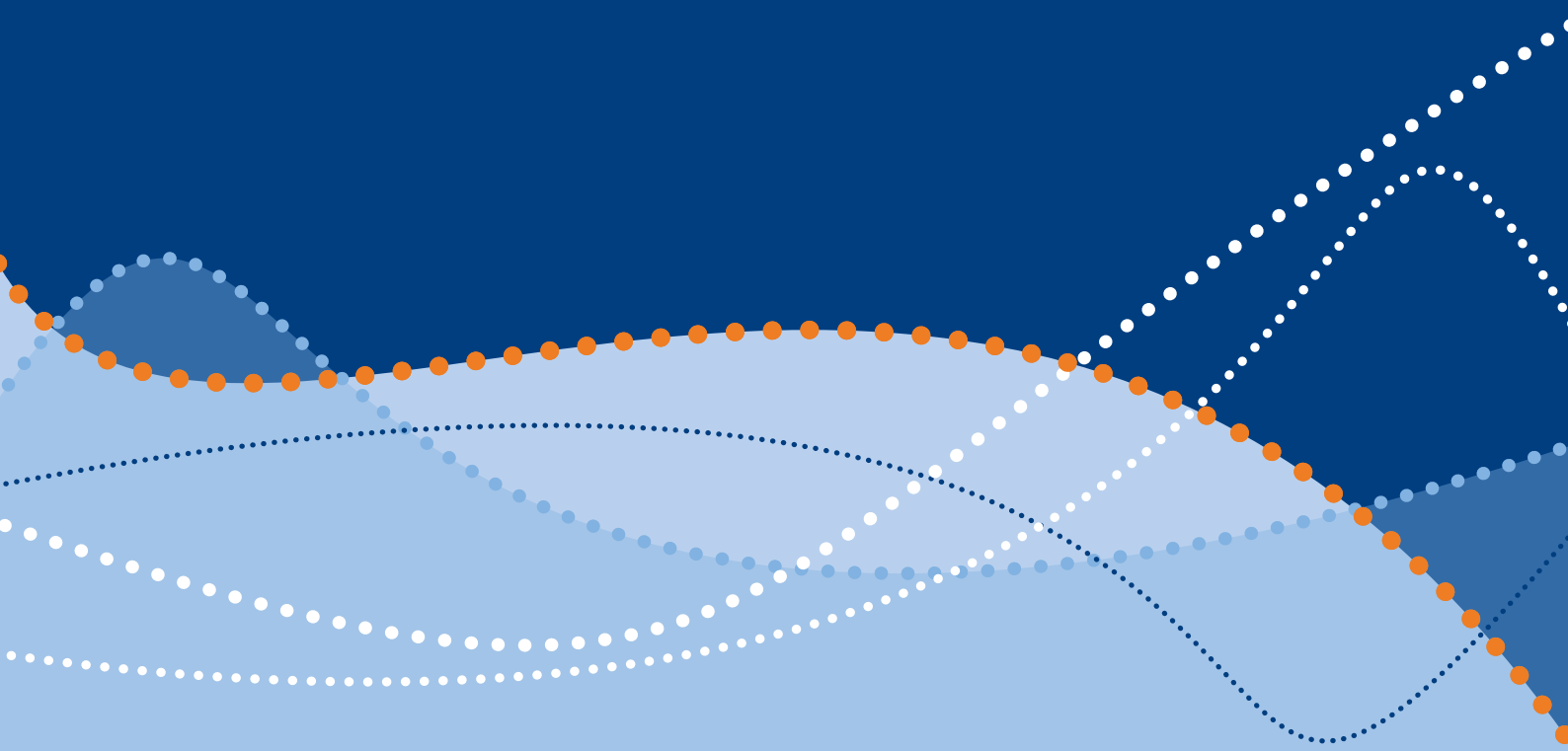
Care Quality Commission

Monitoring the **Mental Health Act** in **2013/14**

Summary



CQC and the Mental Health Act

UNDER THE MENTAL HEALTH ACT 1983 (MHA), THE CARE QUALITY COMMISSION (CQC) HAS A DUTY TO MONITOR HOW SERVICES IN ENGLAND EXERCISE THEIR POWERS AND DISCHARGE THEIR DUTIES IN RELATION TO PATIENTS WHO ARE DETAINED IN HOSPITAL OR SUBJECT TO COMMUNITY TREATMENT ORDERS OR GUARDIANSHIP.

This year marks the 30th anniversary of monitoring of the Mental Health Act 1983 (MHA) and five years since the Care Quality Commission (CQC) became responsible for keeping the MHA under review.

Since 2009, uses of the MHA have grown. At the end of 2013/14, there were 23,531 people subject to the Act, either detained in hospital or under a community treatment order. This represents an increase of 6% from 2012/13. As the number of detained patients continues to increase, we continue to make sure that health and social care services provide them with safe, effective, compassionate and high-quality care.

During 2013/14, we carried out 1,227 MHA monitoring visits, meeting more than 4,500 patients, and our MHA Reviewers carried out 174 inspections with the mental health inspection teams. Our inspections highlighted the variation of care provided to detained patients. Too often we found services that are not routinely involving patients in their treatment. In addition, we are concerned with the issue of bed availability and the increasing number of patients being detained far away from home.

CQC is committed to further strengthening our inspection and monitoring approaches for the MHA.

Independent Mental Health Advocacy (IMHA) services are an important safeguard for detained patients. However, we found that many local authorities are not conducting a needs assessment before commissioning these services. This is worrying and could mean that not everyone who needs it has access to an advocate. We are also concerned that we are still seeing examples of poor practice in restrictive practices, particularly seclusion and long-term segregation.

Providers must ensure that people, and their families or carers, understand their legal rights and are involved in their treatment. Local policies, training and audits should help staff to understand the specific needs of people and their families or carers, while hospital managers should work jointly with other services, including local IMHA providers. Following the publication of the revised Code of Practice in January 2015, we also encourage all providers and commissioners to work together to develop a plan for implementing the new Code that will improve the experience and outcomes for people subject to the MHA.

In addition, CQC expects commissioners and providers to use the local data available from the use of the MHA and work together to plan services that meet the needs of patients. They should pay particular attention to the issues we have highlighted in the full report. We also encourage services to look at their systems and make sure that providers are completing returns to national datasets. This information is essential to help inform local and national improvements to patient care by policy makers, commissioners and providers who use the data to understand the state of care for people affected by the Act.

CQC is committed to further strengthening our inspection and monitoring approaches for the MHA.

As part of our comprehensive inspections we will review providers' application of the MHA, and assess their governance systems and processes. We will look at how we can use our new approach to meet a wider range of people affected by the MHA. Our inspection teams will look at how the MHA is being delivered. This includes reviewing how providers monitor their use of the MHA, such as carrying out audits for local needs assessments. We will be looking for evidence that the issues we raise through our inspections, on behalf of patients, are considered by board members and used to inform local action plans. And we will review our MHA monitoring visits so that they are more focused on patient rights, the experience of being detained and the principles of the MHA.

We will continue to monitor the implementation of the revised Code of Practice. We will work with the Department of Health and others to learn from Code of Practice consultation responses, and to shape our own approaches to regulating and monitoring the MHA. Many of the proposals for change we made to the Department of Health during the consultation are reflected in the new Code. These changes should help patients to understand what happens when they are detained under the MHA, and to challenge services when they do not receive good care.

We are aware of the increasing financial challenges in health and care services. As a result, we will be looking at how we can understand the impact of these on local services going forward. We will also continue to review how we evaluate our MHA activities, how we can continue to improve our role, and how we can encourage improvement for patient care as a result.

The Mental Health Act in action

THROUGH OUR CORE ACTIVITIES OF MONITORING THE MENTAL HEALTH ACT 1983 (MHA) AND IN INSPECTING AND RATING PROVIDERS OF MENTAL HEALTH SERVICES, WE HAVE A UNIQUE VIEW OF THE WAY SERVICES ARE SUPPORTING PEOPLE AND HOW THE NATIONAL AGENDA IS CHANGING THE WAY THE MHA IS APPLIED. THERE ARE A NUMBER OF AREAS WHERE WE CONTINUE TO SEE ISSUES IN PRACTICE.

Using the Act

- Data collection, through our own Intelligent Monitoring and working with other bodies such as the Health and Social Care Information Centre (HSCIC), gives us an important picture about the MHA in action and improves our understanding about how it affects people.
- Figures from HSCIC show that in 2013/14, 18,166 people were detained in hospital, compared with 16,989 the previous year.
- HSCIC data also shows that there is a higher rate of black and minority ethnic people being detained than we would predict from the population demographics. We reiterate our call for providers to carry out ethnic minority monitoring of their activities, to ensure accurate data is available to inform future analysis.

- Some providers are not consistently reporting through national returns. We welcome all approaches, for example from NHS England, to improve provider data returns.

Protecting patients' rights and autonomy

- In 2013/14, 84% of records examined showed that patients had received information about their legal rights.
- There was also evidence of staff discussing rights with patients in 82% of records – an increase from 71% last year.
- However, we have found that staff do not always provide carers with the information and support they need. We strongly recommend hospital staff have additional training and support about their duties under the Care Act 2014.
- Awareness of, and access to, Independent Mental Health Advocates (IMHAs) is still not good enough. In 2014, the IMHA implementation project produced training materials for providers to address this. We will continue to work with the project to look at ways we can improve IMHA provision.

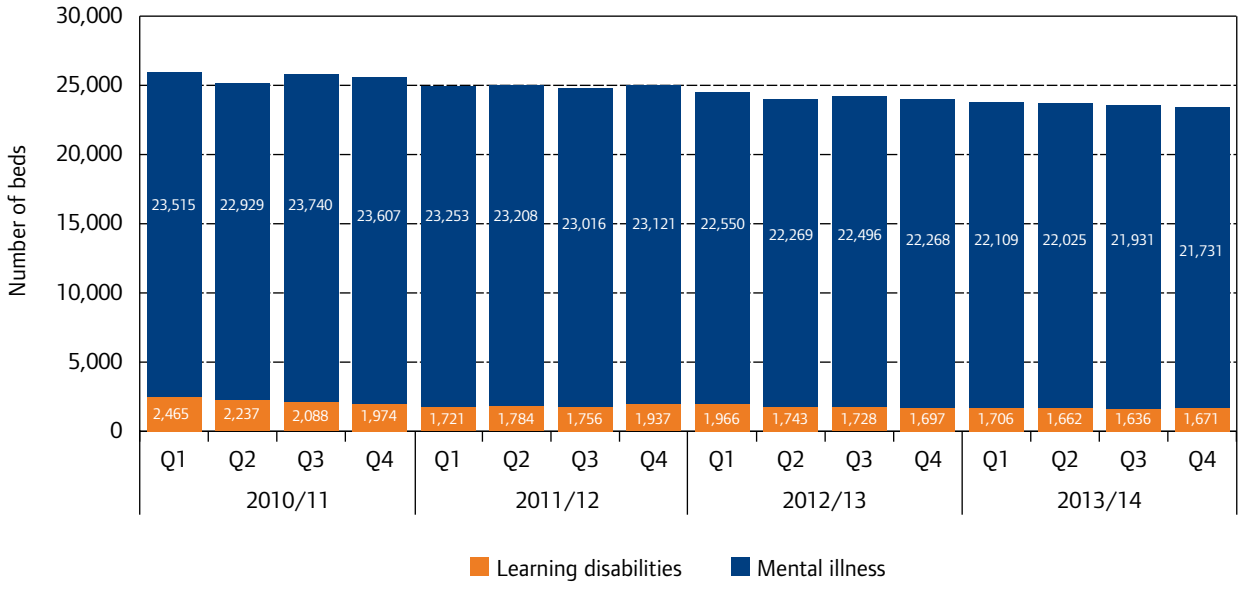
We noted good practice on the ward in relation to the explanation of rights to detained patients. In particular we heard that the Mental Health Act manager runs 'surgeries' on the ward for detained patients.

Extract from inspection report about Prospect Park Hospital, Berkshire NHS Trust, March 2014

Assessment, transport and admission to hospital

- The mental health inpatient system was again running over capacity. The number of available mental health NHS beds in quarter 4 2013/14 had decreased by almost 8% since quarter 1 2010/11 (figure 1).
- This is putting Approved Mental Health Professionals (AMHPs) under extreme pressure, and may lead to the Act being used just to obtain a bed. While it would not be lawful to use detention powers solely as a means to secure access to hospital treatment, AMHPs may be forced to choose this as the least worst option available.

FIGURE 1: Mental illness and learning disability NHS beds open overnight, 2010/11 to 2013/14



Source: NHS England KH03 data collection*

- In 2012/13, there were 21,814 reported uses of section 136 in England. This rose to 24,489 in 2013/14, an increase of 12%. Last year, we carried out a themed programme of work around crisis care, with a specific focus on health-based places of safety, and called for urgent action on our key findings. We reiterate our call for action and again highlight our concern about the use of police stations for people detained under section 136.

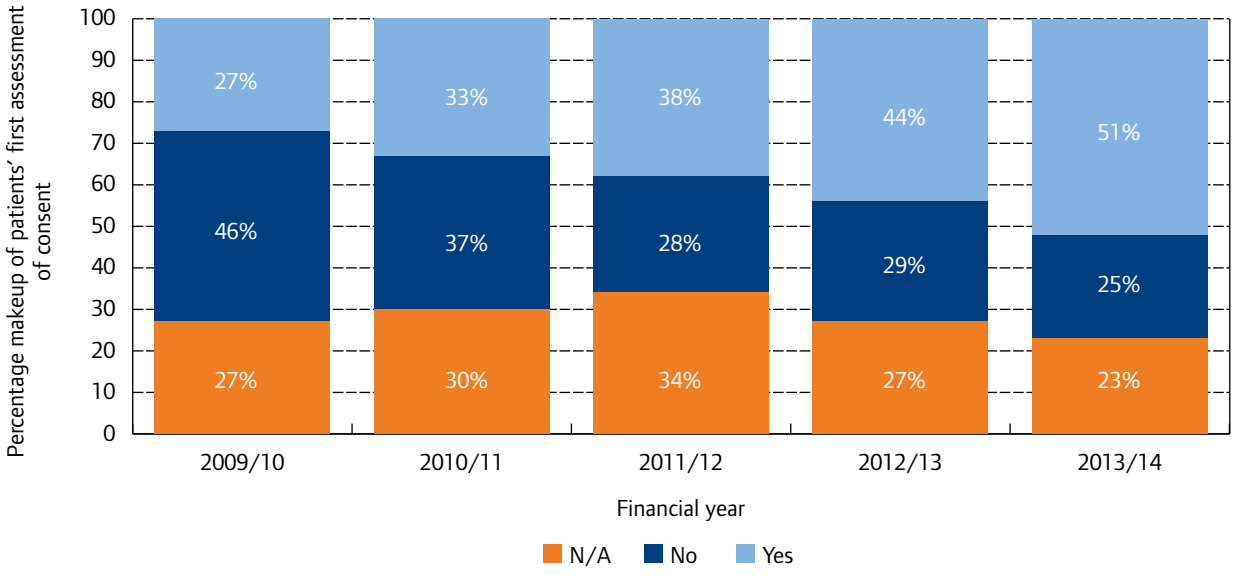
Additional considerations for specific patients

- While there have been small improvements, we are still finding that the provision of, and access to, children and adolescent services is not good enough.
- The needs and best interests of patients under 18 must be taken into account when accessing mental health services, with admissions to adult wards only made when necessary and for limited periods.
- Services for people with a learning disability continue to vary. We are particularly concerned that hospital placements for people with a learning disability are still not appropriate. In 2013, the HSCIC learning disabilities census showed that 1,000 inpatients (40%) were in hospitals more than 50km from their home.
- Admission to hospital can also make mental and behavioural difficulties worse for people with a learning disability, leading to disproportionately long stays in hospitals. The 2013 HSCIC census showed that 65% of patients with a learning disability had been in hospital for over a year.

Care, support and treatment in hospital

- Through our MHA visits we continue to find issues with processes around consent to treatment. Although practice has improved over the last five years, it is unacceptable that in over a quarter of the records checked in 2013/14 there was still no evidence of a patient's consent to treatment on admission (figure 2).
- We are also concerned that patients are still telling us that they had little or no discussion

FIGURE 2: Examination of patient records 2009/10 to 2013/14: evidence of assessment of capacity of consent to treatment at admission



Due to rounding, percentages may not total 100%.
Source: CQC

about their treatment. This is unacceptable and may lead to unlawful treatment.

- We will continue to look closely at these issues during our inspections. We commit to sharing examples of good practice where we find these to help ensure that people are involved in their treatment plans and medication choices.

Treatments subject to special rules and procedures

- In 2013/14, we continued to see a decline in the number of requests for electroconvulsive therapy (ECT) treatment certification, with 127 Second Opinion Appointed Doctor visits per month in 2013/14.
- We were concerned to hear that operating centres offering neurosurgery for a mental disorder (NMD) may be taking on patients without there being a close and continuing link to a mental health service in the patient's home area. This is poor practice and may lead to decisions that are not in the patient's best interests. We will be focusing more on this area.
- We were alarmed that urgent or emergency treatment powers are being used beyond their intended purpose. Providers must make sure that these powers are only being used for the direct and immediate benefit of the patient.

Safe and therapeutic responses to disturbed behaviour

- We carried out 47 seclusion monitoring visits in 2013/14. Although many services are now meeting our expectations, some are still inadequate. We re-emphasise our expectation that providers must make sure patients feel supported, involved and respected by their care team, particularly after a period of seclusion.
- Data on physical restraint practices are still incomplete, with only 27 organisations submitting data to the Mental Health Minimum Dataset. This is unacceptable. All providers must make sure that they are consistently recording all incidents of restraint.
- In 2013/14 we carried out 49 visits to the three high security hospitals. We found issues with long-term segregation and night time confinement.

Leaving hospital

- There were 5,365 people subject to community treatment orders on 31 March 2014.
- In 2013/14, we made 24 visits to look at the use of CTOs and spoke to 175 people under CTOs (table 1).
- We urge commissioners and providers to compare the evidence base on the benefits of placing people on CTOs (for example, impact on patient outcomes and budgets) with their local data.
- Providers must make sure that good care planning is in place for all patients and recognise that the success of a CTO depends on the individual's care plan.

TABLE 1: Number of community treatment order visits and patient interviews completed, 2009/10 to 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14	% increase
CTO visits	7	14	35	12	24	242%
CTO patient interviews	82	41	109	20	175	113%

Source: CQC

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459

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