



Mental Health Alliance

# The Mental Health Act 2007: a review of its implementation

# Contents

<b>Acknowledgements</b>	2
<b>Summary</b>	3
<b>Introduction</b>	3
<b>1. Community treatment orders (CTOs)</b>	4
<b>2. The deprivation of liberty safeguards (DoLS)</b>	9
<b>3. Independent mental health advocacy (IMHA)</b>	14
<b>4. Children and young people</b>	16
<b>5. Race equality</b>	17
<b>6. Section 136 places of safety</b>	19
<b>7. Regulation (the Care Quality Commission)</b>	20
<b>8. The Mental Health Measure in Wales</b>	22
<b>Conclusions</b>	23
<b>References</b>	25

# Acknowledgements

Written by Catherine Jackson and members of the Mental Health Alliance. With thanks to Simon Lawton-Smith, Roger Hargreaves, Rezina Hakim, Marcel Vige, Andy Bell, Rowena Daw, Paula Lavis, Bill Walden-Jones and Alison Cobb.

## Summary

The Mental Health Act 2007 introduced some positive changes, in particular for children and young people and through the introduction of Independent Mental Health Advocacy. Where people have made the Deprivation of Liberty Safeguards (DoLS) work they have improved people's lives. However this period has seen a continuing rise in the number of people under compulsion, with more people going onto community treatment orders than coming off them. Ethnic inequalities among detained patients are further magnified in the use of community treatment orders. The rights people technically have are not being consistently upheld. For example, people are denied their rights if Independent Mental Health Advocacy (IMHA) services are not commissioned adequately or hospital staff do not inform patients about the service. The DoLS scheme is too flawed to assure the rights of people who lack capacity and there are extreme variations in its implementation.

As new NHS structures and organisations are developed, it is essential that outcomes for people subject to the Mental Health Act are properly captured and that implementation of the mental health strategy *No health without mental health* fully includes their rights and needs.

The Mental Health Alliance will continue to monitor implementation of the Act and encourage continuing discussion about legislation that is based on impaired decision-making<sup>1</sup>. Our immediate priorities are:

- to feed into the Government's five year review of the legislation
- to draw up recommendations for an improved scheme to ensure the effectiveness of the Deprivation of Liberty Safeguards and
- to address continuing entrenched race inequalities.

The Mental Health Alliance is a unique coalition of 75 organisations from across the mental health spectrum and beyond. We came together in 1999 to work for humane and effective mental health legislation.

---

1. The Mental Health Alliance view on impaired decision-making is not shared by SANE.

## Introduction

The Mental Health Act 2007 introduced a number of significant changes to the Mental Health Act 1983, with far-reaching implications for mental health service users and their families and carers.

Starting with the 2000 White Paper and continuing through the 2002 and 2004 draft Mental Health Bills, which were subsequently dropped and replaced by the 2006 Mental Health Bill, the Mental Health Alliance campaigned vociferously for truly rights-based legislation that would ensure people with mental health problems were not discriminated against in comparison with people needing treatment for physical illnesses.

What we wanted was a completely new Act built on the principle that people should only be detained and treated without their consent if their capacity to make decisions on their own behalf was impaired and they were at risk to themselves or to others.

The Mental Health Act that was finally passed by Parliament in July 2007 included some measures that we supported, and several that we did not. Since that time, the Alliance has continued to monitor implementation of the Act, to recognise successes and to flag up concerns on behalf of people affected by the Act.

An overarching concern that we will continue to monitor is the increase in the use of compulsory powers (including the use of community treatment orders (CTOs)) for the treatment of people with mental illness, as expressed in the figures of those detained in England and Wales, which have continued to rise. Information and data collected indicates that the number of people subject to detention under the powers of the Act has risen each year since 2000 and they are an increasing proportion of the inpatient population.

In 2009/10, the Mental Health Act was used more than ever before. In England there were 45,755 detentions during the year, that is people admitted under detention or detained while in hospital. In Wales during 2009–10, 1,453 people were detained in hospital under the powers of the Mental Health Act (CQC and Health Inspectorate Reports). There were 16,647 people detained in hospital under the Mental Health Act at the end of 2010/11. This is a

slight increase since the previous reporting period and represents a continuing pattern of increase since 2007/08 although the rate of increase appears to be slowing. However in combination with the number of people on CTOs at 31 March 2011, it is apparent that increasing numbers of people are being subject to restrictions under the Mental Health Act (NHS Information Centre, October 2011).

This report reviews specific areas of concern following the Act's implementation.

# 1. Community treatment orders (CTOs)

## Key issues

- Higher use of CTOs than expected
- Disproportionate use of CTOs for people from BME communities
- Inappropriate use of CTOs
- Lack of adequate community support for patients on CTOs
- Serious delays in obtaining second opinions to authorise treatment
- A concurrent increase in the number of detained patients

Community treatment orders (CTOs) were introduced under the Mental Health Act 2007 with the explicit aim to improve the care and support of some people with severe mental health problems in the community following discharge from psychiatric hospital. CTOs give clinicians powers to recall patients following their discharge from detention in hospital if they relapse or have a change of circumstances and pose a high risk to themselves or others on account of their mental disorder (Code of Practice 25.47). Patients can only be placed on a CTO if they are at the time detained in hospital under a s3 or s37 treatment order of the Mental Health Act 1983.

People placed on a CTO are given what is known as 'supervised community treatment'. This means patients can, at their clinicians' discretion based on CTO criteria, be returned to hospital for compulsory treatment for their mental disorder if they stop taking their medication and/or disengage with services. They can be recalled for treatment for up to 72 hours, after which they must return to the community, or the CTO may be revoked, which means they will be placed on a new treatment order for up to 6 months.

A set of criteria govern the use of CTOs. They may be used where:

- the patient is suffering from a mental disorder such that they need medical treatment

- it is necessary for the patient's health or safety or the protection of others that they should receive such treatment
- treatment can be provided without the patient being detained in hospital, provided there are powers to recall the patient to hospital for medical treatment and
- appropriate medical treatment is available.

The term 'medical treatment' in the Act has a broad meaning that includes nursing, care, habilitation and rehabilitation (learning new skills or relearning old skills).

Importantly, CTOs do not give clinicians powers to force patients to take medication outside a hospital or clinic setting. The clinician may only enforce treatment by recalling the person to hospital if they think this is necessary. However being subject to recall to hospital detention is itself a form of compulsion.

The Alliance has conducted its own research into the implementation and use of the new powers, including surveys of psychiatrists and of service users and carers. The Care Quality Commission (CQC) has also published statistical data on the use of the new powers in its annual reports *Monitoring the use of the Mental Health Act* for 2009/10 and 2010/11 and the NHS Information Centre published (incomplete) data in June 2011 showing the numbers of people subject to a CTO in England. Similarly in Wales, the Health Inspectorate has published statistical data for the use of CTOs in Wales. Together these data suggest a number of areas of serious and continuing concern.

## 1.1 Higher use of CTOs than expected

The Department of Health predicted that some 400–600 patients would be placed on CTOs in the first year.

In fact, a total of 6,237 CTOs were made in England in the first 17 months of their implementation, between November 2008 and end of March 2010 (NHS Information Centre, 2010) – an average of about 350 each month. As at March 2011, some 4,291 people living in the community in England were recorded as being subject to a CTO (though this data was incomplete) (NHS Information Centre, 2011b).

More people are being given CTOs than are being discharged from them, resulting in a gradual accumulation of patients under community compulsion. More than two thirds (68 per cent) of CTOs imposed in England between November 2008 and March 2010 were still in place at the end of this period. Of the 32 per cent that were released from their CTO, roughly half were returned to detention in hospital and half were discharged from any section (NHS Information Centre, 2010). In Wales, during 2009–10, 261 people were made the subject of a CTO, with a total of 426 orders being issued in the 17 months since their introduction in November 2008. This was reported by the Health Inspectorate Wales as being far higher than expected. In Wales in 2010–11 there were 233 patients subject to CTOs, among which there were 87 recalls to hospital, 74 revocations and 78 discharges.

## 1.2 Disproportionate use of CTOs among some BME groups

National statistics (NHS Information Centre 2011b, Care Quality Commission 2011) show that CTOs are being used more frequently with some black and minority ethnic communities (particularly South Asian and Black groups). At the end of March 2011, 19.5 per cent of those on a CTO were Black or Black British. Black and White/Black Mixed groups already experience disproportionate use of coercion and detention under the Mental Health Act 1983 (see the section 5, Race Equality).

Overall, the data indicate that use of CTOs is magnifying an existing disproportionate use of coercion in the treatment of black people. This raises major concerns about race equality and discrimination issues.

## 1.3 Inappropriate use of CTOs

CTOs are being used mainly with patients who are on long-term antipsychotic maintenance medication (81 per cent according to the CQC (Care Quality Commission (2010)) for schizophrenia or other psychoses. This is the group for whom CTOs were primarily designed, on the grounds that this group was at significant risk of relapse and a danger to themselves or others, following discharge from hospital back into the community. However, data suggest that nearly a third (30 per cent) of patients

on CTOs have no history of non-compliance with treatment or of disengagement with services. Moreover, well over one third (36 per cent) of patients on CTOs are not recorded as posing any risk of harm to themselves or to others (CQC 2010). This suggests that CTOs are being used preventatively and probably inappropriately in around one third of cases, and raises serious concerns about human rights as well as the breadth of criteria for CTO imposition.

While data on the numbers of CTOs made, and people subject to CTOs, is published, there is no published data on how long people are kept on a CTO or the reason for discharge (expiry of CTO; clinician decision to discharge from an active CTO; revocation of the CTO (return to hospital); or death). It would be helpful if these data were collected and published nationally in both England and Wales, so a fuller picture of the process and impact of CTOs is obtained.

## 1.4 Delays in second opinion authorisations

Under the Mental Health Act 2007, all patients on a CTO must have their care plan reviewed and certified by a Second Opinion Appointed Doctor (SOAD) within one month of the order being imposed, or within three months of the initial detention, whichever is later. The unexpectedly high numbers of CTOs in the first year of implementation led to serious delays in this process. This meant there was a risk that patients were either being treated illegally (if they were told that they had to continue to follow their care plan), or were at risk of harm (if treatment was halted pending authorisation).

Requests for a SOAD must be received by the CQC, which operates the SOAD system, within one month of the CTO being made. However 40 per cent of the 5,742 requests for a SOAD received by the CQC from 3 November 2008 to 8 March 2010 arrived outside this period. This meant they fell outside the legal time limit for authorisation. This is a clear infringement of patients' rights.

We have welcomed the CQC's awareness of the challenges in administering the SOAD service due to the extra pressures of providing a second opinion for patients subject to CTOs, and its efforts to increase numbers of SOADs.

The Health and Social Care Act 2012 amended the Mental Health Act 1983 so that SOAD authorisation will no longer be needed if the person on a CTO has decision-making capacity and consents to treatment. The Mental Health Alliance supports this amendment, which removes an anomaly whereby treatment cannot legally be given to someone in the community without SOAD approval even if they are willing to take it, and will free up SOAD time to focus on those who lack capacity to consent.

## 1.5 Patient compliance

CQC data taken from SOAD reports for the year 2008/09–2009/10 show that 35 per cent of patients on CTOs were deemed to lack capacity to make decisions about their care and treatment. Of the majority (65 per cent) who were deemed to have capacity, 45 per cent were willing to comply with their treatment, and 20 per cent were refusing to consent to their treatment.

Moreover, according to CQC data, the 20 per cent of patients on CTOs who had capacity and were refusing treatment appeared to be taking their prescribed medication when seen by the SOAD who recorded their refusal of consent. This suggests another disregard of patients' rights. The CQC's report *Monitoring the Mental Health Act in 2010/11* shows continuing misunderstandings of the legal powers of CTOs within some mental health care providers, including the right of a patient to refuse treatment with medication except when recalled to hospital (where the conditions for recall are met).

This all supports the conclusion that, as noted above, people on a CTO may feel they have to accept treatment that they do not want in order to avoid being recalled to hospital.

The Alliance believes it is discriminatory that people with mental health problems can be coerced into accepting treatment they do not want, even when they have the capacity to make decisions about their own treatment and are considered well enough to be discharged into the community.

The Alliance's position remains that mental health legislation should ensure that CTOs are only used for patients with impaired decision-making capacity. The Government has repeatedly stated its commitment to putting patients at the heart of decision-making about their care and treatment and to maximise their choice. Accordingly, those deemed well enough to be discharged from hospital and capable of making all kinds of other choices about their lives, including about their mental disorder, should also be allowed to make decisions about their medical treatment. This would, however, require an amendment to primary legislation – the Mental Health Act 1983 – and regrettably such an amendment was rejected by the Government during debate on the Health and Social Care Bill in 2011.

## 1.6 Patient involvement

The CQC's 2009/10 annual report raises serious concerns about patient involvement in the care planning process. Reports from commissioners suggest some patients on CTOs are not being involved in agreeing their care plans, and in some cases are not even informed about the conditions with which they are expected to comply when they are discharged back into the community. The CQC concludes:

"Almost invariably, those patients who are positive about their experience under a CTO feel supported by and, just as importantly, involved in their care plans... We have found that, where patients are poorly involved in their care planning, they tend to view the CTO as simply a mechanism to enforce compliance with medication and as such a means to achieve the lesser evil of being subject to coercion without detention in hospital."

In 2010/11 the CQC reported that even the legal duties to provide CTO patients with information about their rights were often not being met.

## 1.7 Care under the Supervised Community Treatment (SCT) regime

One of the main reasons for introducing CTOs was to address a perception that community care was 'failing', in that services were not adequately supporting vulnerable people following discharge

from hospital and as a result they were posing a risk to themselves or others.

Roughly one in five patients on a CTO was recalled to hospital at some point in 2009/10, suggesting that supervised community treatment (SCT) was failing in its purpose to keep them well in the community. Indeed, given the recent overall increase in detentions under the Mental Health Act, it is possible that readmission rates have been increased by the introduction of CTOs. We do not know if this reflects on the range of care and support available to them in the community, the high level of need that people still have despite being discharged under a CTO, or whether, as a result of being under a CTO, people's continuing contact with services makes it more likely that staff will identify a relapse requiring readmission where previously they may have lost touch with the patient.

CTOs may be improving compliance with treatment plans by the majority of patients following discharge from hospital, but there is, to date, no corresponding evidence that CTOs in themselves are achieving any improvement in patients' quality of life. Nor is there any recognition of the potential harm to patients' recovery from the medication they may feel coerced into taking.

We note that in Scotland, where there is also compulsory community treatment, though within a different legal framework, Mental Welfare Commission interviews with 128 individuals subject to CTOs found that 85 per cent of people thought that compulsory community treatment had been of at least some benefit to them (Mental Welfare Commission, 2011). We believe there is an urgent need to conduct similar research with people subject to CTOs in England and Wales to assess what they consider the benefits – or disbenefits – of CTO use.

The [Alliance's August 2010 briefing paper](#) on SCT highlighted reports of poor communication between hospital and community clinicians. Community-based services did not always agree with the care plans drawn up by their inpatient colleagues, and in some cases said that care plans were 'unrealistic' or simply could not be provided within available resources.

The Alliance believes that, if someone is to be deprived of their liberty and, after their discharge,

required to accept treatment, that treatment should be adequate, appropriate and of therapeutic benefit. People on CTOs should have access to high quality, comprehensive community support, and this should be agreed with them in their care plan; otherwise, they are being set up to fail.

## 1.8 Conditions

Finally, at the time of the Mental Health Bill 2006, the Alliance drew attention to the fact that there is a wider power to impose conditions on people than in other jurisdictions who have CTOs, where generally the conditions must only cover issues of treatment or residence. We also had concerns, first, that these conditions can be varied by the responsible clinician alone and, second, that there is no right to challenge them in the Tribunal. Given that conditions may interfere with a person's Article 8 rights to private and family life there is a real concern at the lack of judicial scrutiny. Until such time as any human rights challenges occur, we are concerned that this situation persists. At a minimum, research should be conducted into how they are being used, looking expressly at quality of life and human rights.

## Recommendations

- Research should be conducted into the reasons for disproportionate use of CTOs among black mental health patients, which brings a new dimension to existing disproportionality.
- The Government should amend the Mental Health Act 1983 to ensure that CTOs are only used for patients with impaired decision-making capacity.
- Data on how long people are kept on a CTO and the reason for discharge should be collected and published nationally in both England and Wales by the NHS Information Centre and the Welsh Government.
- Hospital staff should ensure that both patients and relevant community mental health staff and services are fully involved in drawing the patients' care plans prior to discharge under a CTO and that patients are informed about their rights.
- Provider organisations should ensure that relevant staff understand the legal powers entailed in CTOs and their limits.
- Research should be conducted into the impact of the conditions set out in CTO patients' care plans on their quality of life and their human rights.

## 2. The Deprivation of Liberty Safeguards (DoLS)

### Key issues

- While the introduction of DoLS was welcome in principle, its implementation has been extremely uneven, with the result that the protections the scheme is supposed to afford to vulnerable people are effectively unavailable in large parts of the country
- Its review and appeals processes do not comply with the requirements of ECHR Article 5(4)<sup>2</sup>, largely negating its intended purpose
- These flaws require remedy, and we need an urgent debate on whether this can be achieved through improvements to the current scheme or whether the regime needs to be radically overhauled or replaced
- The scheme is overly bureaucratic and stretches scarce professional resources
- Nevertheless, where agencies have managed, with a great deal of effort, to make it work reasonably well, DoLS does perform a valuable protective function and has achieved at least some of the objectives set out for it, demonstrating that there is a need for a measure of this kind.

### 2.1 The DoLS scheme

The Deprivation of Liberty Safeguards (DoLS) are an addition to the 2005 Mental Capacity Act (MCA), introduced as part of the 2007 Mental Health Act. They were designed to remedy the incompatibility between English law and the European Convention on Human Rights identified in *HL v UK*, the “Bournewood” case, by creating a procedure whereby people who lack capacity and who need to

---

2. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

be protected from harm can, if it is deemed to be necessary in their best interests, be lawfully detained in a hospital or care home.

The DoLS were implemented from 1 April 2009. They apply to people aged 18 and over who are resident in care homes and hospitals and who:

- suffer from a mental disorder – such as dementia or a learning disability
- lack the capacity to give informed consent to the arrangements made for their care and / or treatment and
- are considered to be at risk of harm if they are not deprived of liberty (as per Article 5 of the ECHR)
- It is in their best interests, according to the MCA, to be deprived of their liberty in a hospital or care home.

Care homes and hospitals (“managing authorities”) must apply to their local authority or Primary Care Trust respectively (the supervisory body) for an independent assessment of any residents/patients in their care who they believe may require the protection of DoLS. The majority of cases involve older people suffering from dementia and living in care homes. Seventy-five per cent of DoLS applications are therefore dealt with by local authorities, and they will handle all of them when the PCTs are abolished.

DoLS cannot be used in respect of people living in supported living schemes or other accommodation not registered as a hospital or care home.

### 2.2 The Alliance’s concerns

The Mental Health Alliance has been monitoring use of DoLS through its member organisations, the quarterly statistics (for England) published by the NHS Information Centre, published court judgements, and the reports of the regulators (CQC, Care and Social Services Inspectorate Wales, Health Inspectorate Wales).

Our [first report on implementation, published in July 2010](#) identified a number of worrying trends.

We found:

- much lower than predicted rates of applications and authorisations, and wide disparities in activity rates between comparable supervisory bodies

- poor understanding of the provisions of the main Mental Capacity Act, meaning that care providers did not know when they were exceeding the powers it gave them and would therefore need to apply for a DoLS authorisation, or how the MCA could be used appropriately, sometimes negating a need for DoLS
- lack of knowledge and understanding, among care providers and their staff in particular, of the meaning of 'deprivation of liberty' in practice
- resistance to use of DoLS among care providers, in part because of lack of understanding of the process, but also due to widespread anxiety and defensiveness about care standards and practice
- some evidence of resistance among supervisory bodies to appointing family members or carers as representatives of detained persons where it was felt they might challenge use of DoLS
- low provision of Independent Mental Capacity Advocate (IMCA) support, despite the statutory requirement in Section 39D of the Act for supervisory bodies to make this available to detained persons and their family representatives
- a high level of legal and procedural errors caused by the complexity of the scheme coupled with inadequate staff training
- very low use of the avenues for review and appeal, particularly by family/carer representatives.

The scheme has now been in place for more than two years. Such a radically new scheme could not have been expected to work perfectly from the start, but evidence suggests that many of the problems we identified in July 2010 remain.

Many of our findings have been echoed in the first reports of the regulators in England and Wales, published in March 2011. The Care and Social Services Inspectorate Wales (CSSIW) report for Wales, for instance, noted inconsistent policies on appointment of Section 39D IMCAs and the choice between DoLS and the Court of Protection to resolve disputes with families.

The CQC report for England expressed concern that the expense and time required to comply with the processes might be a factor in the lower-than-expected level of use. It also noted that "we came across too many examples of people using services who were being cared for in a way that potentially

amounted to an unlawful deprivation of liberty without any consideration of the Safeguards" and "too many examples of managers and staff in hospitals and care homes who were unaware of the Safeguards or who had received no training in them, even towards the end of 2009–10."

The judgement of the Court of Protection in the case of Steven Neary (June 2011– [2011] EWHC 1377 (COP)) further underscored some of our earlier findings, in particular inadequate training leading to a lack of understanding of the basic MCA processes, failure of assessors to comply fully with legal requirements, and the need for automatic appointment of IMCAs and a robust review process. In addition, this case highlighted the potential for conflict of interest where the same local authority managers were responsible for safeguarding actions which involved removing the person to a care placement, while also being responsible for the DoLS function which is intended to protect the person's rights in these circumstances.

### 2.2.1 Activity rates

The statistics for England for 2010–11 (the NHS Information Centre July 2011) showed that the huge variations in activity rates between comparable areas, which had become apparent during the first year of the scheme, appeared to have become entrenched, despite the best efforts of the Department of Health's Implementation Team to reduce them. For example, taking these comparable areas over two years – West Sussex made 206 authorisations, Surrey 21; Ealing made 103, Bromley 4; Leicester made 154, Hull none.

Low rates of authorisation were generally associated with low rates of application. There is evidence that the differences in application rates are driven mainly by the different policies of the supervisory bodies, who have been largely responsible for the training and guidance given to staff of managing authorities in their areas. The statistics show that where a high proportion of applications is turned down, the application rate subsequently falls off.

Despite concerns of the Department of Health and the regulatory bodies about these variations, no credible explanation for them has emerged, other than that they reflect widely-differing local interpretations, primarily by the supervisory bodies,

of the guidance on the meaning of 'deprivation of liberty' in the DoLS Code of Practice. This guidance has not been updated, despite at least 16 published judgements which have gone at least some way to clarifying the meaning since it was drafted. Some supervisory bodies with very low activity rates have claimed that this reflects their success in persuading care providers in their areas to adopt less restrictive care practices. However, this flies in the face of the evidence from the regulators that their inspectors are frequently coming across instances of potential deprivation of liberty and of staff who are ignorant of the legal requirements in these circumstances.

It is for supervisory bodies and managing authorities to keep themselves up to date on new case law and its implications, but judgements are often difficult for non-lawyers to understand or put into context, and very few of the supervisory bodies (over 300 in England alone) or the 20,000 care homes in England and Wales have legal advisers with expertise on this issue. The CQC has asked the Department of Health for "more frequent briefings written in a way which is accessible and more easily applied to practice."

Research conducted by the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry (Cairns et al, 2011) demonstrates the extent of uncertainty about the meaning of "deprivation of liberty". When a range of professionals with a DoLS role were given real-life case examples, the degree of agreement as to whether the cases involved a deprivation of liberty rarely rose above the level of statistical significance. Lawyers with in-depth knowledge did not agree, which led the authors to question whether more training would improve the situation without clear, practical guidance.

### **2.2.2 Safeguards against misuse of DoLS**

DoLS processes require that a measure to deprive someone of liberty must include provision which allows them "to take proceedings by which the lawfulness of their detention shall be decided speedily by a court" but, as interpreted by the courts, it must also include provision for regular review as to whether the grounds for detention are still met.

By these standards, the DoLS scheme is deficient on several counts, whether this is from failures of

understanding or implementation (one particular concern being that families often struggle to understand the process) or flaws in the scheme itself. The ineffectiveness of the review process was highlighted by the judge in the Neary case. It is still little used by detained persons or their representatives; the proportion of authorisations reviewed at their request has fallen between the first and second years, from just over to just under 2 per cent.

To assist them in obtaining reviews or pursuing appeals, family representatives have a statutory right (Section 39D of the Mental Capacity Act) to support from an Independent Mental Capacity Advocate (IMCA). However in the first year "39D" IMCAs were instructed in respect of just 2.25 per cent of authorisations. While figures for the second 12 months may show an improvement, there remain differences in policy between supervisory bodies, with some appointing an IMCA automatically and others just informing the representatives of their right to ask for one.

These formalities combined with the complexity of DoLS inevitably make appeals a lengthy as well as a costly process, and one with which lawyers paid at current legal aid rates may be very reluctant to become involved. Difficulties in accessing solicitors or lengthy waits for hearings were evident in the cases of Neary and of G v E and Others (2010) EWHC 621 (Fam); the consequence was that people concerned were unlawfully detained for nearly a year. The Alliance is concerned that changes to legal aid will make this situation worse.

The Alliance made 10 recommendations to the Government in its July 2010 report, as follows:

1. The Government should undertake its own thorough analysis of the reasons for the lower-than-expected level of applications and the large disparities between supervisory bodies.
2. The process of educating care professionals in the requirements of the main Mental Capacity Act is far from complete, and should be sustained.
3. The Government should issue revised guidance on the meaning of deprivation of liberty which is more comprehensible to care providers, and especially to staff of care homes.

4. The term “deprivation of liberty” gives a negative impression which is creating resistance on the part of service providers. The Government should consider, at the first major review, whether an alternative title could be adopted for the scheme as a whole, which would present it in a more positive light. The original intention was to title it “Protective Care” which had much more positive connotations.
5. Refresher training for assessors should focus on improving their knowledge of the legal requirements and should emphasise the importance of full compliance with them.
6. The Government should clarify the ambiguous guidance in the Code of Practice on the selection of family or carer representatives, to make it clear that they should not be regarded as acting contrary to the detained person’s best interests solely because they object to the authorisation or are likely to challenge it, and that in selecting them the best-interests assessor or supervisory body must observe the requirements of Section 4 of the Act and case law on best-interests decisions.
7. In any revision of the Code it should be made clear that the appointment of assessors “suitable to the particular case” is a statutory duty and not just good practice.
8. Where a friend or family member is selected as representative, the appointment of a Section 39D IMCA should be automatic unless the representative positively declines it.
9. Supervisory bodies should be required, by revision of the Code of Practice, to give full written reasons to representatives for declining to implement a request for a Part 8 review.
10. The Government should consider the implications for the DoLS review process of the High Court’s decision in the case of *Salford City Council v BJ* and issue guidance.

Only one of these recommendations, number 6, has been implemented. Department of Health guidance to supervisory bodies (July 2010) states that family members should not be passed over for appointment as representatives simply because they opposed the authorisation. It also states that

authorisations should not be used to resolve disputes with families about care arrangements but that these should be placed before the Court of Protection. It is too early to say to what extent it is being followed in practice.

We are seriously concerned that the other recommendations are now unlikely to be pursued, given the disbanding of the central DoLS implementation team in England and its regional leads, and the cutbacks in spending which are likely to reduce still further the very small amounts being spent on commissioning Section 39D IMCAs and on the training for all professionals involved in the scheme which is essential if they are to learn to master the excessively complex processes.

### 2.2.3 Training and education

Although the judge in the *Neary* case was very critical of the Best Interests Assessors (BIAs), the general level of competence among BIAs appears to have increased greatly over two years, at least in those areas where the level of activity has been high enough to give them sufficient practice experience.

However it is clear that there is still a need for substantial training opportunities to be given to all those involved in the DoLS process including medical assessors, who in most places conduct the eligibility assessments that determine whether a person comes under the DoLS or Mental Health Act powers. The Schedule of the Mental Capacity Act that defines eligibility is almost incomprehensible, even to lawyers, and a major judgement (*GJ v the FT and Others*, 2009 EWHC 2972 (Fam)) was too complex to clarify the situation.

### 2.2.4 Supported living schemes

Another emerging problem is that the DoLS scheme applies only to residents in hospitals or registered care homes, but deprivation of liberty occurs to a large group of people in supported living schemes, which are now the main type of long-term care provision for people with learning disabilities. Supported living providers who need to deprive someone of their liberty must apply to the Court of Protection, but this can be an expensive and protracted business and it appears to be happening rarely.

This is a complicated situation, because people in supported living schemes are there voluntarily as

tenants (a person must have capacity to sign a tenancy unless someone one has legal authority to sign on their behalf) rather than because it is in their best interests. While in practice they are similarly vulnerable to deprivation of liberty, their status is different. If this barrier can be overcome to extend DoLS protection to people in supported living schemes, the varied management arrangements in this sector would still make it difficult to determine who has the role of managing authority and therefore the Schedules would require substantial revision.

## 2.3 Conclusions

While welcome in principle, the implementation of the DoLS scheme has been extremely uneven, with the result that the protections the scheme is supposed to afford to vulnerable people are effectively unavailable in large parts of the country. Where the agencies have managed, with a great deal of effort, to make it work reasonably well, it performs a valuable protective function. However, in those areas where application and authorisation levels have been very low, too many vulnerable hospital and care home residents are being left without its protection.

Some problems might be overcome by more comprehensive guidance and additional training. However, the level of training necessary for staff of supervisory bodies to master its complexities is unlikely to be affordable in the foreseeable future. Many supervisory bodies have disbanded their specialist DoLS teams and management arrangements, and refresher training is as little as a day or two per year. Local authorities are also concerned about further strains on their budgets if they are not fully compensated financially when they take on the supervisory body role of the PCTs on their disbandment.

Additional training would not, in any case, overcome basic structural flaws. In particular, it would not resolve:

- the absence of a statutory definition of “deprivation of liberty “
- the problems around the interface with the Mental Health Act, with which DoLS has to interact but which operates on different and in many respects incompatible principles.

- the general complexity of DoLS and lack of ‘fit’ with the rest of the MCA, including compatibility with the MCA and correct use of Sections 5 and 6 before resorting to DoLS
- the inadequacy of the review provisions and the unsuitability of the Court of Protection as the appeal body
- the conflicts of interest which are inherent in supervisory bodies also having an active role in actions which lead to deprivation of liberty
- the lack of protection for anyone deprived of their liberty in care settings not registered as care homes or hospitals.

Therefore, the Alliance believes that the scheme, to be effective as intended in protecting people’s liberty, should be subject to a major review. The review would consider not just the operation of the DoLS arrangements but whether there was a more effective and less burdensome way of meeting the requirements of Article 5 of the ECHR in relation to the detention of people who lack mental capacity. The Alliance intends, following consultations with its members, to publish a further paper setting out a range of options.

## Recommendations

- The Government should conduct a review of the DoLS scheme with the aim of preserving the essential purpose of DoLS but making its operation such that it:
  - is much simpler and more straightforward
  - is applied flexibly across the whole range of care provision
  - is fully compatible with the Mental Health Act and the rest of the Mental Capacity Act at the points where they interact
  - avoids conflicts of interest
  - incorporates effective review processes, and
  - does not rely on the Court of Protection as the first stage of appeal.

## 3. Independent mental health advocacy (IMHA)

### Key issues

- Advocacy services have not received additional resources to provide IMHA services
- Commissioners are not requiring or monitoring IMHA provision for BME patients
- IMHA providers are struggling to meet demands for IMHA support in addition to existing caseloads
- Hospital and community health staff are not aware of patients' legal rights to IMHA support and have a poor understanding of the IMHA role
- From 2013, local authorities will be responsible for commissioning IMHA services, which will be competing for funding alongside all the other calls on local authority funding

The right to independent mental health advocacy (IMHA) for all patients detained under the Mental Health Act was an important new provision in the 2007 Act. This includes patients placed on a CTO.

Primary care trusts are responsible for commissioning IMHA services, and are expected to be mindful of the ethnicity and cultural needs of qualifying patients when tendering contracts for IMHA provision.

The Mental Health Alliance has reviewed the performance of PCTs in commissioning IMHA service provision in the first year of implementation. We have also reviewed access to and availability of IMHA provision within mental health trusts and other provider organisations. Our findings are based on data obtained from 35 IMHA provider organisations – some 10 per cent of the total – and their respective PCTs, plus an additional 15 PCTs. We have also drawn on CQC published data.

### 3.1 Lack of resources

Nearly four out of five (78 per cent) of the PCTs we reviewed did not put the IMHA service out to tender. Their explanation was lack of time between the publication of commissioning guidance and implementation of this part of the Act. Most PCTs simply continued the existing mental health advocacy service, with little or no additional resources. According to the CQC's annual report for 2009/10, 18 per cent of 311 inpatient wards surveyed in 2009/10 did not provide access to IMHA services. The CQC has also questioned availability of advocacy to people on CTOs.

In Wales, the Health Inspectorate identified some inequalities in access to IMHAs across Wales. Health boards are required to commission IMHA services for any patient detained in their area, and all had done so. However some registered independent hospitals were not aware who provides their local statutory IMHA service and neither do they have regular contact with their IMHA service, unlike in neighbouring NHS facilities where IMHA services make scheduled visits in addition to responding to individual referrals for support.

More than two thirds of IMHA providers in our survey reported difficulties with the IMHA contract and the PCT. These included:

- underfunding – PCTs have tended not to provide enough funding, or to expect services to continue on the same basis as previously
- difficulties meeting the demand for IMHA support from within existing resources
- spot purchasing, with no formal contract for IMHA provision
- no provision for out-of area patients requiring IMHA support.

Alliance members have been aware of problems for people treated in the independent sector in accessing IMHA support, particularly if they are placed out of area. These commissioning issues are reflected in the CQC's 2010–11 Mental Health Act monitoring report, and need practical resolution; commissioning guidance may need to be strengthened here.

The Health and Social Care Act 2012 transfers responsibility for commissioning IMHA services from primary care trusts to local authorities. It is vital that local authorities have the necessary awareness, expertise and funding to commission IMHA services in accordance with guidance and the Code of Practice and that they learn from the shortcomings seen in some PCTs.

### 3.2 Access and referrals

The majority (85 per cent) of IMHA providers in our review reported problems with referrals to the service. Reasons included lack of knowledge among hospital staff and GPs about the IMHA service and its role and purpose.

There were also reports of hospital staff not knowing how to refer patients for IMHA support, so they were unable to actively encourage patients to exercise their right to an IMHA.

IMHA providers also reported poor understanding among hospital staff and other health professionals about the difference between the IMHA and the non-IMHA mental health advocacy service.

### 3.3 Race equality

By failing to invite tenders for IMHA contracts, PCTs may have missed a vital means to ensure IMHA services adequately meet the needs of the local BME population. The tendering process requires IMHA providers to be able to demonstrate knowledge and experience of meeting the needs of all ethnic communities.

The commissioning guidelines state that an assessment of local need for IMHA support may be carried out before commissioning services. Nearly half (46 per cent) of the PCTs in our review had not

conducted an assessment of local need. Of the 54 per cent who had, more than half made no reference to the requirement to demonstrate capacity to respond to ethnic diversity in the local population.

Most IMHA service providers in our review felt that current IMHA contracts did not adequately address these needs of local BME communities.

Specifically, they reported:

- lack of resources to cater for dialects and languages used within the local community
- lack of requirement, and consequent lack of resources from the commissioner, to provide a service with capacity to engage adequately with minority BME communities
- lack of contact between IMHA providers and BME patients, meaning that the IMHA service itself did not identify a need for a BME focus.

### Recommendations

- Local authorities should receive sufficient funding to fulfil their duties to commission IMHA services when they take over this responsibility from primary care trusts
- Commissioners of IMHA services should be held to account on the level of provision in their area and its availability to people in independent as well as NHS settings, and Health and Wellbeing Boards should monitor this
- Commissioners of IMHA services should make it a contractual requirement that these services are explicitly tailored to the needs of the local BME population, and monitor this.
- Hospital staff should proactively inform patients about their right to access an IMHA service, including if they leave hospital under a CTO.

## 4. Children and young people

### Key issues

- There has been good progress in moving children and young people off adult psychiatric wards but variation between regions

The 2007 Mental Health Act allows children and young people under the age of 16 to be admitted to adult psychiatric wards only in very exceptional circumstances. The Government pledged that no child under 16 would be treated on an adult psychiatric ward within two years of the Act's implementation. In addition, section 31(3) of the Act places a duty on hospital managers to ensure that all patients (voluntary and those detained under the Act) are treated in an age-appropriate environment.

The latest data from the Department of Health (Department of Health, 2011) show significant progress in reducing the numbers of children and young people aged under 18 placed on adult wards, although this progress is less dramatic for young people aged 17–18 (for a small number of whom admission to an adult ward may be appropriate to their developmental age and stage). In 2009/10 NHS authorities reported 32 bed days spent by children and young people aged under 16 on NHS adult psychiatric wards in England. By the end of the third quarter of 2010/11, this figure had dropped to just two. The number of bed days spent on adult psychiatric wards by young people aged 16 to 17 years totalled 7,564 in 2009/10. By the end of the third quarter of 2010/11, the total was 4,512. This is a significant reduction. However these numbers are still high, and there is still work to be done to meet the age-appropriate duty.

Also, there is considerable variation across Strategic Health Authority (SHA) regions and trusts. For example, the South East Coast SHA region reported just 59 occupied bed days on adult psychiatric wards for 16–17 year olds, while Yorkshire and Humber SHA region reported 447. Averages also vary across regions – the lowest recorded to date for 16–17

years old in 2010/11 is the North East, with 60, and the highest is again Yorkshire and Humber, with 324.

Department of Health data also show a continuing increase in the number of bed days in child and adolescent mental health units. This could indicate that more young people are being admitted to Child and Adolescent Mental Health Services (CAMHS) units, instead of adult wards, but the evidence is not conclusive – it could also indicate an increase in demand and, in any case, these numbers tend to fluctuate annually.

### 4.1 Transitions

The transition from CAMHS to adult mental health services (AMHS) is often poorly managed. It is common for young people to be moved from CAMHS to AMHS on their 18th birthday, regardless of their individual circumstances, their health or their current treatment needs. This applies to inpatients and to those receiving their mental health care from community services. The Track study looked at the transition from CAMHS to AMHS and found that 'up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care' (Singh, et al, 2010, cited in Joint Commissioning Panel for Mental Health, 2012).

This seemingly arbitrary move can lead to young people feeling abandoned by services in which they have placed their trust, and may exacerbate the difficulties with which they are struggling. For some it can lead to recurrence of self-harm, eating disorders and even suicide attempts. For young people in inpatient units, the transfer to AMHS can disrupt education, as adult units do not have the same educational resources. This can make it even more difficult for young people to keep up with their studies. Adult units also work very differently: they tend not to offer holistic support to the whole family, which can leave young people feeling isolated, especially as they will also lose the support of their peers.

### Recommendations

- Government should continue to closely monitor the numbers of young people aged under 18

admitted to adult psychiatric wards, and this data should be available for public scrutiny.

- Commissioners should assess local needs to ensure there are enough beds in CAMHS units to accommodate those previously admitted to adult wards
- Commissioners and providers need to ensure that home treatment and intensive community-based interventions are available for young people to reduce the need for inpatient admissions – and the effectiveness and acceptability of these services to young people should be evaluated.
- Commissioners and providers should monitor the numbers of young people making the transition from CAMHS to Adult Mental Health Services (AMHS), and ensure that there is continuity of care and that age-appropriate services and education continues to be provided.

## 5. Race equality

### Key issues

- Continued disproportionate use of detention and coercion with people from some BME groups
- Disproportionate use of the new CTO powers with some BME groups, exacerbating race inequality
- Overall continuing increase in use of the Mental Health Act to treat patients in hospital and the community
- Lack of information to allow exploration of these differing levels of use of detention

The 2007 Mental Health Act does not include a set of principles. Instead, a statement of guiding principles is included in the Code of Practice.

The 'Respect' principle (1.4) states:

'People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patients, including their race, religion, culture, gender, age, sexual orientation and any disability... There must be no unlawful discrimination.'

While this principle is useful in guiding best practice, it is not legally binding. Nor does it, in the Mental Health Alliance's view, even begin to address the continued disproportionate use of the Mental Health Act in the hospital admission and treatment of people from some minority ethnic groups – in particular Black, Black British and Mixed ethnic groups.

There is still considerable disagreement over what this disproportion reflects: higher absolute levels of serious illness among these groups; later presentation to mental health services because of reluctance to seek medical help; over-use of coercion by clinicians based on stereotypical interpretations of cultural behaviours and ways of expression; culturally inappropriate and unacceptable care and treatment resulting in poorer outcomes and longer admissions, or a combination of all these, and more.

The 2010 Count Me In census of mental health patients shows that, while numbers of inpatients in

psychiatric hospitals have fallen overall since the first census in 2005 (although this trend has now gone into reverse, see below), the ethnic differences in admissions, detentions and seclusion have not. The 2010 census yet again reports significantly higher than average rates of hospital admission (between two and six times higher), detention and seclusion of patients from the various Black and White/Black Mixed groups, in comparison with average and below average rates for White, Asian and Chinese groups. Lengths of stay in hospital were also longest for Black groups, and for South Asian groups. This picture has remained broadly unchanged throughout all five of these annual snapshot censuses.

The most recent figures reported in the NHS Mental Health Minimum Dataset (2009/10) show a reversal in the five-year downward trend in numbers of people admitted to psychiatric hospital. The overall number of hospital admissions was 107,765 in 2009/10, a 5.1 per cent rise and the first increase since 2003/04–2004/05. However the largest part of this increase was due to the 30 per cent rise in numbers admitted under the Mental Health Act, from 32,649 in 2008/09 to 42,479 in 2009/10. The numbers of voluntary patients fell by 6.6 per cent. The proportion of patients in hospitals who were detained under the Act rose to 39.4 per cent, to nearly two in every five patients.

This increase in hospital detentions occurred across all ethnic groups, but was particularly sharp for people in the Black group – detentions rose from 53.8 per cent of admissions for this group in 2008/09 to 66.3 per cent in 2009/10.

Rates of use of mental health services overall increased across all ethnic groups, but was much larger for the Mixed ethnic group (17.7 per cent rise) in 2009/10. Mixed, Black and Black British groups are now 40 per cent more likely than people in the White group to be using mental health

services, with or without compulsion (3,800 per 100,000 population, compared with 2,700 for the White group).

The fall in overall numbers of Black and Black British patients admitted to psychiatric hospital between 2008/09 and 2009/10 was entirely due to a decrease in the numbers of voluntary patients, which was greater (by about 600) than the increase in the numbers detained in hospital under the Mental Health Act.

Alongside the increase in hospital detentions, as reported in section 1, there is also evidence of far greater use of CTOs with people from Black ethnic minority groups, further exacerbating the racial disparity.

## Recommendations

- Commissioners should expand and develop community-based services' focus on responding to the needs of BME communities, particularly those who experience disproportionate use of the Mental Health Act. This should include advocacy and befriending services that support people's pathways out of secure mental health settings, move people from CTO to discharge, and enable them to manage productively in society.
- The Government should commission a review of the experiences of pathways into and through care which looks for differences in experience of Mental Health Act processes between different ethnic groups. It should consider decision-making by psychiatric professionals, with the aim of understanding differences in presentation across the client groups.
- As stated in section 1, research should be conducted into the reasons for disproportionate use of CTOs among black mental health patients which brings a new dimension to existing disproportionality.

## 6. Section 136 places of safety

### Key issues

- Continued use of police cells as places of safety
- Poor monitoring and data collection on police use of section 136
- Variable access to hospital-based places of safety
- Risk-averse admission policies to hospital-based places of safety

Under section 136 of the Mental Health Act 1983, the police may take someone who they think appears to be 'suffering from mental disorder and to be in immediate need of care or control' from a public place to a 'place of safety' in order to have them assessed. This may be a police cell, hospital-based facility or other 'suitable place' and the person may be detained for up to 72 hours.

In 2007 the Act was amended to allow patients to be transferred from one place of safety to another without being first assessed by an approved doctor and mental health professional. This means that patients can be taken from a police cell to hospital for assessment.

The Royal College of Psychiatrists recommends that psychiatric units should provide places of safety so that police cells do not have to be used, other than in emergencies, and that a range of venues should be available where people can be assessed in appropriate environments (for example for young people and older people, as well as working age adults).

Research by the Independent Police Complaints Commission (Docking et al, 2008) examined the nature and extent of police custody as a place of safety, the first time national data had been collated. The CQC, in its monitoring report for 2009/10, highlights a number of cases where police cells are still being used, and where the system fails highly vulnerable people.

The CQC annual report for 2009/10 reports that use of hospital-based places of safety has increased

significantly in recent years: from 6,004 in 2006/07 to 12,038 in 2009/10. There was a further increase of 17.2 per cent to 14,111 in 2010/11 (CQC, 2011). However no comparable data are collected on the use of police cells, and the CQC notes that it is not possible to know if this reflects a reduced use of police cells. It may be that availability of hospital-based places of safety has led to an increase in the use by the police of section 136 powers.

The CQC suggests that in some cases use of these powers may be inappropriate and that community mental health teams may need to work with the police to help them decide when it is necessary to use section 136.

However the CQC also highlights cases where the police have been unable to access hospital-based places of safety. In some cases staff have been moved elsewhere to fill gaps in rotas, in others people are turned away because they are thought to be drunk or high on drugs, or they are deemed a risk because of aggressive behaviour.

The CQC recommends that these instances should be monitored carefully, to ensure hospital staff are not being too risk averse and turning away people whose behaviour does not pose a significant risk and should be manageable within existing policies and staffing.

The CQC has also identified a number of cases where individuals have not been seen by a section 12 approved doctor, or have been inadequately assessed before transfer or discharge from the place of safety without having been seen by an approved mental health professional.

In Wales a number of hospital-based 'place of safety' facilities have recently been put in place by health boards. As a result the number of place of safety detentions that occurred in a hospital based facility in 2009–10 was 576 compared to 229 in 2004–05; a rise of some 60 per cent (Healthcare Inspectorate Wales, 2011).

### Recommendations

- Commissioners should ensure that their areas include a range of appropriate places of safety.
- Data on the number of uses of police cells as places of safety should be collected as part of local monitoring, incorporated into the NHS

Information Centre's data and monitored by the Care Quality Commission.

- Provider organisations should review their policy and practice in the use of section 136 to ensure they are not turning people away inappropriately.

## 7. Regulation (the Care Quality Commission)

### Key issues

- Increasing numbers of detained patients in hospitals and the community
- Capacity of CQC resources to fulfil its statutory functions under the Mental Health Act
- Particular concerns about CTO patients' access to CQC commissioners
- Future monitoring of ethnicity and patient experience and care pathways

The Health Act 2008, passed by parliament one year after the Mental Health Act 2007, introduced major changes to the way NHS and independent sector health and social care services are regulated. In April 2009 the Care Quality Commission (CQC) took over from the Mental Health Act Commission the responsibility for inspecting services where people are detained under the Mental Health Act and the Mental Capacity Act.

The CQC is required by law to visit and interview in private anyone detained in hospital under the Mental Health Act and those placed on a CTO in the community. The CQC also operates the SOAD system that ensures that all compulsory treatments are verified by an independent medical expert. The CQC aims to visit every psychiatric ward in England at least once every 18 months. It has yet to provide information on how it intends to provide a comparable level of service to patients on CTOs.

As noted above, the numbers of patients detained in hospital and now in the community continue to grow.

### 7.1 Reporting on the Act

The CQC continues to carry out all of the functions of its predecessor, the Mental Health Act Commission (MHAC). Its commissioners carry out visits and as a result of the Commission's greater statutory powers compared with the MHAC they have more opportunities to address any concerns. The Commission also now publishes an annual

report on the use of the Mental Health Act, replacing the MHAC's former two yearly report. We welcome this frequency of reporting. The Health Inspectorate in Wales has, since 2009, assumed responsibility for monitoring the Mental Health Act in Wales.

## 7.2 CTOs

The CQC's own data show that, in the first five months of CTOs coming into effect, some 1722 requests were made for a SOAD to certify a CTO – much higher than the original estimate (see section 1).

As reported in section 1, the Health and Social Care Act removed the requirement for a second opinion where a patient on a CTO has capacity and agrees to treatment. This, together with the CQC's own efforts to increase the SOAD workforce and improve the efficiency of the system, should help alleviate the pressure.

However providing the capacity to visit people on CTOs in the community will present a major challenge, as the CQC itself admits. It not only spreads resources much more thinly; it also raises practical difficulties about how and where to visit them.

These visits are a crucial aspect of the regulation of the Act and safeguarding of the rights of people subject to statutory powers that may place restrictions on their freedom of movement and activities over very long periods.

## 7.3 Monitoring ethnicity

Another aspect of the Commission's role has been to conduct the annual Count Me In census of patients using mental health inpatient and community services, including their ethnicity.

The final census was conducted in 2010, when the Delivering Race Equality (DRE) programme ended.

The census has provided important data on the ethnicity of people subject to detention in hospital and receiving treatment in the community, enabling comparisons to be drawn between ethnic groups. NHS providers will continue to collect such data for the Mental Health Minimum Data Set and this needs to be collated and published in a way that is accessible and enables people to see and respond to trends. However, what may be missing is information about patients' experiences of treatment and care pathways, and how that varies according to their ethnic origin. It is crucial that the outcomes mental health services achieve (in terms of experience and safety as well as effectiveness) for all ethnic groups are monitored regularly and that commissioners and providers are held to account for year-on-year improvements.

## Recommendations

- The CQC should be resourced sufficiently to carry out its statutory functions under the Mental Health Act and related regulatory activity.
- The CQC should continue to carry out community and inpatient mental health surveys and ensure they can be analysed by ethnic group.
- The data collected by the CQC and the NHS Information Centre should be published so as to show trends relating to ethnic differences in processes and outcomes, and maintain the focus that Count Me In provided.
- The CQC should maintain a programme of special reports on areas of concern for example treatment of BME people under the Act, patient involvement in care and quality of life under a CTO.

## 8. The Mental Health Measure in Wales

### Key issues

- Regulations, Code of Practice, and implementation plans to guarantee holistic, recovery-focused care plan
- Timely referrals for assessments and care plans

In December 2010 the National Assembly for Wales passed the Mental Health (Wales) Measure 2010. The Measure:

- aims to improve access to primary and secondary care and treatment
- introduces a duty to provide care and treatment plans for all those receiving secondary mental health services
- extends access to mental health advocacy support to all mental health inpatients – including almost all service users subject to the Mental Health Act who do not constitute “qualifying patients” under the 2007 Act amendments. (People in custody under s.135 or 136 are not however included.)

The Mental Health Alliance members in Wales have welcomed:

- the provisions in the new Measure
- the Regulations which prescribe an holistic format for Care and Treatment Plans
- the Code of Practice (currently subject to final approval by the National Assembly) which includes clear advisory timescales for the appointment of Care Coordinators and the completion of Care & Treatment Plans.

### Recommendations

- Quality standards for implementation of the new Measure should require Care Coordinators to make full use of the holistic format for Care and Treatment Plans prescribed by the Regulations, routinely addressing all the domains, specifically:
  - physical health
  - medication and other treatment
  - money
  - social life
  - accommodation
  - training and education
  - employment and caring
  - parenting relationships.

# Conclusions

While the Mental Health Act 2007 introduced some positive changes, in particular age appropriate services for children and young people and Independent Mental Health Advocacy, there are areas of serious concern.

As new NHS structures and organisations are developed, it is essential that outcomes for people subject to the Mental Health Act are properly captured and that implementation of the mental health strategy *No health without mental health* fully includes their rights and needs.

The Mental Health Alliance will continue to monitor implementation of the Act and encourage continuing discussion about legislation that is based on impaired decision-making. Our immediate priorities are to feed into the Government's five year review of the legislation and specifically to draw up recommendations for an improved scheme to ensure the effectiveness of the Deprivation of Liberty Safeguards and to address continuing entrenched race inequalities.

Working together we aim to uphold the rights and improve the care of some of the most vulnerable people in the mental health system.

## Recommendations

### Community treatment orders (CTOs)

- Research should be conducted into the reasons for disproportionate use of CTOs among black mental health patients, which brings a new dimension to existing disproportionality.
- The Government should amend the Mental Health Act 1983 to ensure that CTOs are only used for patients with impaired decision-making capacity.
- Data on how long people are kept on a CTO and the reason for discharge should be collected and published nationally in both England and Wales by the NHS Information Centre and the Welsh Government.
- Hospital staff should ensure that both patients and relevant community mental health staff and services are fully involved in drawing the patients' care plans prior to discharge under a CTO and that patients are informed about their rights.

- Provider organisations should ensure that relevant staff understand the legal powers entailed in CTOs and their limits.
- Research should be conducted into the impact of the conditions set out in CTO patients' care plans on their quality of life and their human rights.

### Deprivation of Liberty Safeguards (DoLS)

- The Government should conduct a review of the DoLS scheme with the aim of preserving the essential purpose of DoLS but making its operation such that it:
  - is much simpler and more straightforward
  - is applied flexibly across the whole range of care provision
  - is fully compatible with the Mental Health Act and the rest of the Mental Capacity Act at the points where they interact
  - avoids conflicts of interest
  - incorporates effective review processes
  - does not rely on the Court of Protection as the first stage of appeal.

### Independent Mental Health Advocacy (IMHA)

- Local authorities should receive sufficient funding to fulfil their duties to commission IMHA services when they take over this responsibility from primary care trusts
- Commissioners of IMHA services should be held to account on the level of provision in their area and its availability to people in independent as well as NHS settings, and Health and Wellbeing Boards should monitor this
- Commissioners of IMHA services should make it a contractual requirement that these services are explicitly tailored to the needs of the local BME population, and monitor this.
- Hospital staff should proactively inform patients about their right to access an IMHA service, including if they leave hospital under a CTO.

### Children and young people

- Government should continue to closely monitor the numbers of young people aged under 18 admitted to adult psychiatric wards, and this data should be available for public scrutiny.

- Commissioners should assess local needs to ensure there are enough beds in CAMHS units to accommodate those previously admitted to adult wards
- Commissioners and providers need to ensure that home treatment and intensive community-based interventions are available for young people to reduce the need for inpatient admissions – and the effectiveness and acceptability of these services to young people should be evaluated.
- Commissioners and providers should monitor the numbers of young people making the transition from CAMHS to AMHS, and ensure that there is continuity of care and that age-appropriate services and education continues to be provided.

### **Race equality**

- Commissioners should expand and develop community-based services' focus on responding to the needs of BME communities, particularly those who experience disproportionate use of the Mental Health Act. This should include advocacy and befriending services that support people's pathways out of secure mental health settings, move people from CTO to discharge, and enable them to manage productively in society.
- The Government should commission a review of the experiences of pathways into and through care which looks for differences in experience of Mental Health Act processes between different ethnic groups. It should consider decision-making by psychiatric professionals, with the aim of understanding differences in presentation across the client groups.
- As stated in section 1, research should be conducted into the reasons for disproportionate use of CTOs among black mental health patients which brings a new dimension to existing disproportionality.

### **Section 136 places of safety**

- Commissioners should ensure that their areas include a range of appropriate places of safety.
- Data on the number of uses of police cells as places of safety should be collected as part of local monitoring, incorporated into the NHS Information Centre's data and monitored by the CQC.
- Provider organisations should review their policy and practice in the use of section 136 to ensure they are not turning people away inappropriately.

### **Regulation (CQC)**

- The CQC should be resourced sufficiently to carry out its statutory functions under the Mental Health Act and related regulatory activity
- The CQC should continue to carry out community and inpatient mental health surveys and ensure they can be analysed by ethnic group.
- The data collected by the CQC and the NHS Information Centre should be published so as to show trends relating to ethnic differences in processes and outcomes, and maintain the focus that the Count Me In census provided.
- The CQC should maintain a programme of special reports on areas of concern, for example treatment of BME people under the Act, patient involvement in care and quality of life under a CTO.

### **Mental Health Measure (Wales)**

- Quality standards for implementation of the new Measure should require Care Coordinators to make full use of the holistic format for Care and Treatment Plans prescribed by the Regulations, routinely addressing all the domains, specifically:
  - physical health
  - medication and other treatment
  - money
  - social life
  - accommodation
  - training and education
  - employment and caring
  - parenting relationships.

# References

Cairns et al (2011), "Judgements about deprivation of liberty made by various professionals: comparison study", *The Psychiatrist* September 2011

Care Quality Commission (2010) *Monitoring the use of the Mental Health Act in 2009/10*.

Care Quality Commission (2011a) *Monitoring the Mental Health Act in 2010/11*.

Care Quality Commission (2011b) *Count me in 2010*.

Department of Health (2011) *Integrated Performance Measures Monitoring, CAMHS 2010–11*, [http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Integratedperfomancemeasuresmonitoring/DH\\_112554](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Integratedperfomancemeasuresmonitoring/DH_112554)

Docking et al (2008) *Police custody as a "Place of safety"*, Independent Police Complaints Commission.

Health Inspectorate Wales (2011) *Monitoring the use of the Mental Health Act in 2009–2010*.

Mental Welfare Commission (2011) *Our Annual report 2010/11*.

NHS Information Centre (2011a) *Mental Health Bulletin – Fourth report from Mental Health Minimum Data Set (MHMDS) annual returns 2010*.

NHS Information Centre (2011b) *Mental Health Bulletin – Fifth report from Mental Health Minimum Data Set (MHMDS) annual returns 2011*.

NHS Information Centre (2010) *In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2009/10*.

Singh, S.P. et al. (2010) *Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study*, in Joint Commissioning Panel for Mental Health (2012) *Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services*, Royal College of Psychiatrists. <http://www.rcpsych.ac.uk/PDF/JCP-MH%20CAMHS%20transitions%20%28Feb%202012%29.pdf>

## Mental Health Alliance members

Afiya Trust; Black Mental Health UK; British Association for Counselling and Psychotherapy; British Association of Social Workers; British Psychological Society; Caritas Social Action; College of Occupational Therapists; Ethnic Health Forum North West; Hafal; Institute of Mental Health Act Practitioners; King's Fund; Bipolar UK; Mental Health Foundation; Mind; National Autistic Society; NUS; Rethink Mental Illness; Revolving Doors Agency; Richmond Fellowship; Royal College of Nursing; Royal College of Psychiatrists; SANE; Centre for Mental Health; SIRI; Together; Turning Point; UK Federation of Smaller Mental Health Agencies; UKAN; UNISON; United Response; Voices Forum; YoungMinds; The 1990 Trust; African Caribbean Community Initiatives; Age UK; Alcohol Concern; Association of Directors of Social Services; AWAAZ (Manchester); AWETU; British Medical Association; BME Mental Health Network; Carers UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; East Dorset Mental Health Carers Forum; Family Action; Footprints (UK); General Medical Council; Haldane Society of Socialist Lawyers; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Liberty; Local Government Association; Manchester Race and Health Forum; Mencap; Nacro; NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Social Perspectives Network; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.

## Contact Mental Health Alliance

Alison Cobb, Chair, Mental Health Alliance  
a.cobb@mind.org.uk

Mental Health Alliance, c/o Richmond Fellowship, 80 Holloway Road,  
London N7 8JG

**[www.mentalhealthalliance.org.uk](http://www.mentalhealthalliance.org.uk)**



**Mental Health Alliance**