

Monitoring the Mental Health Act 2015/16

SUMMARY



Foreword

The work of monitoring the Mental Health Act 1983 (MHA) is a distinct but supportive role to CQC's wider regulatory task. It is distinct, in part, because our focus is on reviewing and understanding the experience and effects of care provided for individual patients, rather than assessment of systems and processes. This report sets out our key findings from our work in 2015/16 based on more than 4,000 private meetings with individual patients during our visits to 1,300 wards. It acts as both an account of our activity to Parliament and an outline of the important issues and concerns we heard from patients about their day-to-day experience when subject to the MHA.

In many respects, mental health inpatient services are better places now than in past decades. The expectations of people who use services and professionals around patient involvement, respect for individual rights and the avoidance of unnecessary institutional rules are higher than ever. CQC has played a significant role in this, but we are aware that there is still much to be done to improve.

This is a tough environment for mental health services. We know that mental health funding is tight. The overall reduction in the numbers of inpatient mental health beds, necessary to redirect resources into alternative, less restrictive community provision, may have created pressures on acute admission wards in some areas. We have noted the rising use of the MHA in our previous reports, perhaps in part due to some areas not yet having the right balance of provision in place. The process of changing the balance of provision also requires careful management to make sure wards continue to provide a safe and therapeutic environment for all patients. We will be working with other national partners to look at how this affects the patients behind the numbers, as part of our monitoring activity in 2017.

Our findings in 2015/16 show that managers and staff are not receiving the support to understand and meet the requirements of the MHA and the recommendations of its Code of Practice. We are impatient to see change because the end result is for patients to receive good quality care. Mental health care is only likely to be effective and humane when patients have their voice heard and their preferences are taken fully into account. In particular, I would highlight the need for care planning to be truly co-produced with patients, and individualised to their needs. In many cases, there needs to be better communication between patients and staff, and more time spent in individual discussion.

What is striking is that some services do get this, and show this in what they do. There is good practice in many different types of mental health inpatient units and this report provides some examples. If some can get it right, others can learn from them and adopt their approach. We have had positive engagement with NHS England, NHS Improvement and the Department of Health during the production of this report, and look forward to working with them as they deliver on their priorities for implementing the *Five Year Forward View for Mental Health*.

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



David Behan
Chief Executive

Summary

Background to the Mental Health Act 1983

The Mental Health Act (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a serious mental disorder and who are putting at risk their health or safety, or the safety of other people. The MHA also provides more limited community-based powers, called community treatment orders and guardianship.

The MHA includes safeguards for people's rights when they are being detained or treated by professionals. It does this by providing rules and requirements for professionals to follow. It also provides statutory guidance to mental health professionals and services in the MHA Code of Practice.

Our job is to check that patients' human rights are being protected, and look at how services in England are applying the MHA safeguards. We carry out visits to see how mental health services are supporting patients, make sure providers have effective systems and processes to meet the MHA, and check that staff are being supported to understand and meet the standards set out in the Code.

Key points

- During 2015/16, we carried out 1,349 monitoring visits, and met with 4,282 patients.
- Detention rates have continued to rise in recent years, and 2014/15 saw the highest ever year-on-year rise (10%) to 58,400 detentions.
- The sector is under significant financial pressure. But over the last few years, reports such as the *Winterbourne View – Time for Change* have highlighted inequalities and failings of care for some people who are detained under the MHA.
- Throughout our monitoring visits and inspections, we saw many examples of good practice, and met hundreds of dedicated staff who provide the best support and treatment for their patients.
- In some areas that directly affect patients, their families and carers, and that we have raised as concerns in previous years, we have found little or no improvement:
 - For 12% (515 out of 4,344) of patients interviewed on our visits in 2015/16, there was no evidence that they were informed of their right to an Independent Mental Health Advocate (IMHA). Advocates are an important safeguard, offering support to patients and enabling them to be involved in decisions about their care.
 - There was no evidence of patient involvement in care planning in 29% (1,214 out of 4,226) of records that we examined. Similarly, 10% (452 out of 4,407) of care plans showed that patients' needs had not been considered.
- We expect all services to consistently make it possible for patients to be fully involved in their care and treatment, understand their rights and exercise their autonomy. Only through such an approach can services ensure that those powers are used proportionately and fairly, and that they help the recovery process.
- Overall, we required more than 6,800 actions from providers to improve practice as a result of our monitoring visits. Although we do not rate how well services apply the MHA, if we find poor practice we limit a provider's rating for the question 'are services effective?'
- One year on from its introduction, some providers are not doing enough to implement the revised Code of Practice or inform patients of their rights. Fewer than half of the wards we looked at from September 2015 to April 2016 had provided staff with any form of training on the revised Code, or updated their policies and procedures to reflect the new guidance.

Priorities for change

There is an urgency for change, with more needing to be done by all stakeholders – providers, commissioners, national bodies and regulators – to ensure people receive high-quality and effective care and treatment under the MHA. We are committed to making sure our findings inform

and influence the improvement work taking place across mental health services, for example delivering the aims and ambitions set out in the *Five Year Forward View for Mental Health*.

1. Providers

Providers need to do more to ensure that the MHA is properly applied, and that this supports better care of people detained under the Act. In particular, they must demonstrate stronger leadership, making sure they train and support their staff to have a thorough understanding and knowledge of the Code of Practice and how patients should be involved in their care from the moment they are admitted, to aid their recovery.

Services should also focus on improving their oversight of the MHA safeguards for patients. This is an important part of ensuring good outcomes for patients and failure to have good oversight will always affect the provider's 'well-led' rating.

2. Commissioners

Commissioners should work together to deliver services informed by national guidance and best practice. They should review commissioning contracts to make sure they commission services where they have evidence on how the Act is being applied and that the Code is being met. They should consider how to ensure a model for commissioning, procuring, and delivering services locally that is based on co-production and collaboration with people who use services, and how they are ensuring inequalities are monitored and addressed.

The experiences and views of detained patients should be a routine part of local MHA monitoring, including actively seeking the involvement of local user and advocacy groups.

3. The Department of Health and national agencies

The Department of Health and national agencies should work together on solutions to the issues we identify and focus particularly on early intervention to reduce the rates of detention. NHS England and NHS Improvement need to ensure that the use of the MHA is closely monitored at both local and national level, and focus on providing earlier interventions, and care planning for people repeatedly detained, to reduce rates of detention by 2020/21. This includes targeted work to reduce the over-representation of Black and minority ethnic and other disadvantaged groups.

All agencies must work with NHS Digital to improve intelligence available via the Mental Health Services Dataset (MHSDS), to have better personalised data, across pathways, about the way the MHA is working for people and how different groups are experiencing detention. We expect that provider Boards should be robustly assured that their organisations' monthly returns are complete and accurate.

National agencies should ensure that solutions are identified and implemented in partnership with organisations representing people with mental health problems.

Our actions to encourage improvement

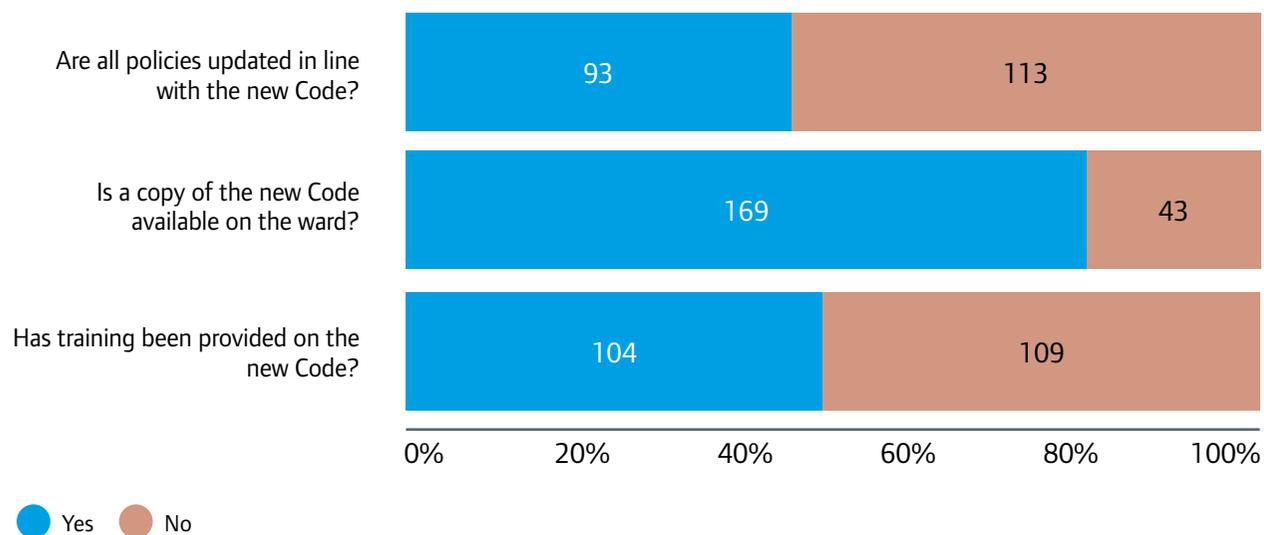
CQC will use its regulatory approach and powers to further encourage improvement in the use of the MHA to ensure better experiences for detained patients. We will:

- Work closely with NHS Digital, NHS England, NHS Improvement and the Department of Health to publish more detailed reports on areas of our monitoring during 2017. This will include carrying out focused visits to look at rising detentions and a review of the way Approved Mental Health Professional services are being delivered.
- Create additional guidance for inspection teams and MHA reviewers on how to assess the way providers continually review the way the MHA operates.
- Review the way we present MHA information in our provider inspection reports, with a focus on how providers monitor the application of the MHA and its safeguards for patients.
- Work with our external advisory group to strengthen how we review equalities information during regular and focused monitoring visits.

Implementing the revised Code of Practice

- The revised Code of Practice came into effect from April 2015, and is designed to promote and support the best possible care and ensure patient's rights are protected.
- We found that staff had been provided with training on the changes in the Code, or with revised policies and procedures to reflect its guidance, on less than half of wards.
- One in 10 records that our MHA reviewers looked at do not show evidence that patients have had their rights explained to them at the point of detention. This leads to patients not knowing what to expect, or understanding their rights under the MHA.

Implementation of the Code of Practice, September 2015 to April 2016



“One of the most common themes has been the issue of practitioner training. We know that best practice, throughout all the different scenarios in mental health care, is detailed in the Code. These guidelines now need to be enforced, without exception, and for this to happen, training has to be consistent and robust across the board.”

Code of Practice expert advisory group member

Source: CQC

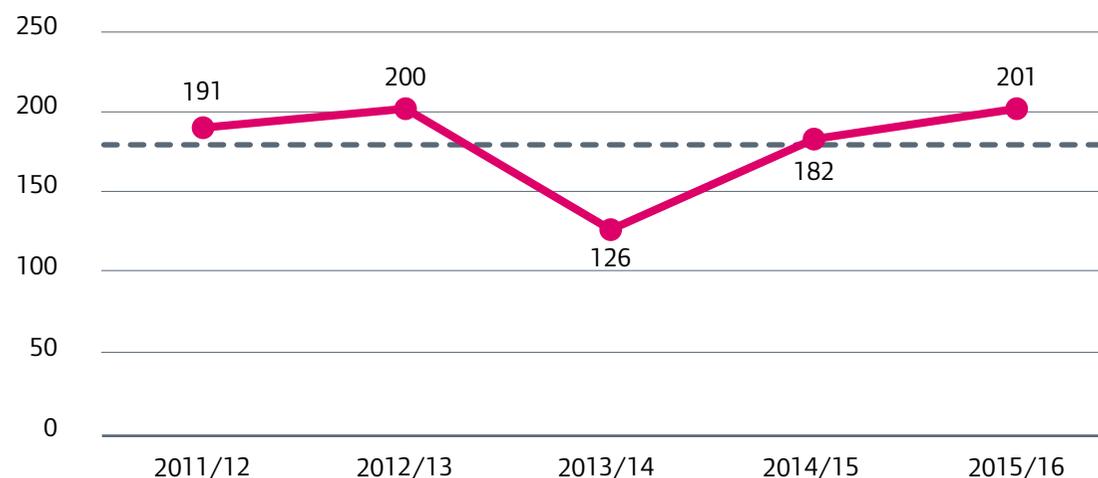
Deaths in detention

- We want to highlight the importance of investigating, reporting and learning from any death of a person detained under the Mental Health Act, particularly when they are 'in state detention' and receiving care and treatment in hospital at the time of their death.
- We have changed our notifications process to reinforce that all deaths of people in detention must be reported immediately to the coroner as expected by the Coroners and Justice Act 2009.
- We were notified of 201 deaths of detained patients by natural causes, 46 deaths by unnatural causes and 19 yet to be determined verdicts. The number of natural cause deaths has fluctuated over the last five years, with a continuous rise since 2013/14, but the underlying trend is broadly flat.

Cause of death of detained patients, 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Natural causes	191	200	126	182	201
Unnatural causes	36	48	36	34	46
Unknown	9	27	36	11	19
Total	236	275	198	227	266

Natural cause deaths of detained patients, 2011/12 to 2015/16



Source: CQC

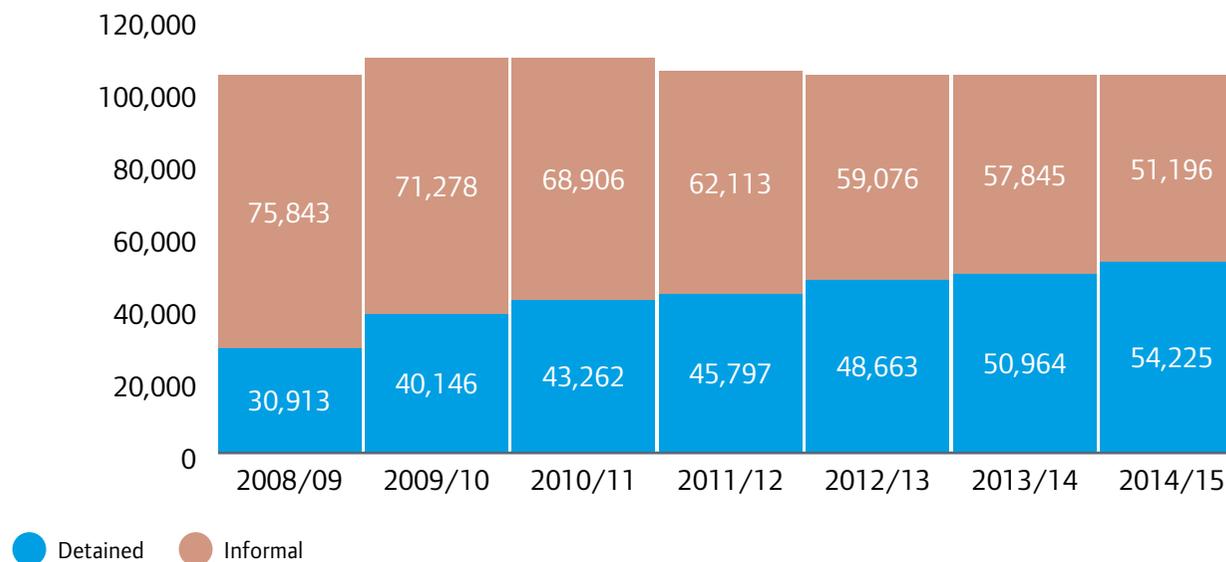
The use of the Mental Health Act

- The number of uses of the MHA has been rising, with the highest ever year-on-year rise (10%) to 58,400 detentions (excluding holding powers) in 2014/15.
- One reason for the rise in detentions could be that less support is being offered to keep patients out of an acute crisis and out of hospital. It may also be related to repeated admissions of the same patient on a rapid cycle.
- We will continue to develop our methodology for assessing MHA information during our assessments of inpatient and community services.
- We will discuss with NHS England and NHS Improvement, how we can support their work to reduce rates of detention through earlier intervention, with targeted work to reduce the current over-representation in acute care of people from Black and minority ethnic groups and other groups of people that experience inequalities.

10% year-on-year rise to 58,400

detentions (excluding holding powers) in 2014/15

Mental health patients at year end, March 2008/09 to 2014/15

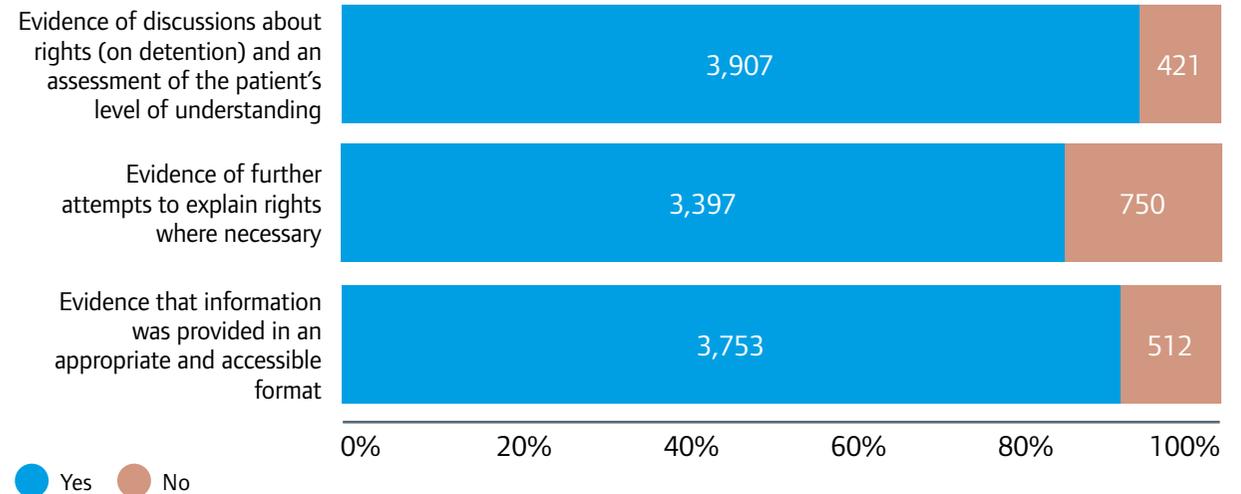


Source: Mental Health Minimum Data Set / Mental Health and Learning Disabilities Data set and Hospital Episode Statistics, NHS Digital; Office for National Statistics

Protecting patients' rights and autonomy

- Services must support patients subject to the MHA to be involved in their care and treatment, understand their rights and exercise their autonomy. Under the MHA, providers need to give patients information about their rights, verbally and in writing, as soon as possible after the start of their detention and community treatment order.
- During our inspections and monitoring visits, we noted that there was no evidence that staff had discussed rights with the patient on admission in 10% (421) of the patient records, and there was no evidence that patients received the information in an accessible format in 12% (512) of records.
- The Code requires staff to remind patients of their rights and of the effects of the Act from time to time, to ensure that the hospital is meeting its legal duties. However, there was no evidence of this happening in 18% (750) of records that we checked.
- Providers are also required to make sure that patients subject to the MHA are aware of the help from Independent Mental Health Advocates. However, in 2015/16, for 12% (515) of patients interviewed on our visits there was no evidence that they had been informed of their right to an IMHA.

Evidence of discussions of rights in examined records, 2015/16



Source: CQC

“The initial shock of being taken forcibly from your home and put in a ward that you know you hate makes you worse: you are not in a fit state to take in your rights at that time, and they’re written in a sort of jargon anyway. So you need to have your rights explained to you when you are at the right moment, by someone willing to let you question them. It’s no good just reading it to you, that’s a waste of time. There’s no substitute for talking to people. The most important thing a psychiatric nurse can do is talk to a patient.”

Service User Reference Panel member

Assessment, transport and admission to hospital

- Approved Mental Health Practitioners (AMHPs) play an important role under the MHA. A key aspect of this role is to decide whether to apply to have someone detained in hospital when two medical recommendations for this have been made.
- During our review of AMHP services, stakeholders told us that there are concerns about the low numbers of AMHPs and the ability to provide a 24-hour service that can effectively respond to patient needs. There is also wide variation in the way AMHP services are running across the country and local oversight, reporting and data captured is poor in many areas.
- In March 2016 we presented our findings in a briefing to the Mental Health Crisis Care Concordant. We recommended that CQC will use its focused visits to help the future development and monitoring of AMHP services.
- We asked the Department of Health, NHS Digital and others to work together to set national standards for AMHP services, identify best practice and improve oversight of AMHP services.

Good practice: engaging patients in life on the ward

“We had a morning meeting, and you can sit around talking, and generally is there anything – have we got any visitors coming in – and sometimes we’d have the newspaper and just talk about the newspaper, talk about things that are going on. All just sitting around, talking, with the staff was lovely. You felt more engaged with them and with everybody else...”

Service User Reference Panel member

“Carers can object to out-of-area placements; some AMHPs are very good at explaining this, but some don’t. Other AMHPs are very good at saying – as in the case of my husband, who said that ‘you’re not taking her out of area’ – the AMHP said ‘I completely support you’, and turned round to the psychiatrist and said ‘you will not get an application’. I know carers all over the country who didn’t know you could do that – weren’t aware that they could step in and stop that section.”

Service User Reference Panel member

The Mental Health Act for children and young people

- On visits to child and adolescent mental health services (CAMHS) in 2015/16, we found issues such as lack of patient involvement in care planning, lack of recording of consent and decisions about capacity to give consent. There was also failures to provide information about legal rights, both for patients who were detained under the MHA and for those who were not. There was also a lack of information about advocacy, and some advocacy services that did not appear to have specialist training in dealing with children and adolescents.
- Services are required to notify CQC after any child or young person under 18 years of age spends more than 48 hours on an adult mental health ward. The numbers of notifications have increased by 2% (from 235 to 240) from 2014/15 to 2015/16. This contrasts with a jump of 22% the previous year (from 193 to 235). We do not know whether this reflects changes in practice, or changes in the level of compliance with the reporting requirement.
- Inpatient care can lead to worsening symptoms and increased thoughts of suicide, which in turn can lead to increased levels of security and delayed discharge. It is crucial for local areas to understand which legal authority is used for inpatient care, and for them to examine patterns of hospital admissions to determine whether community-based interventions are available to avoid inpatient care in the first place.

Inpatients aged under 18 years of age, October 2016

Legal status	Number of patients
Informal	870
MHA, s.2	159
MHA, s.3	242
MHA, part 3	10
MHA holding powers	7
Other acts (ie Children Act)	2
Not known	30

In October 2016, there were more than 400 children and young people (those aged under 18 years) detained in hospital under the MHA.

Care, support and treatment in hospital

- On many visits, we found that discussions about consent to give psychiatric medication are not taking place.
- In 2015/16, we looked at the care records of 3,031 patients who had been detained for less than a year in hospital and found that 5% (163) of records did not show any evidence that a health assessment had been carried out at admission.
- We are looking at how we can use our regulatory powers to encourage better integration between mental and physical health care, and our MHA reviewers plan to take part in pilot visits to acute hospitals in 2016 to help achieve this.

“Good practice requires that doctors listen to the patient’s preference because they may know that certain medications affect them in a bad way and others they get on well with – that should be listened to. And psychotropic drugs should only be part of the holistic treatment of a patient; talking therapies should go along with this.”

Service User Reference Panel member

Good practice: information about treatment

“I did see one example of good practice on a visit – a room with a sign on the door saying come in and discuss your medication – people could come in and talk about their individual medication and I thought that was excellent.”

Service User Reference Panel member

What good looks like

Staff and services have a duty to consider the different ways in which patients’ understanding, level of involvement and opportunity for discussion can be increased when making decisions about their medication. This should include inviting patients to ask questions, explaining their right to withdraw or withhold consent, providing access to other professionals, such as pharmacists or advocates, and, with the support of the patient, involving family and carers in discussions (paragraph 24.34 to 24.53).

Examples from practice

A rehabilitation unit for men ran a monthly drop-in session with one of the trust’s pharmacists where patients could raise issues, request information and discuss medication. These issues were also discussed in ward rounds and in one-to-one sessions with named nurses, and the unit gave patients the opportunity to discuss this area with a professional outside of their treatment team.

Manchester Mental Health and Social Care Trust, Anson Road, April 2016

Leaving hospital

- We check the quality of care plans, including whether they are detailed, comprehensive and developed with the involvement of patients and carers. We found no evidence of patient involvement or patient views in 29% (1,214) of care plans reviewed, and similarly, there was no evidence that patient's views were considered in 26% (1,118).
- There has been a drop in the overall proportion of care plans that we judge to be meeting the Code of Practice expectations in 2015/16, compared with previous year.
- The Code of Practice states that commissioners and services should interpret the definition of aftercare services broadly. This should include health care, social care, employment services, supported accommodation and services to meet the patient's wider social, cultural and spiritual needs, with a view to aid a patient's recovery. However, 32% (1,324 out of 4,086) of care plans reviewed showed no evidence of discharge planning.

32% 1,324 out of 4,086 of care plans reviewed showed **no evidence of discharge planning.**

“When we talk about patient involvement, I’d like to use the word co-production. So care plans should be co-produced, so it’s less something done to people” ... “When you change the language, you can change the practice” ... “When you’re not cutting and pasting from another care plan, but co-producing care plans.”

“It’s very important that you write your own care plan – it’s your chance to say how you want to change your life. People should be encouraged to make advance decisions and planning in advance for any future relapse.”

Service User Reference Panel members

CQC and the Mental Health Act

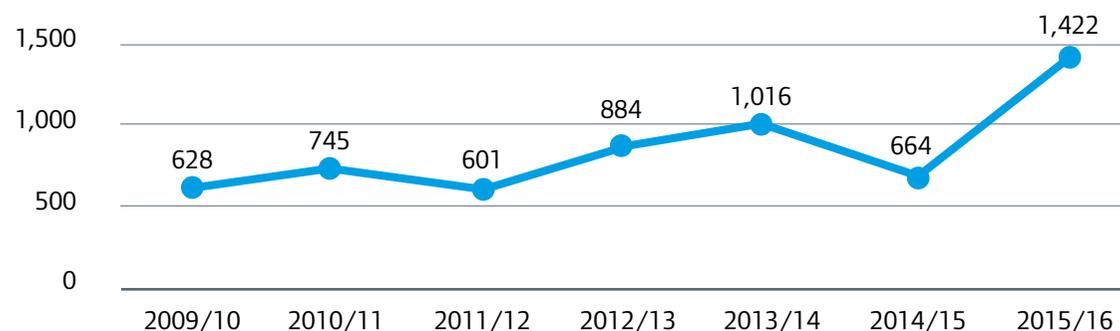
- In 2015/16, we carried out 1,349 visits, met with 4,282 patients and required 6,867 actions from providers.
- Our Second Opinion Appointed Doctor service (SOAD) is an additional safeguard for patients detained under the MHA, providing an independent medical opinion to state whether certain treatments are appropriate. We carried out 14,601 visits to review patient treatment plans, and changed treatment plans in 27% of visits.
- We received 1,422 complaints and enquiries about the way the MHA was applied to patients. Issues identified included medication, care provided by doctors and nurses, leave arrangements and safeguarding concerns. We review all complaints made to us, and investigate if appropriate.

Outcomes of second opinion visits, 2015/16

Outcome	ECT (detained)		Medication (detained)		Community treatment orders	
	Number	%	Number	%	Number	%
Number of visits	1,627	100%	11,991	100%	1,226	100%
Plan not changed	1,257	77%	8,494	71%	964	79%
Plan changed	357	22%	3,430	29%	250	20%
Missing data	13	1%	67	1%	12	1%

Source: CQC

Complaints and enquiries received, 2009/10 to 2015/16



Source: CQC

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