



Monitoring the Mental Health Act in 2017/18



STATE OF CARE

Care Quality Commission

Monitoring the Mental Health Act in 2017/18

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Foreword

This report shows improvement in the aspects of practice that are the focus of our work to monitor the use of the Mental Health Act (MHA). In particular, we have seen improvement in the quality of care planning and how patients are involved in their care. This is commendable at a time of rising demand and increased pressure on mental health services.

However, it is important that this does not mask the fact that many of the wards, in which people are detained under the MHA, are unsafe and provide poor quality care. In our State of Care report, we said that this was our greatest concern for the mental health sector. This is echoed by both the Long Term Plan for the NHS and the report of Professor Sir Simon Wessely's Mental Health Act review.

We have highlighted the high use of restrictive interventions on mental health wards (and the great variation in use between wards), the high number of assaults on patients and staff and the frequency of incidents of sexual assault and harassment. Underpinning these are problems with the physical fabric of wards, which are often located in old and unsuitable buildings, a lack of access to the full range of care interventions and problems with staffing – both number and level of expertise.

We therefore welcome the statement in the Long Term Plan that capital investment from the forthcoming Spending Review will be made available to upgrade the physical environment for inpatient psychiatric care. Action is also needed to ensure that all wards are staffed with a full multidisciplinary team.

We will act on the recommendation of the report of the Mental Health Act review that it revises the criteria used to assess the physical and social environments of mental health wards. We will ensure that our monitoring and inspections of mental health inpatient services assess whether wards offer a fit environment for safe and dignified care, whether

they have enough staff with the necessary skills, whether patients and staff are protected from harm and whether patients have access to the full range of effective treatments – and not just medication. It is important that our ratings and judgements reflect both what we find and the experience of patients.

We will pay particularly close attention to the use of restrictive interventions. The Secretary of State for Health and Social Care has asked CQC to carry out a review of the use of restraint, segregation and prolonged seclusion in settings that accommodate people with mental health problems, a learning disability or autism. We will publish an interim report in May 2019 and a final report by spring 2020, and we will share learning with partner organisations as we go along.

We have also raised concerns over mental health rehabilitation hospitals that are a long way from the patient's home and which may not work actively to enable recovery and discharge. Most of the patients in these hospitals are detained under the MHA – and some are detained for years. It is vital that national agencies work with local health and care systems to move these patients to a less restrictive setting closer to their home.

During 2017/18, we worked with the advisory panel for the Independent Review of the MHA and with its working groups. Over the coming months and years, we will make our contribution to implementing the report's recommendations.

In 2019, we will publish a report of our evaluation of the way the MHA Code of Practice has been implemented. We have done this work in collaboration with patients, providers and experts. We hope that it will identify practical solutions to help improve areas of practice.

Paul Lelliott

Deputy Chief Inspector of Hospitals (Mental Health)





Summary

It is CQC's job to look at how health services in England are applying the Mental Health Act (MHA) and to make sure that patients' human rights are being protected. We carry out visits to check how mental health services are providing medical treatment to people detained under the MHA and are supporting patients to recover. We assess provider management systems and processes to make sure they have effective governance in place over the use of the MHA. We also check that staff are being supported to understand and meet the standards set out in the MHA Code of Practice for patients in their care.

We have worked closely with the Independent Mental Health Act Review team to share intelligence and our analysis of the issues we have reported on over the last decade. We have also increased the number of separate themed publications we produce and have made sure that other CQC publications consider the impact for people subject to the MHA (see appendix A). This report differs from previous reports, in that it sets out high-level findings, and is intended to establish a base-line for data comparison in coming years.

The key findings of our monitoring visits are:

- At a time of pressure on budgets and rising demand, we have seen that improvement is still possible in mental health services. There is a general trend of improvement in the areas that we have measured. This echoes our experience of inspection visits.
- Our greatest concern is about the quality and safety of care provided on mental health wards; in particular on acute wards for adults of working age.
- Our MHA review visits find an increasing amount of care planning that is detailed, comprehensive and developed with patients and carers being involved. However, a substantial proportion of the care plans of detained patients that we have examined are still of a poor quality. We continue to find examples of poor planning, lack of patient and carer involvement, and no evidence of consideration of patients' consent to treatment on admission to hospital. As such, many services need to make specific efforts to meet the MHA Code of Practice's guiding principles and expectations around patient involvement and empowerment.



In 2017/18

- We carried out 1,165 visits, met with 3,993 patients and required 6,049 actions from providers.
- Our Second Opinion Appointed Doctor service carried out 14,503 visits to review patient treatment plans, and changed treatment plans in 27% of their visits.
- We received 2,319 complaints and enquiries about the way the MHA was applied to patients.
- We were notified of 189 deaths of detained patients by natural causes, 48 deaths by unnatural causes and 10 yet to be determined verdicts.
- We were notified of 714 absences without leave from secure hospitals.



1,165

We carried out 1,165 visits



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We met with 3,993 patients



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We required 6,049 actions from providers



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and they changed treatment plans in 27% of their visits



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We received 2,319 complaints and enquiries about the way the MHA was applied to patients

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We were notified of 189 deaths of detained patients by natural causes, 48 deaths by unnatural causes and 10 yet to be determined verdicts

714

We were notified of 714 absences without leave from secure hospitals

Introduction

This report sets out the Care Quality Commission's (CQC) activity and findings from our engagement with people subject to the Mental Health Act 1983 (MHA) and review of services registered to assess, treat and care for people detained using the MHA.

We use information gathered from across our activities to report on the quality of care people are receiving while detained. We also look at how providers use the MHA to make sure that people have access to the right care and treatment when they have, or appear to have, a mental disorder, and their own health or safety, or other people's safety needs protection.

This year we have changed the way we report. We focus this report on our monitoring activity, and use our other publications to raise specific concerns for people's experience and rights when subject to the MHA. We have produced reports on several different topics such as the rise in the use of the MHA to detain people in England, mental health rehabilitation inpatient services, and sexual safety in mental health wards (see appendix A). In 2018, we worked closely with the Independent Mental Health Act Review team to share intelligence and analysis of the issues we have been reporting over the last decade.

How we work

CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. We visit and interview people currently detained in hospital under the MHA, and we require actions from providers when we become aware of areas of concern or areas that could improve. We also have specific duties under the MHA, such as to provide a Second Opinion Appointed Doctor service (see page 19), review MHA complaints (see page 26) and make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also work to highlight and seek action when we find practices that could be in breach of human rights standards during our MHA visits. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM carry out regular visits to places of detention to prevent against torture and inhuman or degrading treatment. Find out more information about this important role and our activities in the UK NPM annual reports.¹

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. The MHA also provides more limited community-based powers, community treatment orders (CTO) and guardianship.

The MHA not only provides powers for clinicians to intervene in the interests of a person's health or safety, but also includes

safeguards for people's rights when they are being detained or treated under the MHA. It does this by setting rules and requirements for professionals to follow. Statutory guidance for mental health professionals and services is set out in the MHA Code of Practice. Doctors, managers and staff in provider services and Approved Mental Health Professionals (AMHPs) should have a detailed knowledge of the Code and follow its guidance, or document the justification for not doing so in any individual case.

Our data

To prepare this report, we analyse data from our activities with patients and local services throughout the year, including our MHA activities and our comprehensive inspections of mental health services. We also discuss matters of importance with experts and analysts. We also analyse information from other national agencies including NHS Digital, NHS England and the Tribunal Service.

In previous reports, we have collated findings from MHA monitoring visits on an annual basis, comparing each year's data with preceding years. In this report, we have revised this approach and now, in part 2 of this report, present data that has been collated in two-year periods. This more closely reflects our visiting patterns, where we seek to visit all wards in psychiatric units that detain patients under the MHA at no more than two-yearly intervals. Also, by taking a longer view of these quantitative changes in visit reports, we hope to provide a fuller picture of trends. Throughout the report we refer to the periods April 2014 to March 2016 as '2014-16' and April 2016 to March 2018 as '2016-18'.

In July 2018, we began to share MHA analysis with NHS trusts and community interest companies that provide secondary mental health services through our CQC Insight reports. CQC Insight is a monitoring tool that brings together relevant information about a provider in one place. We use CQC Insight to monitor potential changes to the quality of care in services. The tool includes national data on the use of the MHA, intelligence from our MHA and SOAD visits and from the MHA notifications, including nationally benchmarked indicators. The analysis can inform decisions about when, where and what to inspect and provide evidence for reporting. This means that the experience of detained patients is embedded in our routine monitoring of providers. Sharing the reports with providers every two months

helps to make transparent the information we use to inform our regulatory activity.

When we revisited our previous findings in our *Monitoring the Mental Health Act in 2016/17* report to compare with the findings from this report, we discovered some errors in the way that we had presented data. As a result, we amended the report in January 2019. More information on the data errors and a list of amendments is available on www.cqc.org.uk/mhareport.





Part 1

KEY FINDINGS FROM OUR MHA ACTIVITIES

This section looks at the data from across our Mental Health Act activities to identify where we think services and the MHA can work better for people.



1.1 National figures on the use of the Mental Health Act

NHS Digital is responsible for collecting data across the health and social care system, including the use of the MHA. In its data release for 2017/18, NHS Digital reported just over 49,500 new detentions in hospital under the MHA during the year.² Of these, 27,971 took place at the point of admission to hospital, 2,983 following assessment under s.136 (an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care), 18,349 following informal admission to hospital, and 257 revocations of community treatment orders. These figures are incomplete due to underreporting, and cannot be compared with the data from previous years.³ As noted in our 2016/17 report, we continue to work with services, NHS Digital and NHS England to improve providers' completion of the data, including through a focus on data submission as part of our reviews of whether providers are well-led in operating the MHA.⁴

Available data continues to show overrepresentation of Black and minority ethnic (BME) groups in the detained population. The broad BME group 'Black or Black British' has the highest rate of detention (288.7 per 100,000 population), more than four times that of the broad 'White' group, which has the lowest rate (71.8 per 100,000 population). Using the more detailed breakdown of BME categories shows the inequalities to be even more marked: the 'Black British' subgroup 'Any other Black background' is detained at 10 times the rate of the 'White British' group (745.9 detentions compared with 69.0 detentions per 100,000 population).⁵ These figures could be distorted by missing data, but are generally consistent with past findings.

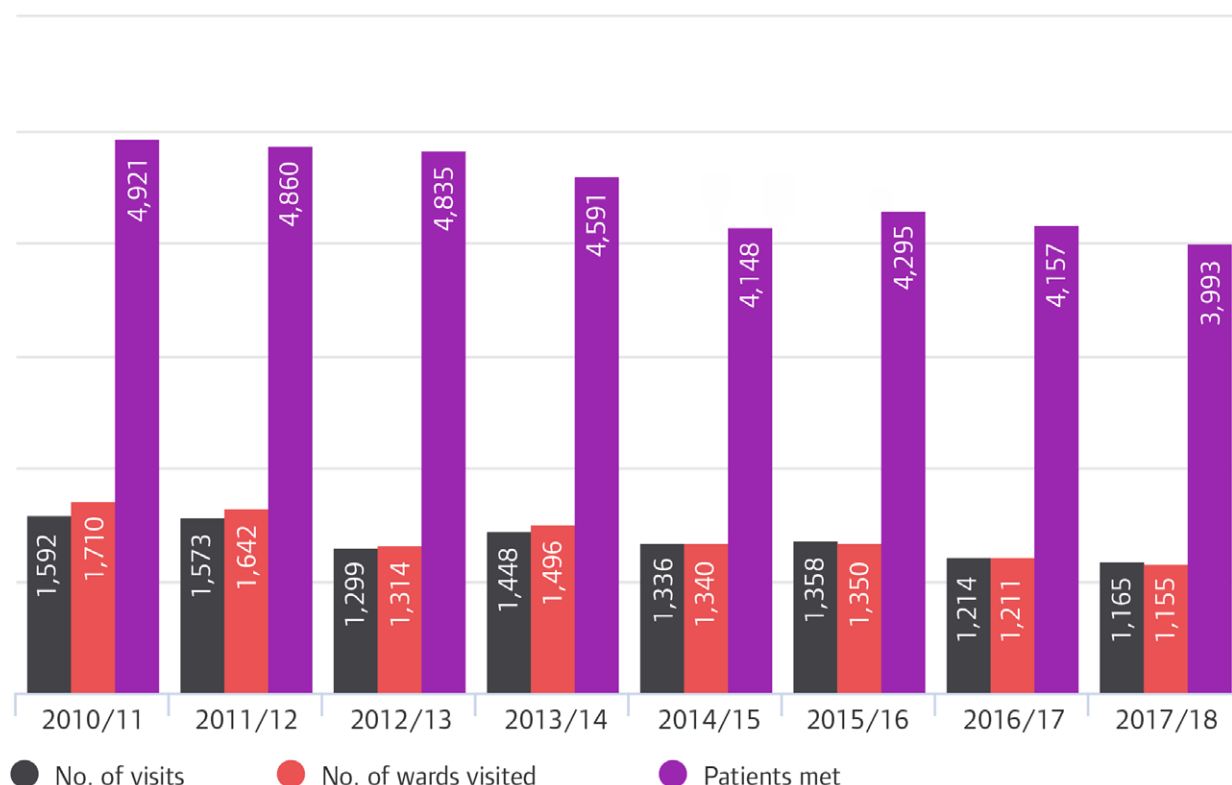
Following our report on rising detentions under the MHA⁶, NHS Digital analysed data to see how many people were detained more than once in the year. This analysis suggests that repeat admissions of the same people are not a major factor in the rising levels of detention in England, with 2017/18

showing 84.6% (33,680) of people were detained only once in the year; 2.4% (966) of people were detained three or more times in the year. People from 'Black' and 'Mixed' BME groups had the highest rates of repeated detention (18.4% and 18.1% of people were detained more than once, respectively, compared with 15.3% in the 'White' group).

MHA visits

In 2017/18, we made 1,165 MHA visits (figure 1). The number of visits has reduced in recent years. However, the overall visiting cycle has not lengthened during this time: we still expect to visit wards no more than at two-year intervals. Therefore, a major factor in the reduction is that there are fewer wards open to visit. Some of the change could also be related to changes to the way our MHA Reviewers work with our inspection teams and how they record activity. It is also possible that more MHA Reviewer time is spent on activities other than visits, including (as many are now full-time CQC employees) internal meetings, report preparation, and annual leave. More MHA Reviewers are now involved in regulatory inspections of services. However, there is still a focus on the way services are meeting their duties under the MHA. Due to the rising rate of detention, our MHA visits are now more intensive: we meet with more patients per visit, and some visits extend to more than one day.

Figure 1 MHA monitoring visits and patients met, 2010/11 to 2017/18



Source: CQC

During our visits, we triangulate information by speaking with patients, reviewing records and speaking with staff. We discuss findings with staff throughout the visit to make sure we understand local processes and record systems. We often report on what we find in care records and highlight if we think there is a recording or care issue when we report to the local leadership team.

Where we have concerns, our report will ask the provider to create an action plan and return it to us. Doing this means that MHA Reviewer visits open a space for constructive challenge, reflection and dialogue with providers.

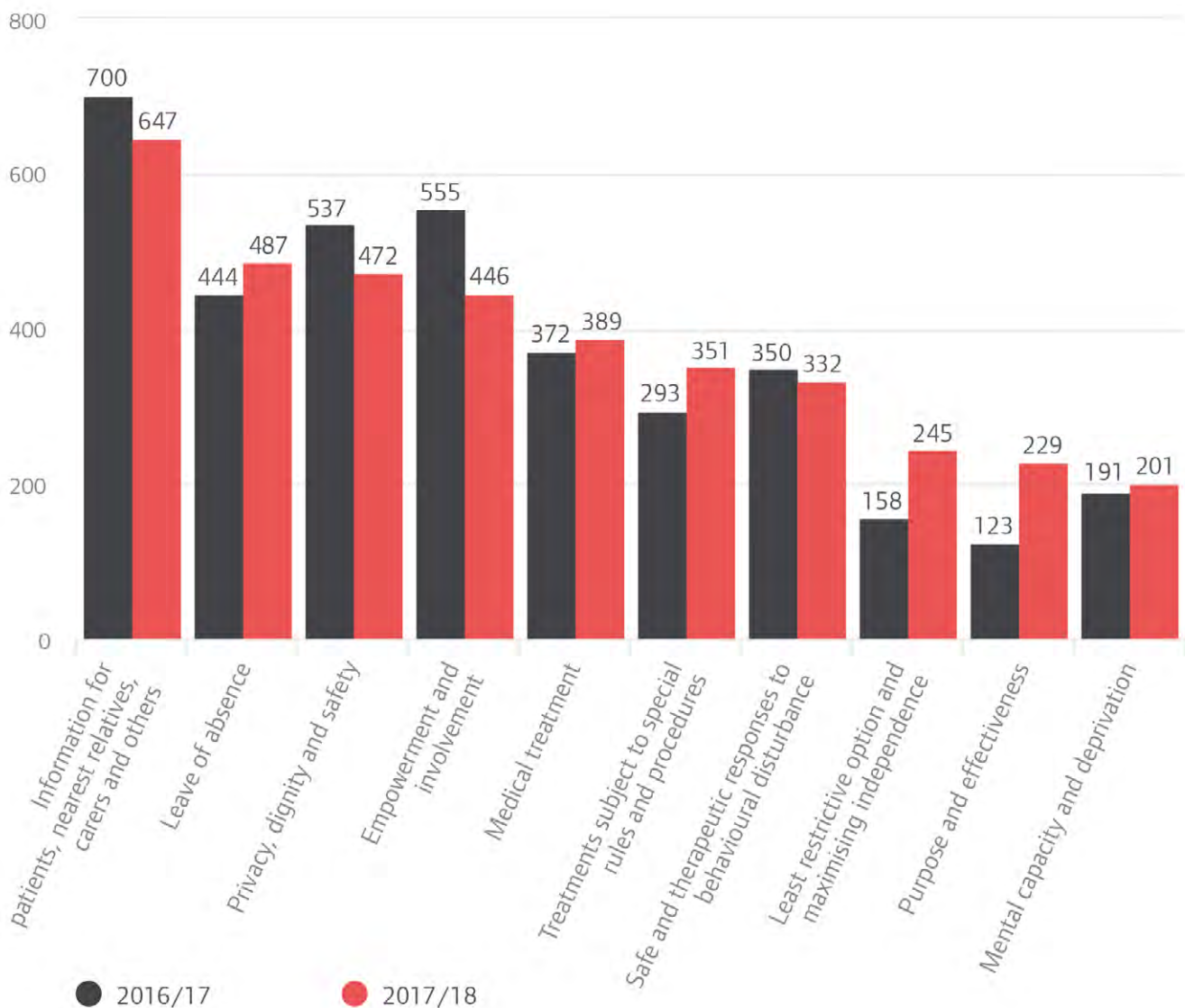
This forms a key aspect of our role as part of the National Preventive Mechanism to prevent ill-treatment of people detained in psychiatric facilities.

1.2 What are the key issues we have found in people's experiences of the MHA?

Through our MHA visiting programme, we raised a total of 6,049 issues with providers, and asked them to tell us what action they would take in response. Of these issues, 1,299 were specific to individual patients and not suitable to be placed into categories. All other actions or responses are categorised by broad subject matter. This allowed us to identify the areas of concern that

we raise most frequently during our visits (figure 2). There were 4,750 requests for response or action in 2017/18 and 4,840 in 2016/17. The key issues that we found were around how information is provided to patients and other relevant people, leave of absence, privacy, dignity and safety, and patient involvement in care planning.

Figure 2 Top 10 categories of areas raised in MHA visit feedback, 2016/17 and 2017/18



Source: CQC

1.21 How is information being provided to patients?

In 2017/18, how information is being provided to patients accounted for 14% of actions raised from non-individual patient issues, with varying degrees of concern.

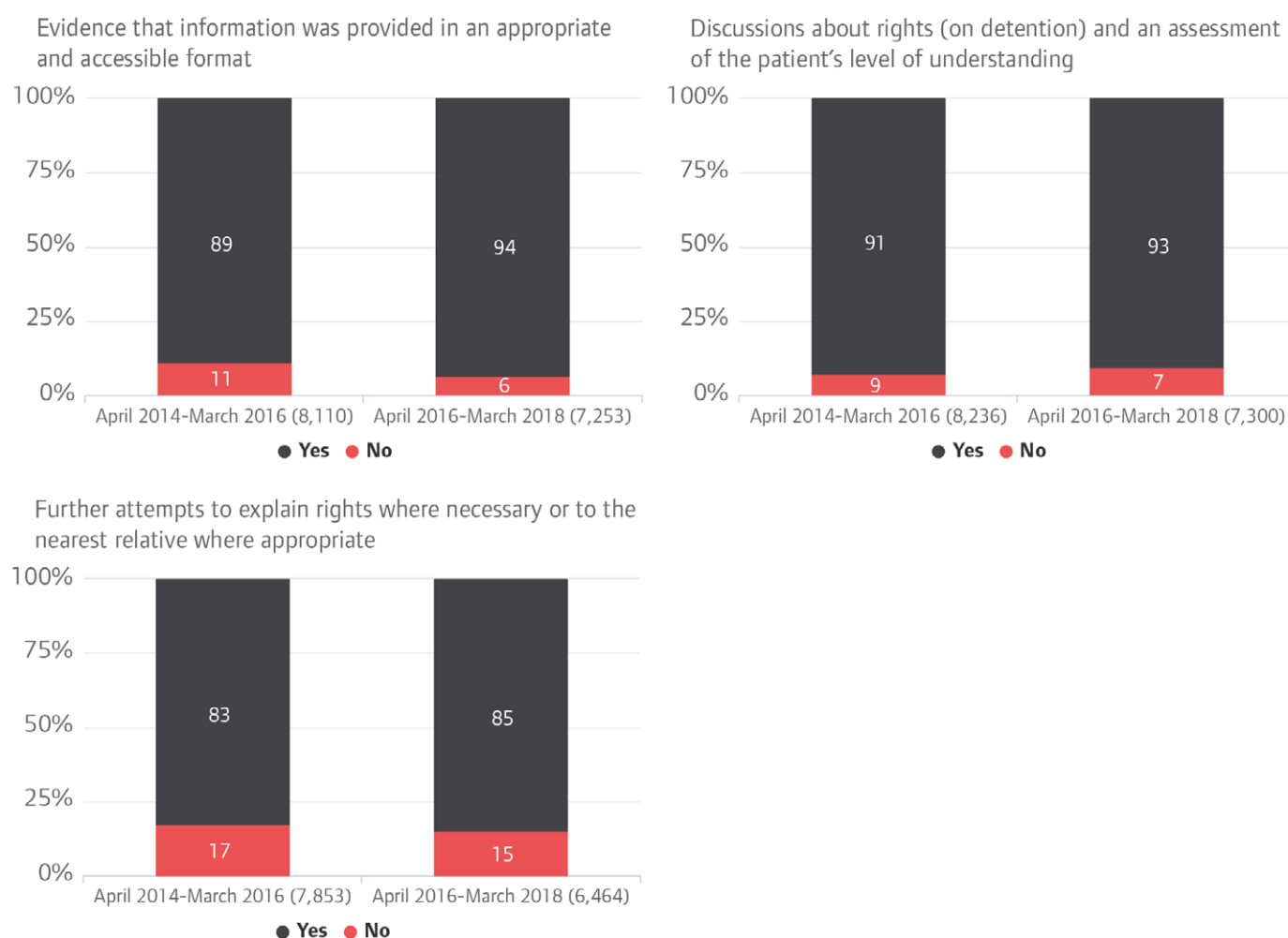
Under the MHA, providers must give patients information about their rights, verbally and in writing, as soon as possible after the start of their detention or community treatment order.⁷ The MHA also requires staff to remind patients of their rights and of the effects of the MHA from time to time, to check the hospital is meeting its legal duties. This allows patients to understand how the MHA will affect them, be involved in their care and treatment and discuss any concerns with staff. It also gives them the opportunity to exercise their rights if they wish to do so, for example by requesting their discharge through an appeal to the tribunal or hospital managers. Similar duties apply in respect of information for nearest relatives.⁸

This is the most frequently raised area of practice from our analysis of records during visits. A common problem is in recording attempts to provide patients or relatives with information about their legal position and rights, or making repeated attempts to explain rights to patients who do not initially understand them. In many cases, patients may struggle to understand information given to them on admission because they are most ill at this point. There can also be difficulties with language: in some hospital catchment areas large numbers of patients do not have English as a first language. We are aware that hospitals share translations of legal information, as these are no longer prepared centrally by government. In most cases, written information is in any case not enough, and hospital staff (with interpreters as appropriate) must talk through the information.

We have seen some progress in this area. There is an overall improvement in services meeting the Code's expectations in 2016-18, compared with findings in 2014-16 (figure 3). Specifically:

- There has been a five-percentage point increase in evidence of patients being provided with this information in an appropriate format, from 89% (7,204 out of 8,110) to 94% (6,833 out of 7,253). This means both orally and in writing, including in accessible formats as appropriate (for example, Braille, Moon, easy read) and in a language the patient understands.
- The data indicates a two-percentage point increase, from 83% (6,513 out of 7,853) to 85% (5,482 out of 6,464) in further attempts to explain rights, or to explain rights to nearest relatives.
- There has been a two-percentage point improvement in rates of discussions about rights and assessments of the patient's levels of understanding, from 91% (7,474 out of 8,236) to 93% (6,784 out of 7,300). The Code suggests that providers should carry out an assessment of how well the information was understood by the recipient and carry out regular checks to ensure that information has been properly given to each patient and understood by them.⁹

Figure 3 Evidence of information provision from examined records, 2014-16 and 2016-18



Source: CQC

1.22 How are people being involved in care planning?

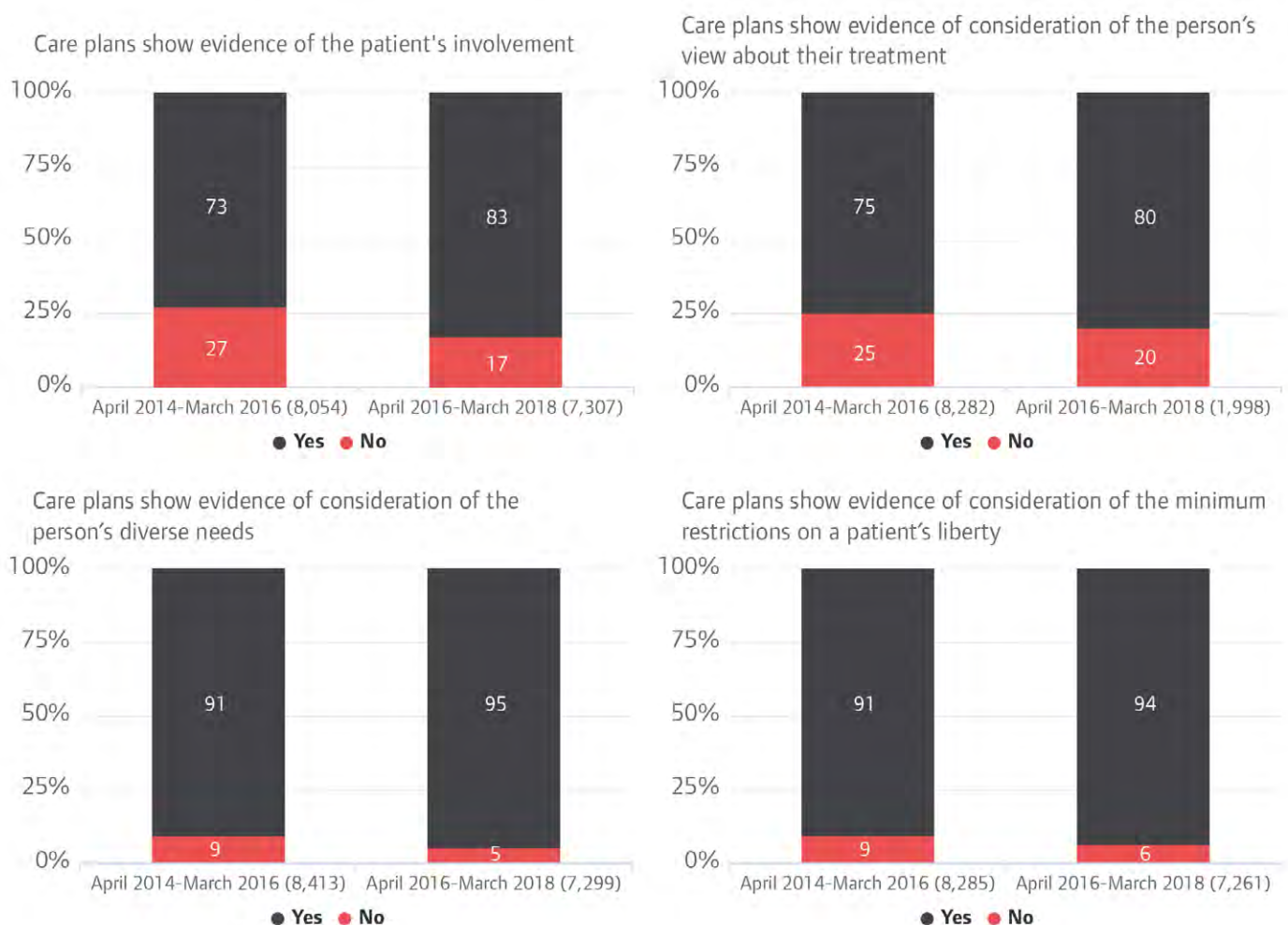
Care planning is still one of our greatest concerns, based on the frequency with which it is raised by MHA reviewers. However, this is also an area that has shown the most improvement when we compare results from 2016-18 with 2014-16. Specifically, we continue to find issues with recording adequate evidence of whether patients consent to treatment, discharge planning and involving patients in care planning.

Although the MHA provides authority for treatment without consent, the principles that should underpin its use require a person-centred care planning approach, consistent with the legislative and international conventions set out in Chapter 3 of the Code of Practice. This is to make sure that individuals are fully supported to be involved in decision-making as much as is appropriate. Patients' views on proposed treatment should be considered and fully documented in care plans, as well as the reasons why professionals take any decision that is contrary to the patient's preferences.¹⁰

We have seen an overall improvement in services meeting the Code's expectations in 2016-18, compared with findings in 2014-16 (figure 4). Specifically:

- The data shows a 10-percentage point increase in evidence of patients' involvement in care plans, from 73% (5,888 out of 8,054) of records examined in 2014-16 to 83% (6,029 out of 7,307) in 2016-18.
- There has been a five-percentage point increase in care plans showing consideration of the person's view about their treatment, from 75% (6,229 out of 8,282) to 80% (1,597 out of 1,998). However, it should be noted that this is based on a reduced sample size.
- Evidence of consideration of the person's diverse needs in care plans increased by four percentage points, from 91% (7,645 out of 8,413) to 95% (6,914 out of 7,299), and evidence of consideration of minimum restrictions to liberty increased by three percentage points from 91% (7,523 out of 8,285) to 94% (6,818 out of 7,261).

Figure 4 Evidence about care planning in examined records 2014-16 to 2016-18



Source: CQC

On our MHA review visits, we do find an increasing amount of care planning that is detailed, comprehensive and developed with patients and carers being involved. However, a substantial proportion of the care plans of detained patients that we have examined are still of a poor quality.

We are pleased to note that the independent review of the MHA identified care planning as a ‘cornerstone’ of its reforms, and has recommended means by which the requirements for good care planning can be encouraged and, where necessary, enforced.¹¹

1.23 Are people accessing Independent Mental Health Advocacy?

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).¹² It has been the case for the last three years that on almost every ward we visit, patients state that they have some degree of access to IMHAs. The very small number of exceptions (less than 1% of visits each year) appear to reflect short-term breakdowns in provision during retendering contracts for advocacy services, or handovers from one provider to another when contracts change.

However, we still hear from service user groups that advocacy services are not as fully available and responsive as they would like, and of concerns over the quality of advocacy.

From 2015, the Code of Practice has advised services that, where a patient lacks capacity to decide whether to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly.¹³ In the first quarter of 2015, immediately before the revised Code’s advice was implemented, we found that some services had concerns over this recommendation, for example about questions on patient confidentiality. We are pleased that now an increasing majority of services appear to be following the Code’s advice. In 2016/17 we found that 85% (544) of 639 wards where we asked about advocacy arrangements for

incapacitated patients were following the Code’s advice. This year, we found such automatic referrals in 91% (985) of 1,080 wards where we asked this question.

We welcome the MHA review recommendations to strengthen the availability, quality and accountability of advocacy services.¹¹ We recognise that issues of training and accountability need wider consultation, and that greater availability would require resources from local authority commissioners. As an opt-out provision appears to be workable in the case of patients who lack capacity to initiate engagement with IMHA services, we particularly support the review’s suggestion that IMHA services should be provided to all qualifying patients on an opt-out basis.

1.24 How are services challenging restrictive practices?

Our MHA reviewers commonly raise concerns about restrictive practices. By this, we mean restrictive practices in the wider sense that encompasses general restrictions on patients through blanket rules, as well as restrictive interventions such as restraint or seclusion. In our previous report, we expressed concern about the way the Code of Practice recommendation for mental health services to reduce restrictive interventions when responding to challenging behaviour was being applied. In December 2017, we published a good practice resource on services that successfully reduced their use of restrictive practices, including the use of restraint, seclusion and rapid tranquilisation.¹⁴ The features that these initiatives had in common were:

- leadership and governance that embedded a positive and therapeutic culture
- a structured programme to reduce restrictive interventions
- staff that provided person-centred care and supported positive behaviour.

In 2018, the Secretary of State called on CQC to carry out a thematic review of the use of restraint, prolonged seclusion and long-term segregation on people with mental health problems, and on

people with a learning disability or autism who are receiving care on mental health wards or in other types of residential settings. It is a concern that 'long-term segregation' (LTS), an intervention once thought of as extreme, and usually limited to higher-security forensic hospitals, is now viewed to be much more commonplace. We will publish an interim report in May 2019 and a final report by spring 2020, and we will share learning with partner organisations as we go along.

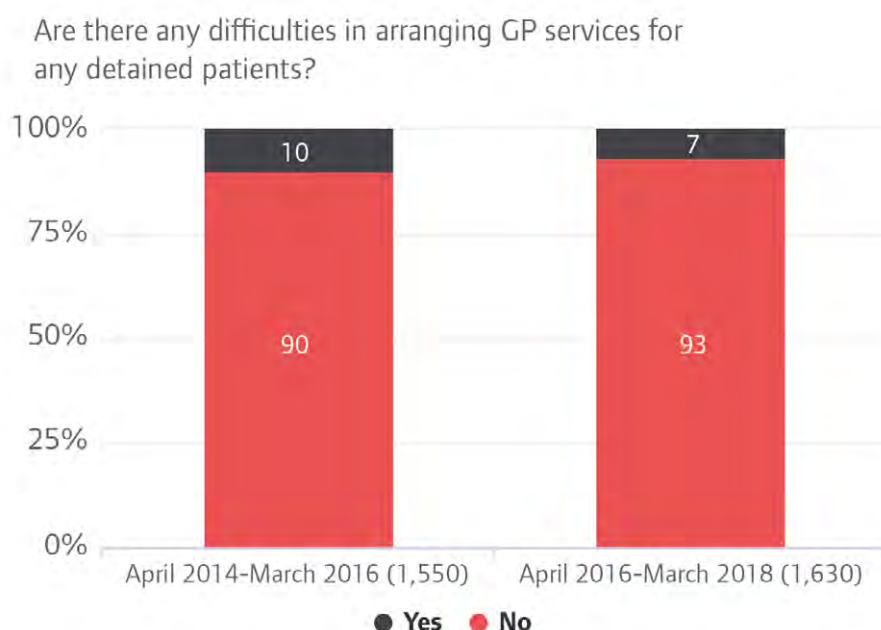
1.25 Are physical health issues being identified on admission?

It is important that hospital admission is taken as an opportunity to adequately monitor patients' physical health. This is especially important given the general health inequalities of people with serious mental disorder, as well as the potential side-effects of much psychiatric medication. We sample records for evidence of whether patients who have been in hospital for less than a year had a physical health check on admission. Compared with

findings in 2014-16, there has been a three-percentage point increase in evidence of such health checks in 2016-18, from 95% (5,471 out of 5,771) to 98% (4,832 out of 4,947). Services need to ensure that physical health checks are of adequate quality, using standards such as 'Improving physical healthcare to reduce premature mortality in people with serious mental illness'.¹⁵

There has been a three-percentage point increase in the number of hospital wards where, when staff were asked on our visits, report no difficulty with access to GP services, from 90% (1,392 of 1,550) to 93% (1,520 of 1,630) (figure 5). However, this also represents 110 wards visited who reported problems in the period 2016-18.

Figure 5 Access to GP services, 2014/16 and 2016/18



Source: CQC

Figure 6 Second Opinion Appointed Doctor visits, 2014/15 to 2017/18

SOAD visits over time			
2014/15	2015/16	2016/17	2017/18
14,375	14,601	14,594	14,503

Source: CQC

1.26 How is the Second Opinion Appointed Doctor service working for patients?

The Second Opinion Appointed Doctor (SOAD) service is an additional safeguard for patients detained under the MHA, providing an independent medical opinion to state whether certain treatments are appropriate.

A SOAD visit would be needed to allow the following treatments in the absence of consent, except in an emergency:

- medication for mental disorder after three months from first administration when a patient is detained under the MHA
- medication for mental disorder after the first month of a patient being subject to a community treatment order (CTO)^a
- electroconvulsive therapy (ECT), at any point during the patient's detention.

CQC is responsible for the administration of the SOAD service, but SOADs are independent and reach their own conclusions by using their clinical judgement. All SOADs are experienced consultant level psychiatrists registered with a licence to practice and subject to revalidation.

When we receive a request from the provider caring for the patient, we have a duty to appoint a SOAD to visit the hospital, to assess and discuss the proposed treatment with a minimum of two professionals involved in the patient's care. SOADs can issue certificates to approve treatment plans in whole, in part, or not at all

depending on their assessment of the treatment plan in an individual case.

In 2017/18, SOADs carried out 14,503 visits. This is similar to the number carried out during the previous three years (figure 6).

Footnote:

- a Or the expiry of the original three-month period applicable from the start of treatment under detention, if the CTO was instigated when this still had more than a month to run. See MHA Code of Practice, para 25.31.

We have previously raised concerns that the consent to treatment provisions in the MHA may fail to meet international human rights expectations. We called for this to be addressed in the run-up to the 2007 Act, suggesting that the three-month period before which a SOAD authorisation is required where a detained patient receives medication for mental disorder without consent should be shortened.¹⁶ We welcome the fact that the independent review of the MHA has recognised this issue. We will be working with government to evaluate the potential resource impacts of their recommendations to address this through SOAD visits much earlier in patients' detention, with an appeal mechanism through the First-Tier Tribunal (mental health).

In 2017/18, 83% (11,998) of SOAD visits looked at proposed medication treatment plans for patients who were subject to the MHA in hospital. This is a small decrease from the 12,081 carried out last year.

The number of visits (1,117) to consider treatment plans for patients on CTOs continued to decline with 1% fewer visits taking place than last year (1,128).

There were 1,697 visits to detained patients in 2017/18 for ECT, of which 1,388 were for ECT only. The remainder were both ECT and medication (figure 7).

Figure 7 Second Opinion Appointed Doctor visits to consider ECT, 2014/15 to 2017/18

ECT visits over time			
2014/15	2015/16	2016/17	2017/18
1,631	1,629	1,642	1,697

Source: CQC

Outcome of SOAD visits in 2017/18

This year, SOAD reviews resulted in 27% of all treatment plans considered being changed. This is similar to the previous year's figure of 26% (figure 8).

Treatment plans for ECT or CTO patients were more likely to be left unchanged in 2017/18 than medication (detained) patients.

Figure 8 Outcomes of second opinion visits, 2017/18

Outcome	ECT (detained)		Medication (detained)		Community treatment orders	
Number of visits	1,697	100%	11,998	100%	1,117	100%
Plan not changed	1,280	75%	8,402	70%	856	77%
Plan changed	397	23%	3,463	29%	232	21%
Missing data	20	1%	133	1%	29	3%

Source: CQC

The MHA can provide authority to give a patient medication (but not ECT) for mental disorder, even where a detained patient retains capacity to give or refuse consent, and is refusing. SOAD visits appear to be marginally more likely to change treatment proposals where the patient is refusing to give consent. In 2017/18, 580

(34%) of visits to consider medication for patients who were refusing consent resulted in a change to the proposed treatment, compared with 3,016 (29%) in the case of patients who were incapable of consenting (figure 9). This is consistent with previous years' findings.

Figure 9 Outcomes of second opinion visits for medication, by patient consent status, 2017/18

Detained		Patient capacity	
		Incapable	Refusing
Outcome	Plan not changed	7,291	1,111
	Plan changed	3,016	580
Total		10,307	1,691

Source: CQC

In 771 visits during 2017/18, the SOADs did not provide a certificate for treatment, of which 151 cases were declining the use of ECT. This is a decrease of 12% in the number of cases where a form was not issued from 2016/17, although before that the numbers had risen steeply from under 300 in 2014/15.

The proportion of cases in 2017/18, where the non-issuing of a form was a rejection of the use of ECT, was 20%. This is the same as the proportion for 2016/17.

Neurosurgery for mental disorder

Before any patient can undergo neurosurgery for mental disorder (NMD), a CQC-appointed panel must approve the treatment. NMD is a surgical operation that destroys brain tissue, or the function of brain tissue, to treat mental disorder.

In 2017/18, the CQC panel received two referrals to consider proposals for NMD. Both were withdrawn before the visits were arranged: in one case the patient changed her mind. In the other, the operating centre suggested

to the referring doctor that they withdraw the request while the centre explored further treatment and care options.

Individualised risk assessments

MHA reviewers check care plans for individualised risk assessments that are updated as a patient's circumstances change.

Equalities data and SOAD visits

Of the 14,503 SOAD visits in 2017/18, 59.9% (8,688) were made to men, 40% (5,800) to women, and 0.1% (12) to transgender people.

In 2017/18, SOAD visits for women were over two times more likely to be for ECT than is the case for men. For 2016/17 this was three times more likely.

Plans for younger adults (18 to 40) were changed in 33% of 2017/18 visits, which is more often than other age groups. This continues the trend of 2016/17. Plans for people aged 61 and over were changed in 20% of 2017/18 visits, making this age group the least likely to have their plan changed following a SOAD visit.

10,766 (77%) of the SOAD visits with ethnicity recorded in 2017/18 were made to White people with 3,180 (23%) made to people from BME groups.

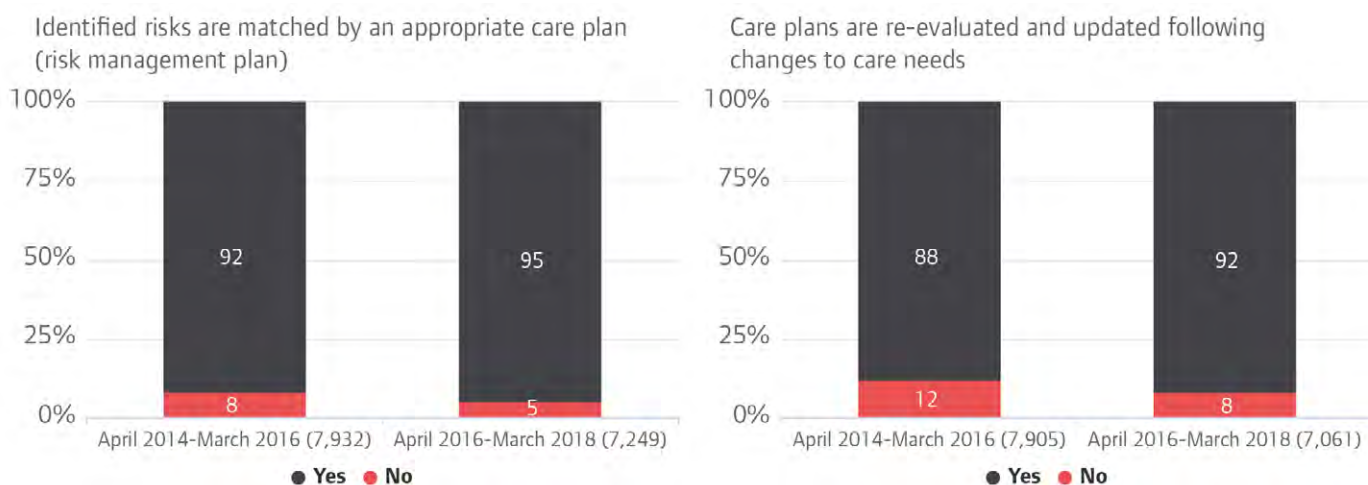
SOAD visits to consider ECT are almost twice as likely to be for White patients than for patients from BME groups, although this may reflect the older demographic of patients usually referred for ECT. The older patients are, the more likely that the SOAD visit involves the use of ECT (20% of visits are to people aged 61 and over).

Treatment plans for White people (21%) were changed slightly less during 2017/18 than that of people from BME groups (26%).

There is overall improvement in services meeting the Code's expectations in 2016-18, compared with findings in 2014-16 (figure 10):

- There has been a three-percentage point increase in identified risks being matched by the care plan judged to be appropriate by the MHA reviewer, from 92% (7,296 out of 7,932) to 95% (6,895 out of 7,249).
- An increase of four percentage points has been made for care plans being re-evaluated following changes to care needs, from 88% (6,924 out of 7,905) to 92% (6,528 out of 7,061).

Figure 10 Evidence of risk assessments and care plans that have been re-evaluated following changes to care needs, 2014-16 to 2016-18



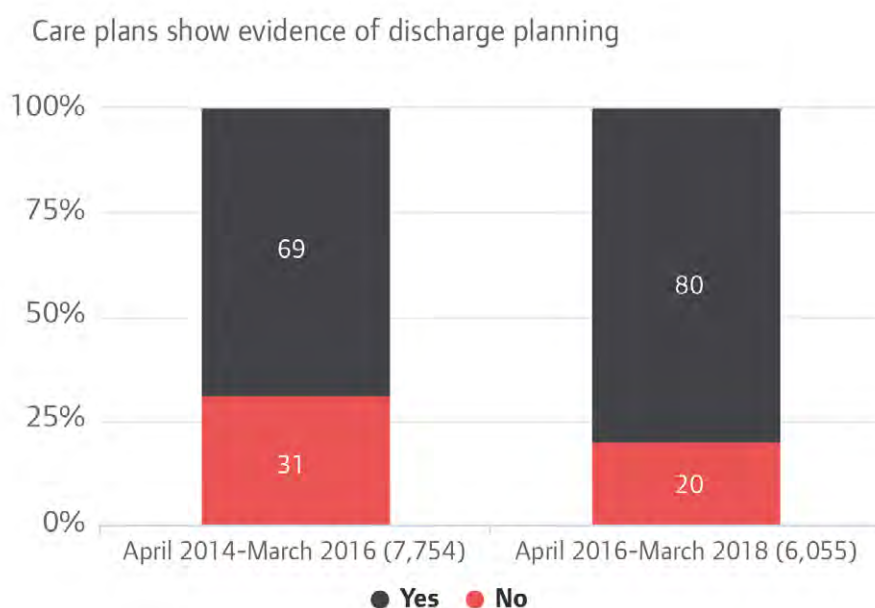
Source: CQC

1.27 How are people being supported in discharge planning?

The Code and Care Programme Approach expect providers to begin discharge planning as soon as the patient is admitted. Services also need to make sure that patients are clear about plans and goals for their recovery and discharge. The Code provides a broad definition of aftercare services. This should include health care, social care and employment services, supported accommodation and services to meet the patient's wider social, cultural and spiritual needs, to the extent that they meet a need arising from or related to that person's mental disorder and could help recovery.¹⁷

In previous reports, we have noted a steady increase in the proportion of care plans examined that showed evidence of aftercare planning. There is an overall 11 percentage point improvement in services meeting the Code's expectations in 2016-18 (4,872 out of 6,055, or 80%), compared with findings in 2014-16 (5,382 out of 7,754 or 69%) (figure 11). We continue to expect providers to review aftercare planning regularly from the point of admission, and fully document in care plans.

Figure 11 Examined care plans showing evidence of discharge planning, 2014-16 and 2016-18



Source: CQC



Part 2

CQC AND THE MENTAL HEALTH ACT

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



In 2017/18

- We carried out **1,165** visits, met with **3,993 patients** and required **6,049** actions from providers.
- Our Second Opinion Appointed Doctor service carried out **14,503** visits to review patient treatment plans, and changed treatment plans in **27%** of their visits.
- We were notified of **189** deaths of detained patients by natural causes, **48** deaths by unnatural causes and **10** yet to be determined verdicts.
- We received **2,319** complaints and enquiries about the way the MHA was applied to patients.
- We were notified of **714** absences without leave from secure hospitals.



2.1 Deaths in detention

All providers registered under the Health and Social Care Act 2008 must notify us about the deaths of people who are detained, or liable to be detained under the MHA.^b In 2017/18, providers notified us of 247 deaths of detained inpatients (figure 12).

The information we receive is reported to our inspection teams for local review and action, including enforcement action where this may be necessary in the Health and Social Care Act.

We also report the collective data quarterly to the Ministerial Board on Deaths in Custody and the Independent Advisory Panel on Deaths in Custody who lead on the collection, analysis and dissemination of relevant information and lessons that can be learned from all deaths in detention in England and Wales. The statistical reports produced by the panel can be accessed on their website: <http://iapdeathsincustody.independent.gov.uk/>.

Figure 12 Deaths of detained patients reported to CQC, 2012/13 to 2017/18^c

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Natural causes	200	126	182	201	186	189
Unnatural causes	48	36	34	46	54	48
Undetermined	27	36	11	19	7	10
Total	275	198	227	266	247	247

Source: CQC

Footnote:

^b Patients 'liable to be detained' include detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. For the purposes of deaths notifications, 'detained patients' include patients subject to holding powers such as ss.4, 5, 135, 136, and patients recalled to hospital from CTO.

^c We use the term 'natural causes' in the sense that it is used by coroners and on death certificates and associated documents. It is used when a person has died from an illness or an internal malfunction of the body not directly influenced by external forces. This does not assume that the death was expected or unavoidable. It does not rule out potential iatrogenic effects of psychiatric treatment on long-term physical health.

Figure 13 Cause of deaths of detained patients reported to CQC, 2012/13 to 2017/18, natural causes

Cause of death	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Aspiration pneumonia	11	5	13	6	4	0
Cancer	12	4	13	14	11	14
Chronic obstructive pulmonary disease	3	4	8	9	6	8
Heart disease	17	21	24	49	29	45
Myocardial infarction	11	7	19	14	4	6
Pneumonia	33	24	35	34	36	23
Pulmonary embolism	16	13	21	19	26	14
Respiratory problems	2	5	6	7	1	12
Unknown	44	9	5	0	29	28
Other	51	34	38	49	40	39
Total	200	126	182	201	186	189

Source: CQC

This year, we are aware of 12 deaths from natural causes of people aged up to 40 years old, all of whom were detained in hospital.

We were told about 11 deaths that occurred within seven days of restraint being used. This includes seven people aged 61 and over and four aged under 60. Our review of these deaths had not identified any deaths during or immediately (within 24 hours) following

restraint by staff. Our inspection teams will complete further reviews once full details are available from the Coroners investigating the deaths.

Three cases have been further investigated by providers; the confirmed causes of death are reported as being not related to the restraint that had occurred.

2.2 Complaints and contacts

We analysed 300 complaints and concerns raised to look for common themes:

- Medical treatment: This category relates to people who feel they have been sectioned unnecessarily, either because they have not

met the criteria to be sectioned, or that they believe they are now well enough to leave. Many people reported that they do not know why they have been detained and often that detention was based on

insufficient evidence. Another common area of complaints was about medication that patients are required to take, or its side effects.

- Staff attitude: Patients or family members complained about staff being apathetic, dismissive, inappropriate or rude. Complaints included that patients felt ignored by staff: from their opinion not being considered when deciding on treatment, to lacking compassion and ignoring simple requests.
- Communication: Many patients felt that they were not appropriately involved in their own care, not informed about services, and that staff were too busy to speak to them. This was experienced in several ways, such as not being informed of the available activities at a service; not meeting with a doctor; not having their rights explained; and not discussing medication with the appropriate

clinician. Some patients described a lack of effort to involve them in their own care plan, for example a health clinician talking with them for a few minutes and then basing their treatment on previous medical records. Complainants reported difficulty in obtaining responses to issues raised with management, and that nothing was being done to address concerns. This included delays in following up internal complaints and obtaining contact details for the IMHA service.

- Diagnosis: Complaints concerning diagnosis focused on the decision to be sectioned, incorrect diagnosis, and disregarding physical health diagnoses.
- Availability of leave: The inability to take leave due to inappropriate behaviour, staff availability, and miscommunication issues were common complaints in this category.

2.3 Absence without leave

Hospitals designated as low or medium security must notify us when any patient liable to be detained under the MHA is absent without leave, if that absence continues past midnight on the day it began.

In 2017/18, we received 714 separate notifications from low and medium secure facilities, 72 more than were recorded in

2016/17 (642). As in the previous year, around three-quarters (74%) of the incidents were recorded by low secure units.

Just over half of such absences occurred when patients stayed away longer than had been authorised. These cases could reflect positive risk taking by providers (figure 14).

Figure 14 Means of absence without leave reported to CQC, 2017/18

Method	Number	%
Failed to return from authorised leave	372	52%
Absented him or herself during escorted leave	217	30%
Absented him or herself from hospital	75	11%
Not known	50	7%
Total	714	

Source: CQC

More than three-quarters of absences were of male patients, and two in five were of patients aged 25 to 34.

Roughly one-third of patients who were reported absent without leave returned to the ward by themselves. A further third were

returned by police, which is a greater proportion than those returned by hospital staff or mental health professionals, although the MHA provides such staff with equivalent powers to that of a police constable to take patients into custody and bring them back to hospital.¹⁸

2.4 Children and young people admitted to adult mental health wards

Services are required to notify CQC when a person under 18 years old is placed in a psychiatric ward or unit intended for adults, where the placement lasts for a continuous period of more than 48 hours.

In 2017/18, there was a 22% fall in the number of such notifications received, compared with 2016/17. However, with numbers of this volume there is inevitable year-on-year fluctuation, as figure 15 shows.

Figure 15 Notifications to CQC of child admissions to adult psychiatric wards

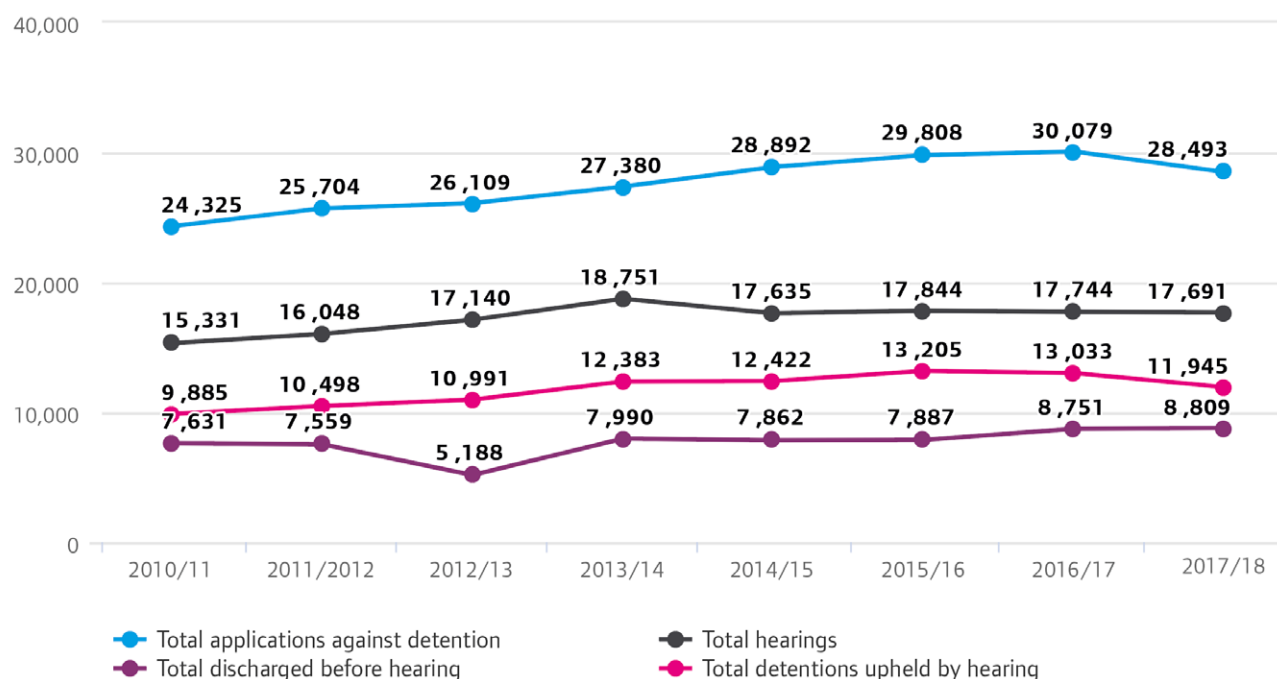
Financial year	Number of child admissions to adult psychiatric wards (notifications received)
2015/16	237
2016/17	256
2017/18	199

Source: CQC

There are circumstances where such admissions may have a clinical or social rationale, for example to access therapies, or because the patient is approaching their 18th birthday or has behavioural problems. However, it is also likely that some placements are simply due to problems in accessing appropriate services.

In our 2017 review of children’s mental health services, we found a lack of access was identified as a problem, as this led to children and young people being supported by adult mental health services teams.¹⁹

Figure 16 First-Tier Tribunal (Mental Health) activity, 2010/11 to 2017/18



Source: Tribunal Secretariat, as published in past CQC *Monitoring the Mental Health Act* reports.

2.5 The First-Tier Tribunal (Mental Health)

CQC works with representatives from the Tribunal Service to identify how our work to offer safeguards and protect patients may impact or support each other. Data provided by the Tribunal shows that there was a slight fall in applications, and a proportionate fall in absolute discharges, for both detained and CTO patients (figure 16). For hearings both against detention and CTO, the outcome of a high majority was no discharge. The number of detained patients discharged before Tribunal hearings rose slightly in 2017/18.

Appendix A: CQC publications complementary to this report

- *The state of health care and adult social care in England 2017/18*, October 2018
- *Sexual safety in mental health wards*, September 2018
- *Mental health rehabilitation inpatient services: Ward types, bed numbers and use by clinical commissioning groups and NHS trusts*, March 2018
- *Are we listening? Review of children and young people's mental health services*, March 2018
- *Mental Health Act – The rise in the use of the MHA to detain people in England*, January 2018
- *Mental Health Act – A focus on restrictive intervention reduction programmes in inpatient mental health services*, December 2017
- *Review of children and young people's mental health services: Phase one report*, October 2017

Appendix B: Involving people

Involving people who have experience of the MHA

We expect mental health services to give people who use their services a voice in planning and delivering their care and treatment. We involve people in our own work in the following ways.

Service User Reference Panel

The Service User Reference Panel gives us helpful information on conducting visits and helps to steer different projects in the right direction. The panel is made up of people who are, or have been, detained under the MHA. Each member is encouraged to share their views on our work and advise us about how we can involve more members of the public.

Some of the members of the Service User Reference Panel also attend our MHA monitoring visits and inspections of health and social care services as Experts by Experience. Their main role is to talk to people who use services and tell us what they say. They can also talk to carers and staff, and can observe the care being delivered.

We have found many people find it easier to talk to an Expert by Experience rather than an inspector. This is just one of the benefits of including an Expert by Experience in our visiting and inspection programme.

Mental Health Act External Advisory Group

An external advisory group provides experience and expertise on our MHA monitoring role. The group meets twice a year, and is in regular email contact between meetings.

CQC is grateful for the time, support, advice and expertise given to the report by the group. The members are:

Anthony Beschizza, Central and North West London NHS Foundation Trust

Nick Brindle, Leeds and York Partnership NHS Foundation Trust

Michael Brown, College of Policing

Deborah Cohen, Association of Directors of Adult Social Services

Guy Davis, East London NHS Trust

Max Edelstyn, Equality and Human Rights Commission

Paul Farrimond, NHS Providers

Dorothy Gould, National Survivor User Network

Sandra Hudson, Bipolar UK

Ian Hulatt, Royal College of Nursing

Brenda Jones, Service User Reference Panel, CQC

Viral Kantaria, NHS England

Richard Kelly, Department of Health and Social Care

Judy Laing, Bristol University

Matthew Lees, Department of Health and Social Care

Clementine Maddock, Royal College of Psychiatrists

Louise McLanachan, Birmingham and Solihull Mental Health NHS Foundation Trust

Ramesh Notra, NHS Digital

Edwin OmoRegie, McMillan Williams Solicitors

Steve Chamberlain, National Approved Mental Health Practitioner Leads Network

Kathy Roberts Association of Mental Health Providers

Jane Shears, St Andrew's Hospital

Geraldine Strathdee, NHS England

Emma Tilley, Independent Police Complaints Commission

Hazel Watson, British Institute for Human Rights

Cathie Williams, Association of Directors of Adult Social Services

Sarah Yiannoullou, National Survivor User Network

Find the terms of reference for the advisory group at: <http://www.cqc.org.uk/content/advisory-groups#tabs-2>.

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