Our activity in 2021 to 2022

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

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Key points

In 2021/22:

- We carried out MHA monitoring reviews of 609 wards – 466 were on-site visits and 143 were remote reviews.
- We spoke with 2,667 patients (2,056 in private interviews and 611 in more informal situations), and 726 carers.
- MHA reviewers took part in Independent Care, Education and Treatment Reviews (ICETRs) for 30 patients between November 2021 and April 2022 and for 82 patients overall.

- Our complaints team received 2,434 new contacts in 2021/22, which were a mixture of complaints and matters dealt with as requests for advice. In addition, we received 6,500 contacts in respect of open cases, most of which relate to complainants that we are helping to use local complaints resolution.
- We arranged 12,005 second opinion appointed doctor visits, a significant decrease in demand from previous years.
- We were notified of 695 incidents of absence without leave.
- 325 deaths of people detained under the MHA or subject to a community treatment order (CTO) were reported to us.

Mental Health Act reviewer visits

In 2021/22, we carried out MHA monitoring reviews of 609 wards – 466 wards had an on-site visit and 143 wards had a remote review. We spoke with 2,667 patients (2,056 in private interviews and 611 in more informal situations), and 726 carers.

In addition, we have continued to review the care and treatment of people with a learning disability and autistic people. In 2021/22, MHA reviewers took part in Independent Care, Education and Treatment Reviews (ICETRs) for 82 patients.

Our MHA monitoring reviews are one way in which we fulfil our responsibilities as a part of the UK National Preventive Mechanism against torture and ill-treatment (see appendix B). After each monitoring review, our MHA reviewers issue a feedback letter setting out our observations and requesting an action plan in relation to any concerns. This feedback is intended to provide a constructive challenge to services to support them in developing the best approaches possible in providing patient care based on the principles set out in the MHA Code of Practice.

During 2021/22 a key focus of our feedback letters has been on how services pass on our feedback to patients on the ward and engage patients in their response. We discuss how services have responded to this feedback in the section on patient-centred care.

Complaints and contacts received by the Mental Health Act team

If people are unhappy with the use of powers or how duties have been carried out under the Mental Health Act, you can make a complaint to us and we will investigate. Complaints can be made by anyone – patients, staff or any member of the public.

The range of issues people raise with us varies. For example, some people ask for help in challenging detention or compulsory treatment. In these cases, we will signpost people to the appropriate way to do this, or to advocacy or Patient Advice and Liaison Services (PALS). Other people may ask us to investigate concerns that have not yet been considered through services' own local complaints resolution processes. In these cases it is usually appropriate for people to try to get the complaint resolved locally and we will signpost and, where appropriate, support people to complain to the service.

During the provider's investigation, if we receive information from either the individual making the complaint or the provider that raises immediate concerns we will pass this information on to the local authority safeguarding team and the safeguarding lead in the service without delay.

In addition, if the person making the complaint sends us more information about their complaint or raises a new matter during the provider's review, we pass this information to the provider and ask them to respond appropriately. We will also respond to any questions people have at this stage about our role and reassure them about how we are supporting them.

Once the provider has investigated the complaint, we expect them to tell the person making the complaint, and us, about the outcome. If the person is not happy with the outcome they can request further support from us.

If we are not satisfied with what the provider tells us about the outcome (for example it is not clear how they reached their decision, or they tell us the patient is 'happy' with the outcome, without providing any evidence of this) we will contact them to give us the information we require.

Where local complaints processes have been exhausted, and it is appropriate for us to carry out our own investigation, the complaint will be investigated by an MHA reviewer. In rare cases, we may decide to investigate a complaint without it being resolved locally first.

As part of their investigation, the MHA reviewer will request any evidence needed from the provider such as the complaint file, the relevant progress notes, incident forms, trust policies, CCTV if relevant, and any documents they feel they need to review the issues. If necessary, the MHA reviewer may visit the location or provider – they may also contact the provider to talk with the appropriate senior staff.

Where relevant, the MHA reviewer may link in with other CQC inspection teams to make sure they are aware of any issues they may need to consider in line with our roles and responsibilities under the Health and Social Care Act. Depending on the issues, they may also seek advice from other CQC teams such as policy and legal.

We report the findings of our MHA reviewer investigation to the person making the complaint and the relevant services. In our report, we look at what happened, what should have happened and where there are any gaps. Where our findings identify failings in a service, we make recommendations for improvements, such as changes in policies, practice or financial compensation for the complainant. We then ask the provider to confirm the actions they will take to implement our recommendations and to tell us when they have done so.

Depending on the outcome of our review, the inspection team may decide to include the area of concern in the next inspection, the MHA reviewer may also decide that they need to do a monitoring visit.

In 2021/22, we received 2,434 new contacts, which comprised a combination of complaints (where a clear complaint is made about a service), other concerns and requests for advice.

In addition, we received an additional 6,500 contacts in relation to open cases. Most of these relate to complaints that are being followed up, with our help, through referral to hospitals or local authorities for them to deal with through their local complaints resolution.

During 2021/22, we opened 18 investigations by MHA reviewers of matters raised in complaints. Four were ongoing at the time of going to press. Of the 14 completed investigations, 5 upheld all aspects of the complaint, 6 upheld aspects of the complaint, and 3 did not uphold any aspect of the complaint. The most common upheld aspects related to failures to communicate effectively with nearest relatives and families or carers (7 upheld), and failures of services' own local complaints systems to address concerns in a timely or appropriate way (6 upheld). We also found failures in communication across teams (2 upheld) and failures to take appropriate account of advance statements of wishes or arrangements for lasting power of attorney (2 upheld).

In addition, we received 8 appeals from high security hospital patients or their correspondents against withholding of mail or telephone monitoring. In 5 cases, we upheld the hospital's decision to withhold mail or carry out telephone monitoring. In the remaining 3 cases, monitoring stopped or withheld items of post were released in the course of our adjudication, so that we did not have to make a formal ruling.

The second opinion appointed doctor 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.

SOAD reviews are needed to allow the following treatments where consent is not given, except in an emergency:

- medicine for mental disorder after 3 months from first administration when a patient is detained under the MHA
- medicine for mental disorder after the first month of a patient being subject to a community treatment order (CTO)
- electroconvulsive therapy (ECT), at any point during the person's detention.

When we receive a request from the provider caring for the patient, we have a duty to appoint a SOAD to assess and discuss the proposed treatment with a minimum of 2 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. CQC is responsible for the administration of the SOAD service, but SOADs are independent and reach their own conclusions by using their clinical judgment.

In 2021/22, SOADs provided 12,005 second opinions for patients. This is a marked decrease in the number of checks carried out annually, with an average of 14,372 checks carried out over each of the previous 5 years.

Not all requests for a second opinion lead to a completed review. Some will be cancelled before the SOAD visit, for reasons that will include patients regaining capacity and giving consent to treatment, and patients being discharged from detention. Delays in arranging SOAD visits may lead to increased numbers of such cancelled requests.

In 2021/22, we received 15,831 requests for second opinions, of which 3,005 (19%) were subsequently cancelled. In 2020/21 we received 15,586 requests, of which 1,378 (9%) were subsequently cancelled. In the 2 years previous to that, request rates were higher (by about 1,000 each year) with cancellation rates of between 14-15%.

The majority (9,085, 76%) of completed SOAD reviews were to consider treatment for patients detained in hospital where the proposal only involves continuing medicine for mental disorder after the initial 3-month period. A further 13% (1,509) of SOAD reviews were to consider treatment of patients detained in hospital with electroconvulsive therapy (ECT). In 270 of these, the proposed treatment also requested SOAD authorisation of medicine for mental disorder. The relatively small proportion of ECT requests for detained patients that also involve medicine (less than 1 in 5) is likely to be a reflection that patients requiring ECT may have been relatively recently admitted to hospital, so authority for any medicines would fall under the 3-month rule.

There were 1,411 SOAD reviews for patients on a community treatment order (CTO) in 2021/22. These reviews must take place after the patient has been on a CTO for 1 month or, if the patient was detained onto CTO within 3 months of them being detained, when that 3-month period expires, whichever is the later date.

The highest proportion of changes made to treatment plans as a result of a SOAD review takes place in the medicines group of detained patients (figures 5 and 6).

Figure 5: Statutory second opinions provided by treatment, detained patients, by outcome, 2021/22

Outcome	ECT	ECT percentage	Medication	Medication percentage	Medication and ECT	Medication and ECT percentage
Plan not changed	1,044	84%	6,546	72%	171	63%
Plan changed	92	7%	2,088	23%	89	33%
Missing data	41	3%	307	3%	3	1%
No form issued	62	5%	144	2%	7	3%
Number of second opinions	1,239	100%	9,085	100%	270	100%

Note: some percentages may not add to 100 due to rounding
Source: CQC, SOAD data, 2021/22

Figure 6: Statutory second opinions provided for all treatments, CTO patients, by outcome, 2021/22

Outcome	Second opinions provided	Percentage
Plan not changed	1,157	82%
Plan changed	209	15%
Missing data	33	2%
No form issued	12	1%
Number of second opinions	1,411	100%

Source: CQC, SOAD data, 2021/22

Out of the 12,005 SOAD visits, ethnicity was recorded for 11,515 patients. Of these, 77% (8,829) of people were White, and 23% (2,686) of people were from ethnic minority groups. Treatment plans were approved without change in 75% (6,624 of 8,829) of cases for White people, and in 72% (1,922 of 2,686) of cases for people from ethnic minority groups.

Through the request forms for second opinions, which are completed by the treating doctor or MHA administrators, we were told that patients refused to consent to taking medicine on 1,104 occasions during 2021/22. Although some data is missing (for 58 cases, or roughly 6% of this total), it is clear that a very small number of these patients were subsequently determined to have capacity to give or refuse consent at the point of certification of treatment by the SOAD (figure 7).

Figure 7: Capacity and consent status at request and certification, 2021/22

1,014 patients were reported to be 'refusing' consent at point of second opinion request, of which:

- Patients determined to be **incapable** by SOAD at certification: 922 (91%)
- Patients determined to be **refusing** by SOAD at certification: 22 (2%)
- Patients determined to be **consenting** by SOAD at certification: 12 (1%)
- Blank (for example, no certificate issued or missing data): 58 (6%)

Source: CQC, SOAD data, 2021/22

Overall, out of 10,765 second opinion requests regarding medicines, SOADs found that only 65 patients were refusing to consent to taking medicines. This comprises the 22 included in figure 5 above, and a further 43 where the responsible clinician had identified the patient to be incapable of consent at the point of the request for a SOAD review.

A very small number of SOAD reviews conclude that the patient is in fact consenting to the proposed treatment, or an agreed variant of such treatment. In 2021/22, SOADs issued 54 certificates of consent to treatment. Twelve of these certified consent to changing the proposed treatment plan, indicating a degree of negotiation as to what would be acceptable to the patient. In the other 31 cases, the reason could be that a patient regained capacity to consent to treatment while the visit was arranged, or that the process of an independent review may have provided reassurance needed for a previously refusing patient to consent. In the remaining 11 cases, either no form was issued by the SOAD (10 cases) or data is missing (1 case).

Notifications of 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 2021/22, CQC were notified of 695 incidents of absence without leave.

The majority of these absences occur because the patient does not return on time from authorised leave (57%), which may reflect positive risk taking by providers. In a quarter of cases, absences relate to patients absconding while on escorted leave (25%). In a further 16% of cases, the patients absconded from hospital. In over half (58%) of cases, patients going absent were reported to have a history of doing so before.

We know that in around a third of cases (31%), the patient returned to hospital voluntarily. A similar proportion (32%) were returned to hospital by the police. For just under a quarter of patients (24%), the hospital was involved in the return.

Figure 8: Method of return from unauthorised absence without leave, England, 2021/22

Method of return	Number of patients	Percentage
Returned by police	220	32%
Returned voluntarily	218	31%
Returned by hospital or other	165	24%
Returned by family member(s)	30	4%
Other	27	4%

Method of return	Number of patients	Percentage
Not specified	35	5%
Total	695	100%

Source: CQC notifications

Notifications of deaths of detained patients

Providers have a legal duty to notify CQC of deaths of people detained, or liable to be detained, under the MHA. The data presented in this section is based on information included in notifications that providers have sent to us and or obtained through the coroner's courts. Our analysis of this data is based on the date of death provided on the notification.

The data does not include all deaths notified to CQC by providers under regulation 17 as we exclude deaths of people who were not detained, or liable to be detained at their time of death – that is, for example, people who were removed from section at their time of death.

Our notifications data may be updated over time leading to changes in overall numbers and/or the categorisation of deaths. These updates may relate to data cleaning, delays in notifying CQC of a death of a detained patient, or new or additional information received through the coroners' courts.

Unlike deaths of detained patients, providers are not required to notify CQC of deaths of people subject to CTO. As such, data is likely to fall below actual numbers of deaths of CTO patients.

Aggregated data on the causes of death of people detained under the MHA should be considered as indicative only (figures 12 and 13). Coding of this data is based on information collected through our death notification process and our approaches are not aligned to those employed in the production of official mortality statistics, such as those produced by ONS.

As at November 2022, we were notified that 325 people died while detained under the MHA or subject to a community treatment order between 1 April 2021 and 31 March 2022. This is a fall on the previous year (363 deaths in 2020/21).

Based on information received from the providers and/or through coroner's courts, we know that 3 in 5 (60%) people who died in detention or while subject to CTO died due to natural causes; 1 in 5 deaths notified to CQC were self-inflicted or accidental.

As at November 2022, the cause of death of 55 detained patients and 8 people subject to CTO were still to be determined. The cause of deaths in detention are usually determined through the coroners' courts, which can lead to a delay for accurate statistical reporting.

Figure 9: Deaths of patients in detention or subject to CTO, 2021/22, England

Classification	Natural	Unnatural	Undetermined	Total
Detained	165	50	55	270
Community Treatment Order (CTO)	31	16	8	55
Total	196	66	63	325

Source: CQC death notifications

Figure 10: Deaths of patients in detention, 2017/18 to 2021/22, England

Type	2017/18	2018/19	2019/20	2020/21	2021/22
Natural causes	189	136	143	268	165
Unnatural causes	48	34	32	33	50
Undetermined	10	25	65	62	55
Total	247	195	240	363	270

Source: CQC death notifications

Figure 11: Deaths of patients subject to CTO, 2017/18 to 2021/22, England

Type	2017/18	2018/19	2019/20	2020/21	2021/22
Natural causes	23	9	21	27	31
Unnatural causes	7	5	10	23	16
Undetermined	4	2	5	15	8
Total	34	16	36	65	55

Source: CQC death notifications

Figure 12: Cause of natural deaths as notified to CQC, April 2021 to March 2022, England

Cause of Death	Detained	CTO	Total
Aspiration pneumonia	11	0	11
Cancer	11	3	14
Chronic Obstructive Pulmonary Disease	7	1	8
COVID-19	8	2	10
Heart disease	29	6	35
Myocardial infarction	8	0	8
Pneumonia	29	4	33
Pulmonary embolism	17	3	20
Respiratory problems	6	1	7
Unknown	4	1	5
Other	35	10	45
Total	165	31	196

Source: CQC death notifications

Figure 13: Cause of unnatural deaths as notified to CQC, April 2021 to March 2022, England

Cause of death	Detained	CTO	Total
Accidental	6	0	6
Another person	0	0	0
Drowning	3	1	4
Hanging	7	5	12
Jumped from building	1	2	3
Jumped in front of vehicle / train	3	1	4
Method unclear / other	3	0	3
Self-poisoning by drug overdose	13	5	18
Self-strangulation / suffocation	12	0	12
Unsure suicide / accident	2	2	4
Total	50	16	66

Source: CQC death notifications

Figure 14: Age at death of patients in detention and subject to CTO, by category of death, April 2021 to March 2022, England

Age	Detained: natural cause of death	Detained: unnatural cause of death	Detained: undetermined cause of death	CTO: natural cause of death	CTO: unnatural cause of death	CTO: undetermined cause of death
17 and under	0	4	2	0	0	0
18 to 20	0	6	4	0	0	0
21 to 30	2	10	6	0	3	1
31 to 40	9	13	8	3	4	1
41 to 50	14	6	7	5	4	1
51 to 60	33	8	11	8	4	3

Age	Detained: natural cause of death	Detained: unnatural cause of death	Detained: undetermined cause of death	CTO: natural cause of death	CTO: unnatural cause of death	CTO: undetermined cause of death
61 to 70	31	2	8	6	1	0
71 to 80	47	1	6	8	0	2
81 to 90	24	0	2	1	0	0
91 and over	5	0	1	0	0	0
Total	165	50	55	31	16	8

Source: CQC death notifications

Figure 15: Recorded ethnicity at death of patients in detention, England, April 2021 to March 2022

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all detained deaths
White: British	117	32	33	182	67%
White: Irish	2	0	2	4	1%
White: Other	4	2	0	6	2%
Mixed: White/Black Caribbean	2	1	2	5	2%
Mixed: White/Black African	1	0	0	1	0%
Mixed: White/ Asian	0	1	0	1	0%
Mixed: Other mixed Background	0	1	1	2	1%
Asian or Asian British: Indian	4	1	1	6	2%
Asian or Asian British: Pakistani	1	0	0	1	0%

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all detained deaths
Asian or Asian British: Bangladeshi	0	0	1	1	0%
Asian or Asian British: Chinese	2	0	2	4	1%
Asian or Asian British: Any other Asian Background	2	0	0	2	1%
Black or Black British: African	5	3	4	12	4%
Black or Black British: Caribbean	9	1	1	11	4%
Black or Black British: Any other Black background	0	0	0	0	0%
Other Ethnic Groups	0	0	0	0	0%
Not stated	0	0	0	0	0%

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all detained deaths
Not known	16	8	8	32	12%
Total	165	50	55	270	100%

Source: CQC death notifications

Figure 16: Recorded ethnicity at death of patients subject to CTO, England, April 2021 to March 2022

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all CTO deaths
White: British	23	10	5	38	69%
White: Irish	0	0	0	0	0%
White: Other	0	1	0	1	2%
Mixed: White/ Black Caribbean	1	2	0	3	5%
Mixed: White/ Black African	0	0	0	0	0%

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all CTO deaths
Mixed: White/ Asian	0	0	0	0	0%
Mixed: Other mixed background	0	0	0	0	0%
Asian or Asian British: Indian	0	0	0	0	0%
Asian or Asian British: Pakistani	0	0	0	0	0%
Asian or Asian British: Bangladeshi	0	0	0	0	0%
Asian or Asian British: Chinese	0	0	0	0	0%
Asian or Asian British: Any other Asian background	0	1	0	1	2%

Ethnicity	Natural Causes	Unnatural Causes	Undetermined	Total	% all CTO deaths
Black or Black British: African	2	1	0	3	5%
Black or Black British: Caribbean	1	0	0	1	2%
Black or Black British: Any other Black background	0	0	1	1	2%
Other ethnic group	0	0	0	0	0%
Not stated	0	0	0	0	0%
Not known	4	1	2	7	13%
Total	31	16	8	55	100%

Source: CQC death notifications