System pressures and the MHA

Key points

- We remain concerned that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time.
- Through our monitoring activity, we have seen how system pressures mean people are detained far from home or in environments that do not meet their needs.
- Services need to balance the increase in demand for inpatient beds with ensuring existing patients are not discharged too soon.

Across the mental health system in England, services remain under significant pressure. A recent report published by Mind describes a mental health crisis, warning that "the scale and severity of mental health need is spiraling" and putting the system "at breaking point".

Data from the Mental Health Services Data Set (MHSDS) that the number of people in contact with secondary mental health services increased by 43% between March 2019 and March 2024, which cannot be accounted for by population growth alone. In successive State of Care reports, we have raised concerns that high demand for community mental health services – without the capacity to meet it – is affecting people's ability to get the care they need, when they need it.

Our special review of Nottinghamshire Healthcare NHS Foundation Trust found evidence of people having to wait several months, and in some cases several years, for community mental health treatment. Similarly, an analysis of free text responses to the 2023 NHS Community mental health survey found that people reported significant waits between referral, assessment and treatment.

In our last Monitoring the Mental Health Act report, we highlighted the importance of early intervention in preventing people from reaching a crisis. Getting the right mental health care, as early as possible, can have a significant positive impact on the trajectory and severity of a person's illness. Not being able to access care in a timely way can lead to people's mental health deteriorating while they wait for support. The Centre for Mental Health's recent Care beyond beds report warns that when there is a delay or complete lack of appropriate intervention, the severity of someone's mental illness can increase, which can lead to more distress and upheaval, as well as higher costs for services.

Figures from NHS England's Mental Health Services Data Set (MHSDS) show an 18% increase in the number of adults with a serious mental illness who accessed community mental health services between March 2023 and March 2024. These people may need to access urgent and emergency care services, and research from the Strategy Unit (hosted by NHS Midlands and Lancashire) shows over 80% of patients presenting at emergency departments with mental health needs are known to specialist mental services. The research also highlighted how people with mental health needs access urgent and emergency services differently. These patients use ambulances more, often arrive out of hours and are more likely to wait longer in emergency departments for assessment and treatment than those with physical health conditions. One in 3 people calling NHS 111 who had a primary mental health complaint were referred to an emergency department, compared with only 11% of callers with a physical health complaint.

Data from MHSDS shows that in 2023/24, the number of very urgent adult referrals to crisis teams more than doubled, reaching 3,063 in March 2024. This suggests people are becoming more unwell while waiting for the help they need. Recovery time in hospital may therefore increase, meaning bed occupancy rates remain high.

This puts pressure on inpatient services, with staff needing to balance the pressure to admit new patients with ensuring existing patients get the care they need. It could lead to people being placed on wards that do not meet all of their needs. For example, very unwell patients may be admitted to an acute ward rather than a psychiatric intensive care ward. In services for older adults, we have seen instances of people with dementia or other cognitive impairments who are placed on wards for people with functional mental health conditions because specialist dementia services are full, meaning people are not cared for in the most dementia-friendly environments. This can affect ward communities, as patients with very different needs are being cared for in close proximity.

Being discharged too soon or not getting enough community support after discharge could mean people's mental health deteriorates again. Research from the Strategy Unit showed almost 2,500 patients in England attended emergency or urgent care departments 5 times or more for their mental health in 12 months.

Inpatient admissions

According to NHS England, in 2023/24, 52,458 new detentions under the Mental Health Act were recorded in England. As at March 2024, there were 16,706 patients recorded as being detained in hospital under MHA powers. Many services have told us that patients seem to be more unwell on admission than in the past, suggesting a lack of supportive interventions prior to admission. We have heard this in relation to admissions from the community, and transfers to hospital from prisons. When people are more unwell on admission it can lead to an increase in recovery time, which not only comes at a significant, potentially long-lasting personal cost for individuals, but also makes it more difficult for services to admit new patients. Data shows that bed occupancy figures continued to be much higher than the 85% standard.

A recent report by LaingBuisson highlights that, while occupancy rates in NHS mental health trusts reached record levels, the independent mental health hospital sector has continued to grow in value. It identifies high NHS occupancy rates as a driver of supply to the independent sector, and estimates that providing publicly funded care (either from NHS or local authority funding streams) accounts for around 92% of the market value.

Amy's story

We spoke with Amy, who explained how a lack of suitable accommodation affected her when she was detained under the MHA. In early 2024, Amy was initially detained under section 136, which is when police can use emergency powers to take people from a public place to a place of safety, often a section 136 suite.

In Amy's case, there were no section 136 suites available within a 4 hour-radius. Amy therefore spent hours waiting in a police staff room. She was accompanied by 2 police officers but lots of people came in and out of the room, sometimes discussing police matters as they were unaware she was there.

Amy is diabetic, and during her time at the police station, she was not provided with any insulin. Eventually, a 136 suite was found for her, an hour away from the police station. When Amy arrived, staff recognised that she needed medical assistance for her diabetes and an ambulance took her to A&E. Amy's mental health was also assessed and she was then detained under section 2 of the MHA.

Amy returned to the section 136 suite as there were no other beds available. She stayed for 5 days under 2-to-1 observation – not because of her needs, but to follow the trust's policy for anyone in the section 136 suite. The suite had infrared sensitive cameras to help staff monitor patients, which Amy said she was not told about initially, leaving her feeling distressed and paranoid.

Other issues made the section 136 suite unsuitable for Amy. The room could be noisy, and as Amy is autistic, she struggled when she could overhear patients in other rooms. She also described murals on the walls where people had carved messages like “kill me” and said she was unable to look outside because the blind was broken. Staffing issues meant she could not always go outside to smoke when she wanted to, and she was not made aware of activities she could take part in on the ward. She told us she felt like “an animal in a cage”.

Amy was disappointed that she was not able to be involved in the ward round and felt excluded from a big conversation about what would happen with her life. The ward manager, who she had not met previously, informed her she was going to be discharged. Amy did not feel ready to leave and told staff she intended to take an overdose. Staff advised they would add this to her notes. Amy felt the service was under pressure to have the section 136 suite back and she was soon discharged.

As Amy had never visited the hospital before, she did not know where she was and was not supported to find her way home. She was distressed and shortly after leaving hospital, took an overdose of insulin. Her mother was concerned about Amy and called the police, who took her to a place of safety once again.

Through our monitoring activity, we also saw patients held in overly restrictive settings as a result of bed shortages. In one instance, a lack of beds on the ward meant seclusion rooms were being used as bedrooms. These spaces are designed to include limited furnishings, and patients may feel unsettled by being put in a space they may have experienced during seclusion. It also prevents the seclusion room from being available for its intended purpose. At another service, we found 16 patients allocated to a 12-bed ward:

> “There were 16 patients allocated to the 12-bed ward. Four informal patients and a detained patient were on overnight leave from the ward. There was only 1 vacant bed

> available on the ward for a patient to return to if they wished to do so, meaning that 4 patients would have no bed to return to."

This demonstrates the impact of bed shortages on patients as, if at any point more than one person needed to return, there would have been no bed readily available for them. In circumstances like this, patients may be moved to another unit or placed in a seclusion room.

We have seen multiple examples of out-of-area placements as result of limited local bed provision, where there was no clinical benefit for the patient to be placed out of area (such as needing support from a specialist service). In 2023/24, NHS Digital data shows there were 5,500 new inappropriate out-of-area placements, a 25% increase on the previous year. In several services, patients were often placed significant distances away from their families and friends. As we highlighted in our last Monitoring the Mental Health Act report, we know that out-of-area placements can make people feel isolated from their support network and this year, some patients told us they missed their families. It can be difficult for families to visit relatives who are placed out of area, for example:

> "The IMHA [Independent Mental Health Advocate] said that they were aware of difficulties for patients caused by them being placed out of area, and that this limited opportunities for families to visit and for home leave. They were aware of 1 patient who had been on the ward for some months and unable to have a visit in that time, due to the distance involved."

A recent report by the Health Services Safety Investigations Body (HSSIB) found that out-of-area placements can harm patients, families and carers and increase a person's length of stay in hospital. It outlined that patients rarely want an out-of-area placement, but their choices and opinions are not always taken into consideration.

To support patients detained far from home, staff at one service offered extra support by driving patients to see their families for regular home visits. However, offering this to patients relies on having enough staff to cover the ward, which, as we discuss in the workforce section, is not always the case.

Grace's story

Grace, a mother of 2 children, told us about her experience of being admitted to a hospital far away from home, and the effect this had on her family. Grace had been admitted to hospital several times for her mental health, but system pressures and being placed far from home made her most recent admission feel isolating and distressing.

In 2023, Grace was assessed and needed to be admitted to hospital but there were no beds available. During this time, different people from the crisis team visited her at home each day. She wasn't told who would be coming or at what time, which she described as stressful, unsettling and disempowering. Her children witnessed everything and were distressed when their mum could not meet their needs.

After 3 weeks, Grace was told that a bed had become available, 5 hours away from home. Grace's husband was concerned about the prospect of her being so far from the children but knew the current situation was not working. Looking back on her experience, Grace can now see this too.

Being placed so far from home meant that Grace did not have any visitors while she was in hospital. Her husband could not drive, and her children suffer with travel sickness. Grace explained that not seeing her loved ones affected her recovery. She reflected that she wasn't always able to talk on the phone as staff were sometimes too busy, her phone wasn't always charged, or she wasn't always allowed to use the ward phone. This took a significant emotional toll and Grace worried about her children feeling that she did not love them.

After 4 weeks, Grace was moved to a hospital closer to home. However, this was still in a different county, an hour and a half away from her house. Her family took a taxi to visit her, but the journey made the children feel ill.

Grace said the month she spent in the first hospital felt much longer. She felt she was taken away from everything she knew and was really scared. Not being able to see Grace had a significant effect on her children. She described how they went to bed crying and when she did see them at the second hospital, it was difficult to interact while they were being monitored.

Grace did not feel she developed therapeutic relationships with staff when she was detained. She explained that her care co-ordinator, who knew her, was too far away to have meaningful input into her care. When she was preparing to come home, reviews were delayed because staff were not able to join online meetings, often due to issues with technology. This meant Grace's discharge was delayed.

Discharge planning and support

The increase in demand for inpatient beds and the need to admit more patients raises concerns about other patients being discharged too soon and then needing to be readmitted. Ward managers told us about the pressure to discharge the "least unwell" patients. Carers have also explained instances where, after struggling to get an admission, their loved one seems to leave hospital too soon while still very unwell.

Short admissions can also limit discharge planning, and we remain concerned about community support for people when they are discharged. A member of our Service User Reference Panel (a group of carers and people who are, or have been, detained under the Mental Health Act) explained how a lack of support with their transition back into the community meant that their mental health quickly deteriorated. They reached a crisis and needed to be readmitted as an inpatient once again. Through our monitoring activity, we heard similar concerns from staff:

> "Staff were concerned that the pressure on the ward to admit patients was affecting the ability to ensure that patients were discharged into a setting that supported them to stay in the community long-term. They cited examples of some patients who had repeat admissions because of breakdown of community support."

In January 2024, NHS England introduced statutory guidance on Discharge from mental health inpatient settings. This outlines how organisations should work together to ensure effective discharge planning and the best outcomes for people when they are discharged from hospital. The guidance sets out that people should receive a follow up from their community health team, intensive support team or crisis resolution home treatment team within 72 hours of discharge. In 2023/24, 73% of people who were eligible received this type of follow up, down from 76% in 2021/22.

The guidance also says that discharge planning should involve people who use services and their chosen carers, starting before or on admission and continuing throughout a person's stay in hospital. This aligns with the MHA Code of Practice. In our special review of Nottinghamshire Healthcare NHS Foundation Trust, we found that the discharge planning process across community mental health and crisis services was not robust, with little evidence of discharge planning in care plans.

Patients detained for treatment under the MHA have a legal entitlement to aftercare, and the MHA Code of Practice gives detailed guidance that encourages health and social care bodies to interpret the definition of aftercare broadly. To meet patients' wider social, cultural and spiritual needs, aftercare should encompass:

- health and social care
- employment services
- supported accommodation and services.

However, the reality of aftercare provided is often far less holistic than the Code's guidance suggests.

We welcome the government's intention to require services to jointly notify a patient in writing if and when they decide to terminate aftercare services on the grounds that a patient is no longer in need of their support. This change in law may help patients to challenge such decisions if they feel they are unreasonable, but there remain few levers in the system to ensure that the aftercare initially provided is adequate for its purpose of meeting patients' needs arising from their mental disorder and reducing the risk of readmission to a hospital.

Through our MHA monitoring activity, we found that many mental health services held daily meetings to discuss discharge planning. Services often supported patients and their families or carers to be involved in discussions about discharge. Families and carers who were given opportunities to be involved in and have oversight of discharge planning spoke positively about this. Some patients told us they felt satisfied with their discharge plans, knowing about the support they would receive once discharged.

However, we found instances where it was unclear whether patients and families had been involved in discussions about discharge. Some patients felt unheard by staff and unhappy about their plans. This is concerning as the MHA Code of Practice outlines that, wherever possible, patients should be engaged in decision making that affects their care and treatment.

We found examples of good practice, where services put measures in place to support patients after discharge. These included maintaining support from ward staff and in one example, doctors were able to provide community support to ensure consistency once patients were discharged from the hospital. Another service arranged visits to discharge placements for patients who were anxious about discharge:

> "Some carers spoke with us about the planned discharge of their relative. While they were supportive of the process and felt that their voice had been heard, there was still some anxiety about the discharge placements failing because of the speed of the discharge. However, we heard about an unannounced visit to a potential placement by a patient and relative so that they could see what it was like. We also heard of plans for patients to go for a meal followed by an overnight stay before they were discharged."

Another service offered 4 weeks of continuity support following discharge to give patients with complex mental health needs the best chance of living independently in the community:

> "Patients at [mental health service] have complex mental health needs and have either

> been in hospital for many years or have a history of repeated admissions. To give these patients the best possible chance of living more independently in the community, staff invited community providers to build a service around the individual needs of each patient, rather than trying to fit the patient into an existing service. Records showed care co-ordinators attended ward rounds for patients who were preparing for discharge. Staff offered up to 4 weeks support to patients and community placement staff following discharge. This provided patients with continuity during the transition to a new placement. Whenever possible, the unit keeps the patient's bed open during this period in case they needed to return. For example, a patient had recently returned to the unit because he was unhappy at the community placement."

While these examples are encouraging, we remain concerned about the scale of challenges affecting the wider mental health system. The British Medical Association described tension between different parts of the system, with general practice, community mental health, and urgent and emergency care all overstretched. Through our monitoring visits, we heard that most inpatient services experienced some delays discharging patients, primarily associated with external factors such as:

- a lack of specialist services and community resources within the area to meet patients' needs
- a lack of capacity when a suitable placement is found
- shortages and a high turnover of care co-ordinators in the community, which complicates discharge arrangements, irrespective of the time and effort from mental health services in discharge planning
- difficulties in securing funding packages to meet the cost of the level of care needed for the patient
- referrals being declined by mental health services.

For people who need support, pressures in the wider system contribute to negative outcomes. Delays in accessing care risk people's mental health deteriorating. In addition, issues around discharge – whether people are discharged too soon or without the support they need – increase the risk of further crises and admissions.