the community. Patients complained that cancellations of leave and trips often resulted in disappointment and frustration, which consequently could result in increased tensions on the ward.

Do patients have access to therapies including psychologists?

4.47 We found access to therapeutic input beyond medication to be extremely variable. Access to occupational therapy, physiotherapy, speech and language therapy and dietetics differs strikingly, even between wards in the same setting. In many cases we found staff were unable to provide an explanation for such variations. It is concerning such therapeutic input is not always accessible by patients as such interventions can assist in recovery and therefore shorten a patient's detention.

4.48 The lack of access to psychological therapies was again a consistent issue raised this year and is of particular concern. Many of the detained patients we spoke to have benefitted from psychological input previously and stated they felt it could assist in promoting 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.

4.49 We also highlighted a lack of facilities on many wards for the provision of therapeutic activities and assessments. Such facilities can often be essential in promoting continued independence for patients and also give an indication of a patient's ability to maintain independence and the level at which they are able to care for themselves. On some wards facilities such as patient kitchens and gym equipment were going unused due to health and safety concerns or due to staff training issues. Such facilities should be used as much as possible to help promote patients' independence in readiness for discharge.

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

Are care plans detailed and appropriate?

4.50 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.

4.51 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[30]) has been adopted. Our visits highlighted some very detailed and inventive approaches to care planning and overall an improvement since last year. However, we are still concerned that in some settings the care plans are of a poor quality. In some instances care plans lacked detail and clear objectives. In some circumstances it would appear they are rarely reviewed and updated and we found that patients and their relatives had little or no knowledge of their content. In many situations it was not evident if the patient had signed their care plan or been involved

[30] 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.

in its development. Other concerns that were apparent were that sometimes outdated care plans remained on ward files long after their review date, on some wards care plans were not evident on ward files and professionals who should input into care plans had not been consulted.

4.52 Care plans will continue to be something we will focus on during our visits by assessing and evaluating their quality.

Is Section 17 leave managed appropriately?

4.53 Under Section 17 of the Act a patient's Responsible Clinician can grant a leave of absence from the hospital. This can be for short or longer periods of time and the patient may be escorted by staff where necessary or unescorted. Patients may also be granted overnight leave or longer stays at home or other suitable accommodation. Leave under Section 17 is important as it can assist a patient in regaining confidence and independence before leaving the inpatient environment. If a patient becomes unwell while on Section 17 leave they can be recalled to hospital.

4.54 We found many examples of good practice taking place surrounding Section 17 leave. Appropriate Section 17 leave documentation included details of clearly defined boundaries and timescales which had been discussed and agreed with the patient and with their family, where rationale for granting, or in some cases refusing Section 17 leave was explained and the individual patient's care plan being used to support assessments of risk.

4.55 However, we also found examples where Section 17 leave was not well planned or documented, which could give rise to confusion by the individual patient or staff members. In several instances Section 17 leave forms were found to not be signed by the individual patient. This raises the question as to whether the patient had been consulted and understood their leave conditions. Where patients were scheduled to stay out overnight with family it was not clear that family members had been consulted or any risk assessments undertaken. This could become an issue, especially in relation to the medication; if a patient was self-medicating this may not

be known or family members may not be aware they were to assist in medication for the patient whilst on leave.

4.56 We also found that the completion of leave forms was not consistent. Old Section 17 leave forms were found in some files and this could lead to confusion among staff members about the leave granted to an individual patient. Leave forms were also found in some cases not to be present with ward notes, which again could lead to confusion. Some of the Section 17 leave forms reviewed were incomplete and risk assessments had not been completed. Inconsistent approaches to the documenting of leave can leave both staff and patients unclear as to what has been permitted and possibly lead to unintentional breaches of conditions.

4.57 It was again noted this year that some wards do not monitor Section 17 leave or evaluate outcomes and whether it has been beneficial to the patient. The Code of Practice states:

> *'the outcome of leave, such as whether it went well or whether the staff or patient had concerns about it, should be recorded in the patient's records. Patients should be involved in discussions about their care planning, of which leave will form a part'* (28.17).

This guidance should be followed as the safety of a patient could be compromised.

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

4.58 Generally, we found staff to interact well with the patients and appeared attentive to this need. On the whole staff were found to interact 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.

4.59 The most effective methodology to meeting the needs of patients has been proven to be a multi-disciplinary team approach. Units that had access to occupational therapists, physiotherapists, psychologists as well as medical staff usually offered 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 medical wards;
- mental health nurses not always having the necessary skills and training to deal with patients' physical health needs; and
- staff on older people's wards having high level of skills and experience in managing patients with cognitive conditions, but not those who were occasionally admitted suffering from functional disorders.

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

4.60 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.

4.61 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. Last year we reported disappointment that transitional arrangements that had been put in place to enable doctors who held RMO status to immediately become approved clinicians without the need to go through the full appointment process had not been taken advantage of by all organisations. We also reported that during our visits we came across problems that can occur when an AC is on holiday or on sick leave (for example the AC is the only person able to make certain decisions and as such delays in such decisions being made could be experienced by patients). We are

pleased to report that such issues have not been reported to us as frequently this year.

4.62 In March 2011 the Welsh Government published further guidance about the system and processes for the Approval of Approved Clinicians in Wales[31]. It is intended that this guidance will further assist individuals and organisations that have interests and responsibilities relating to the approval of Approved Clinicians to understand and fulfil those responsibilities.

Are Section 12 doctors fulfilling their roles appropriately?

4.63 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. Once again, the availability of Section 12 doctors has not been identified as an issue this year.

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

4.64 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 been 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 sometimes be inadequate.

4.65 We have also found, particularly in relation to environment of care issues, that we have repeatedly raised the same issues with some organisations.

[31] http://wales.gov.uk/docs/dhss/publications/110601cliniciansguidanceency.pdf

Chapter summary

4.66 Our review work during 2010-11 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.

Chapter 5: Conclusion and Next Steps

5.1 The figures, trends 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 ensuring 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 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 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.

Number of Admissions by Legal Status

Persons

Legal status (b)	2005-06	2006-07	2007-08	2008-09 (e)	2009-10 (e)	2010-11 (e)
Formal admissions:						
Part II:						
2 (assessment with or without treatment)	836	722	824	954	883	1,014
2 (from ACUS)	.	.	.	0	1	.
3 (to hospital for treatment)	397	402	435	547	415	495
3 (from supervised discharge)	10	9	17	.	.	.
3 (from ACUS)	.	.	.	11	6	.
4 (for assessment in emergency)	67	63	66	56	40	63
Total	**1,310**	**1,196**	**1,342**	**1,568**	**1,345**	**1,572**
Court and prison disposals:						
35 (remanded to hospital for report)	7	4	4	6	7	12
36 (remanded to hospital for treatment)	0	1	0	0	1	4
37 (convicted person sent to hospital for treatment with section 41 restriction)	33	22	39	34	28	44
37 (convicted person sent to hospital for treatment without section 41 restriction)	21	18	28	17	28	32
47 & 48 (prisoner transferred to hospital with section 49 restriction)	27	23	26	31	20	27
47 & 48 (prisoner transferred to hospital without section 49 restriction)	6	3	6	3	3	2
Total	**94**	**71**	**103**	**91**	**87**	**121**
Other powers (c)	22	43	22	14	20	24
Formal admissions Total	**1,426**	**1,310**	**1,467**	**1,673**	**1,452**	**1,717**
Informal admissions	12,033	9,717	9,387	9,428	9,904	9,481
All admissions	**13,459**	**11,027**	**10,854**	**11,101**	**11,356**	**11,198**
of which were first admissions (d)	3,097	*2,585*	*1,820*	*3,022*	*2,633*	*4,793*
Place of safety detentions						
135 (warrant to remove to a place of safety)	18	21	12	29	21	25
136 (removal by police from a public place to a place of safety)	263	316	355	558	555	672
Total	**281**	**337**	**367**	**587**	**576**	**697**

(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.
. The data item is not applicable.

Appendix B

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 healthcare 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. a 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 Mental Health Act Commission 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 Government.