Monitoring the Mental Health Act in 2022/23

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This report sets out CQC's activity and findings during 2022/23 from our engagement with people who are subject to the Mental Health Act 1983 (MHA) as well as a review of services registered to assess, treat and care for people detained using the MHA.

The 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 who are currently detained in hospital under the MHA, and we require providers to take action when we become aware of concerns 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 complaints relating to use of the MHA
- make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also highlight practices that could lead to a breach of human rights standards during our MHA visits, and we make recommendations for action to improve. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM regularly visits places of detention to prevent torture, inhuman or degrading treatment. See Appendix B for more information on our role.

Evidence used in this report

This report is based on the findings from 860 monitoring visits carried out during 2022/23. This involved speaking with 4,515 patients (3,410 in private interviews and 1,105 in more informal situations) and 1,200 carers. We also spoke with advocates and ward staff. We have quoted from feedback letters issued following these monitoring reviews and have not identified the services concerned, apart from some exceptions when we are describing good practice.

This year, alongside speaking with people during our monitoring visits, we also carried out a series of interviews with people who have lived experience of being detained under the MHA or of caring for someone who has been detained. Their experiences illustrate the effect of detention on patients and their loved ones, and other issues highlighted in this report. We have used pseudonyms to maintain their anonymity.

Our other work that has informed this report includes:

- engaging at a policy level with a range of stakeholders in the use of the MHA
- handling information from 2,759 cases received through CQC's complaint system in 2022/23
- participating in 87 Independent Care Education and Treatment Reviews (IC(E)TRs, a process that the Department of Health and Social Care has asked us to take a lead on for the next 2 years.

We thank 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 draws on quantitative analysis of statutory notifications submitted by registered providers, and complaints and/or concerns submitted to us about the way providers use their powers or carry out their duties under the Act. We also use information from activity carried out through our second opinion appointed doctor (SOAD) service. This 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 carried out in preparing the data for publication, this data can change over time as it is taken from a live system.

The report also draws on data from NHS England's Mental Health Services Data Set (MHSDS), with both the annual figures from 2022/23 and monthly performance statistics files used. Figures used in the report relate to the specific data files referenced and were correct at the time of writing.

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 points

Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.

In June 2023, NHS England set out its plans to grow the number and proportion of NHS staff working in mental health, primary care and community care by 73% by 2036/37. While this is encouraging, we are concerned that this is not enough to address the current shortfall and the problems this creates both for patients and staff.

Through our monitoring activity, we have seen how the shortage of doctors and nursing staff continues to have an impact on the quality and safety of care for people detained under the MHA. Increased use of agency staff to fill vacancies makes it difficult for staff to build meaningful therapeutic relationships and provide personalised care to patients who they are not familiar with. Staffing issues are also continuing to take a toll on the mental health and wellbeing of permanent staff.

Furthermore, staffing challenges are not only affecting frontline workers. A lack of agreed long-term funding for the second opinion appointed doctor (SOAD) service is creating problems with resourcing of the service. These issues mean the service is not keeping pace with demand, creating a safeguarding issue for people whose rights are restricted under the MHA.

Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of Black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.

While we have seen examples of NHS trusts making progress in tackling inequality, data from NHS England continues to show that detention rates for Black or Black British people are over 3 and a half times higher than for people in White ethnic groups. We welcome the rollout of the Patient and Carer Race Equalities Framework (PCREF) – the first anti-racism framework for mental health trusts and providers – and we plan to incorporate assessment of the PCREF into our MHA monitoring activity as we develop our approach.

We remain concerned about ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability. This can lead to them being inappropriately detained in hospital, which can have a devastating impact. Too often, people find themselves in the wrong setting for their needs, ending up in seclusion and segregation for long periods.

Although we have seen positive examples of staff celebrating and understanding diverse cultural perspectives, we are concerned that people may be at risk of direct or indirect discrimination in services where staff do not recognise and respect people's protected characteristics as defined by the Equality Act 2010.

Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds means they continue to be cared for in inappropriate environments.

In 2021/22, the average waiting time between referral and the start of treatment for children and young people was 40 days. NHS data shows that in November 2023, there was a record 496,897 open referrals to children and young people's mental health services. Delays in accessing care and treatment increase the risk that the symptoms in children and young people will worsen; YoungMinds found that more than half of young people reported that their mental health got worse while waiting for support.

When children and young people with mental health needs are admitted to hospital, a lack of specialist beds means that we continue to see them being treated on adult wards or general children's wards – often for extended periods and in locations far away from home. We are concerned that care on these wards is compromised by the fact that they are not designed for children and young people who have mental health needs, and that this can pose serious risks for them.

This lack of designated inpatient beds for children and young people has also led to problems with inappropriate ward layouts, as services attempt to accommodate people with differing mental health needs. We are concerned that this, combined with the workforce issues highlighted above, are leading to the use of blanket restrictions.

We expect care to be person centred and are committed to helping services promote positive cultures. While we have seen improvements in some areas, there is still significant work to be done to reduce restrictive practices.

We recognise that the use of restrictive practices may be appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights. But our expectations are clear: everyone working in health and care has a role to play in reducing the use of restrictive practices.

Over the last year, we have seen some positive examples of people being involved in their care and supported as an individual. This has helped to keep them safe and reduce unnecessary restraint.

However, there is a lot more work to do. For example, we remain concerned about the disproportionate use of force against some groups of people, including people from ethnic minority groups, autistic people and people with a learning disability.

It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

Many of the concerns we raise in this report are inherent risk factors and potential warning signs of when a closed culture could be developing.

We have seen examples of good practice, where patients have been involved in decisions around their care and treatment, demonstrating the benefits of an open and inclusive culture. Wider awareness of closed cultures has led to concerns being raised with us directly, allowing us to act quickly and ensure issues are appropriately escalated.

However, this is not common practice. We, along with providers and staff, need to continue to be vigilant to risks and warning signs so that people are not put at risk of deliberate or unintentional harm.

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