Care Quality Commission

Monitoring the Mental Health Act in 2016/17

SUMMARY

STATE OF CARE

Foreword

Mental health has never been higher on the national agenda. In our report on the state of care in mental health services published in July 2017, we commented on the fact that more people than ever are receiving treatment and care for mental health conditions. In some respects, this is a good thing because it is in part due to more people being willing to seek help because of a reduction in the stigma associated with mental ill-health. However, this increase in demand has also contributed to a mental health system that is showing signs of strain; including problems of access, pressures on staffing and unsafe environments on some mental health wards.

The number of people detained in hospital under the MHA has increased in recent years and the proportion of detained to informal patients continues to rise. In some parts of the country, mental health wards now admit few informal patients. In previous MHA reports, we have commented on the limited understanding of the factors that have contributed to this change. In January 2018, we published a report, based on evidence gathered during visits to local areas, and proposed eight hypotheses that could explain the increasing use of the MHA. Our findings support the view that changes to legislation alone may not have a major or immediate effect on the use of the MHA or rates of detention for specific groups.

Our MHA reviewers across the country have reported progress in some aspects of practice relating to the use of the MHA. However, in other aspects, we see no evidence of improvement from previous years. In particular, we continue to be concerned about the quality of care plans, discharge plans and physical health checks.

In 2017, we committed to carrying out focused work on some aspects of the use of the MHA that require closer scrutiny. In our state of care in mental health services report, we highlighted that more than 30 years after the introduction of mental health legislation that enshrined the principle of least restriction, some patients still receive overly restrictive care. To encourage improvement in this area of treatment, our report on restrictive intervention programmes published in December 2017 identified five NHS mental health trusts that have developed strategies and implemented approaches to reducing the need for restrictive interventions; including physical restraint. We will build on this good practice, including working with the Department of Health and Social Care to move towards greater understanding and implementation of the least restrictive option.

It is likely that, for a person whose first experience of mental health care is detention under the MHA, their perception of mental health services, and their willingness to engage with future care, will be greatly influenced by their experience of care provided during that initial admission. It is therefore vital that, while developing community services that can minimise the need for admission, services do not lose sight of the importance of also providing high quality inpatient care for those who need it.

The MHA review, chaired by Professor Sir Simon Wessely, should act as an important lever for improvement in some of the areas of concern we have highlighted in recent reports. CQC will continue to play its part in highlighting good practice, encouraging improvement and acting on behalf of people so everyone gets the help they need when they need it.

I am grateful to the many patients who have shared their experiences with us on visits, and to our Service User Reference Panel and External Advisory group for their invaluable input into this report.

Paul Lelliott
Deputy Chief Inspector of Hospitals (Mental Health)

Key points

The Mental Health Act 1983 (MHA) is the legal framework that provides authority to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people.

It is CQC's job to look at how health services in England are applying the MHA and to make sure that patients' human rights are being protected.

We have seen limited or no improvement in the key concerns we have raised in previous years.

We found that delays in accessing beds are creating difficult situations where patients are left untended in the community, or held in police custody without lawful authority.

We also frequently raise concerns over whether clinicians have recorded evidence of their conversations with detained patients over proposed treatment, or recorded the patients' views on that treatment, as well as whether the patient consents, refuses consent, or is incapable of consent.

32%

Thirty-two per cent (1,034 of 3,253) of care plans reviewed showed no evidence of patient involvement. This was 29% last year.

31%

Thirty-one per cent (550 of 1,788) showed no evidence of the patient's views. In 2015/16, 26% had not been recorded.

17%

Seventeen per cent (588 of 3,372) showed no evidence of consideration of the least restrictive options for care. This compares with 10% of records last year.

24%

Twenty-four per cent (570 of 2,403) showed no evidence of discharge planning, compared with 32% last year.

11%

378 of 3,357 (11%) of records examined showed that patients had not been informed of their legal rights on admission. This is similar to the 10% we reported in 2015/16.

15%

Fifteen per cent (95 of 639) of patients were not automatically referred to advocacy services where they lacked capacity to decide whether to do so themselves.

8%

In 8% of records (193 of 2,303) examined, patients' physical health had not been assessed through examination on admission for patients in hospital for less than a year. In 2015/16, 5% had not been assessed on admission.

Review of the Mental Health Act 1983

In 2017, the Queen's speech set out the government intention to review and reform the MHA. In October 2017, the Prime Minister announced the appointment of Professor Sir Simon Wessely, a former President of the Royal College of Psychiatrists, to carry out an Independent Review of mental health legislation and practice. The government requested Sir Simon to provide an interim report in early 2018, and a final report containing detailed recommendations on its priorities by autumn 2018. The report will consider:

- why rates of detention are increasing – what can be done to reduce inappropriate detention and improve how different agencies respond to people in crisis
- reasons for the disproportionate number of people from certain ethnic backgrounds, in particular Black people, being detained under the MHA, and what should be done about it.

As the independent monitoring body for the MHA, we will be a part of the Independent Review's Advisory panel and working group, using the intelligence we gather to help inform the evidence gathering of the Review. To support the Review to identify practical solutions that can help to improve areas of practice, we will complete a collaborative evaluation of the way the MHA Code of Practice (2015) has been implemented with patients, providers and experts. This work will take place throughout 2018 and we will share the findings throughout the year.

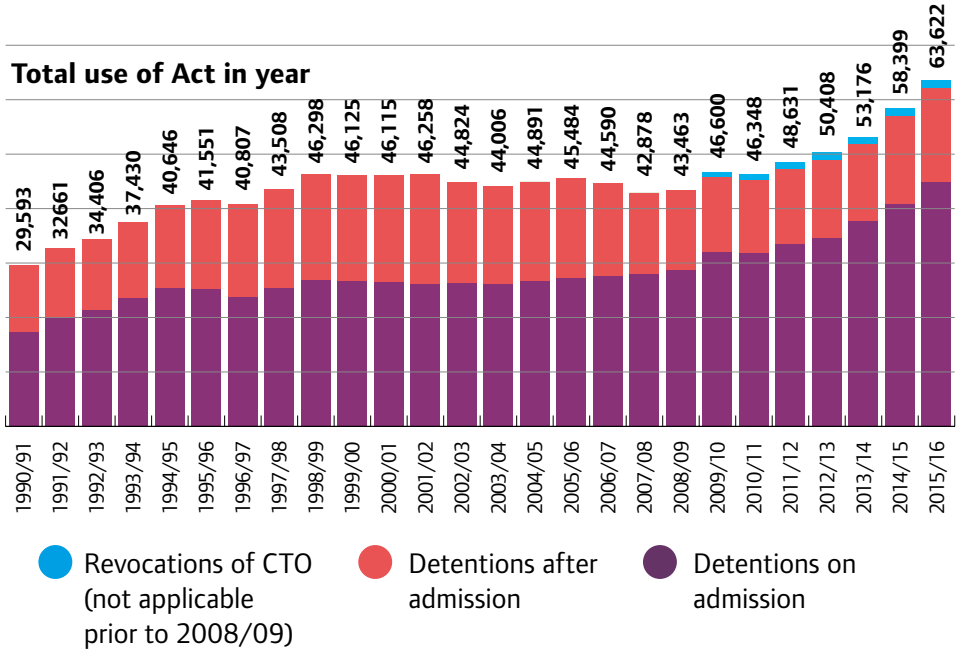
"Reviewing the Act isn't just about changing the legislation. In some ways that might be the easy part. The bigger challenge is changing the way we deliver care so that people do not need to be detained in the first place. In my experience it is unusual for a detention to be unnecessary - by the time we get to that stage people are often very unwell, and there seems few other alternatives available.
But that does not mean this was not preventable or avoidable. The solutions might lie with changes to the legislation, but could also come from changes in the way we organise and deliver services. It would also be naïve to deny that much wider factors, such as discrimination, poverty and prejudice, could be playing a role."

Sir Simon Wessely
Independent Review Panel Chair (2017)

Assessment, transport and admission to hospital

- National data from the last 25 years shows an increasing use of the MHA to treat people in hospitals. As part of our work to gather views on the reasons behind the increase, we visited 12 local services, and found that it is highly likely that a range of factors, both national and local, have contributed to this rise.
- Some services are finding it difficult to access appropriate support to prevent a patient's admission, and patients are not receiving the mental health care they need when they need it from specialist children and young people's mental health services.
- In 2017, we reviewed Approved Mental Health Professional (AMHP) services in England. AMHPs decide whether to apply to have someone detained in hospital when two medical recommendations for this have been made. AMHPs across the country reported that a reduction in beds nationally was having an effect on their ability to complete assessments in a timely manner, particularly when patients needed specialist beds.

Detentions in hospital under the Mental Health Act, 1990/91 to 2015/16



Source: NHS Digital, KP90 / Mental Health Services Data Set (MHSDS)

There has been no increase in the provision of community mental health services to offset the reduction in bed availability in the last five years. Generic community mental health team provision fell slightly during this period.
Centre for Mental Health

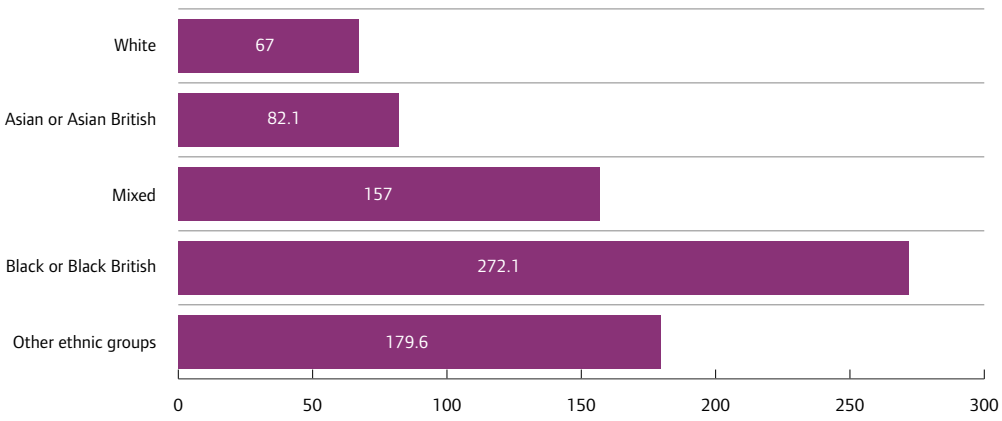
An equality and human rights focus in mental health care

- People from a Black and minority ethnic background are overrepresented in the detained population in England. Detention rates for the 'Black or Black British' population group are more than four times that for the White population group. The reasons behind this are not widely understood.
- The government has said that its wish to tackle inequality in the use of the MHA between population groups is a main motivation behind commissioning the Independent Review of the MHA.
- Some providers have helped to develop the British Institute of Human Rights' guides on human rights, mental health and mental capacity. The guides are part of a project funded by the Department of Health and Social Care to place human rights at the heart of mental health and mental capacity services.
- In 2017, we co-published the equality and human rights good practice resource Equally outstanding. This explores how a focus on equality and human rights can improve the quality of care in times of financial constraint.

People from a Black background are more than twice as likely to live in poverty than those from a white background. Black children are more than twice as likely to grow up in a lone parent family. Black and Mixed ethnic boys are more likely than White boys to be permanently excluded from school and to be arrested as a teenager.

The Lammy Review

Standardised rates of detention under the MHA per 1,000 population, 2016/17

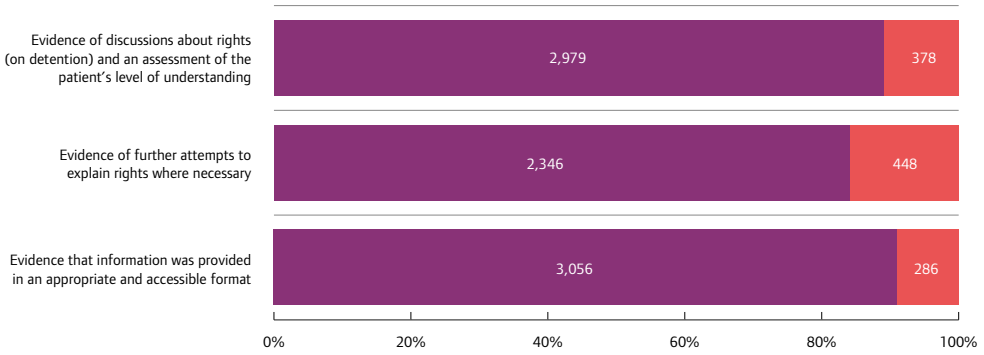


Source: NHS Digital, MHSDS

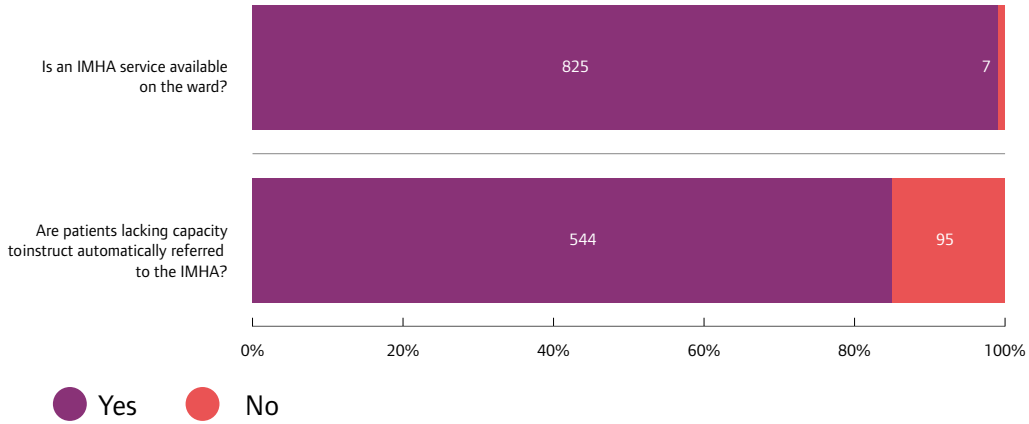
Protecting patients' rights and autonomy

- There was no evidence that staff had discussed rights with the patient on admission in 11% (378) of patient records that we checked. In a further 9% (286) of records, there was no evidence that patients received the information in an accessible format.
- The MHA Code of Practice requires staff to remind patients of their rights and of the effects of the MHA from time to time, to check the hospital is meeting its legal duties. However, there was no evidence of this happening in 16% (448) of records that we checked.
- Under the MHA, providers are required to take practicable steps to make sure that patients subject to the MHA are aware of the help that is available from Independent Mental Health Advocates (IMHAs). On almost every ward we visited throughout 2016/17, patients stated that they had some degree of access to IMHAs.

Evidence of discussions of rights in examined records 2016/17



Evidence of IMHA service provision, 2016/17

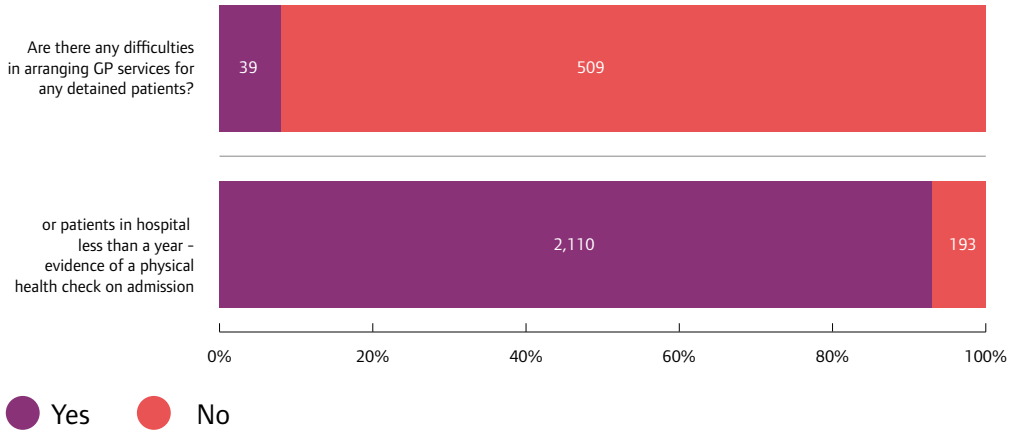


Source: CQC

Care, support and treatment in hospital

- We have seen a decrease in the percentage of wards that have had problems in accessing GP services. In 2012/13, we reported that a quarter of wards we visited did not have ready access to GP services. In 2014/15 and 2015/16 it was around 10% of wards. In 2016/17 it was 7%.
- We continue to find problems with adequately monitoring detained patients' physical health. In 2016/17, we looked at the care records of 2,303 patients who had been detained for less than a year in hospital. Of these, there was no evidence in 8% (193) of records that a health assessment had been carried out at admission. This is a worse result than the previous two years.
- During visits, we frequently raise concerns over whether clinicians have recorded evidence of their conversations with detained patients over their proposed treatment, and recorded the patients' views on that treatment. We also have concerns about whether the patient consents, refuses consent, or is incapable of consent.

Physical health care of detained patients, 2016/17



Source: CQC

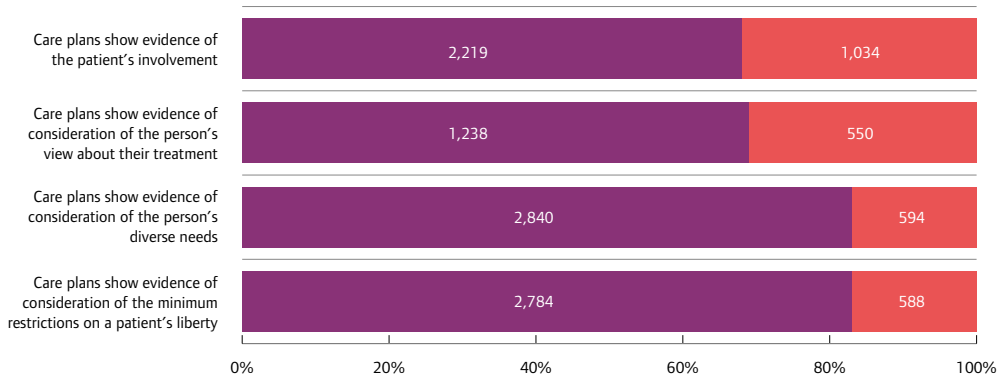
"The ability to impose medication is unique to the Mental Health Act and is always a priority area for review and assessment when I am meeting with patients, reviewing records or speaking with staff. Medication discussions are a critical part of the patient experience and ability to be involved during detention. From my experience, a supportive and meaningful discussion about the treatment options, implications and choices can make a big difference to patient recovery. This can be a positive one, helping them to understand what to expect and how the consultant's proposed treatment plan has been decided, but we also want to highlight when there isn't a record of a discussion and the potential negative impacts when preferences or previous experience with medication is not sought."

Mental Health Act Reviewer

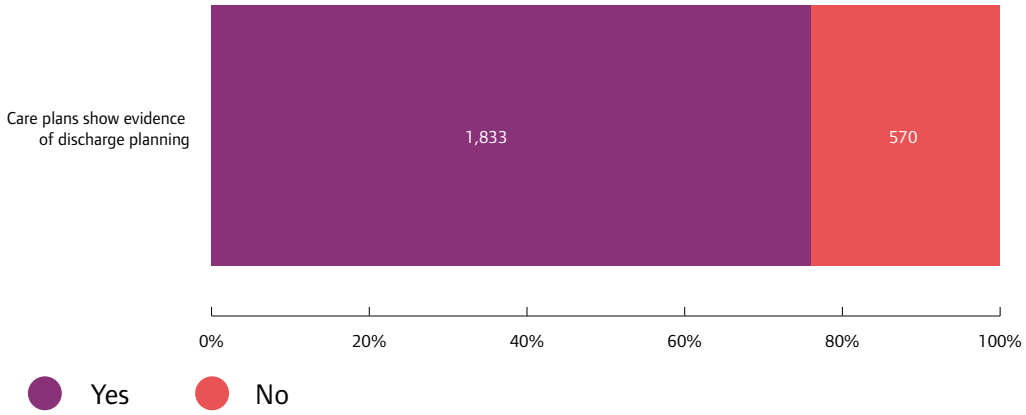
Leaving hospital

- The MHA Code of Practice provides guidance on care planning in the context of the Care Programme Approach, including aftercare planning and individualised risk assessment.
- During our visits in 2016/17, MHA reviewers found no evidence of patient involvement in 32% (1,034) of the care plans they reviewed. This was three percentage points worse than the previous year.
- In 2016/17, 76% (1,833) of care plans examined showed evidence of aftercare planning. This is a higher percentage than the previous year (68%), but we continue to expect providers to review aftercare planning regularly from the point of admission, and fully document this in care plans.
- MHA reviewers check care plans for individualised risk assessments that are updated as a patient's circumstances change. The 2016/17 findings of our MHA reviewers suggest that practice has not improved from the previous year, and may have got worse.

Evidence of patient involvement in care planning in examined records 2016/17



Examined care plans showing evidence of discharge planning, 2016/17



Source: CQC

CQC AND THE MENTAL HEALTH ACT

An outline of CQC's statutory duties in monitoring the Mental Health Act.

1,368

We carried our 1,368 visits

4,114

We met with 4,114 patients

6,475

There were 6,475 actions required from providers

14,594

Our Second Opinion Appointed Doctor service carried out 14,594 visits to review patient treatment plans

26%

and in 26% of their visits they changed treatment plans

2,353

We received 2,353 complaints and enquiries about the way the MHA was applied to patients

186

We were notified of 186 deaths of detained patients by natural causes, 54 deaths by unnatural causes and seven yet to be determined verdicts

642

We were notified of 642 absences without leave from secure hospitals

How to contact us

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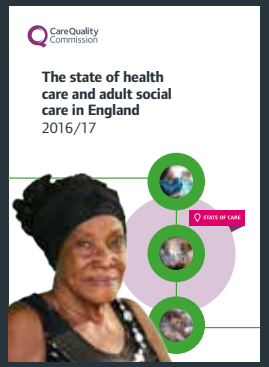

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The Care Quality Commission is a member of the UK's National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.