Monitoring the Mental Health Act in 2023/24

This report sets out CQC's activity and findings during 2023/24 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 need to 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 people's human rights 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 823 monitoring visits (which covered 870 wards) carried out during 2023/24. This involved speaking with 4,634 patients (3,343 in private interviews and 1,291 in more informal situations) and 1,435 carers. We also spoke with advocates and ward staff. Our MHA reviewers issued 823 monitoring reports during this period. A team of analysts carried out a focused qualitative review on a sample of all monitoring reports (20% of reports from each primary service type). Qualitative findings from this review were appraised and developed further by a series of focus groups with MHA reviewers.

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.

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.

In this report, we also use evidence from a 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.

The report also draws on data from NHS England's Mental Health Services Data Set (MHSDS), using both the annual figures from April 2023 to March 2024 and monthly performance statistics files. Figures used in the report relate to the specific data files referenced and were correct at the time of writing.

In addition to the above, we worked with the Strategy Unit (hosted by NHS Midlands and Lancashire), a specialist NHS analytical team, to understand the scale of people attending emergency departments (A&E) because of a mental health crisis and whether this highlighted any inequality.

To do this, the Strategy Unit analysed patient-level data in the Emergency Care Dataset (ECDS), NHS 111 dataset and the MHSDS. They looked at attendance and call rates, and how these varied by characteristics such as age, gender, ethnicity and deprivation. They also examined the characteristics of people's contact with the service, such as the time and mode of arrival, their presenting mental health condition and whether they were already known to mental health services.

Following this work, the Strategy Unit focused on children and young people in 2 ways. The first examined children and young people presenting at urgent and emergency services with mental health needs using the same approach as above. The second piece of work focused on how detentions under the Mental Health Act (MHA) for children and young people (under 25 years old) vary over time and by characteristics such as age, gender, ethnicity and deprivation. They used MHSDS to examine conversions between different sections of the act, length of detention, number of re-detentions and distance from home.

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.

All the data used in the report is quality assured and validated. Some of the data may change over time as it is updated with new information in the live system.

Key points

CQC and the Mental Health Bill

We welcome the Mental Health Bill, which was introduced in the House of Lords in November 2024 and will bring about important reforms to increase the safeguards for people who are detained.

The new statutory principles embedded within the Bill, and accompanying changes to the Code of Practice, will provide for a sharper focus on the rights and experiences of mental health patients, people in custody who have a mental disorder, and people with a learning disability and autistic people.

However, as highlighted in our 2022/23 report, legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.

Systems

We remain concerned that the high demand for mental health services, without the capacity to meet it, means people cannot always get the right care at the right time. Not being able to access care in a timely way can lead to people's mental health deteriorating while they wait for support.

Through our monitoring activity, we have seen how system pressures mean people are detained far from home or in environments that do not meet their needs. Many services told us that patients seem to be more unwell on admission than in the past.

Services need to balance the increase in demand for inpatient beds with ensuring existing patients are not discharged too soon.

Workforce

In 2023/24 there were continuing problems with workforce retention and staffing shortages, as well as concerns around training and support for staff. Although the mental health workforce has grown by nearly 35% since 2019, shortages in both medical and support roles continue to have a negative impact on patient care.

Shortages of doctors also continue to affect the delivery of our second opinion appointed doctor (SOAD) service. We remain concerned about the long-term sustainability of the service, with proposals in the Mental Health Bill due to increase the numbers of second opinions required while reducing the timeframes for delivery of some second opinions.

Inequalities

We are concerned that some of the key issues we raise in this report, including access to mental health support, are particularly challenging for certain groups of people, such as people from ethnic minority groups and those living in areas of deprivation.

We identified several issues around people not understanding their rights, despite services having a legal duty to provide this information.

There was variation in how well services met people's needs. While many provided access to spiritual leaders, we remain concerned about gaps in the knowledge of staff around caring for autistic people.

Children and young people

Children and young people continue to face challenges in accessing mental health care. Increasing demand is leading to long waits for beds, and increases the risk of being placed in inappropriate environments and/or being sent to a hospital miles away from home.

Once in hospital, we are concerned that access to specialist staff is being affected by low staffing levels, leading to patients' needs not being met. In addition, the quality of physical environments for children and young people varies; access to food and drink, and food preparation facilities were key issues for many children and young people.

Challenges in transitions of care between children and young people's mental health services and adult mental health services remain, with many young people still falling through the gaps and not getting the care and support they need.

Environment

Through our MHA monitoring visits, we found that the quality of inpatient environments continues to vary. We are concerned about the impact of poor-quality environments on patients and have seen examples of how ageing and poorly-designed facilities affect people's care.

Being able to go outside brings therapeutic benefits for patients, but access to outdoor facilities varied across services. Gardens were usually well maintained, and in some services, patients were encouraged to grow plants and vegetables. However, we also found examples of unwelcoming gardens and at some services, patients' access to outdoor spaces was limited. This issue was also raised by members of our Service User Reference Panel.