Monitoring the Mental Health Act in 2021 to 2022

This is the 2021/22 edition of Monitoring the Mental Health Act

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This report sets out CQC's activity and findings from our engagement with people subject to the MHA and review of services registered to assess, treat and care for people detained using the MHA during 2021/22.

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals 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 and guardianship.

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 (SOAD) service, review MHA complaints, 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 lead to a 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 torture, inhuman or degrading treatment. More information about this important role and our activities is at appendix B to this report.

Evidence used in this report

This report is based on the findings from our monitoring reviews of 609 wards carried out during 2021/22. These involved private conversations with 2,667 patients and 726 carers. We also spoke with advocates and ward staff. We have quoted from feedback letters from these monitoring reviews and, in the main, have not identified the services concerned, with some exceptions when we are describing good practice.

In addition, we have engaged at a policy level with a range of stakeholders in the use of the MHA, handled 2,434 new contacts in 2021/22 from patients and others, and took part in 82 Independent Care Education and Treatment Reviews (IC(E)TRs).

It is with thanks to all these people, especially people detained under the Act and their families, who have shared their experiences with us. This enables us to do our job to look at how services across England are applying the MHA and to make sure people's rights are protected.

Evidence in this report also draws on quantitative analysis of statutory notifications submitted by registered providers, complaints and/or concerns submitted to us about the way providers use their powers or carry out their duties under the Act and activity carried out by our SOAD service. The second opinion appointed doctor (SOAD) service is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion on the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent. While data validation and cleaning is undertaken in preparing the data for publication, this data can change over time as it is taken from a live system.

The evidence in this report has also been corroborated, and in some cases supplemented, with expert input from our subject matter experts and specialist MHA reviewers to ensure that the report represents what we are seeing in our regulatory activity. Where we have used other data, we reference this in the report.

Key messages

Workforce issues and staff shortages mean that people are not getting the level or quality of care they have a right to expect, and the safety of patients and staff is being put at risk

Workforce issues and staffing shortages remain the greatest challenge for the mental health sector, with pre-existing difficulties exacerbated by the COVID-19 pandemic. Staffing shortages have affected patients' ability to access therapeutic care, with issues including a lack of involvement in decisions about their care, a reduction in ward activities and patients' leave being cancelled. We have heard that this lack of therapeutic interventions is increasing the risk of violence and aggression on the wards, threatening the safety of patients and staff. Issues with staffing shortages have affected how well staff are able to respond to these incidents.

The shortage of qualified mental health nurses is a systemic issue. Some providers have told us about how they are trying to mitigate staffing issues, including improving staff motivation, ensuring better skill mix of staff on duty, and increasing in-house training requirements. Others are seeking alternative solutions, such as employing ward managers and other professionals to substitute for nursing cover. However, this is having a detrimental effect on staff safety and wellbeing, with staff working under sustained pressure and having to take on responsibilities they may not be qualified for.

Gaps in community mental health care are compounding the rising demand on inpatient services, with delays in admission, transfer and discharge

Demand for inpatient services has continued to increase in 2021/22. Gaps in community care is adding to the pressure on mental health inpatient services, with bed availability in many services running close to or above capacity. While some services are managing to accommodate patients without extended delays, many others are struggling to provide a bed, leading to people being cared for in inappropriate environments.

In particular, we continue to be concerned about the impact of the pandemic on children and young people's mental health services (CYPMH), with services struggling to meet rising demand. This is increasing the risk of children ending up in inappropriate environments, such as general children's wards. To manage delays to CYPMH beds, some services have been taking steps, including investing in new health-based places of safety, to care for people while they are waiting for a ward bed.

A lack of beds and gaps in community and social care services are also creating delays in discharging people from hospital. In some services this has led to the development of 'sub-acute' wards whose core purpose is to accommodate patients whose discharge from inpatient care is delayed.

Urgent action is needed to tackle the over-representation of people from some ethnic minority groups and, in particular, the over-representation of Black people on community treatment orders

Despite numerous reports and plans for change, progress in tackling the over-representation of people from some ethnic minority groups subject to MHA powers, in particular the over-representation of Black people on community treatment orders, is too slow. Data from NHS Digital also shows that when ethnicity and deprivation are mapped together, the risks are interrelated.

We support the work underway at a national level to ensure racial equality is experienced across all mental health care, for example through the Advancing Mental Health Equalities Strategy and Patient and Carers Race Equalities Framework (PCREF). However, providers and integrated care systems must take responsibility for addressing health inequalities at a local level. More also needs to be done to understand why people from these groups are more likely to be detained under the mental health act, and what the barriers are to real change.

During 2021/22 we have seen some services taking a positive approach to addressing inequalities. This includes, for example, services identifying members of the staff team to take a leading role for diversity, promoting an equalities approach across wards and supporting staff and patients. In particular, we have frequently heard ward managers and others describe their service as a safe space for lesbian, gay, bisexual and transgender (LGBT+) people. However, further work is needed to ensure people feel respected and safe.

The quality of ward environments is an ongoing concern, with many inpatient environments in need of immediate update and repair

We know how important it is for people to be cared for in environments that make them feel valued, with good quality spaces that respect their privacy and dignity. We have ongoing concerns around the physical environment and condition of wards, which has been made worse by the additional wear and tear created during lockdowns. Many inpatient environments are in urgent need of update and repair but are facing additional waits due to the backlogs in repairs created by the pandemic.

Where wards have been refurbished, we have seen the positive effects this had for patients and staff, with better physical environments improving patient experience and staff morale. However, the current state of repair and arrangement of many wards can have an impact on patient wellbeing. This includes issues around patients not being able to eat together and lack of lockable spaces for people to keep their belongings in.

The very nature of hospital environments means that they are not always suitable for the sensory needs of autistic people and people with accessibility requirements, such as hearing aids. The noise and bright lights of the hospital wards can cause people distress. In addition, we continue to have concerns around the use of dormitories and the non-therapeutic nature of these environments.

Despite the challenges facing services, we have seen examples of good practice around advance planning and applying the principle of least restriction.

We have found some good practice around advance planning for future care. However, we have ongoing concerns about how well people and their carers are being involved in care planning process. We also have concerns about the quality of people's care plans.

In addition, people need better access to advocacy support, and we welcome proposals in the draft Mental Health Bill to improve the availability and flexibility of Independent Mental Health Act Advocates (IMHAs).

Despite the pressures on many services, we have seen evidence of services continuing to take steps to apply the principle of least restriction. This includes challenging blanket restrictions and reducing the use of restraint. Services should continue to implement the Use of Force Act, and review their policies and procedures in line with it.