



# **Monitoring the use of the Mental Health Act in 2011-2013**

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## Foreword

I am pleased to present the findings of Healthcare Inspectorate Wales' (HIW) work relating to monitoring the use of the Mental Health Act in Wales in 2011-12 and 2012-13.

Many people in Wales will at some time in their lives be affected by mental health problems. A number of those who experience a mental health problem may encounter a period of acute mental illness that requires a period of time in hospital. For some individuals it is in their best interest to be admitted to hospital so they can be provided with care and treatment for their mental health problem. In some cases the individual may not agree to the admission or the treatment.

The Mental Health Act 1983 and the accompanying Code of Practice were introduced to offer protection to those who become vulnerable due to their mental health problem. The Act ensures that the decision to compulsorily admit an individual to hospital, deprive them of their liberty and enforce treatment is properly justified and that it is in the individual's best interest. The Act contains safeguards to protect any individual whose rights are restricted by the powers of the Act.

HIW have a statutory responsibility under the Act to monitor how Mental Health services in Wales discharge their duties in relation to patients who are detained in a hospital setting, subject to a Community Treatment Order (CTO) or guardianship. Our monitoring role is to establish that those who are detained under the Act have their voices heard and are supported to make decisions over their care and treatment. We monitor the use of the Act by visiting and speaking with detained patients in hospital settings and reviewing legal documentation to ensure it is in accordance with the requirements of the Act. We also provide a Second Opinion Appointed Doctor (SOAD) service which is responsible for considering whether the proposed treatment for a

detained patient, who is unable or does not consent to the treatment, is appropriate.

The findings contained in this report are based on the work of our Mental Health Act Reviewers and our SOADs in 2011-12 and 2012-13. We hope the this report is informative not only to those responsible for administering the Act, but also to individuals and their families who may have been subject to detention under the Act.

Kate Chamberlain

A handwritten signature in blue ink, appearing to read 'K. Chamberlain', is positioned below the printed name.

Chief Executive Healthcare Inspectorate Wales

## Executive Summary

Healthcare Inspectorate Wales (HIW) is required to produce a report that gives an account of the work we have undertaken to meet our monitoring functions under the Mental Health Act (1983) and our findings.

In this our third report we provide an overview of key figures and trends in relation to the use of the Mental Health Act in Wales and the findings of the work undertaken between 2011 – 2013 by our Reviewers and Second Opinion Appointed Doctors (SOADs).

During 2011-12 we again saw an increase in requests for a SOAD visit. Requests relating to Community Treatment Orders (CTOs) have largely accounted for the year on year rise we have experienced for SOADs. However, in June 2012 amendments were made to legislation that meant SOADs were no longer required to visit every patient placed on a CTO and only those who were not consenting to the treatment plan now require a SOAD visit. This meant in 2012 – 13 we saw the first decrease in requests for a SOAD since we took over the monitoring functions of the Act in 2009.

During 2011 – 13 our Reviewers have continued to visit ward settings across Wales where an individual may be detained under the Mental Health Act. We found patients were cared for by compassionate, committed and caring staff. We also found a number of examples of noteworthy practice and improvements in care that were focused on promoting the recovery of individuals who were detained under the Act. We did however find a number of issues that concerned us:

- incomplete and inefficient patient record keeping – this is especially worrying when related to an individual's capacity to consent to treatment

- evidence was not always available that Patients rights have been explained
- Section 17 leave<sup>1</sup> being poorly planned and not well documented. We also found issues of patients being unable to access Section 17 leave due to staffing issues
- blind spots and ligature points found on wards that can potentially compromise patient safety
- therapeutic activities were not always accessible by patients
- A number of issues relating to the compromise of patients' privacy and dignity.

Where we found issues that concerned us we followed these up with the organisation directly and sought assurances about how they planned to address the actions we raised. Our visits and recommendations are intended to help organisations to improve their Mental Health services and the outcomes of patients.

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<sup>1</sup> Formal permission for a patient who is detained in hospital under the Act to be absent from the hospital for a period of time. This can be on an unescorted basis or on an escorted basis where ward staff are present with the patient for the duration of the leave.

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

## The role and purpose of the Mental Health Act

Most people who come into contact with mental health services in Wales and receive care and treatment in inpatient settings do so on a voluntary basis. Such patients are known as **informal** patients. The rights of informal patients are exactly the same as those rights for patients who have a medical or physical condition. However, there are circumstances where an individual may experience an episode of severe and acute mental illness which requires them to be detained for care and treatment to which they do not agree. Patients who are detained under the Mental Health Act 1983<sup>2</sup> (the Act) are known as **formal** patients.

The main function of the Act is to provide a legal framework to allow for compulsory care and treatment to be given, where necessary, to any individual with a mental disorder who requires such treatment for their own health and wellbeing or for the protection of other people.

The Act allows for individuals to be detained in hospital or required to live in the community, subject to certain conditions as set out in a Community Treatment Order (CTO) or under Guardianship. There are situations in which individuals can be given treatment that they have not consented to or do not have the capacity to consent to. Detention under the Act can last for substantial periods of time for some people.

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

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<sup>2</sup> 2007 amendments to the 1983 Act, <http://www.legislation.gov.uk/ukpga/2007/12/contents>



- 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
- the relatives of individuals who may be subject to the Act.

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
- public places.

The Act impacts significantly on the human rights of individuals who are subject to its powers. The Act is clear regarding the processes that must be followed when consideration is being given to detaining an individual, and the processes that must be followed when an individual is subject to detention or associated restrictions. The Act, and the accompanying Code of Practice<sup>3</sup>, set out safeguards that are intended to ensure that individuals are not inappropriately detained or treated without their consent.

The United Kingdom is a signatory to the UN Optional Protocol to the Convention against Torture. Our role in relation to patients detained under

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<sup>3</sup> Mental Health Act 1983 Code of Practice for Wales.  
<http://www.wales.nhs.uk/sites3/docopen.cfm?orgId=816&id=104742>

the Act and the Mental Capacity Act Deprivation of Liberty Safeguards<sup>4</sup> is part of the UK's National Preventive Mechanism under this protocol. The protocol requires a system of regular visits to places of detention by independent expert bodies, to prevent torture and other forms of ill treatment.

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

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
  - provide a registered medical practitioner, known as Second Opinion Appointed Doctors (SOAD) to authorise treatment in certain circumstances.

Healthcare Inspectorate Wales (HIW)<sup>5</sup> has undertaken the monitoring of the Act since April 2009 on behalf of Welsh Ministers. In taking forward these

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<sup>4</sup> 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>

<sup>5</sup> 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.

responsibilities HIW has established the Review Service for Mental Health which involves:

- visits to patients subject to the powers of the Mental Health Act
- 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.

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
- is enabled to lead as fulfilled a life as possible.

## **Mental Health Act Reviewers**

HIW utilise a pool of Mental Health Act Reviewers (Reviewers) who visit any setting in Wales where a patient is liable to be detained under the Act. Our reviewers visit numerous settings each year as part of a rolling programme of announced, and increasingly, unannounced visits. The majority of these visits take place in psychiatric wards as this is where the majority of individuals subject to the powers of the Act are detained.

During visits, our reviewers talk to individuals who are subject to the detention or restrictions under the Act. Discussions are held in private and only take place when the individual consents. Reviewers explore the individual's views about their care and treatment and ensure they understand their rights and the reasons they are detained and subject to powers of the Act. Our

Reviewers also complete checks on all records and documentation relating to the exercise of the powers of the Act on an individual and seek to ensure that the requirements specified in the Act and Code of Practice have been met.

Our reviewers explore other pertinent issues related to an individual detained under the Act which include the environment of care in which a patient is detained, patients' privacy and dignity, food and nutrition, access to general healthcare, care and treatment planning.

## **Second Opinion Appointed Doctor Service (SOAD)**

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.

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 for each individual patient.

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 (this requirement was amended in June 2012 and thereafter SOADs only visit patients on supervised community treatment who lack the capacity to consent to proposed medical treatment)
- formal and informal patients for whom certain very serious and invasive treatments are being considered<sup>6</sup>.

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, prescribe an alternative route of administration or set a maximum dose level on medication.

## Investigation of complaints

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.

HIW receive a number of complaints by letter, email, telephone or post raising concerns with us each year. 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
- privacy, dignity and cleanliness issues.

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<sup>6</sup> 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.

A number of the issues that are raised with us were outside of our remit and the powers delegated to us, such as complaints from patients stating they should not be detained, to have leave granted, their medication changed or to be released from their detention. In such cases we provide information on the options available to patients and we also signposted individuals to organisations who can help them with such matters, such as the Mental Health Review Tribunal or advocacy services.

Although some of the complaints and concerns we receive are outside of our remit, we take into consideration all the information that we receive. These are an important source of intelligence and we use them to help guide and inform our Mental Health review visit programme.

## **Review of deaths**

We are notified by all hospitals across Wales (NHS and independent hospitals) of the deaths of any patient who were subject to the Act.

Our review of the circumstances of the 25 deaths has identified that two 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**

As well as our inspection and review work described later in this report, we also undertake a variety of other activities related to our responsibilities under the Act. This includes participation in workshops, conferences and training events.

The Mental Health Act also 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).

We have also worked with other UK inspectorates and organisations who undertake a similar role, including the Care Quality Commission, Mental Welfare Commission Scotland and Her Majesty's Inspectorate of Constabulary

## **Annual reporting**

After each year of activity we are required to produce an annual report that gives an overview of the work we have undertaken to meet our Mental Health Act monitoring responsibilities and which sets out the findings from our work.

This is our third report in which we provide an overview of key figures and trends and the findings of the work undertaken in 2011-12 and 2012-13 by our Reviewers and SOADs.

## Chapter 2: Facts, Figures and Trends

In Wales during 2011-13:

- 1,428 (2011-12) and 1,453 (2012-13) people were detained in hospital under the powers of the Mental Health Act;
- 13.3% (2011-12) and 13.8% (2012-13) of individuals admitted to NHS mental health facilities were the subject of a formal admission (detention).

### Detention and admission to hospital under the Mental Health Act

In 2011-12 and 2012-13 there were, respectively, 1,428 and 1,453 people admitted to a hospital in Wales under the Mental Health Act for assessment and treatment. This represents a decrease of 16.8% between 2010-11 (1,717 admissions were made under the Act) and 2011-12. Between 2011-12 and 2012-13 there was a very slight increase in the use of the Act.

As can be seen from **Table 1** the number of people admitted to hospital under the Act (formal admissions) accounted for 13.3% of all inpatient admissions to mental health facilities in 2011-12 and 13.8% in 2012-13.

**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%
2011-2012	10,773	1,428	13.3%
2012-2013	10,523	1,453	13.8%



## Figures produced by Welsh Government

In 2011-12, formal admissions accounted for 12.1% % of all admissions to NHS mental health services and for 71% of all admissions to independent mental health hospitals. In 2012-13, formal admissions accounted for 12.5% of all admissions to NHS mental health services and for 87.4% 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 2011-13**

	Total Admissions		Informal Admissions		Formal Admissions that were made under the Mental Health Act 1983	
	2011-12	2012-13	2011-12	2012-13	2011-12	2012-13
NHS Mental Health services	10,563	10,348	9,285	9,048	1,278	1,300
Independent Mental Health Hospitals	210	175	60	22	150	153
<b>Total</b>	10,773	10,523	9,345	9,070	1,428	1,453

Figures produced by Welsh Government

For NHS providers in Wales in 2011-13, Betsi Cadwaladr University Health Board had the highest number of formal admissions, 299 in 2011-12 and 275 in 2012-13 . Abertawe Bro Morgannwg University Health Board had the highest number of informal admissions in Wales, 2,752 in 2011-12 and 2,555 in 2012-13. Table 3 provides a full break down of mental health admissions by health board in both 2011-12 and 2012-13.

**Table 3: Numbers of mental health admissions by Health Board 2011-13**

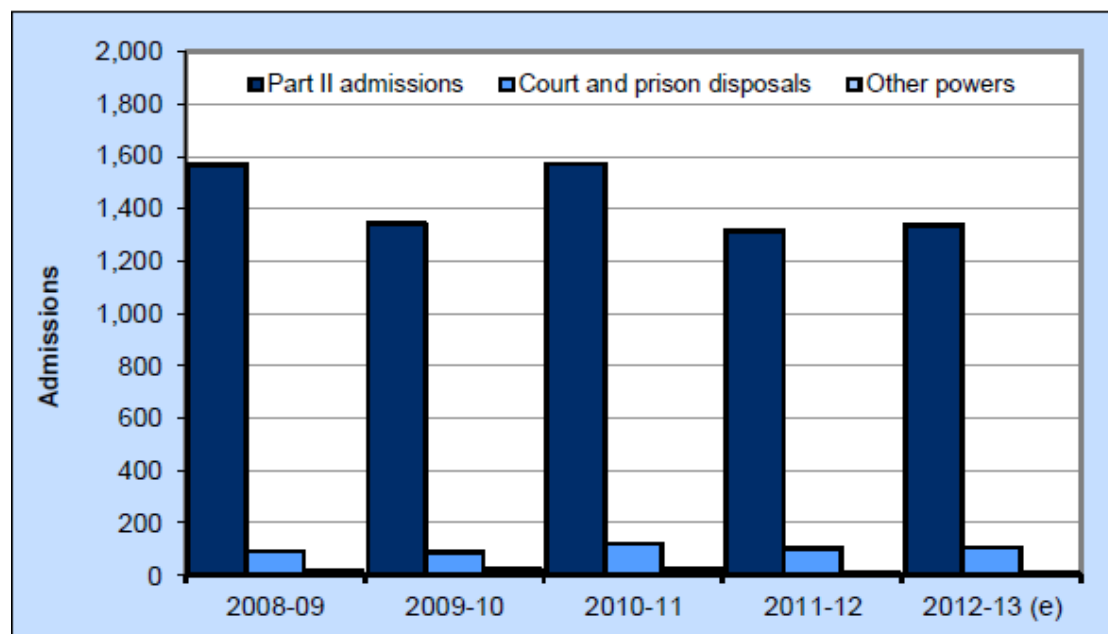
Health Board	2011-12			2012-13		
	Informal Admissions	Formal Admissions	Total	Informal Admissions	Formal Admissions	Total
Abertawe Bro Morgannwg University Health Board	2,752	234	<b>2,986</b>	2,555	251	<b>2,806</b>
Aneurin Bevan Health Board	1,356	153	<b>1,509</b>	1,181	102	<b>1,283</b>
Betsi Cadwaladr University Health Board	2,245	299	<b>2,544</b>	2,270	275	<b>2,545</b>
Cardiff and Vale University Health Board	1,142	244	<b>1,386</b>	1,099	217	<b>1,316</b>
Cwm Taf Health Board	989	192	<b>1,181</b>	962	175	<b>1,137</b>
Hywel Dda Health Board	801	156	<b>957</b>	743	225	<b>968</b>
Powys Teaching Health Board	N/A*	N/A*	<b>N/A</b>	238	55	<b>293</b>

\* numbers for Powys Teaching Health Board for 2011-12 were submitted by other Health Boards who manage services on behalf of the Health Board

## Figures produced by Welsh Government

As can be seen from **Chart 1** below, the majority of people detained under the Act are admitted to hospital under civil powers (known as '*part II admissions*'<sup>7</sup>). 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 A.

**Chart 1: Number of detentions by type since 2008- 09**



## Figures produced by Welsh Government

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

Sections 135 and 136 of the Mental Health Act give police officers powers in relation to individuals who are, or appear, to be mentally disordered. Police officers may use powers of entry under section 135 of the Act to gain access

<sup>7</sup> The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients.

to a mentally disordered individual who is not in a public place. If required, the police officer can remove that person to a place of safety. 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*'

Section 136 of the Act allows police officers to detain an individual who they find in a public place who appears to be mentally disordered and is in immediate need of care or control. Section 136 allows for an individual to be detained in a place of safety for up to 72 hours. During this time period an assessment is undertaken to determine whether hospital admission, or any other help, is required.

Section 136 is used significantly more often than section 135. **Table 4** shows the number of uses of section 135 and 136 in Wales since 2008-09.

**Table 4: Numbers of detentions under Section 135 and 136 2008-13**

	2008-09	2009-10	2010-11	2011-12	2012-13
<b>Section 135</b>	29	21	25	25	18
<b>Section 136</b>	558	555	672	774	842
<b>Total</b>	<b>587</b>	<b>576</b>	<b>697</b>	<b>799</b>	<b>860</b>

**Figures produced by Welsh Government**

As can be seen in **Table 4**, there has been a year on year increase in the use of section 136. It should be noted that the data in **Table 4** is based only on those place of safety detentions that were hospital based. Prior to 2008-09, individuals detained under section 135 or 136 could not transfer between places of safety. However, since April 2008, there has been the power to transfer individuals between places of safety. The Welsh Government identified some quality issues with the place of safety detention data and we have worked jointly with Welsh Government colleagues to review place of safety detention data collection items for future collection periods.

The Welsh Government released guidance in April 2012 which was designed to help promote good practice in the operation of section 135 and 136. The guidance gives information about working together to monitor use of sections 135 and 136 at a local and national level. The guidance introduced a form to be used in each individual case of detention. It is recommended this form is used nationally and our data collection is based on this national form. The use of standardised section 136 forms and more specific data collection will allow us to monitor and report in this area in far more detail going forward. It will also enable us to gather more specific information and allow us to consider the adequacy of designated places of safety.

We have been involved in further work during 2012-13 with Welsh Government policy and statistics colleagues, the police and health providers to capture data on place of safety detentions that are police station based only as well as hospital based place of safety detentions. A pilot period of data collection will commence in the last quarter of 2013. It is hoped improved data collection will give a more accurate reflection of the use of section 135 and 136 in Wales and also provide richer detail in terms of the circumstances of the detained individual by providing a pathway of the detainee whilst under section 135 or 136.

## **Police Cells and section 135 and 136**

Police cells are often used as a place of safety for those individuals detained under section 135 and 136 of the Act. The exact figures of those detained in Police cells are not available and it is anticipated increased data collection in this area will provide accurate figures about instances where this occurs. The Act is clear that Police cells should only be used as a place of safety in 'exceptional circumstances', however, Police cells are being used routinely for detentions under 135 and 136. We are concerned about the use of Police cells as a place of safety.

In May 2012 we were involved in a joint thematic inspection with Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Prisons (HMIP) and the Care Quality Commission (CQC). Fieldwork was carried out across seven Police forces, one of which was based in Wales. As part of the inspections staff were interviewed, policies and protocols examined, custody records reviewed and the views were sought of individuals who had been detained and placed in custody as a place of safety. Following the inspections HMIC published a report, *A Criminal Use of Police Cells?*<sup>8</sup>, which reported the findings and made a number of recommendations.

The report highlighted that in a number of detentions the reason why Police custody had been used instead of health based places of safety were not documented. For detentions where the reason had been documented it was often found that the reasons for not using a health based place of safety were as follows:

- lack of staff at the health-based place of safety
- lack of bed availability at the health-based place of safety
- the person detained was intoxicated
- the person detained was being violent or there was a risk of violence.

This raises a significant question as to whether the availability of health based places of safety are adequately resourced to meet demand.

Through enhanced data collection we will be able to identify the issues surrounding access to health based places of safety.

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<sup>8</sup> <http://www.hmic.gov.uk/publication/a-criminal-use-of-police-cells/>

## Community Treatment Orders

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.

In 2011-12, **357** people were made the subject of a CTO across Wales. During 2012-13, **222** people were made the subject of a CTO. In total **1,238** CTOs have been issued since their introduction in November 2008. Of the 1,238 CTOs issued since November 2008 only 55.1% had ended by 31 March 2013 (either by discharge or by revocation). The number of discharges from CTOs since November 2008 is 389 (31.4%) with 294 (23.7%) being revoked. See **Table 5** below.

**Table 5: 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
April 2011 – March 2012	357	121	109	79
April 2012 – March 2013	222	131	111	69
<b>Total</b>	<b>1,238</b>	<b>389</b>	<b>424</b>	<b>294</b>

## Figures produced by Welsh Government

The number of people transferring onto a CTO in Wales since their introduction in November 2008 has far exceeded the prediction that was made about the use of CTOs in Wales prior to their inception. It was estimated that by the end of March 2013, 259 CTOs would be made in total. As can be seen from **Table 5** the actual number of CTOs made was nearly four times greater than the original forecast with 1,238 CTOs being made. The reason for the higher than expected usage of CTOs is not clear.

Each individual that was transferred onto a CTO in Wales was required to see a Second Opinion Appointed Doctor (SOAD) to review the proposed care and treatment plan. In June 2012, changes were made to the legislation which meant only patients who lacked the capacity to consent to their treatment were required to be seen by a SOAD. Since June 2012, patients who have the capacity to consent to the proposed treatment can have their CTO authorised by their Responsible Clinician. This mirrors the situation that is in place for inpatients who consent or refuse to medication whilst detained in an inpatient setting.



## Chapter 3: Detained Patients and Consent to Treatment

In Wales during 2011-12:

- There were 944 requests for a visit by a Second Opinion Appointed Doctor (SOAD); of these:
  - 880 SOAD requests related to the certification of medication;
  - 64 SOAD requests related to the certification of ECT and medication
  - 387 SOAD requests related to Community Treatment Orders.

In Wales during 2012-13:

There were 758 requests for a visit by a Second Opinion Appointed Doctor (SOAD), of these:

- 691 SOAD requests related to the certification of medication;
- 67 SOAD requests related to the certification of ECT and medication
- 181 SOAD requests related to Community Treatment Orders.

Individuals detained under the Mental Health Act may be given treatment and medication with or without consent for a period of up to three months<sup>9</sup>. The treatment is given under the authority of the approved clinician responsible for their care.

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.

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<sup>9</sup> This three month period does not apply to electro-convulsive therapy (ECT).

## The role of the SOAD

When a patient is happy to consent to the proposed treatment, and has the capacity to consent, the patient's approved clinician can certify treatment. In circumstances where a patient lacks capacity to consent or refuses to consent, the treatment may only be given following certification by a Second Opinion Appointed Doctor (SOAD) that the treatment prescribed is appropriate.

As outlined in chapter one, 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 (since June 2012 this requirement changed and SOADs only required to see patients who lack the capacity to consent to the proposed treatment); and
- formal and informal patients for whom certain very serious and invasive treatments are being considered.

When a SOAD is requested to certify treatment for a patient, he/she visits the patient and discusses the proposed treatment with them and their views on it. The SOAD must also discuss the case with the patient's Approved Clinician and two other statutory consultees, such as nurses and social workers<sup>10</sup>.

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<sup>10</sup> 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.

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. When certifying treatment the SOAD will clearly define the maximum dosages of medication and routes of administration to be used on a certificate.

SOADs play a very important role in 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. The safeguards provided by SOADs ensure that the treatment prescribed to each individual patient they visit is ethical and in line with national guidelines and best practice.

### Requests for SOAD visits received during 2011-13

As demonstrated in **Table 6** there has been a significant increase in the number of requests for a SOAD over the last four years. The increase is largely attributable to the introduction of CTOs in November 2008 as SOADs were required to visit all patients on newly commenced CTOs. SOADs were also required to visit all patients on existing CTOs where changes were made to the patients treatment plan. The data for 2012-13 shows a reduction in the number of requests for SOADs. This can be explained by changes that were made to the Act whereby SOADs are no longer required to authorise the CTOs of patients who have capacity to consent to treatment and instead the patients approved clinician can authorise the CTO on a Form CO8. This mirrors the procedure in place whereby approved clinicians are able to authorise a consenting inpatients medication on a Form CO2.

**Table 6: SOAD requests for certification by type of request**

Request received for certification of:					
	Medication (inpatients)	Medication (CTO patients)	ECT	Both (ECT and Medication)	Total
<b>2006 – 07</b>	428	n/a	106	3	537
<b>2007 – 08</b>	427	n/a	79	5	511
<b>2008 – 09</b>	380	165	60	2	607
<b>2009 – 10</b>	387	356 <sup>11</sup>	57	11	811
<b>2010 – 11</b>	526	297	61	17	901
<b>2011 – 12</b>	493	387	63	1	944
<b>2012 – 13</b>	510	181	59	8	758

SOADs play an important role in ensuring that the treatment individuals detained under the Act are prescribed is ethical and in line with national guidelines and best practice. As such we have very tight timescales for the visits. Once a request is received by HIW for a SOAD, 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.

In our annual report for 2010-11 we described experiencing a number of problems meeting these timescales. We have made significant improvements in meeting our timescales for SOAD requests since 2010-11. However, we still experience some delays, mainly relating to CTO requests, and issues relating to such delays are described overleaf.

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<sup>11</sup> 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.

## Community Treatment Orders

Every patient placed on a CTO was required to be seen by a SOAD up until changes were made to the law in June 2012 regarding the consent status of the individual patient. The SOAD authorises the treatment individuals will receive in the community. The SOAD can also approve treatment to be given should the patient be recalled to hospital.

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.

CTO requests are often harder for a SOAD. Issues our SOADs have reported which impact on the completion of requests include:

- **Patients failing to attend SOAD appointments:** there have been a number of occasions where a SOAD will make arrangements to see a patient to discuss the proposed community treatment and the patient does not attend. In such instances the SOAD will usually try and arrange a second visit to see the patient. We have however had instances where a patient has failed to attend on multiple dates. In such circumstances the SOADs will attempt to re-visit the patient.
- **Responsible Clinicians on annual leave or sick leave:** As part of the process SOADs are required by law to discuss the proposed treatment with the patients Responsible Clinician. While it is not necessary for the Responsible Clinician to be present at the time of the consultation with the patient this is preferable. However, there have been delays by SOADs issuing certificates as they were unable to contact the Responsible clinician due to them being unavailable due to annual or sick leave. In some instances such delays have amounted to the issue of certification being held up for a number of weeks. We would expect arrangements to be put in place so that another Responsible Clinician is

in place to cover any absence of a Responsible Clinician. We would also expect a Responsible Clinician to provide details about any dates of absence and the contact details of the covering Responsible Clinician at the point of the request being made. Unfortunately this has not been happening for all requests we receive.

- **Statutory Consultees:** Several CTO visits have either been delayed or cancelled by our SOADs as they were unable to access the statutory consultees. It is the responsibility of the health board to ensure two suitable consultees who have been professionally involved with the patient can be accessed by a SOAD. We have updated our SOAD request form in view of this to ask for additional/alternative consultees to be nominated in case the primary consultees are unavailable when the SOAD attempts to make contact. A number of requests we receive still do not contain sufficient detail about the statutory consultees and this can cause delays with certification being issued.
- **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.

A number of the issues arise due to their being an expectation that either HIW or the SOADs will make arrangements for visits. We have updated our SOAD request forms so that one nominated individual is provided who can assist the SOAD with co-ordination of the visit where possible.

The Code of Practice is prescriptive in describing that health boards hold responsibility for making arrangements for SOAD visits to take place. At the point of the CTO being made Responsible Clinicians should seek agreement from each individual patient about the location of where a SOAD visit will take place.

## Chapter 4: Patient Experience

The visits we have undertaken during 2011-13 identified issues in relation to:

- Incomplete and inefficient patient record keeping – this is particularly concerning when related to an individual's capacity to consent
- Evidence was not always available that Patients rights have been explained to them
- Section 17 leave being poorly planned
- Blind spots and ligature points which can potentially compromise patient safety
- Lack of availability of therapies and activities for patients

As outlined in Chapter 2, there are over 10,500 admissions in Wales into inpatient Mental Health services every year for treatment of mental disorder. A number (1,428 in 2011-12 and 1,453 2012-13) are detained under the Act which allows for an individual to be admitted, detained and treated in hospital against their will. When detained an individual must be suffering from a mental disorder which requires assessment or treatment. This needs to be given in hospital in the interests of their own health and safety and/or to protect other people. This is the only area in healthcare where someone can be lawfully deprived of their liberty and treatment given without their consent. When an individual is detained under the Act the nature of their illness can mean they are vulnerable and possibly lack the capacity to make informed judgements about certain aspects of their care.

HIW has a duty under the Act to monitor how services in Wales administer their powers and to ensure they are used appropriately so that the human rights of the detained population are protected.

In order to monitor this, HIW Reviewers will visit any setting where a patient is liable to be detained under the Act. Our visits are focused on ensuring that any individual who is subject to detention under the Act is:

- treated with dignity and respect
- made aware of their rights
- cared for in a suitable environment
- given care and treatment in line with relevant guidelines and where possible given the opportunity to influence aspects of his/her care plan

Our reviewers undertake checks on patient documentation by examining legal papers, care plans and risk assessments. They also talk with detained patients, their family and/or carers to seek their views on how the organisation have met their responsibilities in relation to ensuring their rights are explained to them, involved them in their care planning and to establish an overall understanding of their experience of care and treatment. We also interview staff members to gain a picture of their knowledge, understanding and attitudes. Reviewers assess the environment of care to ensure it is appropriate, clean and does not compromise an individual's privacy and dignity. Finally we check to ensure the organisation has policies and procedures in place to ensure the powers of the Act are understood, discharged and delegated appropriately.

During 2011 -12 we undertook 52 visits to hospitals across Wales. In total 37 different hospitals were visited that treat and care for individuals detained under the Act. During 2012 – 13 we undertook 16 visits covering 25 wards within NHS hospitals and units. In addition, our learning difficulty review visits scrutinised arrangements in Independent Hospitals and looked at the application of the Mental Health Act in those settings.



We provide the organisation with initial feedback on the day of the visit and also escalate any immediate concerns we found. We then follow this up with a Management letter sent to the Chief Executive or Responsible Manager<sup>12</sup>.

The rest of this Chapter provides an overview of the findings from our visits during 2011-12 and 2012-13. We have summarised the issues we found under the key questions that our reviewers seek to answer during all our visits. It should be noted that during our visits we have observed numerous examples of notable practice that has been delivered by many compassionate, caring and committed staff at all ward levels. It is intended that the summary of our findings will enable organisations to learn and develop their services.

### **Have the correct legal processes been followed?**

We found that generally the correct legal processes had been followed in relation to detained patients. However, a small number of our visits found issues relating to informal patients (i.e. who are not detained under the Act) where such individuals had gained the impression if they asked to leave they would be detained. During our visits we found no evidence of this practice but did try to seek out whether the rights of the informal patient to leave the ward and other information they should be provided with was present in either the ward information leaflet, the notice boards or information notices on the exit door of the ward. The provision of this information was variable and in some instances none of this information was found. This lack of information could lead an informal patient, who is not subject to the detention powers of the Act, to gain the impression they are not allowed to leave the ward and this could possibly amount to an unlawful deprivation of liberty (also referred to as a 'de facto detention').

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<sup>12</sup> 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.

*A patient who is not detained has the right to leave (other than those subject to authorisation under the DoLs of the MCA 2005). However, patients may be asked by staff to inform them when they leave the ward.*

### **-Paragraph 28.6 Code of Practice for Wales**

The intention of the latter piece of advice from the Code of Practice about informing a staff member about leaving the ward is to make sure that nursing staff can discharge their “duty of care” by ensuring that they know when an informal patient is leaving and returning to the ward. If the member of the medical or nursing staff considers that an informal patient (at the time they are asking to leave the ward) are a risk to themselves or others only then consideration should be given to further assessment. This may result in the detention of the patient usually under Section 5(2) or 5(4) of the Act<sup>13</sup>.

Where wards were found to have a lack of information available to informal patients about leaving we have sought assurances that informal patients are made aware of their rights and that ward staff understand these rights and the appropriate actions to consider should there be concerns about an informal patient who wishes to leave the ward.

### **Are adequate records kept?**

We examine a sample of patient records at each ward we visit. This is to ensure compliance against the Act and to determine that all relevant information is readily and easily available to ward staff. We found the majority of patient records reviewed to be in good order and compliant with the Act. However, we did find a number of examples of poor record keeping. Poor records management can impact on a patient’s care as staff may not be aware of certain patient specific issues if documentation is not well organised

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<sup>13</sup> A registered medical practitioner’s or approved clinician’s (section 5(2)) or a nurses (section 5(4)) holding power used to detain in hospital a person who has agreed to informal admission but then changed his mind and wishes to leave. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the Section or result in detention under a Section 2 assessment order or Section 3 treatment order.

and up to date. Poor recording keeping can become problematic for ward staff to have an accurate awareness of a patient's legal status and care requirements.

We found several common issues across services during our visits this year. These are summarised below:

- staff were not always adhering to the Code of Practice guidance in relation to the recording of certain actions and activities in patient notes that relate to the Act
- incomplete information held in patient records on wards
- patient records not being filed in date order; This can lead to confusion amongst ward staff about the most up to date and pertinent information about a patient
- patient records not available on the ward at the time of the visit. This again can lead to confusion amongst ward staff about a patient's care
- patient's statutory documentation not available in the records. Generally we were informed the information was available but stored elsewhere, however, complete copies of all statutory documentation should be available to ward staff at all times
- we identified issues with some electronic multidisciplinary patient records. They were sometimes unclear, badly written, contained spelling errors, were confusing to read and did not always accurately reflect the dates and events on which legalities and application of the Act had been determined. Some records did not provide a rationale for decisions including detention and discharge from detention
- most reports from Approved Mental Health Professionals (AMHPs) were detailed and clearly supported the criteria for admission under the Act, however, standards of reporting were inconsistent and some did not evidence the decision making process for a patient's detention under the Act
- filing arrangements for patient records were confusing and difficult to locate the relevant information. For example we found in one setting legal and statutory documentation was filed together in alphabetical

order. However, where patients had surnames starting with the same letter there were no additional subdivisions within the records. This could lead to confusion

- patient records were not all standardised and where new local forms had been developed these were not consistent between patient records with some information held on old forms and some on new forms
- patient records found to be in poor physical condition and folders heavily worn. This could lead to the possibility that important documentation could become detached from the files and we observed in some settings duplication of information and loose documentation within the files.

Where organisations were found to have poor examples of recording keeping we have sought assurances from them that these will be addressed. We have asked for audits of patient records to be completed, ensure staff have access to copies of all statutory documentation at all times, provide staff with training in relation to records management (especially in electronic records management), ensure patient records are complete and standardised, replace worn folders so that legal documentation is protected and maintained and ensure that patient records are filed in an appropriate manner to ensure they reflect a comprehensive document allowing ease of reference of patient care.

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

The Act provides a framework of legal authority and safeguards by which treatment for mental disorder, where necessary, may be given to patients who do not wish to receive it. This is usually within the first three months after an individual has been detained. This can include patients who have the capacity to consent to the proposed treatment but do not do so and also those patients who lack the capacity to consent but nevertheless are clear that they do not

wish to be treated. However, the patient's consent and views about treatment should nevertheless be sought if possible prior to administration.

The Code of Practice for Wales states:

*It should not be assumed that a patient subject to the Act will refuse any or all of their treatment, and the patient's consent should be sought for all proposed treatments, even if they may be lawfully given under the Act without consent.*

#### **Paragraph 16.4**

During our visits we focused on issues of treatment and consent to identify if patients understood the nature, likely effects and any risks of treatment. Where patients were unable to consent to treatment we also explore if the correct processes have been followed to ensure the patient is safeguarded. Where patients give consent it is only valid if the individual has capacity. It is therefore crucial that mental health practitioners have a sound knowledge and understanding of mental capacity laws and legislation.

We identified many positive examples during our visits which show organisations have appropriate arrangements in place to ensure that staff satisfy themselves that consent has been sought from a patient and in instances where consent has not been given that the correct processes have been followed. However, we found variation across organisations and have raised concerns about areas of improvement that need to be made in relation to the assessment and recording of detained individuals capacity to consent, specifically:

- no evidence in patients notes of an assessment of capacity being undertaken prior to the commencement of treatment. In some instances patients treatment had been authorised on a CO2<sup>14</sup> form by their Responsible Clinician.

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<sup>14</sup> 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 A**

We found for patient A the Responsible Clinician had made no specific entry in their notes with regard to their capacity to consent to treatment on, or near, the date that the most current CO2 had been signed.

### **The experience of patient B**

There were a number of issues identified in respect of Patient Bs Consent to Treatment certificate. Patient B had a CO2 certificate in place indicating the patient consented to treatment and had capacity to consent. Patient Bs Responsible Clinician had completed the pro-forma evidencing the test of capacity, however, in regard of whether the patient had capacity to consent the Responsible Clinician had put a question mark in the box rather than 'yes' or 'no'. In the written entry the Responsible Clinician appeared unsure as to whether Patient A had capacity to consent, however, the Responsible Clinician continued to issue the CO2 certificate indicating that Patient B had capacity to consent. We immediately escalated this to the Nurse in Charge for review.

In order to issue a CO2 form the responsible clinician is required to make "*a record of their discussion with the patient and of the steps taken to confirm that the patient has the capacity to consent...*" (17.28 of Code of Practice for Wales).

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*"<sup>15</sup>.

Additionally, "*consent will not be valid if the patient has not been given adequate information. All professionals involved in any proposed treatments have a duty to use all reasonable care and skill to give clear and appropriate*

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<sup>15</sup> Mental Health Act Code of Practice for Wales para 16.40

*information to the patient about to treatment and all possible alternatives"*  
(16.31 of Code of Practice for Wales).

In order to comply with the requirements of Section 58 of the Act the Responsible Clinician should follow the guidance and advice of the Code of Practice for Wales to ensure that they can clearly evidence how they have assessed the patient's capacity and how they have informed them of the treatment plan to demonstrate their consent. In each individual instance where a lack of recording of consent and capacity was found we requested the organisation take action and inform us of the measures they had taken to remedy each individual situation.

We also found a number of patients who had been authorised treatment on a CO2 form by their responsible clinician were unclear about the purpose, nature, likely effect and risks of their medication when we spoke with them (although they had consented to the treatment and were willing to take the medication).

In all cases we have recommended patients are given specific information about their treatment in a format that is easy to understand and are then able to continue to refer back to. If patients are given information in a format they can understand then they are more likely to have an understanding of its *purpose, nature and likely effects and risks*. The nursing staff could also have an important role in reinforcing this information during their one-to-one sessions and as part of the information given to patients when they are presenting and re-presenting their rights under Section 132 (see chapter 22.10 of the Code of Practice for Wales).

The Code of Practice for Wales also provides further guidance  
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*"Simply giving standard information leaflets to the patient will not discharge the duty. The information should be relevant to the particular patient, the particular treatment and the relevant clinical knowledge and practice. The*

*information should be the language and format that is best understood by the patient, taking account of that patient's ability to retain and understand that information. In every case sufficient information must be given to ensure that the patient understands in broad terms the nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. A record should be kept of the information given to patients."* Paragraph 16.32

We found examples where patients who had treatment authorised on a CO2 form wished to withdraw consent for a variety of reasons, including experiencing side-effects from the medication. In such circumstances we informed the Nurse in Charge of the patient's wishes and requested that the Responsible Clinician review the medication and discuss consent. The medication may well be appropriate for such patients and could be authorised by requesting a SOAD to authorise such treatment, however, the correct processes should be followed to ensure the patients wishes are taken into consideration and that relevant safeguards are followed.

The authorisation of medication for the treatment of mental disorder lies with the Responsible Clinician. It would be usual for them to record the views of the patient in relation to the medication being proposed and as to whether they consent to it. This is an important discussion and should be reviewed regularly because of the possibility of fluctuating capacity and/or consent. It is therefore of considerable importance that the Responsible Clinician make a record of their discussions and clearly identifies the record as relevant to consent to treatment.

Paragraph 16.35 of the Code advises;

*"The patient should be informed that they may withdraw their consent to treatment at any time and that fresh consent is required before further treatment can be given or reinstated. If patients withdraw their consent (or are considering withdrawing it), they should be given a clear explanation of the likely consequences of not receiving the treatment and (where relevant) the circumstances in which the*



*treatment may be given without their consent under the Mental Health Act. A record should be kept of the information given to patients.”*

The cooperation of a patient to consent to their treatment plan must always be the aim of a clinical team and discussion and negotiation must clearly be a part of this process. This reflects the “empowerment principle” identified in guiding principles of the Code.

## **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?**

The Act stipulates that hospital managers must ensure feasible measures are in place so that patients understand their rights as soon as practicable after detention commences. The Code of Practice states hospital managers should make patients aware of their rights under section 132 and 132A of the Act. Such information includes; details relevant to a patient’s detention and any restrictions, renewal and discharge, information about appeal against detention, information relating to consent to treatment and about access to independent mental health advocates (IMHAs). Paragraph 22.30 of the Code of Practice for Wales states:

*Patients should regularly be given an explanation of their rights and restrictions.*

In most settings we visited we found good compliance with providing patients with information about their rights.

Some variation was found to exist between the organisations we visited. During our interviews with patients we ask if they understand the implications of being detained and if they understand and have been made aware of their rights. We found some evidence of patients having a poor understanding of

their rights. During our visits we also review patient files to look for evidence that their rights have been explained and that it has been documented in their notes that discussions have taken place. In a small number of cases such evidence could not be located. When such a lack of evidence was found we raised this with the organisation with a view to rectification.

### **The experience of patient C**

We examined the records of detained patient C. No evidence could be found in the notes that patient C had been given information regarding their rights. There was also no indication that information had been provided to patient C's relatives. There was also no evidence that staff regularly supported patient C to understand their rights.

We raised this with the organisation and recommended that all staff are made fully aware of their responsibility under section 132 of the Act to inform patients and their relatives (where possible) of their rights.

### **The experience of patient D**

Patient D had signed their rights pro-forma. However, when we interviewed the patient they were unable to recall information about their rights. We explained their rights to the patient and requested that staff provide written information to the patient.

There is also an expectation that patients are re-presented with their rights at regular intervals during their detention. This is crucial to make certain that the patient (or their nearest relative) have an understanding of their legal situation. When a patient is re-presented with such information it should be recorded in the notes of the patient.

### **The experience of patient E**

There was evidence in patient E's file that their rights had been explained shortly after the commencement of their detention. However, it could not be evidenced that these rights had been re-presented at regular intervals thereafter.

Where limited information was available about whether a patient had been regularly provided with information about their rights this was followed up with the organisations concerned. Information about attempts that have been made to re-present a patient with their rights should be accurately reflected in their notes and also the outcome of each attempt. This is particularly important for patients with limited or fluctuating capacity of understanding and attempts should be made to provide their nearest relative with such information and the patient themselves at regular intervals. Detailed information is provided in chapter 22 of the Code of Practice.

We found in one instance the form being used by the organisation to record the presentation of a patient with their rights had a number of deficits. The form quoted the wrong version of the Code of Practice (the form referenced the 1999 version which has been superseded by the Code of Practice for Wales which came into force in November 2008). The form also made no reference to patients having been informed of their statutory right to access an independent mental health advocate (IMHA). There was evidence that the nursing staff were being diligent in discharging the duties of the hospital managers in informing detained patients of their rights, however, it was evident that some of the amendments of the 2007 Act and the Code of Practice were not being accurately conveyed. This also extended to some of the letters being sent to relatives of patients with incorrect referencing of the Act and Code of Practice. We informed the Mental Health Act Administration Department of the errors at the time of our visit. Whilst the Mental Health Act Administrator can monitor and implement compliance with the system the organisation has in place, it is the responsibility of the senior management team and the appointed hospital managers (within the meaning of the Act) to ensure that all forms and letters used accurately reflect current legislation and guidance relevant to patients in Wales.

## Do patients have access to an advocate?

Independent Mental Health Advocates (IMHAs) are part of advocacy services that are available to work closely with patients and their families. IMHAs ensure the views of patients are heard and can also ensure patients are involved in aspects of their care. Advocates attend wards regularly and offer support to patients and their families to understand their rights under the Mental Health Act, help patients to escalate any concerns they may have, attend care planning meetings, mental health review panels and Mental Health Review Tribunals.

We found detained patients had good access to advocacy services. In almost all ward settings we visited there was information available to patients about how to engage with their local advocacy service should they wish to do so.

The Mental Health Measure<sup>16</sup> has extended statutory access to advocacy services to all inpatients with a mental disorder in Wales. This is regardless of whether the patient is in a psychiatric ward or a general health ward. The Measure established that 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.

## Is Section 17 leave managed appropriately?

When a patient is detained under the Act they are only allowed to leave hospital, or a specified hospital unit, lawfully under certain circumstances. One such circumstance when patients are lawfully allowed to leave hospital is

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<sup>16</sup> 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.

when a leave of absence is granted in accordance with section 17 of the Act. Under section 17 of the Act only the patient's Responsible Clinician can grant a period of leave from the hospital (in the case of restricted patients the approval of the Secretary of State for Justice is required). The duration of such leave is very much patient specific and should be risk assessed and carefully planned by the patient's Responsible Clinician. Leave can be for a period of hours or even days. Patients who are granted section 17 leave may be escorted by staff where necessary or unescorted. This will usually be dependent on the risk assessment of each individual patient.

Section 17 leave is an important part of a patient's treatment plan and is often used to help a patient regain confidence and independence before leaving an inpatient environment upon discharge from the Act.

During our visits we always assess the arrangements in place for a patient's access to section 17 leave. We have found many positive examples of patients being facilitated to access Section 17 leave. We expect to see that the appropriate Section 17 leave documentation has been completed fully and include details about the timescale of the leave, any boundaries in place are clearly defined and that the leave has been agreed with the patient, and where necessary, their family. Section 17 forms should contain a clear rationale for granting the leave, or in cases where the leave has been refused the rationale should also be documented.

In most cases, the section 17 leave forms we reviewed were of a good standard containing all the relevant information that we would expect of a good Section 17 leave form. However, we also found examples where Section 17 leave was not well planned or well documented. This can lead to confusion by the patient or staff members when the patient is due to access leave. For example, we reviewed some Section 17 leave forms where the legibility of the handwriting of the Responsible Clinician was very difficult to read. It is important that all statutory documents and any documentation that authorises specific requirements of the Act or Code of Practice are completed in legible handwriting so that all clinicians, nurses, the patient and carers who receive

copies of such documents are able to clearly understand the content of the document and what the authorisation allows for.

Furthermore, Section 17 leave forms should contain detailed information about the purpose, duration, outcome and any conditions attached to the period of leave. We reviewed some section 17 leave forms that provided insufficient detail about the purpose and conditions of leave, nor how it related to the individual patient's care plans and risk assessments. Where such forms have been found we have asked the organisations concerned to inform us of the actions they intend on taking in respect of policies, procedures or training for clinical staff on the legal importance of recording of information and the risk assessment relevant to each section 17 leave that has been sanctioned.

Organisations should satisfy themselves that all section 17 leave that is granted includes details of the conditions attached to it as set out in paragraph 28.16 of the Code of Practice. The paragraph states that the granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. It is good practice for hospital managers to adopt a local record form for the responsible clinician to authorise leave and specify any conditions. Copies of the authorisation of the leave should be given to the patient, any appropriate relatives or friends and any professionals in the community who may need to be informed.

We also found instances where a number of patients from the same wards were on extended periods of section 17 leave. While this may be an integral part of their planned rehabilitation and reintegration programme, there were concerns from some ward staff that with a constant pressure on admission beds, patients could sometimes be sent on section 17 leave before they are ready or where the placements were inappropriate to meet their continuing needs. The constant pressure on beds clearly presents a conflict for clinical teams when making the decision and ensuring that section 17 leave is always appropriate, timely and integral to the patients care pathway. In a number of instances the beds of those patients who are on extended leave could be filled in the interim which could cause problems should the patient be recalled

to hospital. Although patients are supervised and supported by Community Mental Health services, there is often no independent review of continued compliance with conditions, consent to treatment and other patients' rights under the Mental Health Act. Where we have found such concerns we have requested that the organisation inform us of what actions they intend to take to monitor and address the increasing pressure on beds and high numbers of patients on section 17 leave.

We found some leave forms during our visits that had expired or been withdrawn (possibly due to a change in the patients circumstances or due to the leave being suspended). It is considered good practice that an expired or withdrawn form is clearly cancelled to reduce any ambiguity as to whether the leave is still authorised and current. Some of the forms we reviewed during our visits had been cancelled but it was not clear the Section 17 leave form had been marked as cancelled.

During our visits a common theme that emerged was the problems faced by some patients on some wards when accessing escorted Section 17 leave. Escorted Section 17 leave requires a staff member to accompany the patient while accessing their leave. Staffing levels were commonly associated with problems in the access of escorted leave, this was either due to their being unfilled staff vacancies or due to sickness absence of staff members. Several patients highlighted their concerns about limited access to leave and largely blamed staff shortages.

#### **The experience of patients at Ward A**

Three of the four detained patients reported to our Reviewer they had experienced difficulty in utilising their authorised leave, to have time away from the ward into the hospital grounds, as they had been required to be escorted by staff and there were occasions when there were insufficient staff to escort patients. Reasons why the leave had not been facilitated were not stated in the patients' notes.

During several visits we observed some creative thinking by staff to enable patients to access their leave. Where staff vacancies were noted we have requested the organisations concerned inform us on the current staffing levels for the ward, whether this is adequate to meet patients needs, especially in the access of section 17 leave, and whether recruitment will occur.

We also found in several instances that the Section 17 leave forms were not signed by the individual patient. Patients should be in agreement with the parameters of each period of leave that is authorised and this is demonstrated by the patient signing the form. Where forms were not signed by the patient it poses the question as to whether the patient had been consulted and understood their leave conditions and agreed to them. This could lead to issues if a patient breaches a condition of their leave and has not signed the leave form.

#### **The experience of patient F**

We reviewed the section 17 leave form for patient F. We found the conditions of the leave were not clearly stated. There was also no evidence that patient F had signed or refused to sign the leave authorisation, nor was there any information indicating that the patient, relative or carer received a copy of the leave authorisation form.

We found 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 that 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.



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

When we visit settings where patients are liable to be detained under the Act we are keen to assess the environment in which such individuals are resident. Those individuals who may be detained under the Act could spend prolonged periods of time in an inpatient setting and it is therefore crucial the environment is appropriate and conducive to aid their recovery.

We found the vast majority of settings we visited to be clean, homely, therapeutic and in a good decorative state. It was encouraging that many settings visited had made improvements in their environment since their last visit.

We did however find issues on some wards in relation to their environment, such concerns included:

- poor decorative state (marked/damaged walls, no wall furnishings)
- furniture in poor condition
- carpets/floors in poor condition (stained or showing signs of wear)
- poor standards of cleanliness
- strong odours
- outside areas, such as gardens, in need of maintenance.

We found a number of wards where space for private meetings to be held was extremely limited. This can impact on visits to patients by their family and especially children. We visited settings where there were child friendly visiting areas available and this is something it would be appropriate to see in all ward settings.

### **The experience of patients at Ward B**

During our visit to ward B, it was noted there was no designated off ward family and children visiting area for patients to use when relatives visited them. A seminar room on ward B was being used as a visiting area. The room was not fit for purpose as a family meeting room. There were many hazards in the within the room that would be dangerous, especially to children. For example, a wire mess cover on a radiator was torn and broken and sharp wires were exposed. This would be particularly dangerous to children. There were also no toys or facilities in the room.

We acknowledge that for some inpatient environments it is difficult for organisations to reconfigure the ward layout. It is pleasing that after our recommendations many of the organisations estates' department have sought to remedy the issues we have highlighted.

### **Is the environment of care safe?**

We found in most of our visits that the environment of care was safe for patients.

We have made some recommendations to organisations about how the safety of patients could be improved. For example, in one setting visited the layout of the ward meant there were areas that were not directly observable and that some of these blind spots could impact on the health and safety of patients, especially at night.

Ligature points were again found on some wards we visited. The wards where these were found to be present generally had measures in place to manage the risk posed by such ligature points. However, to manage this risk some wards operated areas with "restricted access". This meant the freedom of movement of patients throughout the ward was limited. We also visited a setting where there were ligature points present in a garden area. Due to the

risk associated with these, patients could only access the garden area with staff supervision, however, the shortage of nursing staff at the time of our visit meant patients were unable to access the garden area as much as they would like. While we understand the need to manage such risks, we have recommended that organisations remove the ligature points which in turn would make a significant difference to the life of patients on wards where the presence of ligature points can influence their movement around the ward or into outside areas.

## **Are patients afforded privacy and dignity?**

When we visit inpatient settings we look to see how the privacy and dignity of patients is maintained. Detention under the Act for individuals can impact significantly on their privacy and dignity. Due to the length of time some patients may stay in an inpatient setting it is paramount that every effort is made by organisations to ensure the environment affords individuals privacy and dignity during their time there.

During our visits we have observed several different ward configurations. Some inpatient settings have single bedrooms for patients whereas others have bays, dormitories or shared bedrooms. All ward configurations can pose very different issues in relation to a patient's privacy and dignity and it is something we explore to establish what arrangements organisations have in place to minimise any possible compromise of patients' privacy and dignity.

Despite some wards we visited having single bedrooms for individual patients, we still found some issues that arose concerning privacy and dignity. For example, many patients we spoke to raised concerns about not having access to lockable storage (in the form of either a key for their bedroom and/or lockable cabinet) to house their possessions in their bedrooms. This is an

important issue for patients and it is recommended in the Code of Practice that each patient is provided with secure storage<sup>17</sup>.

### **The experience of patients at Ward C**

Patients are unable to lock their bedroom doors and have nowhere to safely store their personal possessions. The single wardrobes have a curtain to cover the wardrobe contents and the only safe storage is a small wooden cupboard in the ward office. This means possessions patients keep in their rooms sometimes get taken by other patients, or they have to ask a member of staff each time they wish to have something from their stored property. This does not promote self responsibility, privacy or dignity and patients our Reviewer spoke to found this frustrating

Where we have found issues relating to lockable storage we requested the organisation review the arrangements that were in place. It is pleasing to note many organisations where this was an issue in previous years have addressed storage arrangements by purchasing lockable storage and organisations where this has been highlighted this year have been asked to review their arrangements.

We found other issues in relation to patient bedrooms and privacy and dignity.

### **The experience of patients at Ward D**

Individual patients' rooms have observation panels in the doors which provide an element of privacy during the day; however, they are inadequate for close observation of patients during the night when observation is required. There are also no dimmer switches in the rooms and putting the bedroom lights on throughout the night to observe patients is disturbing to their sleep and intrusive.

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<sup>17</sup> Code of Practice for Wales, Paragraph 19.11

## Is gender appropriately managed?

Mixed gender units and privacy and dignity issues can often be directly linked and some of these issues are discussed in the paragraphs above. There are also other circumstances where the management of gender in inpatient settings needs careful consideration, for example;

### **The experience of patient G**

Patient G was on continuous observation whilst in her room at the time of our visit. At the time of our visit a male member of staff was undertaking these observations due to a shortage of female nurses on duty that day. The member of staff was very sensitive to the patient and was clearly aware of privacy and dignity issues. However, this arrangement was not satisfactory for a number of reasons, including the risk to the male member of staff himself should the individual make allegations about his behaviour towards her.

It is unavoidable, due to the nature of some services, that wards are mixed gender and admit both sexes. This can cause a variety of issues for staff in the appropriate management of patients. During our visits we noted many positive examples of ward staff ensuring appropriate gender segregation where appropriate. For example, we would expect to see gender specific sleeping areas, bathing and toileting facilities. However, staff are often faced with significant challenges that can be posed by the ward layout itself;

### **The experience of patients at Ward E**

The mixed gender patient group is causing difficulties for staff in maintaining patient's privacy and dignity. One female patient complained to our Reviewer that a male patient continually entered her room. The ward sister was asked to treat this as a formal complaint.

### **The experience of patients at ward F**

Ward F is a mixed gender ward. The opportunity to provide separate and self-contained facilities for both genders is not possible due to the layout of the building. On the day of our visit there were two women resident in the ward. It was evident from the comments of the members of staff and the two patients concerned that their privacy and dignity were being protected by staff. However, they did express concerns and irritation that some of the male patients wander around in their underclothes and continue to use the designated women only toilet and have poor hygiene.

Our reviewer found there were notices on the toilet to clearly state they were for female use only as well as a polite notice within the toilet advising males that if they had entered the room then they should be aware they were for female use only and to use an alternative male facility. The female patients also confirmed that when males did wander in their underclothing they are guided to return to their rooms and dress appropriately by staff.

Our Reviewer was satisfied that members of staff were aware and vigilant to the needs of the patients to protect their privacy and dignity.

We have previously stated our concerns regarding mixed gender facilities. Unfortunately in some situations we have been advised by organisations that there is little that can be done to address such concerns as they are hampered by the age of buildings and expenditure cannot be allocated to reconfigure ward layouts. Organisations need to remain vigilant about the implications mixed gender wards can have and ensure appropriate management arrangements are in place to ensure patients are not impacted.

### **Are bathroom and toilet facilities adequate?**

Many of the wards we visited have different arrangements in place for bathroom and toilet facilities. Some wards offer bedrooms with en-suite

facilities for patients while others have shared bathrooms and toilet areas. The latter can be problematic.

During our visits we found most settings to have appropriate bathroom and toileting facilities for patients. However, we did find some organisations had isolated issues which needed to be addressed,

### **The experience of patients at ward G**

During a visit to ward G we noted that the female communal bathroom did not have an entrance door or shower curtains. There were only 5 bedrooms with en-suite facilities. The ward was 19 bedded and several female patients had no alternative option other than to use the male communal facilities. This is not satisfactory and compromised the female patients' privacy, dignity and respect.

Other issues that we found during our visits included:

- poor standard of cleanliness and hygiene in toilet/bathroom areas
- A high ratio of patients to a limited number of toilet/bathroom areas
- toilet/Bathroom areas being out of order for extended periods of time.

In all instances where bathroom and toilet facilities were found to be inadequate we have requested the organisation take remedial action as matter of urgency.

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

### Are adequate activities provided?

A varied programme of activities and therapy can have a positive influence on patients and their recovery. During our visits we seek to identify the programme of activities that are available for patients during their stay in an inpatient setting and their views on the programme.

Patients have again reported to us in many settings that there can be a lack of meaningful activities for them to engage in, especially at weekends and in the evenings. It has also been reported to us that activities can sometimes be cancelled at short notice due to staff shortages. These comments were extremely similar across the settings we visited where activities were raised as a concern by patients.

### **The experience of patients at ward H**

In the time we spent on ward H limited activities for patients had taken place. Patients also told us that they often got bored. The staffing levels on the wards during our visit were not conducive to the facilitation and support of activities.

Activities can be an important part of a patient's recovery and such cancellations of planned activities can cause disappointment among patients and also frustration as they can often remain on the ward with little to do.

## Do patients have access to therapies including psychologists?

We observed patients' access to therapeutic input away from solely medication to be inconsistent across organisations. Organisations should



make access available to occupational therapy, psychology, physiotherapy, speech and language therapy and any other therapies that would be considered beneficial to the patient group. Such interventions can aid a patient's recovery and ultimately shorten a patient's duration in inpatient services. Such interventions can enable patients to regain confidence and learn new skills.

A number of wards we visited had limited access to occupational therapists and psychologists.

#### **The experience of patients at ward I**

There is limited provision of ward based therapeutic or psychosocial interventions and this is attributed to a general shortage of staff, particularly those specialising in therapeutic/psychosocial interventions and the absence of a dedicated ward psychologist or psychotherapist.

#### **The experience of patients at ward J**

There is no dedicated Psychologist available to the team and access to a psychology service for referrals and assessments is extremely limited for patients who quite clearly would benefit from increased input.

It was often the case that these extremely valuable services are limited within organisations and thinly spread. This is largely due to a number of posts being lost within the last few years and also with freezes in place on recruitment in some organisations. Where we found limited access to therapies we have asked the organisations to reassure us of the measures they will take to implement such therapies for patients.

## **Chapter 5: Conclusions and Next Steps**

The findings presented in this report highlight the importance of our role in monitoring the Mental Health Act in Wales. The powers of the Act are applied to a significant number of individuals each year and it emphasises the roles undertaken by our Mental Health Act Reviewers and SOADs are crucial in ensuring the rights of those effected by the Act are highlighted and measures are put in place to improve the experience of individuals.

We will continue to work with Health Boards and independent healthcare organisations to ensure any shortcomings identified by our Reviewers and SOADs during the course of their work are addressed.

## Appendix A

### Number of Admissions by Legal Status

Legal status (b)	2008-09	2009-10	2010-11	2011-12	Persons 2012-13 (e)
<b>Formal admissions:</b>					
<b>Part II:</b>					
2 (assessment with or without treatment)	954	883	1,014	894	943
2 (from ACUS) (c)	0	1	.	.	.
3 (to hospital for treatment)	547	415	495	360	351
3 (from ACUS) (c)	11	6	.	.	.
4 (for assessment in emergency)	56	40	63	63	44
<b>Total</b>	<b>1,568</b>	<b>1,345</b>	<b>1,572</b>	<b>1,317</b>	<b>1,338</b>
<b>Court and prison disposals:</b>					
35 (remanded to hospital for report)	6	7	12	10	4
36 (remanded to hospital for treatment)	0	1	4	1	1
37 (convicted person sent to hospital for treatment with section 41 restriction)	34	28	44	31	41
37 (convicted person sent to hospital for treatment without section 41 restriction)	17	28	32	28	26
45A (combined hospital order and prison sentence disposal)	0	0	0	0	3
47 & 48 (prisoner transferred to hospital with section 49 restriction)	31	20	27	29	24
47 & 48 (prisoner transferred to hospital without section 49 restriction)	3	3	2	3	7
<b>Total</b>	<b>91</b>	<b>87</b>	<b>121</b>	<b>102</b>	<b>106</b>
<b>Other powers (d)</b>	<b>14</b>	<b>20</b>	<b>24</b>	<b>9</b>	<b>9</b>
<b>Formal admissions Total</b>	<b>1,673</b>	<b>1,452</b>	<b>1,717</b>	<b>1,428</b>	<b>1,453</b>
<b>Informal admissions</b>	<b>9,428</b>	<b>9,904</b>	<b>9,481</b>	<b>9,345</b>	<b>9,070</b>
<b>All admissions</b>	<b>11,101</b>	<b>11,356</b>	<b>11,198</b>	<b>10,773</b>	<b>10,523</b>
<b>Hospital-based Place of Safety (PoS) detentions - first PoS only (f)</b>					
135 (warrant to remove to a place of safety) (g)	29	21	25	25	18
136 (removal by police from a public place to a place of safety)	558	555	672	774	842
<b>Total (g)</b>	<b>587</b>	<b>576</b>	<b>697</b>	<b>799</b>	<b>860</b>

(a) NHS and independent hospitals.

(b) See notes at end of Release for details.

(c) After Care Under Supervision - See notes.

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

(e) Admissions' data includes an estimate for independent hospitals. See Key Quality Information for more details.

(f) The data collection around sections 135(1) and 136 was changed in 2012-13. Data prior to this are not directly comparable and as such a break has been inserted into the table. See Key Quality Information for more details.

(g) Based on data for only 6 Local Health Boards for Section 135(1) in 2012-13: Excludes Section 135(1) data from Aneurin Bevan LHB as they were unable to provide the information. See Key Quality information for more details.

Figures produced by Welsh Government

Glossary for MHA Report

<b>Advocacy</b>	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also <i>independent mental health advocate</i> .
<b>After-care</b>	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.
<b>Appropriate medical treatment</b>	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.
<b>Approved Clinician</b>	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.
<b>Approved Mental Health Professional</b>	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.
<b>Assessment</b>	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.
<b>Capacity</b>	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.
<b>Care Programme Approach (CPA)</b>	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.
<b>Carer</b>	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.
<b>Child and Adolescent Mental Health Services (CAMHS)</b>	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.
<b>Community Treatment Order (CTO)</b>	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
<b>Compulsory treatment</b>	Medical treatment for mental disorder given under the Act
<b>Consent</b>	Agreeing to allow someone else to do something to or for you; particularly consent to treatment.
<b>Deprivation of Liberty</b>	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.
<b>Deprivation of Liberty Safeguards</b>	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.
<b>Detained patient</b>	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
<b>Detention/detained</b>	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"
<b>Discharge</b>	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.
<b>Doctor</b>	A registered medical practitioner.
<b>Doctor approved under section 12 (also 'section 12 doctor')</b>	<p>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.</p> <p>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</p>
<b>Electro-Convulsive Therapy (ECT)</b>	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.
<b>GP</b>	A patient's general practitioner (or <i>'family doctor'</i> ).
<b>Guardianship</b>	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).
<b>HIW</b>	Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales.
<b>Holding powers</b>	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.
<b>Hospital managers</b>	<p>The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS trust)</p> <p>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.</p>
<b>Hospital order</b>	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.

<b>Human Rights Act 1998</b>	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
<b>Independent Mental Capacity Advocate (IMCA)</b>	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.
<b>Informal patient</b>	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.
<b>Learning disability</b>	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.
<b>Leave of absence</b>	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 ' <i>section 17 leave</i> '.
<b>Local Social Services Authority (LSSA)</b>	The local authority (or council) responsible for social services in a particular area of the country.
<b>Medical treatment</b>	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.
<b>Medical treatment for mental disorder</b>	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.
<b>Mental Capacity Act 2005</b>	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.
<b>Mental disorder</b>	Any disorder or disability of the mind. As well as mental illness, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities.
<b>Mental Health Act</b>	The independent body which was responsible for

<b>Commission (MHAC)</b>	<p>monitoring the operation of the Act.</p> <p>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).</p>
<b>Mental Health Review Tribunal for Wales (MHRT for Wales)</b>	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
<b>Mental illness</b>	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.
<b>Nearest relative</b>	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.
<b>Part 2</b>	<p>The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients.</p> <p>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.</p>
<b>Part 3</b>	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.
<b>Patient</b>	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term ' <i>patient</i> ' should be used in practice in preference to other terms such as ' <i>service user</i> ', ' <i>client</i> ' or similar. It is simply a reflection of the terminology used in the Act itself.
<b>Place of safety</b>	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).
<b>Recall (and recalled)</b>	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.
<b>Regulations</b>	Secondary legislation made under the Act. In most cases, it means the <i>Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008</i> .
<b>Responsible Clinician</b>	The approved clinician with overall responsibility for the patient's case.
<b>Restricted patient</b>	<p>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</p> <p>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.</p>
<b>Revocation (and revoke)</b>	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.
<b>SCT patient</b>	A patient who is on supervised community treatment.
<b>Second Opinion Appointed Doctor (SOAD)</b>	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
<b>Section 12 doctor</b>	See doctor approved under section 12.
<b>Section 57 treatment</b>	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).
<b>SOAD certificate</b>	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
<b>Supervised Community Treatment (SCT)</b>	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.
<b>Three month period</b>	The period of three months from when treatments to which section 58 of the Act would apply are first administered.
<b>Voluntary patient</b>	See informal patient.
<b>Welsh Ministers</b>	Ministers in the Welsh Government.