**Understanding the rising rate of detentions in England**

**Appendix 2: Evidence summaries regarding the proposed hypotheses for the rising rate of detentions in England 1983-2016**

**Contents**

|  |  |
| --- | --- |
| Hypothesis | Page |
| 1. Social and economic hardship | 2 |
| 2. Increased drug and alcohol use | 4 |
| 3. Demographic change (increased numbers of those at risk of detention) | 6 |
| 4. Increasing rates of mental illness | 8 |
| 5. Reduced informal social support | 9 |
| 6. Reduced availability and quality of community mental health services | 10 |
| 7. Reduced availability of alternatives to admission | 11 |
| 8. Reduced quality and/or responsiveness of crisis services | 13 |
| 9. Reduced inpatient bed capacity | 15 |
| 10. Less continuity of care at MHA assessments | 18 |
| 11. Increased focus on safety and risk among mental health professionals | 20 |
| 12. Changes in prescribing practice | 23 |
| 13. Changes in legal and clinical practice in respect of capacity | 26 |
| 14. Introduction of CTOs (and earlier discharge) | 29 |
| 15. Police more likely to bring people to a Place of Safety on s135 or S136 | 30 |
| 16. Better data reporting in recent years | 31 |
| 17. Increase in transfers of care leads to more double counting detentions | 32 |

**1. Economic factors/social deprivation**

While there is international evidence that, at societal level, absolute poverty is negatively associated with involuntary hospitalization rates (Sheridan-Rains et al. 2019), a number of social/economic factors related to poverty have been identified as risk factors for detention at individual level. A systematic review conducted for the Independent Review of Mental Health Act and summarized in the Review report (MHA Review 2018) identified the following as factors associated with increased risk of detention: being in receipt of welfare benefits; living in rented accommodation rather than owning a home; living in an area with high levels of deprivation.

Across the general population in England, many of the relevant socio-economic indicators for which data are available do not clearly show increased exposure to economic hardship over the period of this study. Both the rate of unemployment (ONS 2018a) and the number of landlord evictions per 100,000 population processed by the courts ( Ministry of Justice, 2018) have fallen over the last 20 years, although there was a brief rise and fall in each following the 2008 financial crisis. Relative poverty, defined as the proportion of the population with an income below 50% of the median, and income inequality, measured with the Gini coefficient, have both been fairly stable since the early 1990s (OECD 2018; ONS 2018b). Within England the rate of absolute poverty, defined as the proportion of the population with an income below $21.70 per day, has remained fairly stable over the last 20 years (Jolliffe & Prydz, 2016).

However, these broad social–economic markers may not capture increased exposure to hardship or the effects of austerity for specific vulnerable groups within the population, including people with existing mental health problems. In the consultations conducted for this paper for instance, it was proposed that increased financial hardship and stress from threats or cuts to welfare benefits may negatively affect people’s mental health, with a possible impact on rates of detention. Rates of benefits sanctions (withdrawal of benefits payments in response to adjudged breaches of requirements by claimants) rose rapidly in the period for which data are available. Between 2008 and 2013 the rate of benefit sanctions rose dramatically for people receiving Job Seeker’s Allowance in particular, who make up the substantial majority of employment benefit claimants. Rates of people claiming disability benefits for psychiatric conditions per 100,000 population doubled between 2001 and 2016: an increase in stringent assessments of work capability and threatened benefit cuts has been associated with increased risk of suicide (Barr et al. 2015), although any link to risk of detention has not been established.

Overall however, we lack sufficiently fine-grained data for mental health service users or other vulnerable population groups about change over time in exposure to socio-economic risk factors for detention: this limits how far relationships between economic factors and social deprivation and the rising rate of detentions can be explored.

References

Barr,B. Taylor-Robinson,D. Stucker,D. et al. (2015) “‘First, do no harm’: are disability assessments associated with adverse trends in mental health? A longitudinal ecological study” *J. of Epidemiology and Community Health* 70:4 pp 339-345

GOV.UK. (2018). Modernising the Mental Health Act – final report from the independent review. [online] Available at: <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> [Accessed 25 Feb. 2019].

Jolliffe, D. & Prydz, E.B. (2016). *Estimating International Poverty Lines from Comparable National Thresholds.* The World Bank Development and Research Group. Policy research working paper 7606. http://documents.worldbank.org

Ministry of Justice. (2018) *Mortgage and Landlord possession statistics: January to March 2018.* [Data file]. Retrieved from: https://www.gov.uk

Office for National Statistics (ONS) (2018a). *Unemployment rate (aged 16 and over, seasonally adjusted).* [Time Series]. Release Date: August 14, 2018. Retrieved from: <https://www.ons.gov.uk>

Office for National Statistics (ONS) (2018). *Effects of taxes and benefits on UK household income: financial year ending 2017.* [Data Set]. Release Date: June 20, 2018. Retrieved from: <https://www.ons.gov.uk>

Organisation for Economic Co-operation and Development (OECD). (2018). Income distribution and poverty. *OECD Income Distribution Database*. Retrieved from: https://stats.oecd.org

Sheridan-Rains,L. Zenina,T. Dias, M.C. Jones,R. Jeffreys,S. Branthonne-Foster,S. et al. “Variations in patterns of involuntary hospitalization and in legal frameworks: an international comparative study” *The Lancet Psychiatry* 2019; Published online 3rd April <https://doi.org/10.1016/S2215-0366(19)30090-2>

**2. Increased drug and alcohol use:**

Use of alcohol and drugs have declined over the 15 years (Home Office, Drug Misuse Findings 2017 and Office of National Statistics, Adult Drinking Habits 2018), but trends in the prevalence of alcohol and substance use disorders over the same period are more complex. The rate of hospital episodes for substance misuse has risen markedly in the period 2008-16, but only back to the rate from 1998, when data are first available – following a drop in the decade from 1998-2008. Meanwhile, those for alcohol use disorders rose at first, but have plateaued over the last 10 years (NHS Digital 2018, Hospital Episode Statistics). The Adult Psychiatric Morbidity survey, meanwhile, indicates that the proportion of the population self-reporting either alcohol or substance use disorders peaked in 2000 and has since been falling (APMS). As such, nationwide data indicate that there has not been a rise in problematic substance or alcohol use driving increased rates of mental illness. But it may be that there has been a change in patterns of use of some substances or amongst some particularly vulnerable groups that may be important for understanding the rising rates of involuntary hospitalization. This includes the use of high potency skunk, which has risen in the general population (Freeman et al. 2018) and is now by far the most common type of cannabis used by people with psychosis (Curran et al. 2016, Di Forti 2015), and the use of novel psychoactive substances which may be harmful to mental health (Mdege et al. 2017). Freeman et al. (2018) found a positive time-dependent association between increasing cannabis potency and first-time admission to drug treatment for cannabis, suggesting that increasing potency may be driving an increase in problems associated with cannabis use. Unfortunately, little evidence currently exists on whether, despite declining use at a national level, greater toxicity of certain illicit substances is leading to greater prevalence of severe mental ill health in the UK, and how this relates to rates of detention. Overall, it is unclear what role certain substances may have in rising rates of involuntary hospitalization, but the problematic use of alcohol and most illicit substances is unlikely to be the main driver of the rise.

References

Curran, H., Freeman, T., Mokrysz, C., Lewis, D., Morgan, C. and Parsons, L. (2016). Keep off the grass? Cannabis, cognition and addiction. Nature Reviews Neuroscience, 17(5), pp.293-306.

Di Forti, M., Marconi, A., Carra, E., Fraietta, S., Trotta, A., Bonomo, M., Bianconi, F., Gardner-Sood, P., O'Connor, J., Russo, M., Stilo, S., Marques, T., Mondelli, V., Dazzan, P., Pariante, C., David, A., Gaughran, F., Atakan, Z., Iyegbe, C., Powell, J., Morgan, C., Lynskey, M. and Murray, R. (2015). Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study. The Lancet Psychiatry, 2(3), pp.233-238.

Freeman, T., Groshkova, T., Cunningham, A., Sedefov, R., Griffiths, P. and Lynskey, M. “Increasing potency and price of cannabis in Europe, 2006-16” *Addiction* 2018; published 29th December <https://doi.org/10.1111/add.14525>

Home Office, (2017). *Drug Misuse: Findings from the 2016/17 Crime Survey for England and Wales.*  Drug Misuse Appendix Tables. Retrieved from: <https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew>

Mdege ND, Meader N, Lloyd C, Parrott S, McCambridge J. The Novel Psychoactive Substances

in the UK Project: empirical and conceptual review work to produce research recommendations.

Public Health Res 2017;5(4).

NHS Digital. (2018). Hospital Episode Statistics (HES) - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics [Accessed 26 Feb. 2019].

Office for National Statistics, (2018). *Adult drinking habits in England 2017.* [Dataset]. Release date: 1 May, 2018. Retrieved from: <https://www.ons.gov.uk>

**3. Changes to population demography:**

Some demographic groups are at higher risk of compulsory admission than others. In a large English cross-sectional study, Weich et al. (2014, 2017) highlight being male, aged 18-35, local area deprivation, ethnic density, and ethnicity (especially Black African or Caribbean) as key factors associated with increased risk of detention. Living in an urban area was also identified as a very weak risk factor for detention. Internationally, meanwhile, there is evidence that, at individual level, living in an urban setting or being foreign-born are risk factors for detention (Norredam et al. 2010, Ng et al. 2012, de Wit et al 2010, van der Post et al. 2010), although Weich and colleagues 2014 found that, in England, population density (urbanicity) was not related to rates of detention. In national-level comparisons, the proportion of the population who are foreign born or live in urban environments have not been found to relate to detention rates (Sheridan-Rains et al. 2019).

Over the last 30 years, the proportion of the population of England who is male has stayed around 48-49%, while those aged 18-35 has fallen slightly from 28% to 24%. The proportion of the English population who are form Black and Minority Ethnic groups (BAME) however, has risen from 4.8% to 13.2%, and there has been an increase in particular in Asian and Black African groups (Office of National Statistics, Labour Force Survey, 2018). The proportion of the English population who are foreign-born has also risen, particularly in the last 10 years. (Eurostat 2018) However, given evidence about the extent of increased risk of detention for these population groups, their increased representation in the English population would account only for a small proportion of the observed rise in detentions. There has been only a marginal increase in the proportion of formal admissions that are BAME patients during this period (MH Bulletin 2017/2018).

Overall, although demographic factors are important individual-level risk factor in detention, there is little evidence that changing population demography makes a substantial contribution to the recent rise in involuntary hospitalization rates.

In response to suggestions generated by consultations for this paper, we also explored available data about whether increases in racial tensions or discrimination in society may contribute to rising rates of mental health crises and detentions. Available evidence is too limited to assess the validity of this hypothesis however. English national crime statistics (Gov.Uk Hate Crime, England and Wales, 2018) show a rise in racist incidents and hate crimes since 2010 – although whether this reflects an increase in incidents, or an increase in how often they are reported, is unclear. Conversely, the British Social Attitudes Survey (Phillips et al. 2018) reports a fall in the proportion of people who report holding racially prejudiced views during the period 1983-2013, for which data are available. Whether this corresponds a reduction in experienced racial prejudice is also unclear.

References

Phillips, D., Curtice, J., Phillips, M. and Perry, J. (eds.) (2018), British Social Attitudes: The 35th Report, London: The National Centre for Social Research [online] Available at: http://www.bsa.natcen.ac.uk/downloads/bsa-35-downloads.aspx [Accessed 26 Feb. 2019].

Eurostat. (2018). Migration and migrant population statistics - Statistics Explained. [online] Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Migration\_and\_migrant\_population\_statistics#Migrant\_population:\_almost\_22\_million\_non-EU\_citizens\_living\_in\_the\_EU\ [Accessed 26 Feb. 2019].

GOV.UK. (2019). Hate crime, England and Wales, 2016 to 2017. [online] Available at: https://www.gov.uk/government/statistics/hate-crime-england-and-wales-2016-to-2017 [Accessed 26 Feb. 2019].

Norredam M, Garcia-Lopez A, Keiding N, Krasnik A. Excess use of coercive measures in psychiatry among migrants compared with native Danes. Acta Psychiatr Scand. 2010 Feb;121(2):143-51.

Ng, X. and Kelly, B. Voluntary and involuntary care: Three-year study of demographic and diagnostic admission statistics at an inner-city adult psychiatry unit. International Journal of Law and Psychiatry. 2012. 35(4), pp.317-326.

Office of National Statistics. (2018). Labour Force Survey - Office for National Statistics. [online] Available at: https://www.ons.gov.uk/surveys/informationforhouseholdsandindividuals/householdandindividualsurveys/labourforcesurvey [Accessed 26 Feb. 2019].

Sheridan-Rains,L. Zenina,T. Dias, M.C. Jones,R. Jeffreys,S. Branthonne-Foster,S. et al. “Variations in patterns of involuntary hospitalization and in legal frameworks: an international comparative study” *The Lancet Psychiatry* 2019; Published online 3rd April <https://doi.org/10.1016/S2215-0366(19)30090-2>

van der Post L, Visch I, Mulder C, Schoevers R, Dekker J, Beekman A. Factors associated with higher risks of emergency compulsory admission for immigrants: A report from the ASAP study. International Journal of Social Psychiatry. 2011;58(4):374-380.

Weich S, McBride O, Twigg L, et al. Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. Southampton (UK): NIHR Journals Library; 2014 Dec. (Health Services and Delivery Research, No. 2.49.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK263740/ doi: 10.3310/hsdr02490

S. Weich, O. McBride, L. Twigg, C. Duncan, P. Keown, D. Crepaz-Keay, E. Cyhlarova, H. Parsons, J. Scott, K. Bhui, Variation in compulsory psychiatric inpatient admission in England: a cross-classified, multilevel analysis, Lancet Psychiatry 4 (8) (2017) 619–626.

de Wit, M., Tuinebreijer, W., van Brussel, G. and Selten, J. Ethnic differences in risk of acute compulsory admission in Amsterdam, 1996–2005. Social Psychiatry and Psychiatric Epidemiology. 2010. 47(1), pp.111-118.

**4. Rising Rates of mental illness**

The number of people in contact with the secondary mental health services has risen from 1.1 million in 2003 to 2.6 million in 2016, constituting an approximate rise from 83 to 114 per 1,000 population. This is likely to reflect an increase in the prevalence of severe common mental disorders (CMDs) in the general population, estimated by the Adult Psychiatric Morbidity Survey (APMS) to have risen from 7.9% in 2000 to 9.2 in 2014). It may also reflect an increase in the prevalence of psychotic disorders in the English population, although this is less clear-cut. APMS data suggest rates of psychotic illnesses have increased from 4% to 7% between 1993 and 2014. However, further corroboration of this possible rise in the prevalence of psychosis in England is needed. The entire increase in APMS psychosis prevalence was reported at the latest time point when data are available (2014). Hospital Episode Statistics (HES) show no increase in the number of completed consultant episodes for people with psychosis during this period. Kirkbride et al. (2012) reported that there is no epidemiological evidence that the incidence of schizophrenia and other psychoses rose in England between 1950 and 2009.

While the rates of severe common mental disorders in the English population appear to be rising it is not clear how far this relates to detention rates. (No relationship was found in international level comparisons, for example – see Appendix 1). The extent of any rise in prevalence of psychosis is unclear: it is these conditions which bring the highest risk of detention (Gov.uk, Modernising the Mental Health Act, 2018).

References

GOV.UK. (2018). Modernising the Mental Health Act – final report from the independent review. [online] Available at: https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review [Accessed 25 Feb. 2019].

NHS Digital. (2018). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014 [Accessed 26 Feb. 2019].

NHS Digital. (2018). Hospital Episode Statistics (HES) - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics [Accessed 26 Feb. 2019].

J.B. Kirkbride, A. Errazuriz, T.J. Croudace, C. Morgan, D. Jackson, J. Boydell, R.M. Murray, P.B. Jones, Incidence of schizophrenia and other psychoses in England, 1950–2009: a systematic review and meta-analyses, PLoS One, 7 (2012), p. e31660

**5. Reduced available informal social support**

A systematic review of social and clinical factors associated with increased risk of detention conducted for the Mental Health Act Review and summarized in the Review Report (Walker et al. in prep) identified a number of factors relating to social support as risk factors for detention: being single, or divorced, separated or widowed; living with friends or relatives rather than a partner; lacking social support or an informal care-giver.

However, there is little available data about change over time in available social support at population level of for specific social or clinical groups. The Congdon social fragmentation index measures standardized levels of number of household who have moved out of the area, non-married adults, one person households, and private renting (Congdon 1996). Congdon index data are collected nationally every ten years through the Census (Office for National Statistics, UK census). This indicates very little change nationally between 1991 and 2011 in the extent of available informal social support. However, as with economic indicators in hypothesis one, this very broad measure may not reflect specific changes in available social support over the period, and does not indicate whether there has been any change in the social support available to specific groups already at elevated risk of detention e.g. mental health service users.

References

Congdon P. Suicide and parasuicide in London: a small-area study. Urban Studies 1996; 33: 137–158.

Office of National Statistics. (2012). Census - Office for National Statistics. [online] Available at: https://www.ons.gov.uk/census [Accessed 26 Feb. 2019].

Walker,S. Mackay,E. Leverton,M. Dalton-Locke,C. Lloyd-Evans,B. Johnson,S. “Clinical and social factors associated with an increased risk of involuntary psychiatric care: A systematic review and meta-analysis” (in prep)

**6. Reduced availability or quality of community mental health services**

After adjusting for inflation, NHS reference costs data indicate that NHS spending on mental health care per capita has risen over the last 15 years (Gov.uk, NHS reference costs 2018). However, the number of people in contact with the secondary mental health services has risen markedly (NHS Digital, Mental Health Bulletin, 2017) and consequently spending per service user has fallen. Regarding Community Mental Health Teams (CMHTs), the most common secondary mental health mental health service providing longer term community care: over the last 10 years, the number of CMHT care episodes per 1,000 of the general population has remained fairly stable but the number of care episodes completed by CMHTs per person in contact with the secondary mental health services has fallen. These data suggest the reach of community mental health services may have increased over the last year, while the intensity of care provided to individual service users may have decreased. Weich and colleagues (2014) provide some evidence that the extent of community mental health service provision does relate to detention rates: in a cross sectional, national study using data from 2011, they found that higher area spend on community mental health teams (but not crisis care spend or total mental health spend) was associated with lower rates of detention; but that NHS Trusts with community mental health services rated as good quality had higher rates of detention than other services. Together, these data are all consistent with a hypothesis that community mental health services over the past decade may have become better at identifying people who meet criteria for detention – through increased service reach – but less able to provide the intensive service response which may help to avert detentions for people in crisis – through reduced service provision to individual service users.

References

GOV.UK. (2018). NHS reference costs. [online] Available at: https://www.gov.uk/government/publications/nhs-reference-costs-2015-to-2016 [Accessed 27 Feb. 2019].

NHS Digital. (2017). Mental Health Bulletin: 2016-17 Annual Report - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-2016-17-annual-report [Accessed 27 Feb. 2019].

Weich, S., McBride, O., Twigg, L., Keown, P., Cyhlarova, E., Crepaz-Keay, D., Parsons, H., Scott, J. and Bhui, K. (2014). Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. Health Services and Delivery Research, 2(49), pp.1-90.

**7. Reduced availability of alternatives to admission**

Crisis Resolution Home Treatment Teams (CRHTTs): The largest single change to the availability of crisis alternatives to admission during the period 1983-2016 was the nationally-mandated introduction of CRHTTs following the NHS Plan of 2000, with the aim of serving 100,000 people annually (DH 2000). There was a rapid expansion of CRHTTs between 2001 and 2004 (Glover et al. 2006). Before this national implementation, many local areas lacked any specific community crisis services available at evenings and weekends.

Three national surveys allow us to compare the availability of CRHTTs in 2005, 2011 and 2016 (Onyett et al. 2008, Lloyd-Evans et al. 2017, Lloyd-Evans et al. 2018). In 2005, n=243 CRHTTs were mapped, with an average caseload size of 20 patients. In 2011, n=233 CRHTTs were mapped in all NHS Trusts in England, with an average caseload of 27 patients. In 2016, n=198 CRHTTs were mapped, with an average caseload of 29 patients: two NHS Trusts no longer provided a separate CRHTT service, but nearly one-third of teams (n=59) reported having a separate, rapid response crisis assessment service in addition to CRHTTs – a major service change since 2011.

Routinely collected national data collected in the Mental Health Bulletin (NHS Digital, Mental Health Bulletin, 2017) indicates that, in this decade, the number of care episodes per 100,000 population provided by CRTs may have risen slightly, and the number of CRHTT contacts per person in contact with secondary mental health services fluctuated but did not clearly increase or decrease overall. This is also inconsistent with a narrative of diminishing access to community crisis care.

Crisis Houses: Data on the availability of residential crisis houses offering an alternative to acute psychiatric hospital admission are also available from three national surveys. In 2005, n=42 crisis houses were mapped nationally (Johnson et al. 2009). In 2011 (Lloyd-Evans et al. 2017), n=65 CRHTTs and in 2016 (Lloyd-Evans et al 2018), n=85 CRHTTs reported they had access to a crisis house.

Acute Day Units: The number of CRHTTs reporting access to an Acute Day Unit or Day Hospital as an alternative to admission barely changed from 2011 to 2016 (n=40 and n=41 respectively) (Lloyd-Evans et al 2017, 2018). In 2016, n=28 CRHTTs also reported local provision of a separate “crisis cafe” service, where patients in crisis could spend time and access a mental health assessment at evenings or weekends – another substantial service innovation since 2011.

Taken as a whole, these figures describe a marked increase in the availability of crisis alternatives to admission since the NHS Plan in 2000, and no clear evidence of reduced availability over the last decade. The hypothesis that rising rates of detention are driven by reduced availability of crisis alternatives therefore appears to be unsupported by available evidence.

References:

Glover, G, Arts, G, Babu, KS (2006) Crisis resolution/home treatment teams and psychiatric admission rates in England. British Journal of Psychiatry 189: 441–5.

The Health Foundation. (2010). The NHS Plan: a plan for investment, a plan for reform (2000) | Policy Navigator. [online] Available at: https://navigator.health.org.uk/content/nhs-plan-plan-investment-plan-reform-2000 [Accessed 27 Feb. 2019].

Lloyd-Evans, B, Slade, M, Jagielska, D, Johnson, S (2009). Residential alternatives to acute psychiatric hospital admission: systematic review. British Journal of Psychiatry 195, 109–117

Lloyd-Evans B, Paterson B, Onyett S, Brown E, Istead H, Gray R, Henderson C, Johnson S. National implementation of a mental health service model: a survey of crisis resolution teams in England. Int J Ment Health Nurs 2017; 27(1): 214–26.

Lloyd-Evans, B., Lamb, D., Barnby, J., Eskinazi, M., Turner, A., & Johnson, S. (2018). Mental health crisis resolution teams and crisis care systems in England: A national survey. BJPsych Bulletin, 42(4), 146-151. doi:10.1192/bjb.2018.19

NHS Digital. (2017). Mental Health Bulletin: 2016-17 Annual Report - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-2016-17-annual-report [Accessed 27 Feb. 2019].

Onyett, S., Linde, K., Glover, G., Floyd, S., Bradley, S., & Middleton, H. (2008). Implementation of crisis resolution/home treatment teams in England: National survey 2005–2006. Psychiatric Bulletin, 32, 374–377

**8. Reduced responsiveness or quality of crisis services**

The national implementation of CRHTTs in the early 2000s almost certainly improved the overall quality of available community crisis care in England, but there is limited and inconclusive information about changes in the quality of CRHTT care since then, and we have been unable to find information about changes in the quality of care in other crisis services.

Lloyd-Evans and colleagues (2018) compared findings from national surveys in 2016 and 2011, concluding that there were significant improvements in the accessibility and responsiveness of services, with more teams offering a full 24/7 service, accepting self-referrals and serving older adults. They noted that almost no teams were fully adherent to national policy implementation guidelines (DH 2001) at either time point however.

It is possible that staffing levels in CRHTTs have reduced over the last two decades. In 2005 (Onyett et al. 2008), there was an average of 0.88 full time equivalent staff per patient on the CRHTT caseload (mean 17.6fte staff for a mean team caseload of 20). In 2011 (Lloyd-Evans 2017), this ratio was reduced to 0.74 staff per patient (20fte staff: 27 caseload) and to 0.72 in 2016 (21fte staff: 29 caseload) (Lloyd-Evans 2018). Between 2010 and 2015, an increase of referrals to CRHTTs of 18%, in the context of CRHTT budget cuts of 8%, has also been reported (McNicol 2016). Together, these data suggest increasing resource pressures on CRHTTs over the last decade (during which rates of detention have risen most rapidly), with a plausible but unproven impact on the amount or quality of crisis care provided. Conversely however, national data, available through the Mental Health Bulletin (NHSD 2017) does not show a clear reduction in the number of care episodes per CRHTT service user.

Moreover, the plausibility of a reduction in the quality of crisis alternatives as a driver of rising rates of detentions also rests on an assumption that crisis alternatives can prevent compulsory admissions in the first place. This is unsubstantiated by any trial evidence (Bone et al. 2019.). Trials of CRHTTs (Johnson et al. 2005) and crisis houses (Fenton et al. 1998) reported no significant reduction in compulsory admissions for these service models. A recent trial of a service improvement programme for CRHTTs (Lloyd-Evans et al. 2019) was successful in increasing teams’ model fidelity and reducing overall inpatient admissions, but had no effect on compulsory admissions. Secondary data analysis conducted for this paper confirmed that changes in teams’ total score or any subscale score on the trial measure of CRHTT fidelity had no association with changes in numbers of compulsory admissions (although associations with fidelity were found for other trial outcomes). A study analysing national data on detentions in 2011, found no association at provider Trust level between spend on community crisis services and rates of detention (Weich et al. 2014).

Overall then, it is uncertain that the responsiveness or quality of crisis alternatives to admission has reduced at any point during the study period, or that the availability or quality of crisis alternatives has any relationship to rates of detention.

References

Bone,J. McCloud,T. Scott,H. Machin,K. Markham,S. Persaud,K. et al. “Interventions to reduce compulsory psychiatric admissions: a rapid evidence synthesis” *EClinical Medicine* 2019; Published 9th April <https://doi.org/10.1016/j.eclinm.2019.03.017>

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P. and Millet, C. 2005. The experience of work-related stress across occupations. Journal of Managerial Psychology, 20: 178–187.

Fenton WS, Mosher LR, Herrell JM, Blyler CR. Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. Am J Psychiatry. 1998;155(4):516–22.

Lloyd-Evans B, Paterson B, Onyett S, Brown E, Istead H, Gray R, Henderson C, Johnson S. National implementation of a mental health service model: a survey of crisis resolution teams in England. Int J Ment Health Nurs 2017; 27(1): 214–26.

Lloyd-Evans, B., Lamb, D., Barnby, J., Eskinazi, M., Turner, A., & Johnson, S. (2018). Mental health crisis resolution teams and crisis care systems in England: A national survey. BJPsych Bulletin, 42(4), 146-151. doi:10.1192/bjb.2018.19

Lloyd-Evans,B. Osborn,D. Marston,L. Lamb,D. Ambler,G. Hunter,R. et al. “The CORE Service Improvement Programme for mental health Crisis Resolution Teams: results from a cluster-randomised trial” *BJPsych* 2019; published 14th February <https://doi.org/10.1192/bjp.2019.21>

McNicol, A. (2016) “Mental health crisis teams given too many high risk cases” *Community Care Magazine* https://www.communitycare.co.uk/2016/10/06/mental-health-crisis-teams-given-many-high-risk-cases/

NHS Digital. (2017). Mental Health Bulletin: 2016-17 Annual Report - NHS Digital. [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-2016-17-annual-report [Accessed 27 Feb. 2019].

Onyett, S., Linde, K., Glover, G., Floyd, S., Bradley, S., & Middleton, H. (2008). Implementation of crisis resolution/home treatment teams in England: National survey 2005–2006. Psychiatric Bulletin, 32, 374–377

Weich S, McBride O, Twigg L, et al. Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. Southampton (UK): NIHR Journals Library; 2014 Dec. (Health Services and Delivery Research, No. 2.49.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK263740/ doi: 10.3310/hsdr02490

**9. Reduced inpatient bed capacity**

The provision of NHS psychiatric inpatient beds in England reduced continuously and by over 50% in total between 1988 -2016, from nearly 70,000 to under 30,000 (CQC 2018a). In the context of this large reduction in beds, for the period since 2003/4 for which we have data, NHS Digital’s Mental Health Bulletin show a gradual fall in overall admissions. The Mental Health Minimum Data Set and Hospital Episode Statistics data however show very little change in the number of current inpatients at year end between 2008 and 2016, but a change during this time period in the proportion of detained patients from 30% of all those admitted to over half (CQC 2016). We have only located data on bed occupancy rates for the period 2011-2016 (NHSE KHO3 data): during this period mental health bed occupancy rates rose only slightly from 87.1% to 89.9%, although were at all times above the maximum 85% level recommended by the Royal College of Psychiatrists (RCPsych 2011).

Bed cuts and difficulties with accessing inpatient beds have been identified as contributing to the rise in detentions in England by mental health staff and patients (CQC 2018), and was the most common proposed reason for the rise in the call for evidence stakeholder consultation conducted by the Independent Review of the Mental Health Act in 2018. Four mechanisms through which difficulties with accessing beds might lead to otherwise preventable detentions can be identified:

i) Psychiatrists and AMHPs might (unlawfully) decide to detain a patient who could have been voluntarily admitted, in order to facilitate prompt access to a bed. A survey of junior psychiatrists by the Royal College of Psychiatrists in 2014 found that 18% of respondents said their decision to detain a patient would be influenced by the fact that doing so may make the provision of a bed more likely, and 37% reported seeing a colleague’s behaviour influenced in this way (MHT 2014). A report from the Care Quality Commission however, said it found no evidence of psychiatrists “gaming” the system in this way (CQC 2018b).

ii) Informal admission is either not offered to, or is delayed for, a patient who then cannot be adequately supported by community crisis services, deteriorates further, and is subsequently compulsorily admitted

iii) A patient is offered voluntary admission but only in a hospital far from home, which they therefore decline and are consequently detained.

iv) Bed pressures lead to patients being discharged prematurely (in order to free a bed), leading to relapse and a second compulsory admission which might have been avoided with a longer initial admission. Regrettably, the KP90 data recording system used by NHS Digital until 2016/17 did not link episodes of detention to individual patients, making it impossible to say with confidence to what extent the rise in detentions reflects more people being detained, or the same number of people being detained more often. Analysis of health records data from 2009-16 from six London boroughs conducted for the MHA Review (Oram 2018 in prep) indicated that in these areas, the rise in detentions was entirely due to more people being detained, rather than more frequent detentions for the same number of patients – but this may not necessarily reflect the national picture.

Regardless of the specific mechanism, are bed cuts driving the rise in detentions? Keown and colleagues (2011) analysed the relationship between annual rates of detentions and psychiatric bed provision between 1998 and 2008. They found a strong negative relationship between the two variables, which was strongest when a one-year time lag was introduced into the model (r=-0.58): i.e. the clearest link between bed cuts and detention rates is that detentions rise in the year following bed cuts. This provides some evidence that the relationship may be causal. The authors conclude: *“Our findings support the hypothesis that changes in provision of mental illness beds in the NHS are associated with subsequent changes in the rate of involuntary admission over the short to medium term.”*

Two qualifications can be made to this important finding however. First, the relationship between bed cuts and detentions was still moderately strong (r>-0.4) with a time lag one year the other way – i.e. bed cuts follow a rise in detentions too; they don’t just precede them. This suggests that the majority of the relationship between the two variables may be coincidental rather than causal. Second, a likely consequence of bed cuts is an increase in transfers of care between NHS providers for detained patients, who may be moved between hospitals, including to and from private providers, as beds become available. An element of the rise in reported detentions in the year following bed cuts may therefore be artefactual rather than real, due to increased double counting rather than a real rise in detentions.

Three further considerations generate some uncertainty about the causal relationship between bed availability and rates of detention.

i) Bed cuts during the period, and especially since the NHS Plan of 2000, have occurred in the context of a rapid expansion in community crisis provision. At local level, bed cuts and expansions in community crisis provision have often been co-occurring (Jacobs and Barrenho 2011). Bed cuts do not necessarily lead to increased bed pressures, if accompanied by increased access to community crisis alternatives. Recent surveys of Crisis Home Treatment Teams suggest their reach and accessibility may have continued to increase during this decade (Lloyd-Evans 2018). The reduction in beds and voluntary admissions may in many instances not reflect a problem, but a successful deinstitutionalisation of crisis care provision for patients who consent to treatment, which coincides with a rise in the number of detained patients which has other causes.

ii) If pressures and lack of bed availability are driving an increase in detentions, we would expect to see a relationship between bed occupancy rates and rates of detentions at area level – i.e. those NHS Trusts with most pressure for beds have the highest detention rates. In a national study by Weich and colleagues (2014) using data from 2011 retrieved from the Mental Health Minimum Data Set, the authors found that bed occupancy rates were more closely related to detention rates than bed numbers were, but that in a fully adjusted model, there was no independent association between bed-occupancy and detention rates at provider Trust level. (The lead author from this study cautions however that any relationship between bed occupancy and detention rates might be obscured in the data, because bed occupancy rates are artificially capped at 100% in the official statistics.) Weich and colleagues also found no independent association at area level between average length of inpatient stay and detention rates (Weich et al. 2014), which does not support a hypothesis that premature hospital discharge is a driver of detention rates.

iii) An international review of detention rates and legislative systems for compulsory admission in high income countries conducted for the MHA Review (Sheridan-Rains et al. in press) explored the relationship of a variety of legislative, social and economic, and service provision variables to detention rates at country level. Of all the variables explored, the strongest association was between inpatient bed provision and detention rates. This was a positive association: i.e. counties with more psychiatric beds detain more people. While the explanations for this relationship are uncertain, viewed through this wider lens, it seems improbable that bed cuts are playing a substantial role in driving a rise in detentions in England.

Overall then, bed cuts and lack of bed availability are repeatedly identified by stakeholders as contributing to the rise in detentions, and plausible mechanisms have been proposed. However, empirical evidence to support this hypothesis is inconclusive.

References

Care Quality Commission (2016) “Monitoring the Mental Health Act in 2015/16” <https://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf>

Care Quality Commission (2018a) *“Mental Health Act: the rise of the use of the Mental Health Act to detain people in England”* online publication [Accessed 7th May 2019] <https://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf>

Care Quality Commission (2018b) *“Monitoring the Mental Health Act in 2016/17”* online publication [Accessed 7th May 2019] <https://www.cqc.org.uk/sites/default/files/20180227_mhareport_web.pdf>

Jacobs,R. & Barrenho,E. (2011) “Impact of crisis resolution and home treatment teams on psychiatric admissions in England.” *BJPsych* 199(1):71-6

Keown,P. Weich,S. Bhui,K. Scott,J. (2011) “Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study” *BMJ* 343:d3736

Mental Health Today (2014) *“Survey reveals extent of mental health beds crisis”* 02/06/14: Web resource <https://www.mentalhealthtoday.co.uk/survey-reveals-extent-of-mental-health-beds-crisis>

NHS England 2018: KH03 data <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

Royal College of Psychiatrists (2011) Do the right thing: how to judge a good ward [Online] Available from: www.rcpsych.ac.uk /pdf/OP79\_forweb.pdf (accessed 21 September 2017)

Sheridan Rains et al. (2019) Variations in patterns of involuntary hospitalization and in legal frameworks: an international comparative study (in press)

Weich S, McBride O, Twigg L, et al. Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. Southampton (UK): NIHR Journals Library; 2014 Dec. (Health Services and Delivery Research, No. 2.49.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK263740/ doi: 10.3310/hsdr02490

**10. Less continuity of care at Mental Health Act assessments**

Stakeholders who were consulted in generating hypotheses for this paper proposed that assessments for compulsory admission where none of the assessors knows the patient well might lead to more conservative assessments of risk, or the suitability of less restrictive alternatives to detention, resulting in increased risk of detention. A perceived reduction in the involvement of patients’ GPs in Mental Health Act assessments was proposed as illustrative of this, and a possible contributory factor to the rising rate in admissions.

A small study conducted in one London NHS Trust (Wickersham et al. 2019) audited Mental Health Act assessments during a period in 2016/17. They found that, in line with policy guidelines (MHA Codes of Practice 2015), at least one assessor with some prior knowledge of the patient was involved in almost all assessments. However, the extent of this knowledge of the patient, or when the assessment team included a GP, were not evaluated in this study. In qualitative interviews for the study, psychiatrists and Approved Mental Health Professionals (AMHPs) proposed a number of factors relating to the assessment process, which could help to minimize the chance of an outcome of detention. These included: assessing as a team, not individually; discussion with involved community mental health teams and professionals; and presence at an assessment of a care-coordinator or other professional known to the patient, and/or a member of the local Crisis Home Treatment Team, to help consider the viability of community alternatives to admission. In quantitative analysis, the presence of a community professional (the patient’s care coordinator or a member of the Crisis Home Treatment Team) at a MHA assessment was associated with lower likelihood of an outcome of detention. Whether or not all assessors were present at the same time during an assessment was not associated with assessment outcome however.

This study by Wickersham and colleagues is the only one we have identified which has quantitatively explored how process factors relate to the outcome of assessments for compulsory psychiatric hospital admission. A Norwegian study (Hustveld et al. 2014) explored predictors of compulsory and voluntary hospital admission, finding that detention was less likely for referrals made by a patient’s GP, rather than a physician not previously known to the patient.

There is therefore some limited preliminary evidence that full involvement at Mental Health Act assessments of mental health professionals who know a patient well, who can provide full assessment about their circumstances and known risks, and who can help fully consider potential alternatives to compulsory admission, may help reduce detentions. We have been unable to find data to quantify whether or to what extent there have been changes since 1983 in the involvement of GPs in Mental Health Act assessments, or to what extent assessors know the patient or have been involved in their care. Evidence that continuity of care has reduced at MHA assessments since 1983, and could have contributed to a rise in detentions, is therefore lacking.

References:

Wickersham,A. Nairi,S. Jones,R. Lloyd-Evans,B. “ The Mental Health Act Assessment Process and Risk Factors for Compulsory Admission to Psychiatric Hospital: A Mixed Methods Study” *Br J Social Work* 2019; bcz037 published 11th April 2019 <https://doi.org/10.1093/bjsw/bcz037>

Department of Health (2015) “Mental Health Act 1983: Codes of Practice” DH, London [s. 14.73, p.125]

Hustold,K. Larsen,T. Auestad,B. et al. (2013) “Predictors of involuntary hospitalizations to acute psychiatry” Int. J. Law and Psychiatry 36:2, 136-143

**11. Increased focus on safety and risk management among professionals**

An increased focus on risk and risk management has been described within psychiatric services in response to homicide cases committed by individuals diagnosed with mental health problems in the 1990s and the perceived public reaction to these events (Royal College of Psychiatrists, 2008). High profile examples include homicides committed by Christopher Clunis (Lelliott & Audini, 2003) and Michael Stone (Pickersgill, 2012). A survey by the Royal College of Psychiatrists (RCPsych) in 2008 found that Psychiatrists felt the focus of their professional role had shifted towards more state-defined public protection as opposed to the welfare of individual service-users following these events and the ensuing legislative response. The Mental Health Act (2007) introduced a series of measures intended to extend the reach of compulsory treatment powers and augment risk management (Pilgrim, 2007). It has also been suggested that in a climate of limited resources and growing public concern with risk, individuals that pose high risk to themselves or others may be prioritised (RCPsych, 2007).

A sense of “moral outrage” has been described following public tragedies (Szmuckler & Rose, 2013), which may promote legislative change. For example, Michael Stone had been diagnosed with a personality disorder, which led the Department of Health to suggest that a previous assertion that personality disorders are “untreatable” created a legislative “loop hole”, precluded compulsory treatment under the 1983 Mental Health Act for individuals experiencing personality disorders (Maden & Tyrer, 2003). Therefore, the Mental Health Act 2007 replaced the notion of “treatability” with “acceptability”, enabling compulsory treatment of an individual if an “acceptable” treatment was deemed available, though it has been argued that this is an arbitrary distinction in terms of administration of the Act (Sen & Irons, 2010). The MHA 2007 also amended the legal definition of “mental disorder” into one, broadly defined term. Singh et al. (2017) found that across three mental health trusts, there was no increase in the number of Mental Health Act assessments of individuals diagnosed with a personality disorder during the first three years following the introduction Act, though there was an increase in assessments individuals with “unspecified mental disorder” or a learning disability. However, there was no corresponding increase in the proportion of individuals experiencing a learning disability or unspecified mental disorder being detained (Singh et al., 2017). National statistics regarding the rates of detention of individuals diagnosed with a personality disorder are not available, and the extent of any impact of the legislative changes in the MHA 2007 on detention rates is unknown.

Mental health professionals may also experience pressure to prioritise risk management due to a “culture of blame” (National confidential enquiry into suicide and homicide by people with mental illness, 2006). This refers to the inference of professional negligence or responsibility when either suicide or rare events such as homicide by an individual experiencing mental distress occur (RCPsych, 2007). Public perception has previously emerged as a concern for mental health professionals regarding the use of positive risk taking strategies within community settings (Robertson & Collison, 2011). Bowers et al. (2006) also found that professionals within an inpatient setting feared being blamed for serious untoward incidents (such as patient suicide or homicide) and that these incidents led to an increase in restrictive practices, such as tranquilization. Whether any similar change in culture and attitude to risk has occurred among mental health staff in community settings is unclear. It is possible that the more recent updates to the Mental Health Code of Practice may represent a shift back in attitudes to positive risk-taking through embedding the principle of the “least restrictive option” (Department of Health, 2015). Stone (2018) found that the majority of Approved Mental Health Professionals (AMHPs) interviewed considered alternative strategies to the use of the Mental Health Act following presentation of a case vignette and often explored less restrictive community options. However, nearly half of the AMHP participants opted for detention and frequently cited risk as the guiding force for their decision (Stone, 2018). Risk has previously emerged as the most pertinent factor governing Mental Health Act decisions by clinicians (Singh et al., 2013) and has been found to independently predict detention (Singh et al., 2014, Wickersham et al. 2019).

Overall therefore, there is some evidence to suggest that an increased focus on risk among mental health professionals in England could have contributed to an increase in use of detention. Legislative changes in 2007 may have contributed to this. However, current evidence is insufficient to quantify any change in clinicians’ attitudes to risk and over time, and how this may have influenced detention rates.

References:

Bowers, L., Simpson, A., Eyres, S., Nijman, H., Hall, C., Grange, A., & Phillips, L. (2006) Serious untoward incidents and their aftermath in acute inpatient psychiatry: the Tompkins Acute

Ward Study. *International Journal of Mental Health Nursing,* *15*, 226–234. doi: 10.1111/j.1447-0349.2006.00428.x

Department of Health (2015) *Mental Health Act 1983: Code of Practice*. Norwich, United Kingdom: TSO information and publishing solutions. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/435512/MHA\_Code\_of\_Practice.PDF

Lelliott, P., & Audini, B. (2003) Trends in the use of part II of the Mental Health Act 1983 in seven English local authority areas. *British Journal of Psychiatry, 182,* 68-70.

Maden, T., & Tyrer, P. (2003) Dangerous and Severe Personality Disorders: a new personality concept from the United Kingdom. *Journal of Personality Disorders, 17 (6),* 489-496. [doi: 10.1521/pedi.17.6.489.25356](https://doi.org/10.1521/pedi.17.6.489.25356)

National Confidential Inquiry into Homicides and Suicides by people with mental illness (2006) *Five year report of the national confidential inquiry into suicide and homicide by people with mental illness. Avoidable deaths.* The University of Manchester. https://www.research.manchester.ac.uk/portal/files/70178286/avoidable\_deaths\_full\_report\_december\_2006.pdf

Pickersgill, M. (2012) How personality became treatable: the mutual constitution of clinical knowledge and mental health law. *Social Studies of Science, 43 (1),* 30-53. doi: 10.1177/0306312712457722

Pilgrim, D. (2007) New mental health legislation for England and Wales: some aspects of consensus and conflict. *Journal of Social Policy, 36 (1),* 79-95. [doi: 10.1017/S0047279406000389](http://doi.org/10.1017/S0047279406000389)

Robertson, J.P., & Collinson, C. (2011) Positive risk taking: whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society, 13 (2),* 147-164. doi: 10.1080/13698575.2011.556185

Royal College of Psychiatrists (2007) *‘Giving up the culture of blame.’ Risk assessment and risk management in psychiatric practice,* Briefing document for the Royal College of Psychiatrists. Royal College of Psychiatrists, London. https://www.rcpsych.ac.uk/pdf/Risk%20Assessment%20Paper%20-%20Giving%20up%20the%20Culture%20of%20Blame.pdf

Royal College of Psychiatrists (2008) *Rethinking risk to others in mental health services*: *Final report of a Scoping Group*, College Report CR150. Royal College of Psychiatrists, London. https://www.rcpsych.ac.uk/pdf/CR150%20rethinking%20risk.pdf

Sen, P., & Irons, A. (2010) Personality disorder and the Mental Health Act 1983 (amended). *Advances in Psychiatric treatment, 16,* 329-325. doi: 10.1192/apt.bp.109.006841

Singh, S.P., Islam, Z., Brown, L.J., Gajwani, R., Jasani, R., Rabiee, F., & Parsons, H. (2013). Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *Programme Grants Appl Res;* **1** (3). doi: 10.3310/pgfar01030

Singh, S.P., Burns, T., Tyrer, P., Islam, Z., Parsons, H. & Crawford, M.J. (2014). Ethnicity as a predictor of detention under the Mental Health Act*. Psychological Medicine, 44,* 997-1004. doi:10.1017/S003329171300086X

Singh, S., Paul, M., Parsons, H., Burns, T., Tyrer, P., Fazel, S., Deb, S., Islam, D., Rugkåsa, J., Gajwani, R., Thana, L., & Michael J. Crawford, M.J. (2017) A prospective, quantitative study of mental health act assessments in England following the 2007 amendments to the 1983 act: did the changes fulfill their promise? *BMC Psychiatry, 17,* 246-253. [doi: 10.1186/s12888-017-1391-2](https://doi.org/10.1186/s12888-017-1391-2)

Stone, K. (2018) Approved Mental Health Professionals and detention: an exploration of professional differences and similarities. *Practice, Social work in Action*.[doi: 10.1080/09503153.2018.1445709](https://doi.org/10.1080/09503153.2018.1445709)

Szmuckler, G., & Rose, N. (2013) Risk assessment in mental health care: values and costs. *Behavioural Sciences and the Law, 31,* 125-140. doi: 10.1002/bsl.2046

Wickersham,A. Nairi,S. Jones,R. Lloyd-Evans,B. “ The Mental Health Act Assessment Process and Risk Factors for Compulsory Admission to Psychiatric Hospital: A Mixed Methods Study” *Br J Social Work* 2019; bcz037 published 11th April 2019 <https://doi.org/10.1093/bjsw/bcz037>

**12. Changes in prescribing practice**

Clozapine is recommended for use by individuals experiencing symptoms of psychosis who do not respond to two previously offered anti-psychotic medications and are thus deemed “treatment resistant” (NICE, 2015). In the consultations with stakeholders for this paper, a reduction in prescription of clozapine was proposed as a contributory factor to the rise in detentions over the last decade, if alternative medications are less effective in preventing relapse and potential detention for this patient group.

Clozapine is the only drug that is licensed for use by treatment resistant individuals (Howes et al., 2012) and there is some evidence to support the ability of clozapine to directly reduce hospital admissions amongst this service-user group (Land et al., 2017). It has previously been suggested that clozapine is under-prescribed in the United Kingdom (Warnez & Alessi-Severini, 2014) with one study finding that the delay to use was four years and that a third of service-users were receiving anti-psychotic poly-pharmacy prior to commencing clozapine (Howes et al., 2012). A survey of UK psychiatrists also found that 41% preferred to use many other antipsychotics prior to initiating clozapine and 42% were working with less than 5 patients to whom they prescribed clozapine (Tungaraz & Farook, 2015). This may be due to the side effect profile of the medication, since a reduction in white blood cell count is fairly common and other rare yet potentially life-threatening conditions may also develop through using clozapine, such as agranulocytosis and myocarditis (De Berardis et al., 2018). Clozapine prescriptions only represent 0.1% of total anti-psychotics prescribed and this figure has remained stable when reviewed in 2007 and 2014, though the overall daily dose of clozapine in the UK showed an increase of 5% across this period (Roberts, Neasham, Lambrinudi & Khan, 2018). It is not possible to combine different dose strengths of clozapine as reported in routine data, which limits interpretation of overall prescription trends in clozapine (NHS Digital, 2013), and the available data do not support a definitive reduction in clozapine prescriptions (Roberts et al., 2018). Although it remains possible that relapse rates amongst those eligible for clozapine use may be inflated due to “under-prescribing” of this medication, the limited available evidence does not clearly indicate any reduction in clozapine prescription over time that may have influenced rates of detention.

NICE (2014) guidance recommends Long Acting Injectable antipsychotics (LAIs) as an alternative to oral antipsychotic medication for individuals who are unable or choose not to adhere to suggested antipsychotic medication, where medication adherence is a treatment priority. A reduction in the quantity of LAIs prescribed to this service-user group could therefore lead to reduced antipsychotic adherence and an increase in subsequent relapse rates and detentions. The data available supports a decrease in preparations of some First Generation Antipsychotics, such as pipotiazine between 2004 and 2004 and 2017 (NHS Digital, 2004 to 2017). However, there has been a corresponding increase in the number of Second Generation Antipsychotics available as LAIs across the same period, such as the initiation of prescriptions of olanzapine and aripiprazole as injectable formulations from 2014 and 2015 respectively (NHS Digital, 2004 to 2017). Combining different dose preparations of LAIs is not possible due to varying standardized quantity units, which limits comparability in prescription trends (NHS Digital, 2013). However, the available data suggests that depot medication continues to be prescribed by practitioners. Moreover, evidence suggests that LAIs may not in fact increase adherence to a greater extent than other routes of antipsychotic administration (Leucht et al., 2011; Sendt, Tracy & Bhattacharyya, 2015). NICE guidance (2014) also indicates a role for service-user preference when choosing a route of antipsychotic administration rather than adopting a sole focus on adherence. We therefore lack any clear evidence of a role for LAI prescription trends in increasing detention rates.

References:

De Berardis, D., Rapini, G., Olivieri, L., Di Nicola, D., Tomasetti, C., Valchera, A., Fornaro, M., Di Fabio, F., Perna, G., Di Nicola, M., Serafini, G., Carano, A., Pompili, M., Vellante, F., Orsolini, L., Martinotti, G. and Di Giannantonio, M. (2018). Safety of antipsychotics for the treatment of schizophrenia: a focus on the adverse effects of clozapine. *Therapeutic Advances in Drug Safety*, *9 (5),* 237-256. DOI: [10.1177/2042098618756261](https://doi.org/10.1177%2F2042098618756261)

Howes, O.D., Vergunst, F., Gee, S., McGuire, P., Kapur, S. & Taylor, D. (2012). Adherence to treatment guidelines in clinical practice: study of antipsychotic treatment prior to clozapine initiation. *The British Journal of Psychiatry, 201 (6),* 481-485. doi: 10.1192/bjp.bp.111

Land, R., Siskind, D., McArdle, P., Kisely, S., Winckel, K. & Hollingworth, S.A. (2017). The impact of clozapine on hospital use: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica, 135,* 296-309. DOI: 10.1111/acps.12700

Leucht, C., Heres, S., Kane, J.M., Kissling, W., Davis, J.M., & Leucht, S. (2011). Oral versus depot antipsychotic drugs for schizophrenia—A critical systematic review and meta-analysis of randomised long-term trials. *Schizophrenia Research, 127 (1-3),* 83-92. [doi: 10.1016/j.schres.2010.11.020](https://doi.org/10.1016/j.schres.2010.11.020)

National Institute for Health and Clinical Excellence. (2014). Psychosis and schizophrenia in adults: prevention and management. Clinical guideline 178. <https://www.nice.org.uk/guidance/cg178>

National Institute for Health and Clinical Excellence. (2015). Psychosis and schizophrenia in adults. Quality standard 80. <https://www.nice.org.uk/guidance/qs80>

NHS Digital. Prescription Cost Analysis. (2004 to 2017)

NHS Digital. Prescription Cost Analysis (PCA) Glossary. V2. 04-06-13. https://www.nhsbsa.nhs.uk/

Roberts, R., Neasham, A., Lambrinudi, C. & Khan, A. (2018). A quantitative analysis of antipsychotic prescribing trends for the treatment of schizophrenia in England and Wales. *Journal of the Royal Society of Medicine Open, 9(4),* 1-7. DOI: 10.1177/2054270418758570

Sendt, K-V., Tracy, D.K. & Bhattacharyya, S. (2015). A systematic review of factors influencing adherence to antipsychotic medication in schizophrenia-spectrum disorders. *Psychiatry Research, 225 (1-2),* 14-30. doi: [10.1016/j.psychres.2014.11.002](https://doi.org/10.1016/j.psychres.2014.11.002)

# Tangaraz, T.E. & Farooq, S. (2015). Clozapine prescribing in the UK: views and experience of consultant psychiatrists. *Therapeutic Advances in Psychopharmacology, 5(2),* 88-96. doi: [10.1177/2045125314566808](https://dx.doi.org/10.1177%2F2045125314566808)

# Warnez, S. & Alessi-Severini, S. (2014). Clozapine: a review of clinical practice guidelines and prescribing trends. *BMC Psychiatry, 14,* 102-106. [doi: 10.1186/1471-244X-14-102](https://doi.org/10.1186/1471-244X-14-102)

**13. Changes in legal and clinical practice in respect of capacity**

Informal admissions have been enshrined in the Mental Health Act (MHA) since 1959. Until 2005, patients who lacked capacity to consent to their admission to hospital for psychiatric treatment, and who were not objecting, were treated informally. However, the “Bournewood” case [1], which was decided by the European Court of Human Rights, stated that a person kept in hospital in conditions which amount to a deprivation of liberty must have a lawful process to authorise the confinement, and a right to review of the detention, to be compatible with the European Convention on Human Rights (ECHR). The “acid test” for a deprivation of liberty was decided in the “Cheshire West”[2] case with the result that most patients within psychiatric hospitals will be deemed to be deprived of their liberty.

*What are the lawful processes by which a patient who lacks decision making capacity may be admitted to hospital for psychiatric treatment?*

In order to “plug the Bournewood gap”, the Deprivation of Liberty Safeguards (DOLS) [3] were introduced as an addition to the Mental Capacity Act 2005 (MCA 2005) [4] in 2008. Thus patients being treated in hospital for a psychiatric disorder, who were not objecting but lacked capacity to consent to their confinement, could either be made subject to the MHA or the DOLS to legally authorize the deprivation of liberty.

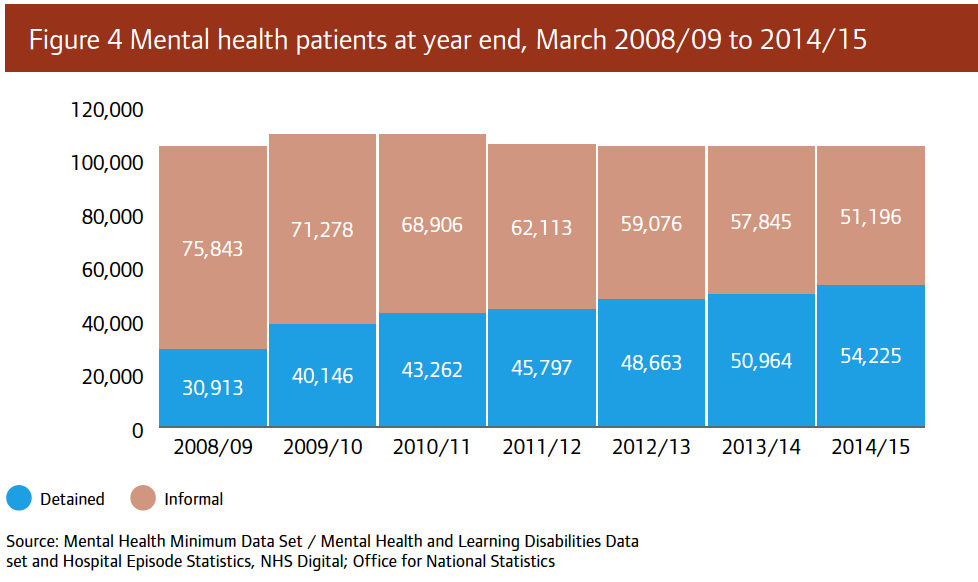
|  |  |  |
| --- | --- | --- |
|  | Patient has capacity to consent or refuse admission | Patient lacks capacity to consent or refuse admission |
| Patient is objecting to admission | MHA 1983 | MHA 1983 |
| Patient is not objecting to admission | Informal  (Rarely MHA 1983 e.g. consent fluctuating) | MHA 1983 or MCA 2005 (DOLS) |

Table 1: Current lawful processes by which a patient may be deprived of their liberty in a hospital for medical treatment of a mental disorder.

*How many patients have been affected by this change in the law?*

A recent systematic review [5] found that approximately 45% of patients in both general adult and older age psychiatric wards lack decision making capacity to consent to admission and treatment (Lepping et al. 2015). However, some of these studies may be an underestimate as patients who were lacking capacity to decide whether or not to participate may have been excluded.

A study by Owen and colleagues of one English psychiatric unit [6] found that 22% of patients lacked capacity to consent to treatment and were admitted informally. This suggests that they were not objecting to admission and/or treatment and so were not detained under the MHA. This study was carried out prior to the legal changes brought into the law of England and Wales in 2008. There has been consistently approximately 100,000 mental health in-patients a year between 2008 and 2015, which is demonstrated in the figure four from the CQC report for 2015/16 [7]. If 22% of patients across England lack capacity to consent to their admission and treatment, but are not objecting, then up to 22,000 extra patients a year would need to be detained under the MHA or DOLS to prevent an unauthorized deprivation of liberty.



In practice, due to the different decision makers in the two Acts, and lack of availability of DOLS assessors in an emergency, many psychiatric patients will be admitted under the MHA 1983. This is reflected in the numbers of psychiatric inpatients subject to each regime. In 2017/18 there were 4,670 DOLS applications for patients in mental health establishments in England, of which 3,945 were completed [8]. In contrast, at least 49,551 people were detained under the MHA 1983 over the same period [9]; this figure is an under-estimate as not all provider organisations submitted data. The mechanism for collecting data changed between 2015 and 2016, which accounts for the reduction from 54,225 detentions reported in 2015.

If the figures in the Owen study [6] are extrapolated across England, then 22,000 patients are lacking capacity but not objecting to their treatment for a mental disorder. DOLS figures suggest that 4,000 are lawfully deprived of their liberty through the MCA at present, then up to 18,000 patients a year in this group are being admitted under the MHA.

*Limitations of available evidence*

The Owen study [6] was conducted in a general adult psychiatry ward in Central London and the figures of patients who are deemed to lack treatment decision making capacity may be higher or lower in other geographical areas and psychiatric specialties.

The Owen study assessed capacity to consent to treatment, rather than admission to hospital.

There may still be patients who lack capacity to consent to their admission are admitted informally and are de facto deprived of their liberty without a lawful process in place.

The Owen study was conducted nearly 10 years ago, and the prevalence of patients who lack capacity to consent to their admission for treatment of a psychiatric disorder may have changed during that time.

Capacity and objection data are not routinely collected and so these estimates are based on one single study of 350 consecutive general adult inpatients.

The method of National data collection changed between 2008 and 2016 so that the figures pre-and post the changes are not directly comparable.

References

HL v UK (2005) 40 E.H.R.R. 32

*P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19 at paras 49 and 54.

DOLS Procedure in Schedule A1 Mental Capacity Act 2005

MCA 2005 Schedule 1A s5(4) states that where P objects to being a mental health patient or to being given some or all of the mental health treatment then DOLS is not available and so detention must be under the MHA 1983.

Lepping.P. Stanly,T, Turner,J. (2015) “Systematic review on the prevalence of lack of capacity

in medical and psychiatric settings” *Clinical Medicine* 15(4) pp 337-43

Owen GS, Richardson G, David AS, Szmukler,G. Haywood,P. Hotopf,M. “Mental Capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study”. *BMJ* 2008; 337 a:448

Care Quality Commission “Monitoring the Mental Health Act in 2015/16”. Care Quality Commission, 2016.

NHS Digital. Mental Capacity Act (2005) Deprivation of Liberty Safeguards, England 2017/18. Published 02 October 2018 (web resource) <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/annual-report-2017-18-england> [Accessed 18th July 2019]

NHS Digital. Mental Health Act Statistics, Annual Figures 2017/18. Published 09 October 2018.

**14. Introduction of Community Treatment Orders (CTOs)**

CTOs were introduced in amendment to the Mental Health Act in England in 2007, introducing for the first time for civil patients a legal requirement to adhere to treatment in the community following a compulsory admission, or risk recall to hospital. In our consultations with stakeholders for this paper, two mechanisms by which CTOs might contribute to an increase of detentions were proposed. First, the threshold in practice for CTO recall to hospital might be lower than for a new compulsory admission following a Mental Health Act assessment. Second, CTOs may be used as a means to facilitate early discharge from hospital which, if premature, could lead to more frequent relapse and subsequent compulsory readmission.

Both of these mechanisms assume that CTOs lead to higher rates of readmission to hospital. This is contradicted by available evidence. The only UK randomised controlled trial of CTOs (Burns et al. 2013) and a recent systematic review of all available evaluations (Barnett et al. in 2018) found no difference in rates of readmission for people discharged from compulsory hospital on a CTO or not on a CTO. It is also unclear from official government statistics whether the rise in rates of detention reflects the same patients being detained more frequently, or more patients being detained. An analysis of anonymised patient records across six London boroughs conducted for the Independent Review of the Mental Health Act (Oram et al. in prep), which found that the rise in compulsory admissions over a seven year period from 2009-2016 was entirely due to more people being detained; not the same people being detained more frequently. This is not consistent with a hypothesis that more repeat detentions of patients on CTO is driving rising rates of detentions. In any case, CTOs could at most be a small contributor to the overall rise in detentions: only just over 1500 people in total were readmitted to hospital while on a CTO in 2015/16, out of a total number of detentions of over 60,000.

The hypothesis that the introduction of CTOs has contributed to the rising rate of detentions since 2007 is therefore not supported by current evidence.

References

Burns T, Rugkasa J, Molodynski A et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. Lancet 2013;381:1627‐33

Barnett,P. Matthews,H. Lloyd-Evans,B. Mackay,E. Pilling,S. Johnson,S. “Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis” *The Lancet Psychiatry* 2018; 5(12) p1013-1022

**15. Police more likely to bring people to a health-based place of safety.**

Mental Health Act statistics held by NHS Digital (NHS Digital 2016) indicate that the number of places of safety orders (section 135 and 136) per population have been rising since the 1990s. Between 1989 and 2016 the rate rose approximately 20-fold from 2.6 per 100,000 to 42.56. The number of conversions from s.135 or s.136 to section 2 per 100,000 population have risen 10-fold over this same period (from 0.62 in 1989 to 6.62 in 2016) and to section 3 6-fold (from 0.13 to 0.79). How many of these people would otherwise reached detention in hospital via other pathways is unknown, but the rise in detentions via a place of safety order is consistent with the hypothesis that the police are becoming better at identifying people who meet criteria for detention in hospital, and that some of those now admitted via a place of safety order may previously have been arrested or left in public spaces or at home.

Keown (2013) reported on a cross-sectional analysis of regions in England noting rise in the proportion of places of safety orders happening in hospitals coinciding with a fall in the use of police cells for this purpose. However, the author also notes that the shift towards using hospitals more is unlikely to account for all of the increase in the use of place of safety orders reported in Mental Health Act statistics, and that it is likely that the number of people subject to a place of safety order per population is also rising.

References

Keown P. Place of safety orders in England: changes in use and outcome, 1984/5 to 2010/11. The Psychiatrist 2013;37:89–93. doi:10.1192/pb.bp.111.034348

NHS Digital (2016) *“Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16”* NHS Digital, London

**16. Better data reporting in recent years**

**17. Increase in transfers between hospitals during admission leads to double counting**

In reporting the annual rates of detentions in England for this paper for the period 1983-2016, we have used nationally-collected data from the KH15/KH37, then KP90 datasets, reported annually by NHS Digital (formerly by the Health and Social Care Information Centre HSCIC). These datasets report aggregated data about the number of detentions, based on returns from provider organizations: detentions cannot be linked to individual patients. We have used these datasets in our paper because they are acknowledged by NHS Digital to be more complete than the nationally-collected Mental Health and Learning Difficulties Dataset patient-level returns about detentions, which are incomplete and undercount the total number of detentions (NHSD 2016).

In 2016/17, NHS Digital switched from using the KP90 dataset to a new Mental Health Service Data Set (MHSDS), which provides individual patient-level data. However, MHSDS returns for 2016/17 were acknowledged to be incomplete, and not comparable with previous KP90 data. We have therefore not used detentions data since 2016 in this paper.

Based on site visits and review of available national data, the Care Quality Commission’s 2016/17 annual report on the use of the Mental Health Act in England proposed two factors relating to data quality which might contribute to the apparent rise in rates of detention (CQC 2018). The first of these was that improved completeness over time of local returns to national datasets may have inflated the reported number and rise in rate of detentions. The second was that double-counting of “transfers on section” (where patients transferred between hospitals run by different provider organizations during a detention may be included in both organizations’ returns) may have increased over time.

**Better data reporting:** Neither the Care Quality Commission (CQC 2018) not NHS Digital (NHSD 2017) are able to quantify the extent of any gaps in annual data-reporting by provider organizations. In 2014, HSCIC report conducting a triangulation exercise with other available data sources to assess the completeness of KP90 returns: they concluded that, historically, data reporting has been good, and that barring occasional, minor data reporting errors, mandatory information from providers about detentions “should be complete” (HSCIC 2014). We note however that the quality of detentions data was rated as medium risk by the UK Statistical Authority’s quality assurance monitoring (NHSD 2017).

**Increased double-counting of “transfers on section”:** NHS Digital report that of 32,765 hospital admissions for detained patients in 2016/17 recorded in the new MHSDS database, 7091 (22%) were “transfers on section” for patients already detained – which might potentially have been double-counted under the old KP90 system, inflating total numbers of recorded detentions. Based on data from 35 selected providers in 2015/16 and 2016/17, NHS Digital estimated that 4,326 out of 25,500 detentions (17%) were “transfers on section”. Whether or not these transfers in section were double-counted led to a difference between a 12.8% fall in recorded detentions from 2015/16 KP90 data to 2016/17 MHSDS data, and a 2% rise.

Double-counting of “transfers on section” seems therefore to have inflated reported numbers of detentions. Has this double-counting become more marked over time however, and thus contributed to the rising rate of detentions? NHS Digital report that the number of transfers of inpatients between different provider organizations more than doubled between 2011/12 and 2015/16 (NHSD 2016), but that the extent of “transfers on section” within this number is uncertain. As inpatient beds have more than halved over the last 20 years and local beds may not always be available, we might expect an increase in “transfers on section” for detained patients, but the extent of this in reality is unknown.

Overall then, improvement in data reporting is a possible contributory factor to the rising rates of detentions, and increased double-counting of detained patients moving between organizations is a probable contributory factor. The scale of these phenomena is hard to quantify. However, data analysis conducted for the 2018 Mental Health Act Review suggests it may not be negligible. An analysis of anonymized patient records in two large, London NHS Provider Trusts, found no rise in rates of detention at all in one London NHS Trust between 2009-2016 (a 13% rise in the number of detentions in the context of a 14% rise in the catchment area population), and a much lower rise from 2007-16 in the other than would be expected from national data (33% rise in the context of a 14% population rise) (Oram et al. submitted). While this may, at least in part, have other explanations (such as increased use of private providers to care for detained patients), and may not be typical, it also suggests that the actual rise in rates of detentions in England may be less than the reported rise, due to artefactual increases in data recording of detentions.

References

NHS Digital (2016) *“Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16”* NHS Digital, London

NHS Digital (2017) *“Mental Health Act Statistics, Annual Figures 2016/17: Background Data Quality Report: Experimental Statistics”* NHS Digital, London

Care Quality Commission (2018) “Monitoring the Mental Health Act in 2016/17” Care Quality Commission, Newcastle

Health and Social Care Information Centre (2014) “Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013/14” HSCIC, London

Care Quality Commission (2018b) “Mental Health Act: the rise of the use of the Mental Health Act to detain people in England” Care Quality Commission, Newcastle

Oram, S. Colling,C. Pritchard,M. et al. (submitted) “Patterns of use of the Mental Health Act 1983, from 2007-08 to 2016-17, in two major secondary mental healthcare providers in London.”