



Reforming the Mental Health Act

The implications of the NIHR Mental Health Policy Research Unit's work for the Independent Review

Introduction

In December 2018, Professor Sir Simon Wessely published the final report of his year-long independent review of the Mental Health Act. The review was commissioned by the Prime Minister following a Manifesto pledge to change the Mental Health Act, to stop the year on year increase in the use of compulsory powers and to address the stark race inequalities in its use.

The report, *Modernising the Mental Health Act*, contained 154 recommendations aimed at making the Act work better for people. Many of the recommendations were for legislative changes to the Act itself. Others were for wider changes to improve the context in which the Act is used: for example to invest in updating inpatient facilities or to develop new quality standards for working with people from Black, Asian and Minority Ethnic communities.

The NIHR Mental Health Policy Research Unit (MHPRU) at University College London and King's College London was established in 2017. Its aim is to help the Department of Health and Social Care and others involved in making nationwide plans for mental health services to make decisions based on good evidence. It makes expert views and evidence available to policymakers in a timely way and carries out research that is directly useful for policy. The MHPRU is managed by academics at UCL and KCL in partnership with collaborators from City University and University of Birmingham. Centre for Mental Health and The Mental Elf work alongside the Unit to ensure its work is accessible and relevant to policymakers, practitioners and the public.

The research studies

The Policy Research Unit carried out nine discrete pieces of work in support of the independent review to provide evidence to enable Sir Simon and his team to make the most informed decisions about what it should recommend. A further study was conducted by

Dr Shubulade Smith and colleagues alongside. This briefing paper summarises the key findings and conclusions of those ten studies and explores their implications for both national and local policymakers and commissioners.

The Research Unit studies

1. Understanding increasing rates of compulsory detention in psychiatric hospital in England (Sheridan Rains, Weich *et al.*)
2. Patterns of use of the Mental Health Act 1983, from 2007-08 to 2016-17 in two major secondary mental healthcare providers in London (Oram *et al.*)
3. Variations in patterns of compulsory hospitalisation and in legal frameworks: an international comparative study (Sheridan Rains, Zenina *et al.*)
4. Clinical and social correlates of involuntary psychiatric care (Walker *et al.*)
5. Ethnic variations in compulsory detention (Barnett, Mackay *et al.*)
6. Interventions to reduce compulsory psychiatric admissions (Bone *et al.*)
7. Crisis Planning Interventions for People with Psychotic Illness or Bipolar Disorder (Molyneaux *et al.*)
8. Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness (Barnett, Matthews *et al.*)
9. A qualitative meta-synthesis of patients' experiences of assessment and detention under mental health legislation (Akther *et al.*)
10. A qualitative meta-synthesis of carers' experiences of compulsory admission under mental health legislation (Stuart *et al.*)

The ten studies cover a wide range of issues but divide into five groups. The first group explores the rise in the use of the Mental Health Act since 2007 in two local areas (Oram *et al.*) and since 1983 nationally (Sheridan Rains, Weich *et al.*). The second group looks at patterns and variations in the use of mental health legislation: internationally (Sheridan Rains, Zenina *et al.*) between ethnic and

migrant groups (Barnett, Mackay *et al.*) and across a range of social and clinical factors (Walker *et al.*). The third group explores means of preventing or reducing the use of the Act, comparing a wide range of approaches (Bone *et al.*) and looking specifically at crisis planning interventions (Molyneaux *et al.*). One study investigates evidence about the impact of compulsory community treatment (Barnett,

Matthews, *et al.*) and the final two focus on the experiences of patients (Akther *et al.*) and carers (Stuart *et al.*).

Between them, these studies provide a wealth of information and insight into the use of mental health legislation both in England and Wales and internationally. As a result, they have provided important pointers for the Mental Health Act Review. At the time of writing, the

Government's full response to the Review has not yet been published.

But the findings and conclusions of the research can also be applied both nationally and locally, by policymakers, commissioners, service providers and funders now to inform policy and practice to help to ensure that people have better experiences of support for their mental health. It also highlights priority areas for future research.

Rising use of the Mental Health Act

One of the biggest questions facing the Review was to investigate why use of the Mental Health Act has increased. The Act is now used twice as often in England as it was in 1983, and while rates of detention in England are close to average by international standards, they are rising here faster than in most other countries. Limits to national data mean it is not possible to say how far this is because more people are being sectioned or if some people are being detained more often (Sheridan-Rains, Weich *et al.*).

In the two London NHS trusts whose data was studied by Oram *et al.*, however, the rise in detentions coincided with a rise in the number of people using their services, with no increase in the proportion of service users being sectioned or evidence of the same people being detained more often. Whether this is reflected nationally is unclear, but there has been a growth in the number of people using secondary mental health services in England in recent decades.

Sheridan-Rains, Weich *et al.* looked at a range of possible explanations for rising use of the Act to see what evidence existed to support them. They found three explanations that were supported by evidence.

The first was “an unintended consequence of national and international legislation and English case law” in relation to the assessment of capacity: that people who are in hospital who lack decision-making capacity but are not objecting to admission may increasingly be subject to the Mental Health Act rather than being admitted voluntarily.

The second was an observed steady increase in the prevalence of mental health problems in the population as a whole. And the third was as a consequence of community mental health services seeing more people without a corresponding increase in services' resources, reducing the intensity of support they can give to people at risk of relapse and compulsory admission.

This study also noted that some commonly proposed explanations for the rise in detentions, for example the impact of austerity, lack clear empirical support.

The rise in detentions has coincided with reductions in NHS psychiatric beds. However, the authors conclude that the evidence does not clearly suggest that bed cuts are a cause of higher detention rates.

Variations in the use of compulsory powers

The largest group of studies sought to understand why some groups of people are more likely to be sectioned than others. Sheridan-Rains, Zenina *et al.* looked at international studies to see what factors were linked with greater use of compulsory powers. They found that rates of compulsion vary much more between countries than rates of mental illness. But there was limited evidence that this is due to differences in legislation. The only demographic, economic or healthcare factors that were associated with greater use of compulsion were a larger (not smaller) number of psychiatric hospital beds and a lower rate of absolute poverty.

A review of the factors that make an individual more likely to be detained (Walker, Mackay *et al.*) found that being male, single or previously married, a non-homeowner, and being unemployed or receiving benefits all increased risk. Having a diagnosis of psychosis or bipolar disorder, having previously been detained, or having been brought to hospital by the police also made compulsion more likely. The study notes that being brought to mental health services by the police may in itself be traumatic and lead to distress and behavioural disturbance that increases the person's chances of being admitted compulsorily.

Being perceived as a risk to others was the strongest single risk factor for compulsion. By comparison, risk to self was not associated with compulsion among those admitted to hospital. This suggests that perceptions of risk to others are at the heart of the use of compulsion.

The Review was asked by the Prime Minister to look specifically at why some Black, Asian and Minority Ethnic groups are so starkly over-represented among those detained under the Mental Health Act. Barnett, Mackay, *et al.* looked at international studies and found that “all minority populations internationally, including migrants, were subject to increased risks of detention”. Yet half of the studies they reviewed offered no explanation and others simply repeated “untested explanations” with no supporting evidence such as higher rates of drug use or a greater stigma of mental illness. Such assumptions, they point out, “may serve to entrench narratives of racial determinism” without enabling us to understand what lies behind the data. Instead, the authors call for further investigation that includes exploration of why minority groups have higher rates of psychosis, have different experiences leading up to being detained and are perceived to present a higher risk of violence.

Reducing reliance on compulsion

Two studies sought evidence about what might help to reduce reliance on compulsory admissions to hospital. The first (Bone *et al.*) looked at a range of possible interventions. Of the fifteen they reviewed only two showed clear evidence of reducing the risk. These were advance crisis planning and self-management interventions. Early intervention services for people with psychosis also showed some promise and they have other important benefits too.

Other interventions were not found to reduce detentions (for example crisis resolution teams showed no impact on the risk of detention, but do reduce the overall risk of being admitted to hospital) or do not as yet have any evidence in either direction (for example crisis houses).

Bone *et al.* note that few studies of these interventions even tried to collect data on compulsory admissions, despite the significance of this experience in people's lives.

Molyneaux *et al.* looked in more detail at the evidence for crisis planning interventions. The average effect from five trials of crisis planning interventions was an impressive 25% reduction in compulsory admissions for people with bipolar disorder or psychosis (although average effects for the studies where these were measured did not show a reduction in rates of voluntary admissions or admissions overall). They also found a high likelihood that these interventions are cost-effective.

Improving patient and carer experience

Two studies sought evidence about the experiences of both patients and carers of assessment and detention under mental health legislation. They aimed to understand how people experienced the process, what made it worse and what could make it better. Such evidence is crucial given the clear message throughout the review that it is very often the ways people are treated when they are at their most vulnerable that matter most.

Akther *et al.* found that fear and distress were frequently experienced while people were detained, particularly when force and restraint were used, but that these could be reduced or mitigated where staff formed “caring and collaborative relationships” with them and when they provided clear, relevant information. The authors found that patients wanted “basic information about why they were being detained for treatment, how long they would be detained and how they could access legal information about their rights”. And where this was provided “this appeared to reduce fear and the impact of coercion”. Patients also wanted to be more involved in making decisions than they currently were. There was some indication that, where patients had previously agreed to the use of compulsion when they become unwell, they were less likely subsequently to view their involuntary admissions as coercive.

This study found that safety and the physical fabric of inpatient wards were also important factors in people’s experiences. Female patients in particular spoke of feeling unsafe in wards, the use of excessive force, restraint and seclusion made some feel unsafe, and many patients described wards as “noisy, overcrowded and unclean”, or “akin to prison”.

They concluded with a call for a greater emphasis on coproduction on inpatient wards to “provide more voice to patients and staff, and physical and social environments that are more conducive to recovery”. This theme was prominent in the Review report, including a call for large-scale investment in updating the mental health estate across the NHS estate.

Stuart *et al.* carried out a similar exercise in relation to carers (families and friends). The review found that carers wanted more information, acknowledgement and support. They struggled to know where to turn for help, especially in cases of a patient’s first episode, and faced distressing situations, such as self-harm, for which they felt ill-equipped. Carers wanted earlier intervention rather than waiting for a crisis. By the time detention was necessary, some carers already felt let down by services. Many carers described detention as ‘traumatic’, a process of ‘extreme stress’ and internal conflict. While wanting the best for the patient, carers found themselves ultimately having to consent to coercion and, consequently, risk losing the patient’s trust and the breakdown of their relationship. Many carers reported being excluded by staff and were frustrated and baffled why their knowledge of the patient was not sought in order to optimise care. The emotional impact of detention, particularly successive detentions, can be long lasting and damaging to a carer’s own health.

This study concluded that there remains a need for services to “work in partnership with carers”, and not just while a person is in hospital, and to support carers with their own wellbeing.

Community treatment orders

Community treatment orders were introduced in the 2007 Mental Health Act as a form of discharge from hospital in which the person continues to be subject to compulsory powers in the community. They were among the more controversial provisions of the 2007 Act and explored in detail during the Review.

Barnett, Matthews *et al.* looked at international evidence on whether CTOs or their equivalents elsewhere were able to reduce readmissions to hospital or increase people's engagement with community services. They, like other reviews, found no evidence that CTOs reduce readmissions or lengths of stay in hospital but did find that they "might have some benefit in enforcing use of outpatient treatment or increasing service provision, or both". They concluded that, given the paucity of evidence of the benefits of CTOs, "alternative methods of reducing repeat admission...should be investigated" such as investing in better admission alternatives or community services when people are discharged from hospital.

And they added that "in the absence of clear, consistent evidence on clinical benefits and the removal of patient liberty involved" and the potential extra cost involved, there is not enough evidence to justify the use of CTOs. But they also noted that it was possible that people "with more severe illness who are typically excluded from randomised controlled trials" may benefit more from CTOs.

In their reflection on this study, the lived experience working group expressed their disappointment that the studies reviewed were limited to measures of readmissions and not "what difference interventions make to the quality of people's lives and wellbeing". They noted the absence in this, and most other studies, of the impact on people with personality disorder diagnoses, people from BAME communities and people with learning disabilities. And they posed the question: "would coercion be needed if people could easily access appropriate community services?"

Conclusions and implications for policy and practice

The Review report drew on all of the research studies produced by the Unit in making its conclusions and recommendations. The Review also carried out extensive consultation and sought evidence widely.

The studies summarised here are thus a part of a bigger picture that contributed to the thinking of the Review and which now provide the context for the next stage of policymaking. Where the findings relate to legislation, it will be for the Government and for Parliament to determine how they reform the Act. But there are implications in these studies for a much wider range of bodies, including the NHS (nationally and locally), local authorities and more.

Tackling rising use of the Act

The Review set out to understand why the use of the Act has been rising. It is clear from the PRU's research that there is no single explanation for this phenomenon, and that often-cited, simplistic explanations, such as reductions in inpatient bed numbers, may not be to blame. The growing number of people using mental health services, and reductions in the intensity of community support, do however appear to be relevant. It is therefore welcome that NHS England's recent Long Term Plan set out to boost the capacity of 'core' community mental health services.

Variations and inequalities

The Review also sought to understand why some groups of people are more likely to be subject to the Act and to have poorer experiences. The available research provides few answers to these questions, making them a priority for future studies. It is evident, however, that decisions to detain an individual very often hover around their perceived dangerousness, particularly to other people. And inequalities in mental health clearly also link closely to those in society as a whole (in all societies). The studies found that rich countries tend to detain more people and the people they detain tend to be poor. Simply increasing the resources available to mental health services is unlikely to be enough to stem the rise in detentions or reduce inequalities in the use of coercion: targeted intervention is needed, including wider action to reduce overall inequality and the daily injustices too many people experience in their lives.

Preventing the use of the Act

The PRU's research has found limited evidence of what works to reduce the use of compulsion in mental health services. It presents a clear case for crisis planning and self-management interventions, which the Review strongly supported. While giving advance statements a greater legal status awaits legislation, the routine use of crisis planning can be incorporated into practice much sooner. For other interventions thought to reduce use of the Act, such as early intervention in psychosis and crisis resolution and home treatment, the evidence was inconclusive. Nonetheless both of these approaches bring other significant benefits.

Community treatment orders

Like most other studies of community treatment orders, the PRU's evidence review was largely negative about their projected benefits. There is

clear evidence that CTOs are not achieving their intended purpose of reducing readmissions for patients who have been detained. CTOs may result in patients receiving more community care, but this does not seem to result in fewer relapses, and a CTO in any case should not be required to ensure community support is available.

The Review's conclusion on CTOs was that they need to be curtailed by tightening up the legislation around them. In the meantime, given the coercive nature of CTOs and limited benefits, there is a case for service providers and decision-makers to act to minimise their use within the existing legislation and to seek more effective forms of support for people when they are discharged from hospital.

Improving people's experiences of the Act

The area where the research points most clearly in one direction is in what needs to be done to improve the experiences of both service users and carers. Being sectioned, or seeing someone you care for sectioned, can be traumatic and distressing, with long-lasting consequences. But where both patients and carers are given clear information about their rights and what to expect, where staff build good relationships with them, and where the use of force is minimised, these experiences can be significantly improved. There is clearly a role for an expanded advocacy function here, some of which requires legislation but some of which could be done by investing in provision within the current system. But the way professionals are trained, managed and supervised is also key.

Finally, the research once again pointed to the importance of the physical fabric of inpatient wards on the wellbeing of those within them. The need to invest in improving those facilities in the next Spending Review is clear and pressing.

Conclusions

The research carried out for the Review by the PRU highlights continuing inequalities in who is detained: inequalities in the use of compulsion that map closely onto inequalities and injustices in society as a whole. It reminds us of the longstanding negative experiences of patients and their families when they are detained in hospital. For too many people, services that seek to improve people's health are experienced as overly coercive, as not treating people with dignity and as

uncommunicative. But it also shows that there are signs of hope: that drawing on evidence of what works we can begin to reduce the use of compulsory powers and give people and their families a better experience of mental health care.

The Review made a case for change to the Mental Health Act and to the ways it is used. The PRU research programme provides a guide in understanding how this can be achieved.

Acknowledgement

This report is a secondary review of research previously published by the National Institute for Health Research (NIHR) Mental Health Policy Research Unit. The briefing represents the

Centre's interpretation of the key findings from the research of relevance to policymakers and commissioners.

References

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All other cited papers are pre-publication at the time of writing (March 2019). Summaries are collected in the Report of the Independent Review of the Mental Health Act:

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