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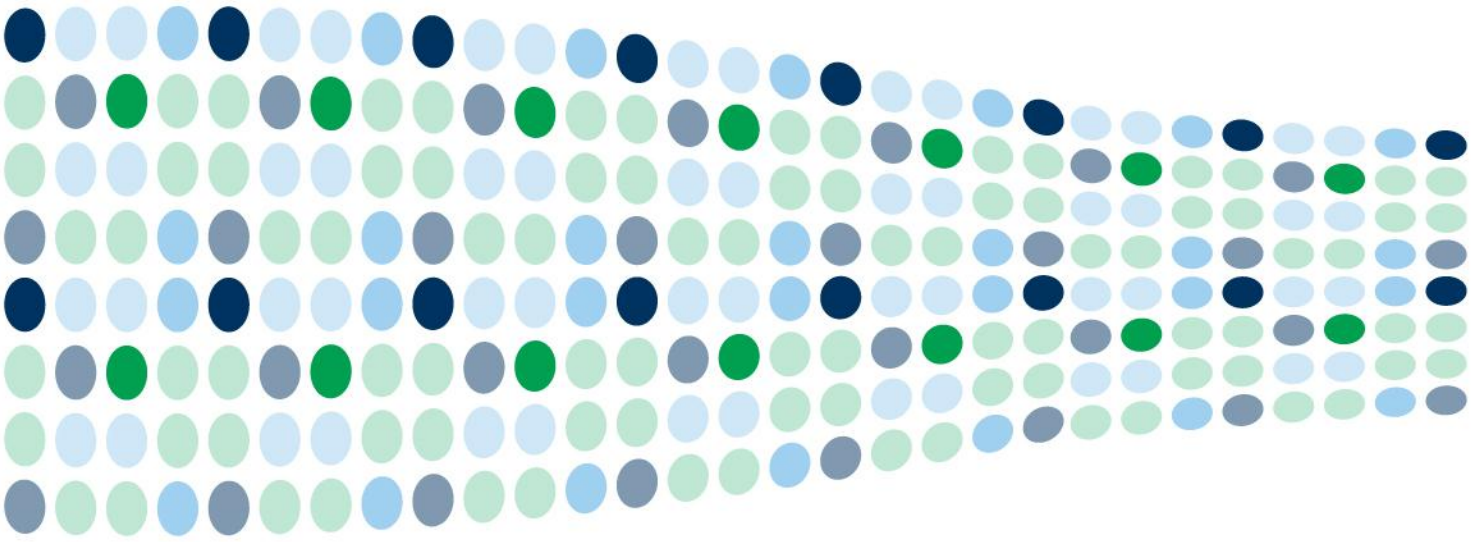
Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment:

Annual report, England, 2013/14



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0300 303 5678

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These statistics are important in monitoring uses of The Act and will be of interest to mental health professionals as well as service users, their families and representative organisations.

Author:	**Community and Mental Health Team, Health and Social Care Information Centre**
Responsible statistician:	**Claire Thompson, Principal Information Analyst**
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Contents

Executive Summary

Key Findings:

At the end of the 2013/14 reporting period (31st March 2014):

- There were a total of 23,531 people subject to The Mental Health Act ('The Act'). Of these, 18,166 were detained in hospital on longer term hospital orders[1] and 5,365 were being treated in the community on Community Treatment Orders (CTOs). The total is 6% (1,324) more than at the end of the previous reporting period, and 32% greater than at the end of 2008/09, the year CTOs were introduced.

During the 2013/14 reporting period:

- The Act was used 53,176 times to detain patients in hospital for longer than 72 hours, 5% (2,768) more than during the 2012/13 reporting period and 30% more during 2003/04.
    - In 65% (34,806) of cases, detentions were made on admission to hospital, but they were also made following a stay as an informal patient and/or a short term or emergency detention order had been used (14,087 cases), following a Section 136 order (2,882 cases) or following revocation of a CTO (1,401 cases).
- Independent sector providers (ISPs) are increasingly being used to care for detained patients; overall 10% (5,162) of longer-term detentions (lasting >72 hours) under The Act were in ISPs, which is 6 percentage points larger than ten years ago (4% or 1,530). 82% of detentions in ISPs were on admission compared with 64% in NHS providers.
- The number of new CTOs issued was 5% lower than during the previous reporting year (4,434 compared with 4,647) suggesting that uptake following their introduction may now have levelled off. The number of people subject to CTOs (5,365) as a proportion of all those subject to The Act at the end of the year[2] has increased since their introduction to level off at around 23 per cent from March 2013 onwards. This compares to 17% back in March 2010, after CTOs had been available for a year.
- The figures show that the total number of Place of Safety Orders[3] made has increased by 5% (1,166) to 23,343 since 2012/13. Of the 23,036 Place of Safety orders made using Section 136, the proportion where the individual went to a hospital rather than a police custody based Place of Safety increased from 64% (14,053) during 2012/13 to 74% (17,008) this reporting year (reflecting an 21% increase in uses of hospital based-, and a 24% decrease in police custody based-, Place of Safety Orders).

[1] 'Longer term hospital orders' refers to those lasting longer than 72 hours. It excludes uses of Section 4, 5(2), 5(4) and Place of Safety Orders in healthcare provider based Places of Safety under Sections 135 and 136.
[2] 'All subject to The Act' is a count of people on both longer-term and short term detentions plus those on Community Treatment Orders.
[3] The 2012/13 figure has been revised to include an estimated figure of 120 for British Transport Police so that totals for 2012/13 and 2013/13 are comparable.

Introduction

Content of this release

This report summarises information collected during 2013/14 about uses of The Mental Health Act (1983) ('The Act'), as amended by The Mental Health Act 2007 ('The 2007 Act') and other legislation. Under The Act, people with a mental disorder may formally be detained in hospital in the interests of their own health or safety, or can be treated in the community but subject to recall to hospital when necessary for assessment and/or treatment under a Community Treatment Order (sometimes referred to as 'Supervised Community Treatment' or 'SCT'). Data were collected via the Health and Social Care Information Centre (HSCIC) online Omnibus KP90 collection from all organisations in England which provide Mental Health Services and make use of the Mental Health Act 1983 legislation, as amended by the Mental Health Act 2007, and other legislation. This includes high security psychiatric hospitals as well as other NHS service providers and independent hospitals.

All figures are at England level, and are derived from the KP90 collection unless otherwise stated. Figures do not include people subject to Guardianship under the Mental Health Act, or those subject to a deprivation of liberty under the Mental Capacity Act. They also do not include transfers (a person arriving at a provider who is already subject to The Act should not be counted a second time). We have extended several analyses to include a ten rather than five year time series and this include report charts. For user convenience, set of ten-year analyses used to prepare this report are provided as a separate set of reference tables.

Experimental analysis of MHMDS provides further detail about age, gender, ethnicity, repeat uses of the Act and these are referenced where appropriate in the 'Uses of the Mental Health Act – Demographics section'. The 'Experimental Statistics' section includes a more detailed comparison of summary figures produced from KP90 and the Mental Health Minimum Dataset (MHMDS) and provides explanations for some of the variation between the information from different sources. Additional statistics from Prison Health Reporting Systems and Police Custody Databases which add value and context are included in the 'Part III – Court and Prison disposals' and 'Place of Safety detentions' sections respectively.

The content of this release comprises of data for the 2013/14 reporting year as follows:

- This report comprising summary statistics, tables, charts and commentary;
- KP90 national reference data tables (with an organisational breakdown and crude detention rates);
- KP90 Ten year time series data tables;
- Experimental data tables (from KP90, MHMDS, Police Custody Databases and Prison Health Reporting System);
- A machine readable dataset of underlying data (with a supporting metadata file).

The background data quality report is now included in the Appendices of this report.

This release is published at: http://www.hscic.gov.uk/pubs/inpatientdetmha1314

Format

A number of improvements[4] were made to these statistics in response to user feedback received during a public consultation on this publication held in early 2012[5]. Changes included refinements to measures and terminology as well as redesigned reference tables. We continue to use the new format, measures and terminology in this release; information on how to calculate pre-2012 measures is provided in the Appendix to this report. Figures in old format 'formal detentions' not included but the methodology is included in the Appendices.

In line with the NHS Anonymisation Standard[6], figures below national level are rounded to the nearest 5 and all values below 5 have been suppressed. Rates and percentages are based on unrounded figures, but are themselves rounded to the nearest 0.1.

Collecting the data

KP90

The KP90 is a long established aggregate collection which is returned by all types of services responsible for the care of patients detained under The Mental Health Act 1983 ('The Act'). This includes adult secondary mental health, child and adolescent mental health (CAMHS), learning disability services and acute services. The KP90 records uses of The Act during the year and the number of patients detained on a single day (31st March each year), but does not include patient demographic information such as ethnicity and age.

Data are collected via the HSCIC online Omnibus KP90 collection tool[7]. This report additionally includes for some experimental analysis sourced from the Mental Health Minimum Dataset (MHMDS), a national mandated administrative dataset, and from police custody databases and the Prison Health Reporting System.

Information was initially collected using the aggregate return KH15 on a financial year basis along with the KH16 return, which collected information on changes in legal status, from NHS Trusts. Information on behalf of private hospitals was completed by Health Authorities using the KO37 return. These three forms were replaced in 1996/7 by the KP90 form which is still in use today. We are currently working towards retiring the KP90 return in order to reduce NHS burden (as recommended by the Secretary of State's Fundamental Review of Returns). The intention is to replace the data source with existing 'administrative' datasets which are collected as part of routine service provision. These are the Mental Health Minimum Data Set (MHMDS)[8] and the Child and Adolescent Mental Health Services Dataset (CAMHS)[9]. The MHMDS is due to be superceded by the Mental Health and Learning Disabilities Data Set (MHLDDS)[10] in September 2014.

[4] Methodological Changes – see 'Mental Health' section: http://www.hscic.gov.uk/pubs/methchanges
[5] Mental Health Act statistics consultation, Health and Social Care Information Centre: http://www.hscic.gov.uk/MentalHealthAct_stats_consultation
[6] Anonymisation Standard for Publishing Health and Social Care Data: http://www.isb.nhs.uk/library/standard/128
[7] Admissions, Changes in Status and Detentions under the Mental Health Act Collection (KP90): http://www.hscic.gov.uk/datacollections/kp90
[8] Mental Health Minimum Data Set: http://www.hscic.gov.uk/mhmds
[9] Child and Adolescent Mental Health Services Data Set (CAMHS): http://www.hscic.gov.uk/mhmds
[10] Mental Health and Learning Disabilities Data Set (MHLDDS): http://www.hscic.gov.uk/mhldds

Retiring the KP90 Collection

Following a recommendation arising from the Secretary of State's Fundamental Review of NHS Returns[11] it is intended to replace this collection with administrative sources. As well as reducing burden on service providers, this will have the advantage of richer data which can add value e.g. patient demographics and pathways, and being available on a timelier basis.

National Statistics Status

The National Statistics status of this release has been withdrawn pending a successful transition between the existing data source (KP90) and a new data source (MHMDS and other administrative collections) being used as a basis for the statistics. Full details of this decision are in the assessment report that can be found on the UK Statistics Authority's website.

Feedback

We welcome feedback on any aspect of these statistics, as well as any other comments you would like to make. We are particularly interested in receiving comments from service users and/or their relatives or representatives. If you would like to provide us with some feedback please contact us through: enquiries@hscic.gov.uk

11 Fundamental Review of Data Returns – Consultation Response: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170873/FDR_cons_response_v0_23_clean.pdf

Background

The Mental Health Act

At least half of the patients being treated for mental health (psychiatric) problems in England in recent years were in hospital on an informal basis[12]. The others were in hospital as a 'formal' patient; this means that they had been admitted to hospital on a compulsory basis under The Mental Health Act 1983 (known as 'detained' or 'sectioned' under The Act). The main Act of Parliament covering the care and treatment of people with mental health problems.

The Mental Health Act 1983 ('The Act') is main Act of Parliament covering the care and treatment of people with mental health problems. It sets out how and when a person can be admitted, detained and treated in hospital without consent. In order to apply it, certain professionals must agree that this must be done because the health or safety of the individual, or that of other people, is at risk. The individual must be considered to have a 'mental disorder'; the definition of this term was broadened as a result of The 2007 Act.

Mental health law is about balancing the need to detain people in order to protect them or other people from harm and the need to respect peoples' human rights and autonomy[13]. Whilst the application of The Act to means that an individual loses certain rights (such as freedom and refusal of treatment), it also sets out patient rights e.g. that an individual has a right of appeal and help from an advocate, and free aftercare once released from certain Sections. These are outside the scope of data collections made as part of this release but more information can be found in the Code of Practice for the Mental Health Act.[14]

The various Parts and Sections of The Act have different purposes, durations and other features which will be discussed in more detail in the relevant parts of this report. The majority of Sections used to detain patients fall under Parts II and III of The Act, which cover 'civil Sections' and 'forensic Sections' (those applied under Criminal Law). More information is provided in the relevant sections of this report, with further details in the Appendix.

Changes to Mental Health law

The Mental Health Act 2007 made some major amendments to the existing 1983 Act. These included the introduction of Community Treatment Orders, which came into effect in November 2008 and replaced Supervised Discharge. They allow suitable patients to be treated in the community rather than under detention in hospital and were intended to address the problem of 'revolving door' patients (those that end up being repeatedly detained in hospital), although a person does not need to have been readmitted in order to be placed on a CTO.

The Code of Practice to The Mental Health Act was also updated to reflect and clarify these changes. Five key principles were introduced which included the using the least restrictive options, and involving the patient in their care decisions, wherever possible.

Another key change was to wider the definition of 'mental disorder', which became 'any disorder or disability of the mind' and removed older exclusions and categories. Learning disabilities continued to

[12] About 75%, according to MIND http://www.mind.org.uk/information-support/legal-rights/mental-health-act-the-mind-guide/#.VCGC_ZRdWO0. Our figures (2013 Bulletin) show that 57,263 out of 105,224 patients whose records were in MHMDS returns were not subject to The Mental Health Act at any point during the 2012/13 reporting year. http://www.hscic.gov.uk/catalogue/PUB12745

[13] Changes to the Mental Health and Mental Capacity Acts: implications for patients and professionals: Ian Hall and Afia Ali: http://pb.rcpsych.org/content/33/6/226.full

[14] Code of Practice: Mental Health Act 1983: http://www.lbhf.gov.uk/Images/Code%20of%20practice%201983%20rev%202008%20dh_087073%5B1%5D_tcm21-145032.pdf

not be a reason to use some parts of The Act[15] (unless associated with abnormally irresponsible or aggressive behaviour).

The change also gave the Police a new power to transfer people between places of safety, although our current collections cannot record this.

Other changes to The Act were made as a result of the Health and Social Care Act 2012, the Mental Health (Discrimination) Act 2013, and the Care Act 2014; references are provided in the Appendix.

The Mental Health Act and the Mental Capacity Act

The Mental Capacity Act allows among other provisions the restriction of freedom of individuals who do not have capacity to agree to decisions e.g. regarding their freedom, finances, and choices about health assessments, treatment and visitors. The 2007 Mental Health Act made changes to The Mental Capacity Act 2005 including the introduction of Deprivation of Liberty Safeguards (DoLS) from 2009. DoLS are used to restrict liberty of individuals who are not detained in hospital under the Mental Health Act (i.e. those either not subject to the Mental Health Act, or those on a CTO or Guardianship order), for example for patients who need to be deprived of their liberty in a care home. CTOs cannot authorise deprivation of liberty but can dictate where a person must live, so if a DoL order is used the stated place of residence must not be contradictory under the two orders.

Where a person lacks capacity, the Mental Capacity Act should always be used in preference to the Mental Health Act to admit and detain in hospital for treatment, provided they don't object to or resist the admission or treatment. The Mental Health Act (Part II Section 3) should only be used where necessary.

Deprivation of liberty orders are applied for by the responsible care home or hospital and are authorised (or not) the responsible supervisory body[16]. The safeguards are intended to ensure that this is only done when it is in the best interests of the individual and also to provide a framework to determine whether a deprivation of liberty is already occurring for existing cases, and whether or not this is appropriate, as well as reviewing or monitoring existing arrangements).

More detail is provided in the Appendix to this report.

[15] Learning disabilities are only covered under The Act for unrestricted treatment sections and CTOs in exceptional cases (where an individual exhibits unusually irresponsible or aggressive behaviour).
[16] Following the dissolution of PCTs in 2013 as a result of the 2012 Health and Social Care Act, all deprivation of liberty orders are made by Local Authorities. Prior to this, orders for persons in social care settings were managed by Local Authorities and those for persons in health settings were managed by Primary Care Trusts (PCTs).

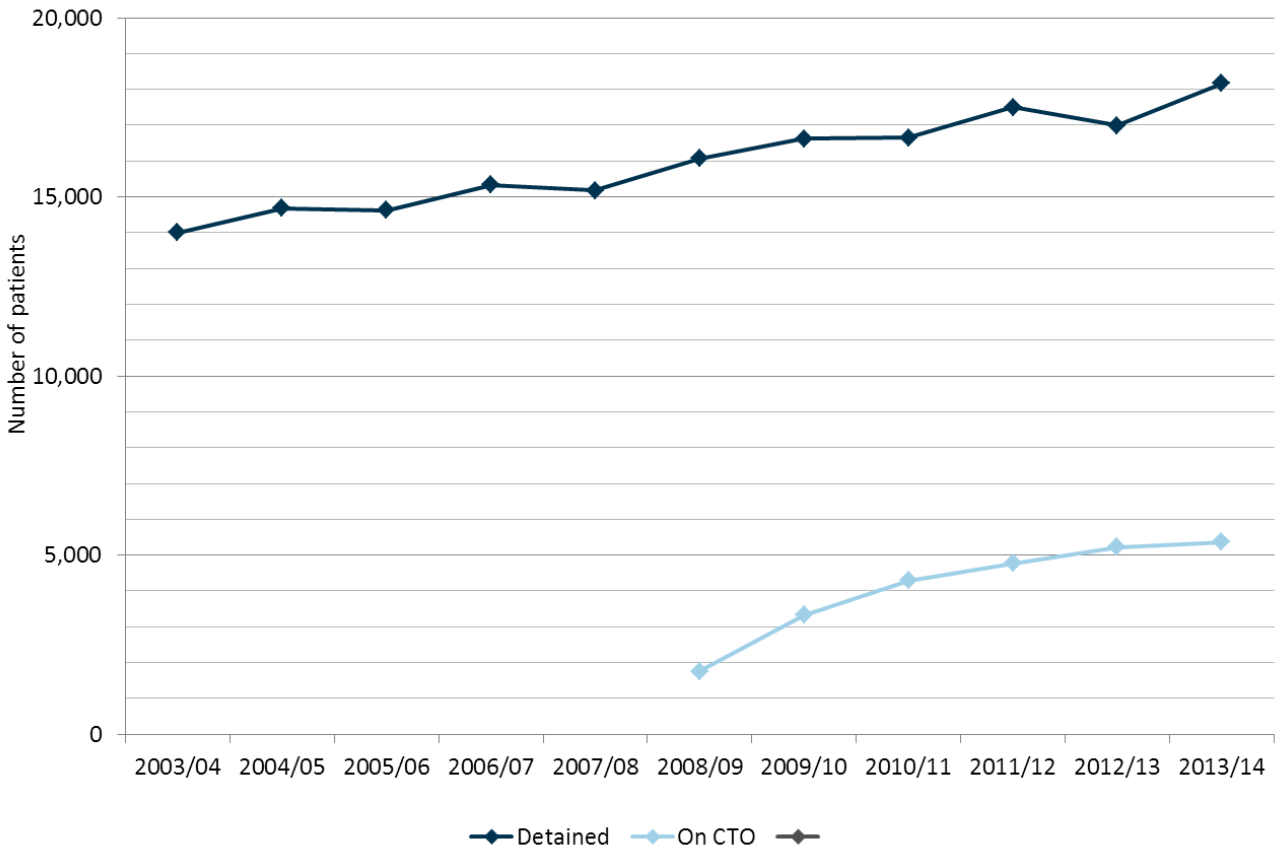
Findings

People subject to The Mental Health Act

At the end of the 2013/14 reporting year (31st March 2014), there were a total of 23,531 people subject to the Mental Health Act[17] ('The Act'), as amended by The Mental Health Act 2007 and other Acts (see Appendix). Of these, 18,166 were detained in hospital[18] and 5,365 were being treated in the community on Community Treatment Orders (CTOs). The total is 6% (1,324) more than at the end of the previous reporting period, and 32% greater than at the end of 2008/09, the year CTOs were introduced.

Before the introduction of CTOs a patient could be treated in the community under Section 25A (aftercare under supervision) but the KP90 did not record these patients so we cannot provide a total figure for patients subject to The Act before 2008/09.

Figure 1: Patients detained in hospital or on Community Treatment Orders on the 31st March 2014; 2003/04 – 2013/14



Source: Tables 4 and 5 of the ten year time series tables

[17] 'Subject to the Mental Health Act' refers to patients who were detained in hospital (see next footnote) and patients being treated in the community on CTOs.
[18] 'Patients detained in hospital' refers to both longer-term hospital orders which last longer than 72 hours and short-term orders, which last up to 72 hours and include Place of Safety detentions in hospital under Sections 135 and 136. For further information, please see the Appendix.

Figure 1 above shows snapshot counts for the last ten years of patients detained in hospital or on a CTO on the 31st March each year. The number detained in hospital has risen by nearly a third (30% or 4,166) in the last ten years. Most years the number increased, but two 'dips' were observed (1% decline during 2007/08 and a 3% decline during 2012/13).

CTOs were introduced in November 2008 and since the 2008/09 reporting year; the number of people subject to them on the 31st March has more than doubled (an increase of 206% or 3,610) and increases have been observed every year since their introduction. Between 31st March 2013 and 31st March 2014, the number of people subject increased by 3% (147). A decrease for new CTOs issued during the reporting period (see 'Community Treatment Orders' section later in this report suggests however that CTO uptake following their introduction may now be levelling off. The number of people subject to a CTO as a proportion of all those subject to The Act at the end of the year[19] has increased since their introduction to 'level off' at around 23 per cent from March 2013 onwards. This compares to 17% back in March 2010, after CTOs had been available for a year.

Table 1: Patients detained in hospital or on Community Treatment Orders on the 31st March 2014 – rates per 100,000 population

numbers and crude rates per 100,000 population

		subject to The Act		*of which:*			
				subject to detention		subject to CTO	
	Estimated Population	*no.*	*rate*	*no.*	*rate*	*no.*	*rate*
2014	53,865,800	23,531	43.7	18,166	33.7	5,365	10.0
2013	53,493,700	22,207	41.5	16,989	31.8	5,218	9.8
2012	53,107,200	22,267	41.9	17,503	33.0	4,764	9.0
2011	52,642,500	20,938	39.8	16,647	31.6	4,291	8.2
2010	52,196,400	19,947	38.2	16,622	31.8	3,325	6.4
2009(1)	51,815,900	17,828	34.4	16,073	31.0	1,755	3.4
2008	51,381,100	-	-	15,181	29.5	-	0.0
2007	50,965,200	-	-	15,339	30.1	-	0.0
2006	50,606,000	-	-	14,625	28.9	-	0.0
2005	50,194,600	-	-	14,681	29.2	-	0.0
2004	49,925,500	-	-	14,000	28.0	-	0.0

Source: Tables 4 and 5 of the ten year time series tables/ Office of National Statistics: Mid-year Population Estimates

'-' not applicable

(1) CTOs were introduced part-way through the 2008/09 reporting year in November 2008.

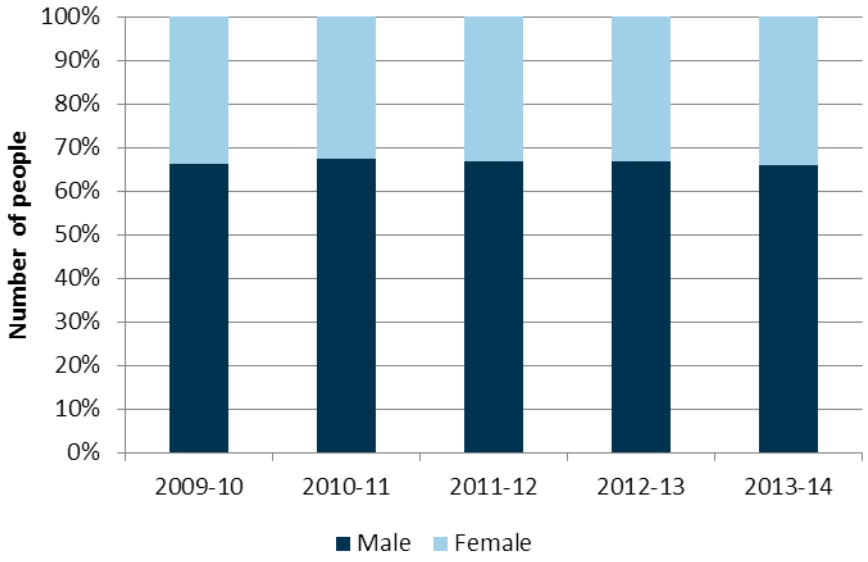
Table 1 shows the snapshot counts in Figure 1 displayed as a proportion of the population (these are 'crude rates' which are not adjusted in any way e.g. for age or gender). Since the introduction of CTOs, there was an increase in the rate of people subject to The Act from 34.4 per 100,000 population during 2008/09 to 43.7 during 2013/14. As we do not have figures for people subject to supervised community discharge we cannot compare these rates to any prior to 2008/09.

[19] 'Subject to The Act' refers to all people on CTOs, longer-term and short-term detentions (including Place of Safety Orders).

Demographics

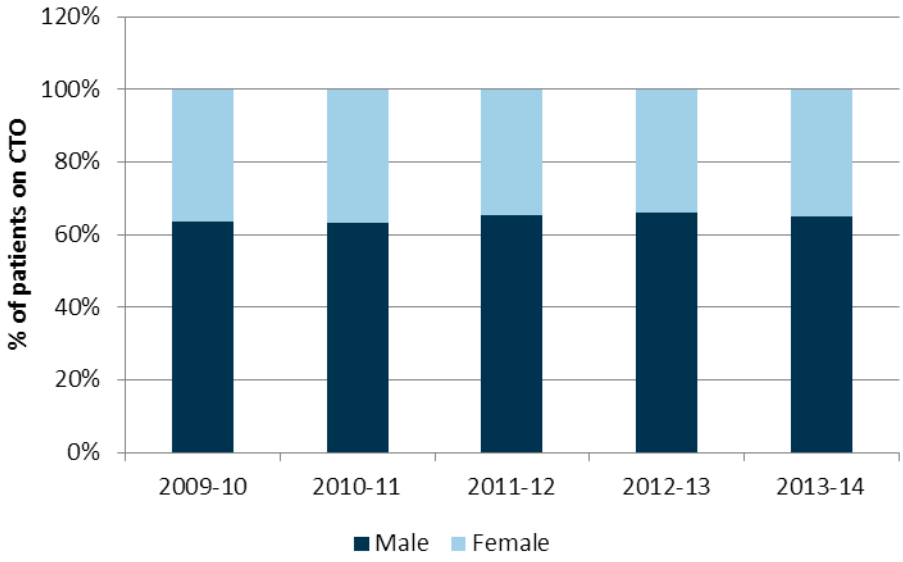
Gender

Figure 2: Patients detained at 31st March: proportions by gender; 2009/10 – 2013/14



Source: Table 8 of the reference data tables

Figure 3: Patients on CTO at 31st March: proportions by gender; 2009/10 – 2013/14



Source: Table 8 of the reference data tables

The proportion of people subject to detention or CTO under The Act who were male has remained consistent at around two thirds over the past five years. On 31st March 2014, 66% of detained patients (11,968) and 65% of patients subject to CTO (3,489) were male. These figures are

consistent with figures recorded over the past five years where approximately two thirds of each group were male.

For the 31st March 2014 snapshot counts, a learning disability was cited as the primary reason for using The Act for 8% (1,405) of patients detained in hospital; this is important as learning disabilities are only covered under The Act for unrestricted treatment sections and CTOs[20] in exceptional cases (where an individual exhibits unusually irresponsible or aggressive behaviour). To provide some context, a 2013 survey[21] counted 3,250 patients in England[22] with learning disabilities and/or autistic spectrum disorders (including Asperger's Syndrome) and/or 'behaviour that challenges' occupying CQC registered inpatient beds for mental and/or behavioural healthcare at midnight on the 30th September. Of these, nearly four fifths (78% or 2,528) were subject to detention under The Act. Comparing the two figures suggests that for perhaps half of the detained patients captured in the Census had been detained and a learning disability had been the primary reason for using The Act.

[20] The Act may be used with learning disability as a primary reason for using it under Part II sections 2, 4 and 5.
[21] Learning Disabilities Census Report, England – 30 September 2013, Further Analysis: http://www.hscic.gov.uk/catalogue/PUB14046
[22] The Learning Disabilities Census covers England, but includes service users with a ward stay in England and a residential address in another U.K. country. A small number of providers submitted data for service users resident in England (or receiving services commissioned by an English commissioner), but with a ward stay in another U.K. country. This data is also reported (under 'Other U.K. country'), but readers should note that coverage for this subset of service users is likely to be low.

Use of the Mental Health Act

The next sections of this report describe the number of times The Act was used to detain or restrict patients. Uses of Guardianship under The Act are not included, and are the subject of a separate HSCIC release[23]. A patient may be admitted to hospital on a compulsory basis under The Act for assessment and/or treatment of a mental health disorder. Provided that the processes in The Act are followed, this may be done regardless of the patient's wishes. This is often referred to as 'sectioning', and a patient may be sectioned more than once during the year.

Longer term detentions

This report section describes all detentions lasting over 72 hours, and these may occur in a variety of circumstances:

- Detentions before or at the point of admission to hospital ('detentions on admission');
- Detentions made whilst a patient is already in hospital being treated for a mental health condition on an informal basis ('detentions subsequent to admission');
- Detentions following the use of a Section 136 by the Police;
- Detentions following the revocation of a Community Treatment Order (CTO).

Uses of short-term detentions (those lasting up to 72 hours) are covered later in a separate part of this report.

Table 2: Longer term detentions by type of detention, 2009/10 -2013/14

numbers

	2009-10	2010-11	2011-12	2012-13	2013-14
All detentions:	**46,600**	**46,348**	**48,631**	**50,408**	**53,176**
Detentions on admission to hospital:	30,187	29,557	30,900	32,224	34,806
Detentions subsequent to admission:	13,712	13,397	13,680	14,249	14,087
Detentions following use of Section 136:	1,922	2,376	2,582	2,426	2,882
Detentions following revocation of CTO:	779	1,018	1,469	1,509	1,401

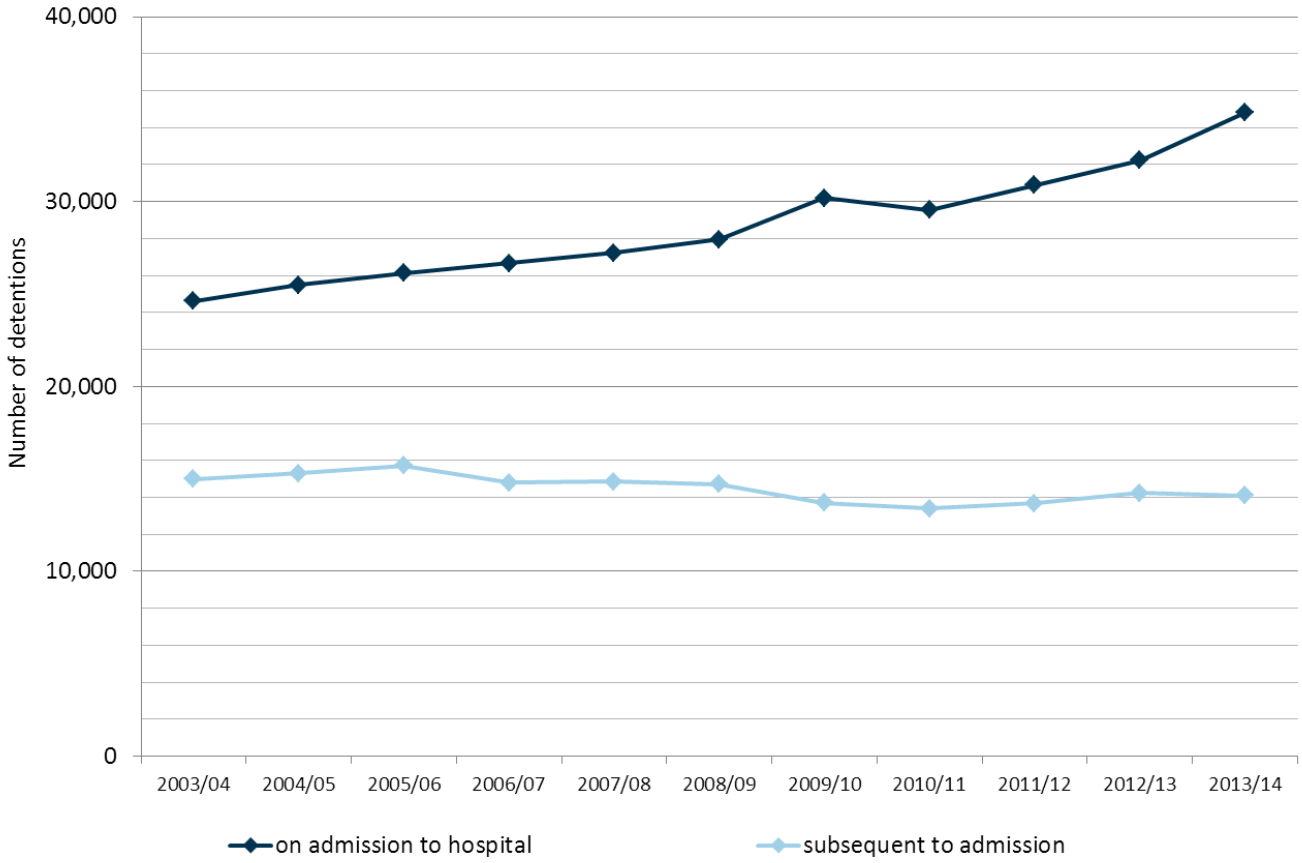
Note: The 'All longer term detentions' figures exclude: Short term detention orders (Sections 4, 5(2), 5(4), 135 and 136); Detentions following the use of Section 135; Detentions following recalls from conditional discharge. Section 136 uses in custody suites are out of scope of the current KP90 collection

Source: Table 1 of the reference data tables

In the reporting year 2013/14, there were a total of 53,176 longer-term detentions under The Act. The 'All longer term detentions' figure has risen by 5% (2,768) since 2012/13 and 65% of these detentions were made on admission to hospital. Uses of detentions on admission and detentions following the use of Section 136 increased since 2012/13 (up by 8% (2,582) and 19% (456) respectively). Conversely, the number of detentions subsequent to admission and detentions following CTO revocation fell between 2012/13 and 2013/14 (down by 1% (162) and 7% (108) respectively).

[23] Guardianship under the Mental Health Act 1983, England 2013-14, National Statistics: http://www.hscic.gov.uk/catalogue/PUB14853

Figure 4: Longer term detentions by type of detention, 2003/04 -2013/14



Source: Table 1 of the reference data tables

Over the past ten years, the number of longer term detentions has risen by 30% (12,319). Uses of detentions on admission has increased by two fifths (41% or 10,188) whilst the number of detentions subsequent to admission has fallen by 6% (913).

Rates and regional analysis

Table 3: Longer term detentions 2009/10 - 2013/14

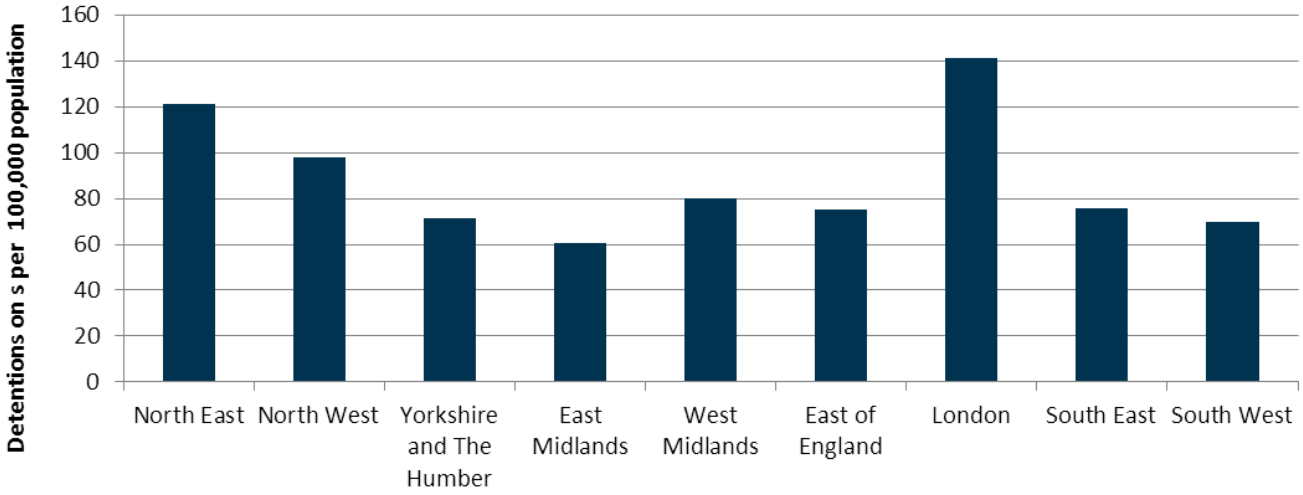
numbers and crude rates per 100,000 population

	Estimated Population	*detentions*	
		no.	*rate*
2013/14	53,865,800	53,176	98.7
2012/13	53,493,700	50,408	94.2
2011/12	53,107,200	48,631	91.6
2010/11	52,642,500	46,348	88.0
2009/10	52,196,400	46,600	89.3
2008/09	51,815,900	44,543	86.0
2007/08	51,381,100	44,093	85.8
2006/07	50,965,200	43,038	84.4
2005/06	50,606,000	43,361	85.7
2004/05	50,194,600	42,122	83.9

Source: Table 1 of the ten year time series tables/ Office of National Statistics: Mid-year Population Estimates

Table 3 shows that the use of longer term detentions generally increased over the past ten years, although there were two dips between 2005/06 and 2006/07, and 2009/10 and 2010/11. The rate of detentions per 100,000 follows the same pattern, with an overall increase of 15 percentage points in the ten years.

Figure 5: Longer term detentions per 100,000 population in NHS providers by Government Office Region, 2013/14



Source: Table 11 of the reference data tables

Figure 5 shows the regional variation between rates of longer term detention uses in NHS providers under The Act. These figures are presented by Government Office Region for NHS providers here, and are provided by Area Team (new NHS geography) in the reference data tables. Compared with the national rate of 89.1 per 100,000 population, three regions had higher rates (London -140.9; the North East -121.3; and the North West -98.1). The other regions had rates of detention that were

lower than the national rate, with the East Midlands having the lowest at 60.8 detentions per 100,000 population.

All rates are for the area where treatment is being provided, as the KP90 collection does not include details about where a patient's home might be. One of the key findings in the Learning Disabilities Census 2013[24], which includes detained patients with learning disabilities, was that just fewer than one in five patients were being treated in wards 100km or more from their residential postcode. Patient postcode of residence is collected in the administrative datasets such as the MHLDDS and we hope in future to be able to provide this kind of information for all detained patients.

Type of provider

Table 4: Longer term detentions by type of provider, 2012/13 - 2013/14

			numbers and percentages	
			change:	2012/13-2013/14
	2012-13	2013-14	*no.*	*%*
Total	**50,408**	**53,176**	**2,768**	**5**
on admission to hospital	32,224	34,806	2,582	8
subsequent to admission	14,249	14,087	-162	-1
following use of Section 136	2,426	2,882	456	19
following revocation of CTO	1,509	1,401	-108	-7
NHS providers	**46,151**	**48,014**	**1,863**	**4**
on admission to hospital	28,779	30,574	1,795	6
subsequent to admission	13,490	13,254	-236	-2
following use of Section 136	2,411	2,837	426	18
following revocation of CTO	1,471	1,349	-122	-8
Independent providers	**4,257**	**5,162**	**905**	**21**
on admission to hospital	3,445	4,232	787	23
subsequent to admission	759	833	74	10
following use of Section 136	15	45	30	200
following revocation of CTO	38	52	14	37

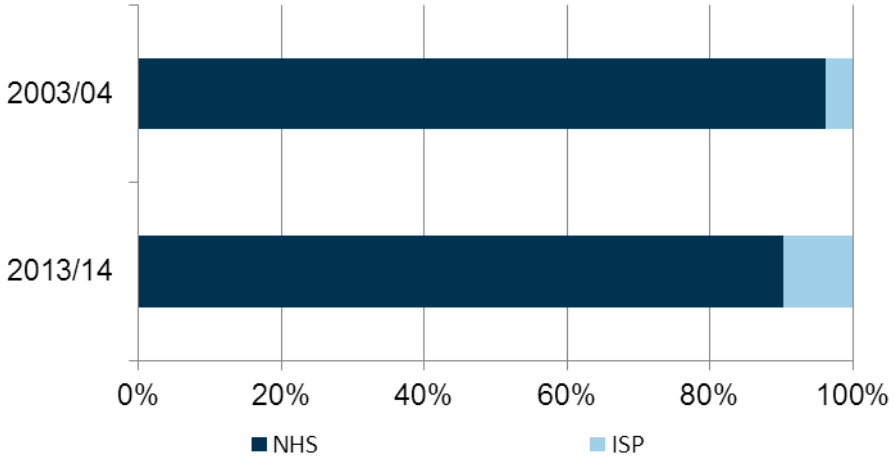
Source: Tables 2a and 2b of the reference data tables

NHS providers were responsible for 90% of longer term detentions during 2013/14 and consequently the changes seen overall by type of detention (described in the on page 14 earlier) can largely be attributed to changes in figures recorded for these organisations. Whilst the number of detentions subsequent to admission and following revocation of a CTO decreased between 2012/13 and 2013/14 overall and for NHS providers, the number for Independent Sector providers (ISPs) increased for every type of longer term detention.

Over four fifths (82%) of detentions in ISPs during 2013/14 were on admission, compared with 64% in NHS providers. This reflects a difference in services provision, and many of these patients will be admitted directly from the Courts (see 'Part III' later in this report).

[24] Learning Disabilities Census Report: http://www.hscic.gov.uk/catalogue/PUB13149

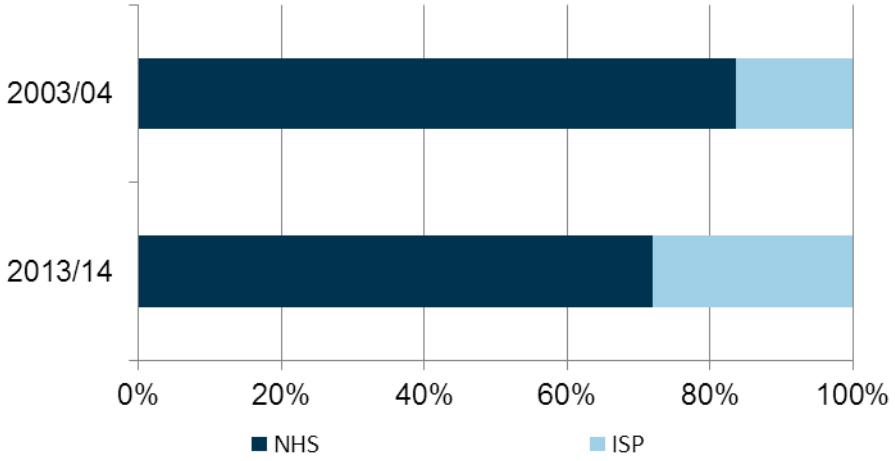
Figure 6: Longer term detentions by type of provider; 2013/14



Source: Tables 2a and 2b of the ten year time series tables

The figures in Table 4 above suggest that care of detained patients is increasingly being commissioned from non-NHS providers. Between 2012/13 and 2013/14, the number of longer term detentions in Independent Service Providers (ISPs) increased by 21% (905). At 5,162 detentions, this is 10% of all longer term detentions and is more than double the proportion ten years ago (4% or 1,530).

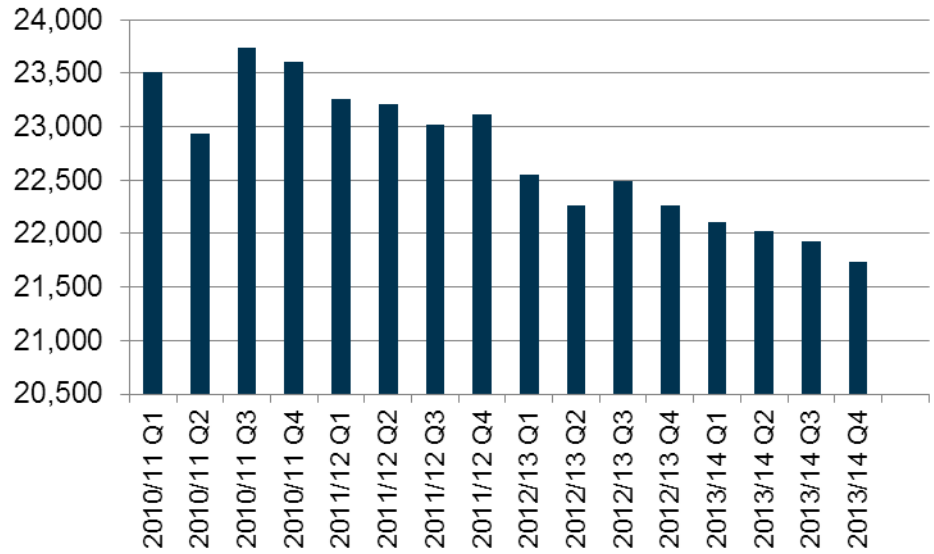
Figure 7: Patients detained in hospital at the end of the reporting period (31st March)



Source: Table 4 of the ten year time series tables

Figure 7 shows the number of detained patients at the end of the reporting year for context (this includes short term detentions; see 'People subject to The Act' section earlier in this report). On 31st March 2014, independent sector providers were responsible for 28% (5,081) of patients detained in hospital under The Act; ten years ago this proportion was 16% (2,292). For more information please see Table 4 of the ten year time series.

Figure 8 Average daily available NHS Mental Illness beds open overnight, quarter 1 2011/12 – quarter 4 2013/14



Source: KH03 return, NHS England[25]

The increase in use of independent sector providers to care for patients with a mental disorder in England may be linked to decreasing bed availability in NHS mental health providers; figure 8 shows that the number of available mental health beds open overnight under the care of consultants between 2010/11 and 2013/14 has been decreasing. A 'thematic probe' on the subject of bed occupancy in psychiatric inpatient facilities was recommended by the Care Quality Commission (CQC) at a public board meeting in September 2013[26].

[25] Bed Availability and Occupancy figures; NHS England: http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

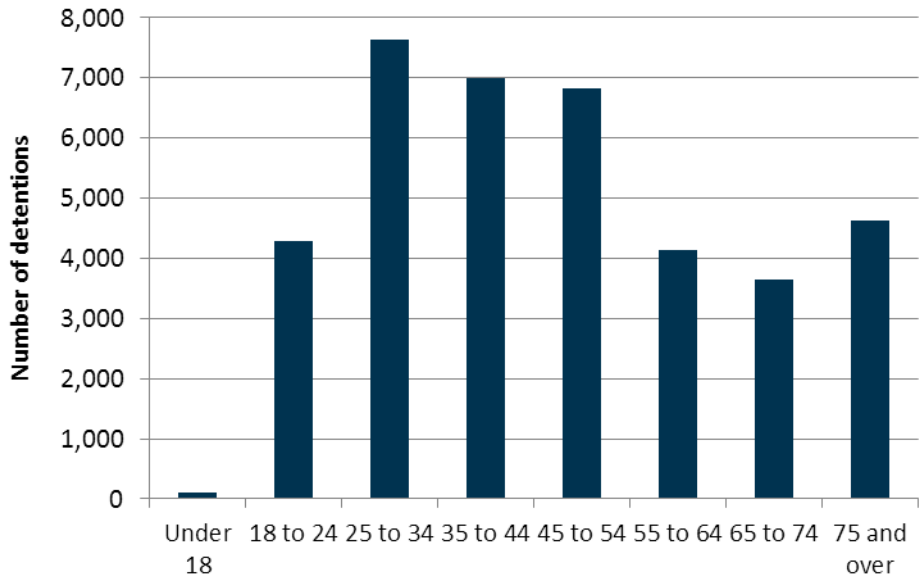
[26] Care Quality Commission (CQC): Thematic reviews – future topics and proposals for a more systematic approach to topic selection: http://www.cqc.org.uk/sites/default/files/documents/cm_071309_item_9_thematic_reviews__future_topics_and_topic_selection.pdf

Demographics

The Mental Health Minimum Dataset (MHMDS) (see 'Experimental Statistics' section below) contains record level data about the care of patients in adult secondary mental health services[27]. This type of provider accounted for an estimated 72%[28] of longer-term detentions recorded in the KP90 return during 2013/14 (see Table 1 of the experimental data tables). The MHMDS is a very rich data source, and contains demographic data not collected in the KP90 which can be used to add value to our statistics.

Age

Figure 9: Longer term detentions by age band, 2013/14



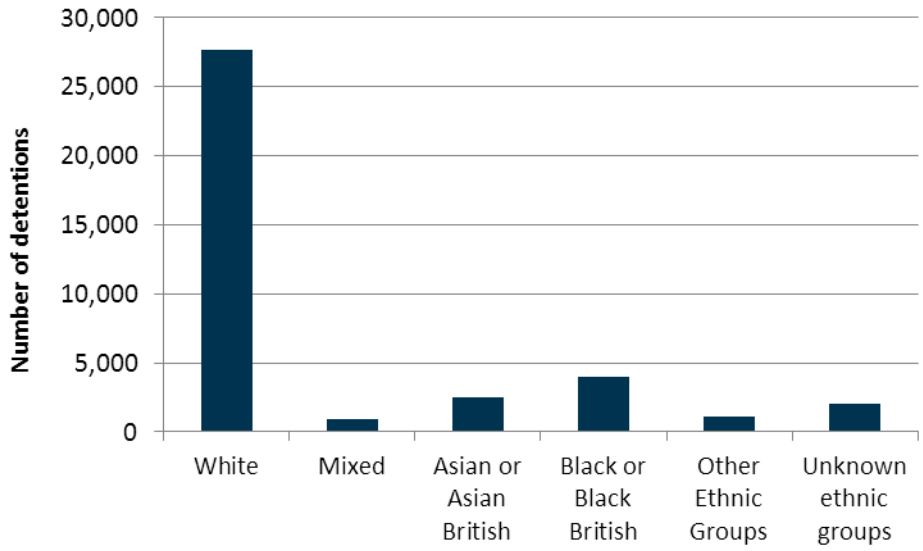
Source: Annualised MHMDS file; Table 10a of the experimental data tables

Figure 9 shows that the highest number of longer term detentions in adult secondary mental health services during 2013/14 was for patients in the 25-34 age group. This was followed by detentions of patients in the 35-44 and 45-54 age groups; in total these three groups accounted for over half (56%) of detentions. The average (mean) age of patients was 47.2 years of age.

[27] A small number of patients aged under 18 are cared for in adult secondary mental health services.
[28] The MHMDS excludes learning disability, child and adolescent mental health and acute services. Coverage of independent service providers in the MHMDS is currently poor, See 'Experimental statistics' section below for more information.

Ethnicity

Figure 10: Longer term detentions by broad ethnic group, 2013/14



Source: Annualised MHMDS file; Table 11a of the experimental data tables

Figure 10 shows that during 2013/14 nearly three quarters (72% or 27,697) of detentions were of patients in the 'White' ethnic group. Within the black and ethnic minority group categories, there were more longer-term detentions of people in the 'Black or Black British' category than in any other category (these detentions accounted for 10% or 4,012 of all longer term detentions). Ethnicity in MHMDS is specified by the person, and this is the likely reason that the number of detentions where the ethnicity was 'not stated' or 'not known' was quite high (5%; or 2003).

Detentions on admission to hospital

This section looks at detentions on admission to hospital in more detail.

Part II – 'Civil detentions'

Unless an individual is being detained in hospital via the Criminal Justice System, they will be detained under Part II of The Act, using either a Section 2 or Section 3 order. Two doctors must examine the patient and agree that the patient should be detained (further details are provided in the Appendix to this report).

Section 2 is usually used to assess then treat a patient if required, so if the individual has not been sectioned before it is more likely that this will be used than Section 3. Section 3 is used specifically to treat a patient, and the appropriate treatment must be available when the order is made.

Section 2 lasts for a maximum of 28 days, and cannot normally be renewed. A patient may be transferred onto a Section 3 from a Section 2 for longer term detention. A Section 3 lasts for 6 months at first and can be renewed as appropriate.

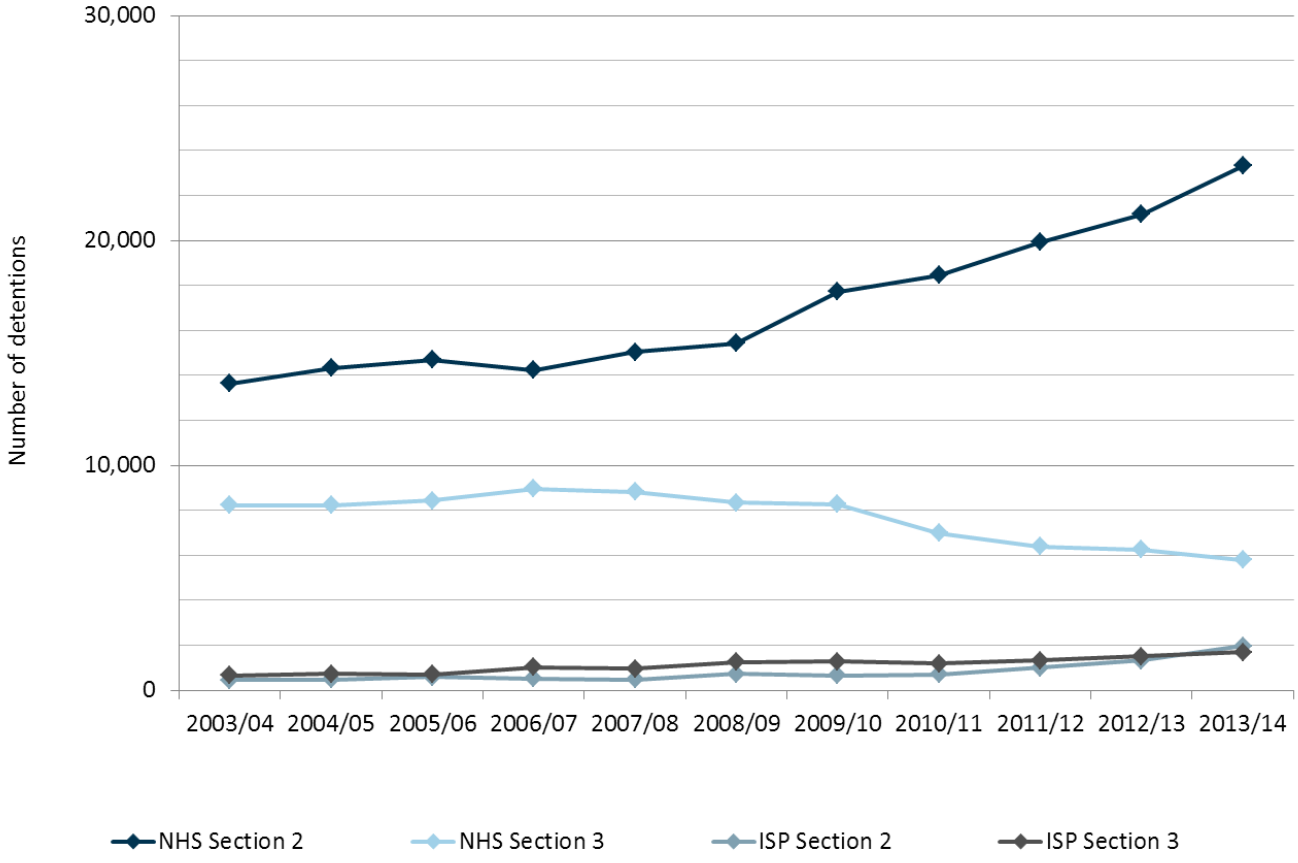
Table 5: Detentions under Part II by type of provider, 2012/13 - 2013/14

	2009-10	2010-11	2011-12	2012-13	2013-14
Part II Total	**27,930**	**27,337**	**28,632**	**30,253**	**32,781**
Section 2	18,385	19,163	20,931	22,477	25,300
Section 3	9,545	8,174	7,701	7,776	7,481
Part II Total - NHS providers	**25,996**	**25,448**	**26,304**	**27,413**	**29,116**
Section 2	17,719	18,467	19,920	21,153	23,326
Section 3	8,277	6,981	6,384	6,260	5,790
Part II Total - Independent providers	**1,934**	**1,889**	**2,328**	**2,840**	**3,665**
Section 2	666	696	1,011	1,324	1,974
Section 3	1,268	1,193	1,317	1,516	1,691

Source: Tables 2a and 2b of the reference data tables

During 2013/14, Part II of The Act was used to detain people on admission to hospital a total of 32,781 times. This is a 8% (2,528) increase in civil detentions since the previous reporting period. Uses of Part II of The Act accounted for 94% of the 34,806 detentions made on admission to hospital in 2013/14 (consistent with previous reporting years). Uses of Section 2 had increased since 2012/13 (by 13% or 2,823), whereas uses of Section 3 had decreased (by 4% or 295). The number of Section 3 uses excludes patients detained as a result of revocation of a CTO; more information is provided in the 'Community Treatment Orders' section of this report.

Figure 11: Section 2 and 3 uses by type of provider; 2003/04 – 2013/14



Source: Tables 2a and 2b of the ten year time series tables

Uses of Section 2 increased by 10% (2,173) in NHS providers and by 49% (650) in independent sector providers between 2012/13 and 2013/14. Over the past ten years, annual uses have increased by 71% overall (9,676) in NHS providers and by 329% (1,514) in ISPs. In 2013/14, Section 2 uses accounted for 76% of the 30,574 detentions on admission in NHS providers and 47% of the 4,232 detentions on admission in ISPs.

Uses of Section 3 decreased by 8% (470) in NHS providers and increased by 12% (175) in ISPs between 2012/13 and 2013/14. The ten year picture in Figure 11 shows an overall decrease in use of Section 3 by 30% (2,445) in NHS providers but an increase of 159% (1,039) in ISPs. During 2013/14, Section 3 uses accounted for 19% of the 30,574 detentions on admission in NHS providers and 40% of the 4,232 detentions on admission in ISPs.

Part III – 'Court and Prison disposals'

Part III of The Act sets out how people in contact with the Criminal Justice System who have a suspected or diagnosed mental health disorder receive appropriate treatment and care. It includes those who are charged pre-trial, those who are convicted but pre-sentence and those whose sentence is a hospital order by the Magistrate and Crown Courts, and those under sentence. Various hospital orders (sections) allow a person to be transferred at any stage in criminal proceedings to hospital for assessment and/or treatment (regardless of the offence). Various hospital orders (sections) allow a person to be transferred at any stage in criminal proceedings to hospital for assessment and/or treatment (regardless of the offence).

During 2013/14 there were 1,847 uses of Part III of The Act, which is 3% fewer than during 2012/13, but 15% (246) greater than ten years ago in 2003/04 (see Table 1 of ten year time series tables). The highest number of annual uses of Part III during the past ten years were for 2008/09 and 2010/11,

each where 2,138 orders were made under Part III of The Act. Part III uses accounted for a higher proportion of detentions on admission during 2013/14 in independent sector providers (13%) than in NHS providers (4%).

Table 6 Detentions under Part III by Section

			numbers and percentages	
			change: 2012/13-2013/14	
	2012-13	2013-14	*no.*	*%*
Total	**1,788**	**1,847**	**59**	**3%**
Section 35	69	77	8	12%
Section 36	16	22	6	38%
Section 37 (with Section 41 restrictions)	435	448	13	3%
Section 37 (without restrictions)	326	315	-11	-3%
Section 45A	3	2	-1	-33%
Section 47 (with Section 49 restrictions)	404	414	10	2%
Section 47 (without restrictions)	41	43	2	5%
Section 48 (with Section 49 restrictions)	371	394	23	6%
Section 48 (without restrictions)	14	11	-3	-21%
Other Sections - 38, 44 and 46	109	121	12	11%

Source: Table 1 of the reference data tables

For persons charged with a criminal offence punishable by imprisonment but not yet tried in Court, Section 35 and 36 apply, for assessment, and assessment and treatment of, mental disorders respectively. There were 99 uses of these orders during 2013/14, representing an increase of 16% since 2012/13.

Section 37 is used for persons found guilty by a Court for a criminal offence punishable by imprisonment. Instead of serving the sentence/punishment[29], the person is detained in hospital due to their mental health. A restriction order (under Section 41) can be added which means that the permission of the Secretary of State for Justice is required to discharge, move or send the patient on leave. There were a total of 763 uses of Section 37 during 2013/14, which is consistent with the total of 761 uses during 2012/13.

Section 47 is used to transfer serving prisoners to hospital when assessment and/or treatment are needed; Section 48 is similar and used for those remanded in Prison to await trial. Restriction orders under Section 49 can be added by The Ministry of Justice which have the same effect as those described above. There were 457 uses of Section 47 (a 3% increase) and 405 uses of Section 48 (a 5% increase) since the previous reporting period.

For information on other orders in Table 6 above, please see the Appendix to this report.

[29] A custodial sentence ('judicial') sentence involves mandatory custody of the prisoner, usually in prison. Other types of sentences or punishments are 'non-custodial' e.g. suspended sentences or restriction orders.

Table 7 Part III Transfers [1] by originating prison

numbers[2]

	All Mental Health Act transfers from	*of which:* Section 47 (sentenced)	Section 48 (unsentenced)	Sections 35, 36, 37 and 38
England Total	**1,123**	**440**	**459**	**224**
BNSSSG[3]	**70**	15	35	20
Derbyshire and Nottinghamshire (including Ranby)	**80**	40	30	10
Durham, Darlington and Tees (including Cumbria)	**45**	25	15	*
East Anglia	**95**	50	20	25
Kent and Medway	**130**	50	65	15
Lancashire (excluding Cumbria)	**140**	75	30	35
London	**295**	55	170	65
Shropshire and Staffordshire	**110**	45	55	10
Thames Valley (including Dorset)	**80**	40	20	20
West Yorkshire (excluding Ranby)	**80**	40	20	20

[1] Some prisons were not able to submit data in every quarter as follows: Quarter 1 - 0 prisons; Quarter 2 - 0 prisons; Quarter 3 - 6 prisons; Quarter 4 - 15 prisons.

[2] Figures at sub-England level have been rounded to the nearest 5 in line with HSCIC disclosure controls. Figures of less than 5 have been replaced with "*".

[3] Bristol, North Somerset, Somerset and South Gloucestershire (excluding Dorset).

Source: Prison Health Reporting System, Mental Health Numeric Indicators submission, NHS England

Table 7 shows experimental data collected from Prisons during 2013/14 which add context to the hospital based KP90 figures, and show showing where patients admitted under Part III of The Act originate from. Experimental figures collected from Prison Health Reporting Systems suggest that figures for Section 48 may be under recorded on hospital systems (405 uses during 2013/14; see Table 6); a figure of 459 transfers from prison to hospital was recorded for 2013/14 even though some prisons had not been able to submit data during quarters 3 and 4 of the reporting year.

Other types of detentions on admission

A small number of people are detained under other Acts which cover areas such as unfitness to plead in court, not guilty by reason of insanity, other criminal legislation, and children (although the Mental Health Act is usually used). More information is provided in the Appendix. During 2013/14, these uses totalled 178, a decrease of 3% (5) since the previous reporting year.

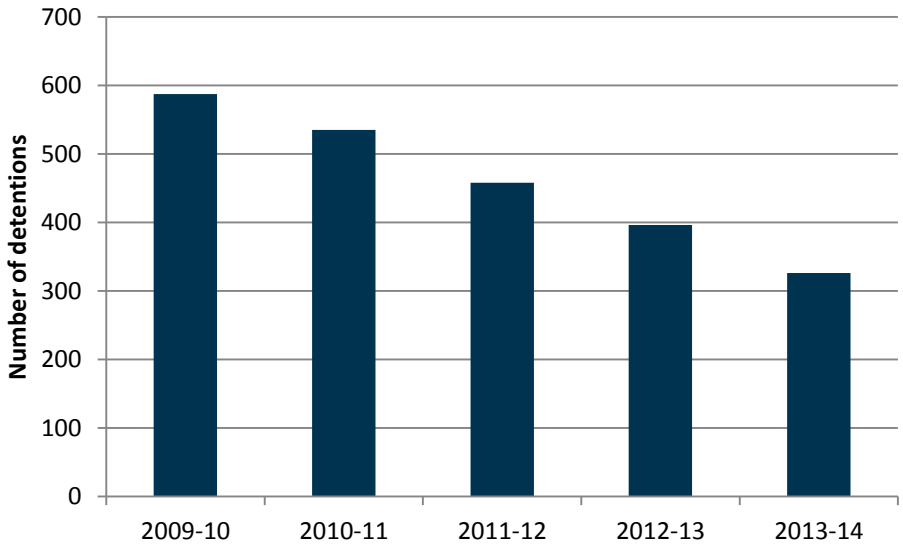
Short term detention orders

Short term orders authorise detention for a maximum of 72 hours with the intention of ensuring an assessment is made of the person's mental health to determine whether they require further assessment and possibly treatment. A person may be transferred to another Section following a short-term order, or released. The types of short-term orders that can be made under The Act are discussed below, and more information on changes from and to Sections is presented in Tables 6a and 6b of the reference data tables. Whilst 'Place of Safety' under Sections 135 and 136 orders are also short-term, these are discussed in a separate section later in the report.

Section 4

Section 4 is used in emergency cases to detain a person so that their mental health condition can be assessed in hospital (i.e. like a Section 2, but for only up to 72 hours). It only needs to be recommended by one doctor, and can only be used when awaiting confirmation from a second doctor would cause 'undesirable delay'. Treatment under Section 4 requires patient consent, although emergency care can be given if the patient lacks capacity to consent.

Figure 12: Uses of Section 4; 2009/10 - 2013/14



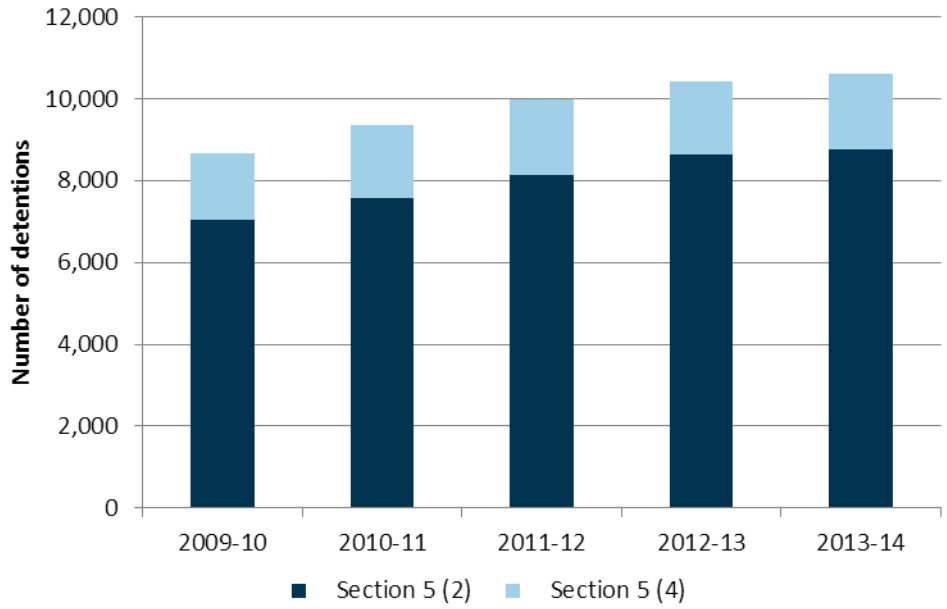
Source: Table 5 of the reference data tables

Figure 12 shows that uses of Section 4 during 2013/14 decreased by 18% (70) since the previous reporting year, continuing a downward trend in uses over the last five years. The changes introduced by the MHA 2007 meant that both doctors required for a Section 2 or Section 3 may work in the same hospital whereas previously a doctor had to be found from another hospital or general practice. The Approved Mental Health Professional (AMHP), who makes the application, can also work in the same hospital. While generally all three professionals should not work in the same team, the Code of Practice advises that it is better to use three professionals from the same team and complete a Section 2 than use a Section 4. These changes may make it quicker to field the team required for a Section 2 or Section 3. Further, there may be increasing availability of section 12 approved doctors.

Section 5(2) and 5(4)

Section 5 may be used if a patient is already in hospital as an informal patient. It is commonly referred to as a 'holding power' and is used to prevent the patient leaving hospital if the medical team has concerns that the patient ought to be detained under the Mental Health Act. Doctors and other approved clinicians can detain any in-patient for up to 72 hours under Section 5(2). Nurses who are trained and qualified to work with people with mental health disorders or learning disabilities can detain a patient receiving inpatient treatment for a mental disorder under Section 5(4) for up to 6 hours, or until a doctor or is available to make an assessment.

Figure 13: Uses of Section 5; 2009/10 - 2013/14



Source: Table 5 of the reference data tables

Figure 13 shows that uses of Section 5(2) and 5(4) have both increased since the previous reporting year, 5(2) by 1% (an increase of 111) and 5(4) by 4% (an increase of 78). Uses of these powers have increased by a small amount each year over the past five years.

Community Treatment Orders

CTOs (Part 17A of The Act) were introduced in 2008 under the 2007 Mental Health Act amendments. They replaced Supervised Discharge and allow for patients on unrestricted orders[30] to be treated within the community rather than under detention in hospital, under certain conditions[31]. CTOs are suitable for patients on unrestricted treatment orders (Section 3, or an unrestricted Part 3 order such as Section 37). The patient must keep in regular contact with their mental health team and attend hospital when instructed for assessment and/or treatment. Failure to meet any conditions of the CTO will usually result in the patient being recalled to hospital by the responsible clinician for assessment and/or treatment. CTOs last for up to 6 months initially and can be extended, first by up to 6 months, and then subsequently for up to a year.

A CTO can end either following revocation (where the patient is put back on the Section they were on before they went on the CTO) or discharge (where the patient is no longer subject to The Act, and cannot be detained).

Table 8: Uses of Community Treatment Orders; 2008/09 - 2013/14

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	**Total**
New Community Treatment Orders	**2,134**	**4,107**	**3,834**	**4,220**	**4,647**	**4,434**	**23,376**
CTO recalls to hospital	207	1,217	1,601	2,082	2,272	2,316	**9,695**
Revocations of CTO	143	779	1,018	1,469	1,509	1,401	**6,319**
Discharges from CTO	33	1,010	1,167	1,712	2,162	2,230	**8,314**

Source: *Table 7 of the ten year time series tables*

Table 8 shows uses, recalls and ending of CTOs (by revocation or discharge) since their introduction in 2008. Since CTOs may be renewed, figures for one reporting year may relate to CTOs which began in an earlier reporting year.

CTOs: starting and ending

In total, 23,376 CTOs have been issued and, except for 2008/09 (where they were introduced part way through the year in November), more than 3,800 were issued each year. The number of new CTOs issued in 2013/14 was 5% (213) lower than during the previous reporting year, suggesting that uptake following their introduction may now be 'levelling off'. The majority of CTOs are issued to people who are under Section 3 (92% of new CTOs issued in 2013/14) and an increasingly larger proportion have been issued by independent sector providers (which accounted for 5% of new CTOs in 2013/14 but only 1% in 2008/09). See Tables 7a and 7b of the reference data tables for more details.

[30] A patient can only be considered for a CTO when under Sections 3, 37, 47, 48 or 51 and only if there are no concurrent restriction orders or directions.

[31] Conditions will include the patient making themselves available for required examinations and may also include additional conditions such as activities which they must or must not undertake (e.g. drinking alcohol). Additional conditions must not constitute a deprivation of liberty and can only be used to ensure the patient receives medical treatment, prevent harm to the patient's health or safety or to protect other persons.

During 2013/14, a total of 3,631 CTOs ended by either revocation or discharge (1% less than during 2012/13, where 3,671 ended). Over a third (39% or 1,401) were revoked rather than discharged (i.e. the person had their original Section reinstated and they again became detained in hospital). This is lower than during 2012/13, when 41% of ended CTOs were revoked. Since their introduction there has been some considerable discussion in the scientific press as to the ethics of issuing them, and whether or not they are a good way of treating people with mental disorders. The figures suggest that a quarter (27%) of all CTOs issued since their introduction have been revoked, and 36% resulted in discharge; this is open to a number of different interpretations.

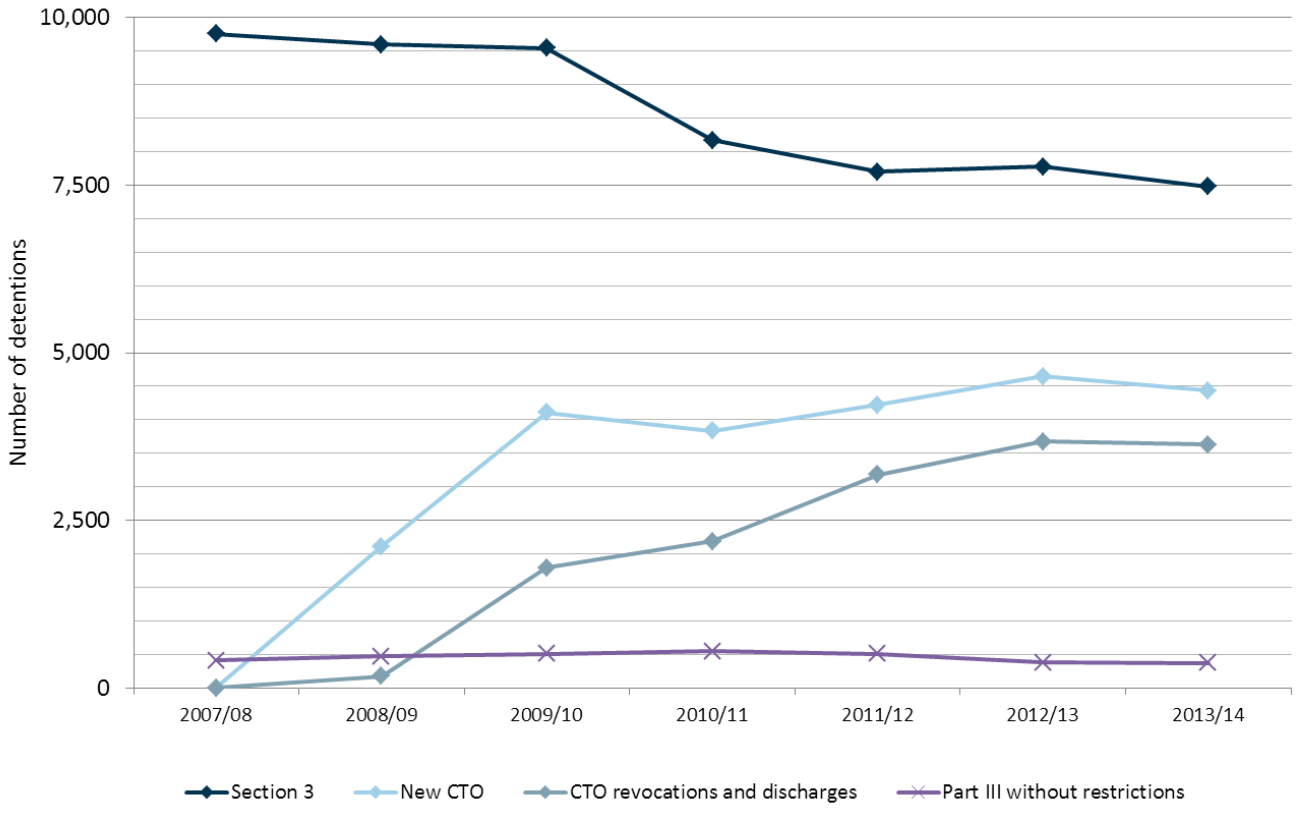
Each year more CTOs have been issued than are ended, resulting in an increasing number of people being subject to CTOs. Overall, since their introduction, 23,376 CTOs have been issued and 14,633 (63%) have ended. This suggests that there were 8,743 CTOs in place at the end of 2012/13 (from the cumulative number of CTOs to date since their introduction in 2008 minus the cumulative number of CTOs ended by revocation or discharge). However, the number of people reported as being subject to a CTO at the end of 2013/14 (5,365) was much smaller than the calculated number of CTOs in place at this time. As a person can only be subject to one CTO at any point in time, this difference could be due to one of more of these factors causing recording issues:

(a) Under-counting the number of CTO revocations;
(b) Under-counting the number of CTO discharges;
(c) Over-counting the number of CTOs issued (e.g. by including renewals);
(d) Under-counting the number of people subject to a CTO on the 31st March (e.g. by not including those on recall);
(e) People transferring on CTO to a provider outside of England (not captured in the KP90).

It is possible that some of these data issues are due to difficulties resulting from service provision arrangements. Many services in England have different teams responsible for detained patients and patients in the community, and the team may change as soon as the patient is placed on a CTO[32].

[32] 'A Clinician's Brief Guide to The Mental Health Act' (Third Edition): Tony Zigmond, p70

Figure 14: CTO use compared with underlying eligible Sections; 2007/08 – 2013/14



Source: *Tables 1 and 7 of the ten year time series tables*

The time series in Figure 14 shows that the number of CTOs ending during each reporting has increased over time until the 2013/14 reporting year, where a decrease was seen. The same pattern was seen for new CTOs being issued, except for in 2010/11, where the number of CTOs ending since the previous reporting year increased while the number of new CTOs being issued fell.

Figure 14 also shows the relationship between the numbers of CTOs issued and the number of uses of the Sections from which a patient might be placed on a CTO. We have suggested in previous reports that the rise in CTO use may be linked to the decrease in Section 3 use. The time series shows that except for a slight rise during 2012/13, the number of uses of Section 3 has declined each year since 2008/09, when CTOs were introduced whilst the number of new CTOs issued has increased each year except the most recent. The number of unrestricted Part III sections issued has also been decreasing since 2010/11 (although during 2013/14, only 8% of new CTOs were issued to patients on these Sections).

Recalls of CTO

During 2013/14, there were 2,316 recalls of CTOs, a 2% rise since 2012/13. The number of CTO recalls has increased each reporting year since their introduction, and is likely to reflect the increasing total number of active CTOs.

A person subject to a CTO may be recalled to hospital for the following reasons:

- To provide treatment for the mental disorder (possibly without consent);
- Where there is a risk to the safety or health of the individual;
- Where there is a risk to the safety of other people;
- For an assessment with a view to renewing the CTO;
- For an assessment by a second opinion doctor.

A person may be recalled several times whilst on a CTO.

Note that recall is not necessary for all examinations and it may be possible for the patient to attend hospital without recall in some circumstances (so their legal status remains as a CTO patient in the community).

A recall will result in either the individual being returned to the community or the CTO will be revoked and the patient will be placed back on their original treatment Section.

Place of Safety detentions

Part X (ten) of The Act gives the police powers to take people who appear to be suffering from a mental disorder to a 'Place of Safety[33]' for assessment using Section 135 or Section 136. Consent of the individual is not required, and they can be detained for up to 72 hours (and cannot be renewed). Patients can be transferred between Places of Safety during this time. After assessment, the person will either be taken to hospital (if not already there) and detained under The Act, admitted informally to hospital, or released.

Section 135

Section 135 requires a warrant from a magistrate which allows the Police to enter any premises to search for the individual. This includes patients who have gone absent without leave from detention in hospital and those who are believed to be suffering from a previously untreated mental disorder. The Police Officer must be accompanied by an approved mental health professional (AMHP) (with a doctor as well in some circumstances) and if appropriate and feasible the assessment will be made on the premises. The Code of Practice for The Act[34] recommends a planned decision on the individual's destination, whether it be a Place of Safety or another place that they 'ought to be', and therefore it should almost never be necessary to use a police station as a Place of Safety for people removed under Section 135.

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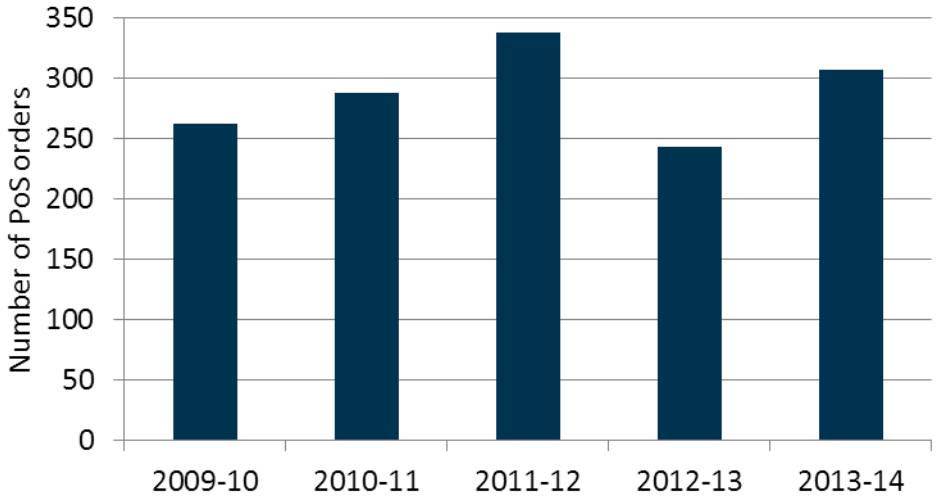
33 A 'Place of Safety' (PoS) is defined for the purposes of The Act as:

- Residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1947;
- A hospital (including an independent hospital);
- A police station ;
- A care home for mentally disordered patients;
- Any other suitable place where the occupier is willing temporarily to receive the patient.

34 Department of Health Mental Health Act Code of Practice; Section 10:11, page 74: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597

Figure 15: Section 135 uses in hospital based places of safety; 2009/10 – 2013/14



Source: Table 5 of the reference data tables

Figure 15 shows that uses of Section 135 in hospital based places of safety (dedicated 'Place of Safety suites' and Accident & Emergency (A&E) Departments) have increased by just over a quarter (26% or 64) since the last reporting year, although over the past five years have remained fairly constant. Section 135 uses accounted for just 2% of Place of Safety orders during 2013/14 and 61% of these involved male subjects. For more information, please see Table 5 of the reference data tables.

These Section 135 figures are known to be an undercount of uses overall because they do not include uses where the assessment made results in the person:

- Being taken straight to hospital for detention under Section 2 or 3 (rather than to a place of safety);
- Being admitted to hospital informally;
- Not being removed to a Place of Safety (released or being taken to the place they 'ought to be');
- Being removed to police custody based Place of Safety rather than a hospital based one[35] (although this should not normally be necessary).

We are hoping to work with local authorities and approved mental health professionals in the future to increase the depth of our reporting of Section 135 uses and welcome further feedback and comment in this area.

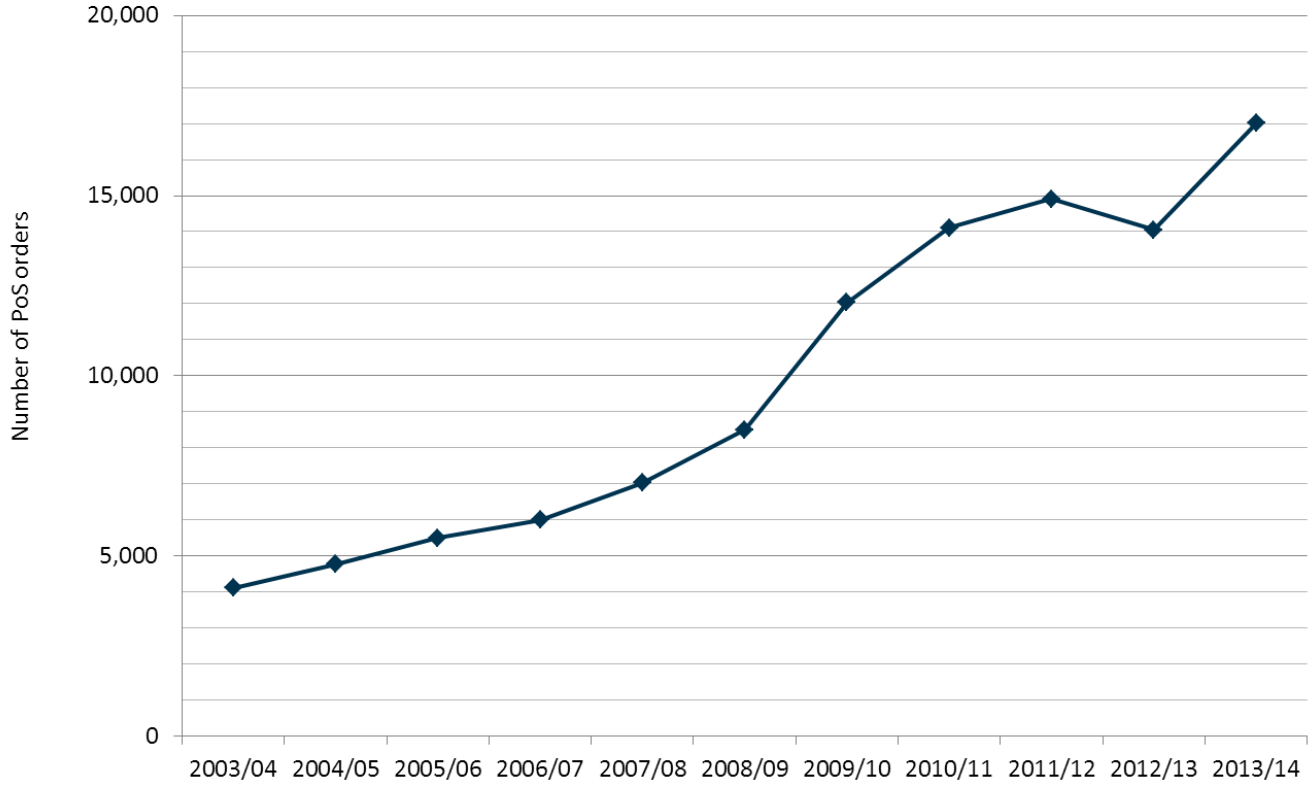
Section 136

Under Section 136 the Police can remove an individual to a Place of Safety from a place to which the public have access. A warrant is not required. The Code of Practice for The Act recommends that the default Place of Safety should be a hospital based facility. Within these, emergency and specialist units should only be used where a medical problem requires urgent assessment and management[36].

[36] Department of Health Mental Health Act Code of Practice; Section 10:21-22, page 77: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4132161

Section 136 in hospital based places of safety

Figure 16: Section 136 uses in hospital based Places of Safety; 2003/04 - 2013/14

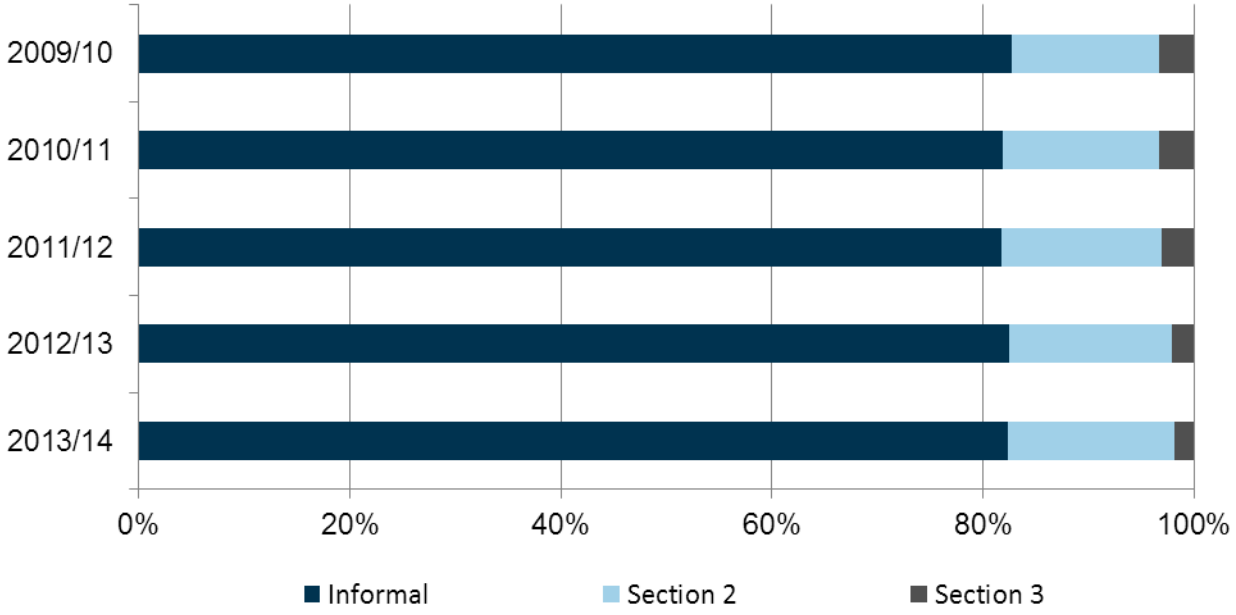


Source: Table 6 of the ten year time series tables

During 2013/14, there were 17,008 Section 136 orders made to hospital based Places of Safety; this is 21% (2,955) larger than during the previous reporting period and more than 3 times the number made ten years before (an increase of 314% or 12,902). Over the past ten years, the numbers have shown a continual year-on-year increase (except for during 2012/13, where a 6% (849) decrease occurred since the previous reporting period). A small proportion of these detentions will have occurred in A&E departments rather than dedicated 'Place of Safety' suites, but the exact number is not recorded.

Outcomes of Section 136 in hospital based places of safety

Figure 17: Outcomes of Section 136 use in hospital based Places of Safety; 2009/10 - 2013/14



Source: Tables 6a and 6b of the reference data tables

Figure 17 shows that the majority of Section 136 uses have not resulted in detention; this applied to 82% (13,403) during 2013/14 and this proportion has stayed relatively constant during the past five years. A person who is not detained following use of a Section 136 in a hospital based place of safety will either be discharged or will remain in hospital informally, but data on these outcomes is not collected. Detention under Section 2 followed 16% of Section 136 uses in 2013/14, and detention under Section 3 followed 2% of uses. Over the past five years, there has been a slight proportional increase in Section 2 (by 2 percentage points) and decrease in Section 3 uses in these circumstances and this may be linked to the increasing use of CTOs as discussed earlier in the report.

Comparison of Section 136 uses in police and hospital based places of safety

The Code of Practice for The Act[37] states that a police station should only be used as a place of safety on an exceptional basis, and notes that if a hospital based place of safety is not available, options in addition to police custody suites should also be considered. Exceptions may include where an individual is excessively intoxicated (and cannot be safely managed) or poses a risk of serious violence or danger to themselves or to others. A lack of available beds was also identified as a reason why police custody based places of safety might be used more commonly than hospital based in some areas in a joint report by monitoring bodies[38].

Local arrangements between health providers and Police will vary, and may mean that such patients are normally taken to police custody based places of safety in the first instance but then transferred. Assessment may not necessarily occur at the initial place of safety as a person may be transferred to

[36] Department of Health Mental Health Act Code of Practice; Section 10:21-22, page 77: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4132161
[38] A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs: http://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf

a more appropriate place of safety. Local policies for putting Section 136 into practice should be agreed by the Police, Health Authority and Social Services Authority.

Table 9: All uses of Place of Safety orders (where recorded); 2009/10 – 2013/14

	2009-10	2010-11	2011-12	2012-13	2013-14
Total Place of Safety Orders	**..**	**..**	**23,907[e]**	**22,177[r]**	**23,343**
Section 136 detentions where place of safety was a hospital	12,038	14,111	14,902	14,053	17,008
Section 136 detentions in police custody suites	..	..	8,667[e]	7,881[r]	6,028
Section 135 detentions where place of safety was a hospital	262	288	338	243	307

'..' Information not available.

'e' Estimated figure.

'r' Revised figure to include an estimated 120 uses by the British Transport Police, which provided data for the 2013/14 collection but not 2012/13.

Source: Table 5 of the reference data tables and Table 12 of the experimental data tables

Table 9 provides the fullest picture possible to date on uses of Place of Safety orders. These data were collected from both hospital (KP90) and Police Force IT systems and include the major uses of Section 135 and Section 136. These figures do not include uses where the individual is released or admitted to hospital informally, or, in the case of Section 135, where the individual is put onto a Section 2 or 3 before they reach hospital. They also do not include uses where the person is taken to an alternative place of safety (e.g. the homes or relatives or friends willing to accept the individual), so the scale of this practice is unknown. It is assumed that a negligible number of Section 135 uses resulted in the person being taken to police custody based Place of Safety, as this should not normally occur.

The figures show that the total number of Place of Safety orders made has increased by 5% (1,166) to 23,343 since 2012/13. Of the 23,036 orders made using Section 136, the proportion where the individual went to a hospital rather than a police custody based Place of Safety increased from 64% (14,053) during 2012/13 to 74% (17,008) this reporting year (reflecting an 21% increase in uses of hospital based-, and a 24% decrease in police custody based-, Place of Safety Orders).

The number of orders made to police custody based Places of Safety decreased for the second year since figures have been recorded, by 24% (1,853). Whilst some Police figures are experimental and/or estimates, we are confident that these reflect a real decrease in use as information collected each year on data quality has showed that accuracy has been improving (undercounts are present, but likely to be much larger in earlier figures[39]). The drop in the proportion of police custody based Place of Safety Orders may reflect initiatives undertaken as a result of the joint report which aimed to significantly reduce inappropriate use of Police Custody for Section 136 detentions by April 2016[40]. The recommendations aim to reduce the use of police custody in all but the most exceptional circumstances, and improve the capability of the health service to deal effectively with the

[39] See 'Experimental statistics' section below for more information on data quality in the Police Force IT systems collection.

[36] A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs: http://www.justiceinspectorates.gov.uk/hmic/media/a-criminal-use-of-police-cells-20130620.pdf

increase in overall numbers being taken to hospital-based places of safety. They also aim to reduce the length of time spent in police custody based facilities where used.

The Government is also currently reviewing the results of a survey on the operation of Section 135 and 136 with the aim of making sure that the legislative framework supports getting the right support for people at the right time[41].

Regional figures from the Police IT systems collection are included in the experimental analysis tables.

[41] Review of the Operation of Sections 135 and 136 of the Mental Health Act in England and Wales – A survey (Department of Health/Home Office): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/301724/ReviewOperationS135S136.pdf

Experimental statistics

Replacing the KP90 with administrative data sources

We are actively working to implement the recommendations of the Fundamental Review of Returns[42] in reducing the burden on our data providers and are aiming to retire the KP90 as a data collection once it is demonstrable that alternative administrative data sources are capable of supporting the production of comparable statistics.

Tables 1-8b of the experimental data tables show progress towards the aim of being able to replicate KP90 statistics using administrative data. The reference data tables have been reproduced where possible using figures from the annualised[43] 2013/14 Mental Health Minimum Dataset (MHMDS) data file. KP90-derived figures are shown alongside, together with measures which assess the difference between them.

Coverage of administrative data sources in comparison with KP90

The KP90 is collected from all providers who make use of the Mental Health Act legislation to detain and provide care for detained patients. It includes specialist adult mental health services, learning disabilities services, child and adolescent mental health services and acute providers. The Mental Health Minimum Dataset for 2013/14 was collected from providers of specialist adult mental health services only. From September 2014 its scope was expanded to include providers of care to learning disabilities and autistic spectrum disorder patients and it was renamed the 'Mental Health and Learning Disabilities Data Set' (MHLDDS)[44] to reflect this.

For NHS providers, coverage of the MHMDS (as a proportion of counts from KP90) was generally quite good, especially for Part II (where an estimated 81% of Section 2 and 66% of Section 3 detentions in 2013/14 were captured). Part III coverage was lower, with an estimated 57% of detentions during 2013/14 being captured.

Table 3b of the experimental data tables show that overall, only an estimated 61% of Section 136 uses recorded in the KP90 are being captured by the MHMDS; this information is shown at organisational level in Tables 8a and 8b. The low estimate may be due to local practices around recording details of people who are taken to hospital based places of safety. Once a decision is made that a person does not need to be detained for treatment or care then the authority to detain them ends, and it may therefore be difficult to obtain details if a person is not already known to services. Section 135 uses were better recorded at an estimated 67% of those recorded in the KP90; this is likely to be because these people are often already known to services.

Another potential reason for poor Section 136 recording in MHMDS is a timeliness issue; since the MHMDS return is now made on a monthly basis, the window for recording Section 136 information is not large because these are short term Sections.

For NHS organisations, the number of CTOs recorded was actually 43% higher in the MHMDS than the KP90. This may mean that administrative data sources are better at capturing uses of Community Treatment Orders (this report notes problems with their capture in the KP90 return in the 'Community Treatment Orders' section above). Please see Tables 7a and 8a of the experimental data tables for an organisational level comparison.

Only 9 independent sector providers returned the MHMDS during 2013/14, and this equates to an estimated 32% of KP90 coverage for the 'All detentions' measure (this compares with 76% in NHS providers).

[42] Fundamental Review of Returns – Consultation Response: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170873/FDR_cons_response_v023_clean.pdf

[43] MHMDS data is collected on a monthly basis. Records for the year are reconciled ('annualised') so that episodes are counted only once.

[44] Mental Health and Learning Disabilities Data Set: http://www.hscic.gov.uk/mhldds

The KP90 this year included two new questions designed to help assess the scale of the gaps in coverage between available administrative data sources and the KP90. It also allows us to better compare the numbers of people reported as being in specialised adult mental health services. By subtracting the number of people detained in LD and CAMHS services from the total people detained on the 31st March (Table 8 of the reference data tables) we can estimate how many people recorded in the KP90 were detained in specialist adult mental health services. Using this figure we can then compare the KP90 and MHMDS returns more directly.

Of the 13,085 patients in NHS facilities, there were 675 in LD services and 188 in CAMHS services and therefore an estimated 12,222 people in specialist adult mental health services on the 31st March. 9,686 people were recorded as being subject to detention in specialist adult mental health services in MHMDS returns (an estimated 74% coverage).

Table 10: Patients detained in independent hospitals which returned the MHMDS, as at 31st March 2014

England — *numbers* [1]

Organisation	KP90 Total	*of which:* Learning Disability Services	Child and Adolescent Mental Health Services	Specialist adult mental health services (estimate)	MHMDS
England Total	**5,081**	**341**	**719**	**4,021**	**1,713**
St Andrew's Healthcare	730	75	195	455	640
Cygnet Health Care Limited	660	*	10	650	135
Partnerships in Care Limited	650	*	95	555	565
Cambian Healthcare Limited	330	*	20	310	215
Care UK Mental Health Partnerships Limited	55	5	*	45	15
Plymouth Community Healthcare CIC	50	*	*	50	50
Fairhome Care Group (W.L.) Limited	45	*	45	*	35
Raphael Health Care Ltd	45	*	*	45	45
NAViGO Health and Social Care Community Interest Company (CIC)	10	*	*	10	10

Providers are ordered by the number of detained patients as recorded in the KP90 on the 31st March 2014.

(1) Figures at sub-England level have been rounded to the nearest 5 in line with HSCIC disclosure controls. Figures of less than 5 have been replaced with "*". Subtotals may not add to totals due to rounding.

Source: Table 9b of the experimental data tables

Where returned, most MHMDS counts of patients in specialist adult mental health services are lower than those from KP90 although it is interesting to note that some are higher. It also appears that there are some patients in CAMHS services who are returned as part of the MHMDS; they may be patients accessing more than one type of service, or fitting other MHMDS inclusion criteria. These issues equally may represent data quality errors in one or both returns. Please see tables 9a and 9b of the experimental data tables for a full comparison of patients detained in both NHS and independent providers, as returned in via KP90 and the MHMDS.

Table 11: Patients detained in independent hospitals which did not submit an MHMDS return as at 31st March 2014; counts by type of service

England — *numbers* [1]

Organisation	KP90 Total	of which: Learning Disability Services	of which: Child and Adolescent Mental Health Services	of which: Specialist adult mental health services (estimate)	MHMDS
England Total	**5,081**	**341**	**719**	**4,021**	**1,713**
Priory Secure Services Limited	160	30	*	130	*
Alpha Hospitals (NW) Limited	155	*	60	95	*
Priory Healthcare Limited	100	20	*	80	*
Four Seasons (Granby One) Limited	95	40	15	40	*
Affinity Healthcare Limited	95	*	25	70	*
Oakview Estates Limited	75	*	65	10	*
Riverside Health Care	65	*	10	50	*
Cambian Learning Disabilities Limited	55	*	*	55	*
St George Care UK Ltd	*	*	*	*	*
Alternative Futures Group Limited	50	*	25	25	*

Providers are ordered by the number of detained patients as recorded in the KP90 on the 31st March 2014 – only the 'top ten' are shown.

(1) Figures at sub-England level have been rounded to the nearest 5 in line with HSCIC disclosure controls. Figures of less than 5 have been replaced with "*". Subtotals may not add to totals due to rounding.

Source: Table 9b of the experimental data tables

Table 11 shows the largest independent sector providers (in terms of detained patients on the 31st March) which did not submit any MHMDS information during 2013/14. Some of the differences are due to Learning Disability (LD) and Child and Adolescent Mental Health Services (CAMHS) being outside of the 2013/14 scope of MHMDS but on 31st March 2014 there were still over 2,000 patients in independent sector providers (an estimated 2,308 or 57%) in the KP90 but not the MHMDS return who should have been (this was estimated by subtracting the LD and CAMHS patients from the total count of detained patients in the KP90 return, and expressing the MHMDS total from this).

Data quality metrics

As part of our monthly reports from MHMDS[45], we publish counts of people subject to detentions on admission and CTOs under The Act. For each reporting month we also produce and report on organisational level data quality measures for key data items, and data consistency measures, in MHMDS. These are calculated for both provisional and final data with the aim of giving data providers an early look at their data quality. These are as follows:

DQM10: Validation /Completion (VODIM) of Legal Status Classification Code field;
DCM1: Measure of duplication of Mental Health Act episodes (episode counts at the end of the reporting period, mental health care spells with an associated open episode at the end of the reporting period, and the difference between the two).
DCM4: As DCM1, but for Community Treatment Order episodes.

It is important that providers and commissioners monitor all these metrics closely and ensure that their submitted records (MHMDS) and counts (KP90) are comparable and accurately reflect service activity.

[45] Monthly Mental Health Minimum Dataset Returns: http://www.hscic.gov.uk/mhmdsmonthly

Plan to retire the KP90

We will use the baseline LD figures from KP90 to assess Mental Health Act information being received from LD services. There is currently an extended delay in initiating the CAMHS dataset and the HSCIC and stakeholders are considering various options. Please see our website for more details[46].

Once CAMHS is online we will look at similar metrics and at that point, provided that comparable figures are obtained to our baseline CAMHS measures, then organisations can stop submitting the KP90. Although independent sector providers are obliged to return the MHMDS, it is evident that few are actually doing so. We are working with stakeholders and providers to try to resolve this issue, since we cannot retire the KP90 wholly without being able to receive this information. There will still remain one gap in our Mental Health Act statistics and that is from acute NHS hospitals, as these are outside the scope of administrative mental health data collections (their activity is returned and published as Hospital Episode Statistics (HES)[47]). One method might be to undertake a limited KP90 collection for these organisations but we are looking at other options.

Adding new dimensions to our Mental Health Act statistics

This report includes experimental analyses using MHMDS as the data source which build on the statistics published in 2011/12 and 2012/13. We have produced these using an improved methodology which allows us to categorise Mental Health Act episodes into measures used in the reference data table, enabling more efficient and consistent reporting. An assessment of this methodology is made in the 'Data Quality' section below. We have included these experimental statistics in the 'Demographics' section of the report above; please also see Tables 10a-11b of the experimental data tables. Our 2012 consultation[48] identified that these demographics are some of the most sought after dimensions in Mental Health Act reporting; in particular, the Count Me In" ethnicity census[49] highlighted the importance of having information about the ethnicity of people detained under The Act. The last census took place in 2010 but these figures show that the MHMDS is an equally valuable source of this information.

[46] Child and Adolescent Mental Health Services Data Set: http://www.hscic.gov.uk/CAMHS
[47] Hospital Episode Statistics: http://www.hscic.gov.uk/hes
[48] Mental Health Act statistics consultation: http://www.hscic.gov.uk/MentalHealthAct_stats_consultation
[49] 'Care Quality Commission looks ahead as last Count Me In census is published': http://www.cqc.org.uk/content/care-quality-commission-looks-ahead-last-count-me-census-published

Background Data Quality Information

This section contains the background data quality report for the 2014 release of annual Mental Health Act statistics data. The statistics included in this release are the latest available annual figures, covering the reporting period 1st April 2013 – 31st March 2014.

Collection results are analysed within SQL server management studio and tables for display in the report and for the reference table document are generated using SQL Reporting Services. The products included in this release comprises of data for the 2012/13 reporting year as follows:

- This report comprising summary statistics, tables, charts and commentary;
- KP90 national reference data tables (with an organisational breakdown and crude detention rates);
- KP90 Ten year time series data tables;
- Experimental data tables (from KP90, MHMDS, Police Custody Databases and Prison Health Reporting System).

This section aims to provide users with an evidence based assessment of the quality of the statistical output of the accompanying mental health bulletin publication by reporting against those of the European Statistical System (ESS) quality and related dimensions and principles[50] appropriate to this output.
In doing so, this meets our obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics[51], particularly Principle 4, Practice 2 which states:

Ensure that official statistics are produced to a level of quality that meets users' needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors, and other aspects of the European Statistical System definition of quality.

[50] The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.
[51] UKSA Code of Practice for Statistics:
http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html

Assessment of statistics against quality dimensions and principles

Relevance

The 'Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment, Annual figures, England 2013/14' report presents information on uses of the Mental Health Act, as amended 2007, during the period 1st April 2013 to 31st March 2014. High level summary statistics are presented as tables and figures with commentary and detailed tables are supplied in a separate spreadsheet document. The following areas are addressed:

- Trends in detentions under the Mental Health Act;
- Detentions on admission (formal admissions);
- Use of short-term detention orders (Sections 4, 5(2), 5(4), 135 and 136);
- Uses of Community Treatment Orders;
- People subject to the Mental Health Act at 31/03/12;
- Detentions in NHS hospitals by region;
- Experimental Mental Health Act statistics from the Mental Health Minimum Dataset (MHMDS);
- Experimental Mental Health Act statistics from Police Custody Databases;
- Experimental Mental Health Act statistics from the Prison Health Reporting System.

Information is presented as counts of incidents (uses of the various Sections and Parts of the Mental Health Act), and counts of people (those subject to the Mental Health Act as at 31st March 2013). Various percentage calculations are applied to support the commentary, such as percentage change since the previous reporting period and certain proportions (e.g. people subject to the Mental Health Act, for whom a learning disability was the primary reason for using the Mental Health Act). Rates calculations are also included using Office for National Statistics population estimates.

A list of tables is included in the Appendices.

Accuracy and reliability

KP90

Since completion of the KP90 is mandatory, this element of this publication should be a complete census of organisations providing for patients detained under the Mental Health Act (both NHS and Independent facilities). Historically coverage has been good both for NHS and independent provider organisations, and before the data collection was open we undertook a triangulation exercise using known data sources in order to ensure that coverage was as complete as possible. For the 2014 collection we have additionally been able to use our Learning Disabilities Census return to cross-check whether any organisations with detained patients made this return but did not submit a KP90 return in 2013. In liaison with our Data Collections team, we sent notification of collection letters out to organisations thus identified as potentially having detained patients on March 31st. Similarly we cross-checked our KP90 returns against lists of acute hospitals elsewhere in the HSCIC to raise awareness of the collection (acute hospitals often have a low number of detained patients one year and none the next, but it is still important that they provide a return (even if it is a 'nil' return notification by email).

Data were collected from 131 NHS providers; two providers (Barnet and Chase Farm Hospitals NHS Trust (RVL) and East Kent Hospitals University NHS Foundation Trust (RVV)) were unable to submit a return.

Data were collected from 229 Independent Sector hospitals and these were aggregated into 90 provider groups for display, using details from the Care Quality Commission (CQC).

All analyses and outputs were dual run and checked according to internal quality assurance standards. No adjustment or imputation of figures was made to these figures prior to publishing. Whilst patterns of service provision may have changed locally, the national figures monitor total uses and people subject to detention or CTOs under the Mental Health Act 1983 and are not thought to be sensitive to variations. Data users working with the machine readable dataset for this report at local level are welcome to contact for further information received as part of the collection process on changes to local services.

Please note that immediately prior to publication of the 2010/11report, we were advised of some incorrectly submitted figures for that reporting year. The total number of CTOs administered by Lincolnshire Partnership NHS Foundation Trust (RP7) should have been 31 rather than 16 (an increase of 14 Section 3 to CTO changes and 1 Section 37 to CTO change). Whilst national totals were not significantly changed, this does affect 2010/11 totals for CTOs issued. Only 2010/11 data are affected.

MHMDS

The MHMDS is a rich, person level dataset that records packages of care received by individuals in contact with NHS funded specialist health services and these packages of care vary widely. This means that each record contains different elements of the dataset. It is also an area where there have been frequent changes in service models and organisational changes, such as mergers, Therefore no single approach can measure the completeness and accuracy of the data collected and reported nationally. A comparison of the coverage of MHMDS and KP90 data is provided in the ‘Experimental Statistics’ section of the report and this includes details of relevant metrics which are published with our monthly reports.

Many provider submissions include incomplete or duplicated information, particularly in relation to information about different types of episodes (hospital providers spells, Mental Health Act event episodes, etc.), which makes it difficult to compile a consistent picture of patient pathways across individual submissions. We have used new methodology to categorise Mental Health Act episodes from the MHMDS into distinct categories before reporting in order to minimise the possible impact of such issues. Comparisons made in the experimental data tables to information from the KP90 show that for some large mental health providers there was a good match. However it is clear that there is still much work which needs to be done to ensure comprehensive recording of Mental Health Act related information across all providers in the MHMDS. We will continue to liaise with providers and stakeholders in order to improve the accuracy of this dataset.

Prison Health Reporting System and Police Custody Databases

Assessments of accuracy of the other experimental data sources are made in the relevant sections of the report.

Timeliness and punctuality

This report is based on an annual collection, for which the submission window was open between April and May 2014. Results were published in October 2014.

Accessibility and Clarity

Accessibility

The publication is accessible via the HSCIC internet as a series of Excel spreadsheet tables and a report in PDF format. Larger print formats are available on request.

Clarity

This report is divided into sections, each covering a theme, as listed in the 'Relevance' section above. Figures are labelled with the identifier for the reference data table which contains the associated detailed information. A full explanation of the data is given in the commentary, drawing on information displayed in the tables and figures from the report as well as the background reference tables.
Summary information describing the Sections and Parts of the Mental Health Act relevant to these data are provided in the Introduction section of the report. More detailed information is found in the Appendix.

Coherence and comparability

Coherence

In order to promote the use of MHMDS as a data source for information about patients subject to detention or compulsory treatment under the Mental Health Act some analysis of Mental Health Act information was first included in MHMDS Routine Quarterly reports throughout 2010/11 and in the 2011 Mental Health Bulletin, which was continued in subsequent years (until the quarterly MHMDS Reports were superceded by monthly MHMDS reports.

Experimental analysis on long and short term detentions in hospital by organisation was first featured in the September 2012 quarterly MHMDS release and was included in a special feature in May 2014 as part of the monthly MHMDS release[52] . Similar analysis assessing the comparability of this measure for figures derived from the KP90 and MHMDS is presented as part of this publication in the experimental statistics workbook. We have built on our initial work from 2011/12 and 2012/13, and now include further replications of KP90 measures using MHMDS as a data source.
The annual Mental Health Bulletin provides a count of people who had been inpatients during the year and who were subject to the Mental Health Act 1983 at some point during the year, but this is not directly comparable with the measures in the KP90 (people are counted only once at their highest level of being restricted, as opposed to the KP90, which counts every use of The Act except for one snapshot count at the end of the reporting year).

Since April 2013 we have published some basic Mental Health Act information as part of our routine monthly reporting from MHMDS. This only covers secondary mental health services for adults and so the scope is more restricted than the KP90 collection. The monthly reports include for each provider / CCG of GP practice pairing, counts of patients subject to the Mental Health Act 1983 at the end of the month and an in month count of detentions on admission. At national level the count of people subject to the Mental Health Act 1983 is broken down in to patients detained in hospital and patients on CTOs.

For each reporting month we also produce and report on organisational level data quality measures for key data items, and data consistency measures, in MHMDS. These are calculated for both

[52] Monthly Mental Health Minimum Data Set (MHMDS) Reports, England – February Summary Statistics and related information: http://www.hscic.gov.uk/catalogue/PUB14125

provisional and final data with the aim of giving data providers an early look at their data quality. These are as follows:

- DQM10: Validation /Completion (VODIM) of Legal Status Classification Code field;
- DCM1: Measure of duplication of Mental Health Act episodes (episode counts at the end of the reporting period, mental health care spells with an associated open episode at the end of the reporting period, and the difference between the two).
- DCM4: As DCM1, but for Community Treatment Order episodes.

We will continue our development work on MHMDS using the monthly reports as a mechanism to work with providers to improve the quality of Mental Health Act statistics within MHMDS.

Information from Learning Disabilities Services, one of the known gaps in MHMDS when compared with the KP90, is now flowing. The Child and Adolescent Mental Health Services (CAMHS), another known gap, is however delayed. Our comparative analysis between the KP90 and MHMDS data sources identifies that some major independent sector groups are not submitting MHMDS as required. An assessment of the magnitude of these gaps and further details are provided in main body of this report. Please see the main publication report for more detail.

Comparability

The data collection has remained basically the same over the ten years covered in this report, although some additional items were added to the collection in 2008-09 to reflect amendments to the Mental Health Act 1983 and the introduction of Community Treatment Orders. This means that historical data for uses of supervised community treatment are not available (2008/09 data on uses of CTOs only covered 5 months of 2008/09). The report is marked clearly to reflect this.

Following our consultation[53] on Mental Health Act statistics, the 2011/12 report made some changes to the reporting measures used:

- The term ‘formal admissions’ has been superseded by the term ‘detentions subsequent to admission’ and this measure no longer includes uses of Part II Section 4 of The Mental Health Act;
- The ‘all detentions’ figure discussed in Section 1 of this report now includes detentions made following CTO revocation and no longer includes changes from an informal status to Section 5(2) or Section 5(4). This figure is now also included in reference data Table 1;
- Uses of Part II Section 4 have been moved from reference data Table1 to Table 5, and Table 5 additionally includes uses of Section 5(2) and Section 5(4);
- Uses of CTOs have been moved from reference data Tables 6a and 6b to new reference data Tables 7a and 7b.

Further details are provided in the methodological change paper[54] for this publication. Care should be taken to ensure any comparisons are being made on a like-for-like basis if comparing these figures with external sources that cite previous editions of our publication.

[53] Mental Health Act statistics consultation, Health and Social Care Information Centre: http://www.hscic.gov.uk/MentalHealthAct_stats_consultation

[54] Methodological Changes – see ‘Mental Health’ section: http://www.hscic.gov.uk/pubs/methchanges

Trade-offs between output quality components

Certain tables in the reference data and report are based on NHS facilities only, rather than including all organisations. Independent facilities have been excluded because organisation codes relating to these are not reliable (and vary from year to year). It is not possible therefore to produce a time series and therefore these data have not been provided at organisational level.
Experimental MHMDS analysis on uses of The Mental Health Act for 2012/13 is based on an annual file, compiled from twelve monthly submissions. This new data product reduces the duplications and inconsistencies arising across quarterly returns and supports more reliable pathway analysis.

Assessment of user needs and perceptions

Significant improvements to these statistics were made for the 2011/12 report (and going forward) in response to user feedback received during a public consultation on this publication held in early 20128. Changes include refinements to measures and terminology, redesigned reference tables and new analyses derived from the MHMDS and police custody databases. Where definitions of measures have changed since the 2010/11 edition of this publication, a methodology for producing the old measures has been included in the Appendix to the report so that users can calculate these figures if required using data supplied in the underlying machine readable dataset and/or the reference data tables.

Footnotes to tables and commentary in the report were improved, highlighting areas in Mental Health Act statistics which are out of scope of the current KP90 collection and areas where there have been changes to these statistics. Further details are provided in the 'Comparability' section of this paper above.

This year we have also added further information at organisation level on various uses of The Act as well as more detailed information on uses of Section 136 in police stations; improvements in the accuracy and consistency of the police custody collection have made this possible. These were areas identified as being important to data users during our consultation, during expert working groups, and from collecting feedback throughout the year.

Part of the consultation was around assessing the impact on users of a potential change of data source for this publication from the KP90 to the MHMDS in advance of the Secretary of State's fundamental review of NHS data collections[9] recommendations being published. This release includes further comparisons of statistics derived from both data sources as part of a programme of quality assessment of Mental Health Act data within MHMDS and will allow us to engage data providers to work with us in this area. We will continue this work via other publications such as our monthly MHMDS Reports.

Note that the data source will not be changed until we have finished our thorough assurance process, and can address all gaps in coverage and that all measures can be reliably replicated.

Our programme of development work on Mental Health Act statistics continues and we welcome feedback on any aspect. Should you wish to contact us, please use the following email address, citing 'Mental Health Act statistics' in the subject line: enquiries@hscic.gov.uk.

Performance, cost and respondent burden

We are required to report on uses of the Mental Health Act at organisation level so the collection is necessarily a census of organisations which provide Mental Health Services and make use of the Mental Health Act 1983 and related legislation. The KP90 collection is currently the only comprehensive source of data suitable for Departmental use in monitoring the uses of The Mental Health Act in England and has Ministerial backing. Decisions taken regarding subjecting patients to any form of compulsion under The Mental Health Act are controversial and in order to judge whether the provisions are being used appropriately it is vital to monitor how many of these clinical decisions are made across the country every year.

Whilst the KP90 collection is estimated to be quite expensive (estimated at around £150L per year during 2012/13), the proposed move to source the data from administrative data collections would, once fully implemented, reduce the burden of this collection to solely that which is already used to fill in the administrative data collections.

Confidentiality, Transparency and Security

KP90 returns are aggregate and, whilst they contain low counts of uses and people subject to The Act by organisation, they do not contain personally identifiable information. MHMDS data are received by the HSCIC in a pseudonymised format in order to protect the confidentiality of individuals. All releases are assessed for disclosure risk prior to publication using and disclosure controls are applied where appropriate to ensure the disclosure risk complies with the NHS Anonymisation Standard. In particular, this applies to sensitive information on recovery from illness, and where tables are presented at regional level. Further details are provided on the 'Introduction' sheet of the reference data tables. For transparency, we publish constructions and derivations for metrics used; these can also be found on worksheets in the reference data tables.

Please see links below to relevant HSCIC policies:

Statistical Governance Policy (see link in 'user documents' on right hand side of page)

http://www.hscic.gov.uk/pubs/calendar

Freedom of Information Process

http://www.hscic.gov.uk/foi

Data Access and Information Sharing Policy

http://portal/Documents/Policies/DAIS%20Policy%20Final%204.0%20updated.pdf

Privacy and data Protection

http://www.hscic.gov.uk/privacy

Appendices

Appendix 1: Reference data tables

Table	Title
Table 1	Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status, 2009/10 - 2013/14
Table 2	Detentions under the Mental Health Act 1983 in NHS facilities by legal status, 2009/10 - 2013/14
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Table 8	Patients detained under the Mental Health Act 1983 and patients on Community Treatment Orders by Mental Health Act 2007 mental category at 31 March, 2014, by gender
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Table 3	Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status (summary table), 2003/04 - 2013-14
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Table 7	CTOs issued, recalled, revoked and discharged under the Mental Health Act 1983 in NHS facilities and independent hospitals, 2003/04 - 2013/14

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Table 2	Detentions under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status and gender, 2013/14
Table 3	Uses of short-term detention orders under the Mental Health Act 1983 in NHS facilities and independent hospitals by legal status and type of provider, 2013/14
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Table 14	Transfers from Prison under Part III of the Mental Health Act, 2013/14

Appendix 4: Pre-2011/12 publication format statistics

Prior to the 2011/12 report, we used the following measures in our reporting. These have been superceded by new measures which are documented in a methodological change paper[55] but these can be calculated from underlying organisational data supplied in the machine readable data file.

The superceded 'All detentions' figure included:

- Detentions under Part II Sections 2, 3 and 4;
- Detentions under Part III Section 35, 36, 37 (with and without Section 41 restrictions), Section 45A, Section 47 (with and without Section 49 restrictions, Section 48 (with and without Section 49 restrictions), other Sections (Section 38, Section 44 and Section 46);
- Detentions under previous legislation (fifth schedule) and other Acts;
- Changes from informal status to Section 5(2) or Section 5(4);
- Changes from informal status to Section 2;
- Changes from informal status to Section 3;
- Detentions following the use of Section 136.

The superceded 'Total formal admissions' figure includes:

- Detentions under Part II Sections 2, 3 and 4;
- Detentions under Part III Section 35, 36, 37 (with and without Section 41 restrictions), Section 45A, Section 47 (with and without Section 49 restrictions, Section 48 (with and without Section 49 restrictions), other Sections (Section 38, Section 44 and Section 46);
- Detentions under previous legislation (fifth schedule) and other Acts.

The superceded 'Detentions subsequent to admission' figure includes:

- Changes from informal status to Section 5(2) or Section 5(4);
- Changes from informal status to Section 2;
- Changes from informal status to Section 3.

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Appendix 5: Background information on the Mental Health Act 1983

A brief outline of the main Sections of the Mental Health Act 1983 under which people can be formally detained in hospitals is given below. These Sections are shown separately in the tables. Previous legislation (Fifth Schedule of the Act) refers to people admitted to hospital under the Mental Health Act 1959 under transitional arrangements in place when the 1983 Act came into force. "Other Acts" includes Criminal Procedure (Insanity and Unfitness to Plead) Act 1991, Section 47 of the National Assistance Act 1948, Sections 1, 2 or 12 of the Children and Young Persons Act 1969, Children Act 1989, and Section 3 of the Powers of Criminal Courts Act 1973.

Part II admissions

Part II of the Act allows a patient to be compulsorily admitted under the Act if he/she is suffering from mental disorder as defined in the Act and where this is necessary:

- In the interests of his/her own health;
- In the interests of his/her own safety;
- For the protection of other people.

The relevant Sections are:

- Section 2: admission to hospital for assessment (maximum length of 28 days – cannot be renewed);
- Section 3: admission to hospital for treatment (maximum length initially 6 months – can be renewed for a further period of 6 months then for further periods of 1 year);
- Section 4: admission for assessment in emergency (maximum length 72 hours);
- Section 5(2): power to hold informal patients already in hospital (maximum length 72 hours);
- Section 5(4): nurses' holding power on an informal patient already in hospital and receiving treatment for a mental disorder (maximum length 72 hours).

Sections 4 and 5(2) have a detention limit of 72 hours, and cannot be renewed.

Part III admissions

Part III of the Act relates to people involved in criminal proceedings. The relevant Sections are:

- Section 35: accused person remanded to hospital for report;
- Section 36: accused person remanded to hospital for treatment;
- Section 37: convicted person sent to hospital for treatment (called a hospital order) - either with or without a restriction order under Section 41;
- Section 38: convicted person sent to hospital for assessment prior to sentencing (an interim hospital order);
- Section 44: potential Section 37 patient committed to hospital by a magistrates court pending a crown court hearing for restriction order;
- Section 45A: sentenced person given a hospital direction and limitation direction alongside a prison sentence. The hospital direction is equivalent to a Section 37 hospital order and the limitation direction is similar to a restriction order under Section 41;
- Section 47: prisoner, serving a sentence, transferred from prison to hospital - either with or without a restriction direction under Section 49;
- Section 48: prisoner, not sentenced, transferred from prison (or other form of detention) to hospital - either with or without a restriction direction under Section 49;

- Sections 35 and 36 have a detention period of 28 days and can be renewed for two further periods of 28 days - 12 weeks in total. Section 37 is renewable after 6 months, while Section 38 cannot be renewed beyond a period of 12 months.

Section 37 patients with Section 41 restrictions, patients subject to hospital and limitation directions under Section 45A and Section 47 and 48 patients with Section 49 restrictions do not have their detention renewed. They are subject to continuous detention until such time as they are either discharged, their restrictions end, or, in the case of Section 45A, 47 and 48 patients, they are returned to prison.

Place of safety detentions

Part X (10) of the Act gives the police powers to remove a person who appears to be mentally disordered to a place of safety for assessment by a doctor and an approved mental health professional. The relevant Sections are:

- Section 135: warrant to search for and remove a patient to a place of safety;
- Section 136: removal by police from a public place to a place of safety;
- Sections 135 and 136 have a detention limit of 72 hours, and cannot be renewed.

Community Treatment Orders

The Mental Health Act 2007 introduced Community Treatment Orders (also referred to as supervised community treatment). Patients detained in hospital for treatment under Section 3 (and certain Part III Sections) can be discharged from detention onto a Community Treatment Order (CTO) to continue their treatment in the community. While on a CTO, they can, if necessary, be recalled to hospital for up to 72 hours for assessment and/or treatment. In this bulletin, this is called “CTO recall to hospital”. If they need to remain detained in hospital for more than 72 hours, their CTO can be revoked. If that happens, they go back to being detained under the Section they were on before going onto the CTO (“revocation of CTO”). A discharge from CTO occurs when a patient’s CTO ends without being revoked. Community Treatment Orders were introduced on 3 November 2008.

After care under supervision

The Mental Health (Patients in the Community) Act 1995 introduced a new power of aftercare under supervision (Section 25A) which came into force on 1 April 1996. It was also called “supervised discharge”. After care under supervision applied to patients discharged from detention under Section 3, 37, 47 or 48 who presented a substantial risk of serious harm to themselves or other people unless their care is supervised.

Aftercare under supervision was abolished from 3 November 2008 by the Mental Health Act 2007. Transitional arrangements meant that all patients on after-care under supervision had either to be discharged, transferred to a CTO, or dealt with in some other way under the Mental Health Act 1983 by 3 May 2009 at the latest.

Category of mental disorder

Until 2 November 2008 a person detained under the Act was assigned a category of mental disorder - mental illness, psychopathic disorder, mental impairment or severe mental impairment - (except people subject to Sections 2, 5(2), 5(4), 135 and 136) and previous issues of this publication included analyses by category of mental disorder.

The Mental Health Act 2007 abolished these four separate categories of mental disorder from 3 November 2008 and replaced them with a single definition of ‘mental disorder’. A decision was taken in conjunction with the Department of Health to remove the Mental Categories from the data collection form for 2008-09.

Hospitals were therefore asked to collect information on whether a learning disability was the primary reason for the patient being detained and this was included in the data collection form and organisations were provided with advice on how to map the old mental categories to the new options on the form. In broad terms, the new category of "learning disability as primary reason for use of the Act" is equivalent to the old categories of "mental impairment" and "severe mental impairment". However, the new categories are also used for patients detained under short-term Sections (including Sections 2 and 4), whereas previously no category was assigned to those patients.

Summary of differences between The Mental Health Act and The Mental Capacity Act

MHA	MCA/DoLS
Based on risk	Based on best interest
Any age	>18
Hospital only	Hospital or care home
Can override capacitous refusal	Only if the patient lacks capacity
Can generally override valid and applicable advance refusals of medical treatment	Advance refusals of medical treatment must be honoured
Can be used solely for the protection of other people	Cannot be used solely for the protection of others

Appendix 6: Returns used

From 1996-97

Following a review by the Department of Health, requirements for information on detained patients, a new return, KP90, was introduced for 1996-97. This return replaced returns KH15 and KH16, previously completed by NHS trusts, and KO37, completed by health authorities on behalf of private hospitals in their area. It was also completed by the three SHAs managing the high security hospitals. The information collected on the return is essentially the same as that previously collected on KH15 and KH16 with additional information on informal admissions and formal and informal residents at the end of the year. The recording of changes in legal status has been simplified compared with KH16.

From 2001-02

High security psychiatric hospitals

The three high security hospitals were integrated into NHS Trusts: With effect from 1 April 2001, Broadmoor Hospital became part of the West London Mental Health NHS Trust and Rampton Hospital became part of the Nottinghamshire Healthcare NHS Trust. Ashworth Hospital became part of the Mersey Care NHS Trust with effect from 1 April 2002. Data on detained patients are now supplied directly to the Information Centre by each of the three Trusts on return KP90.

Private mental nursing homes

From 1 April 2002, the National Care Standards Commission (NCSC) took over responsibility from the Health Authorities to provide data for Private mental nursing homes authorised under Section 23 of the Registered Homes Act 1984 to detain patients under the provisions of the 1983 Mental Health Act. Data for the year 2001-02 was therefore supplied to the Department via the NCSC.

Independent hospitals

Sections 3 of the Care Standards Act 2000, which came fully into force from 1 April 2002, defined an independent hospital as being any establishment, other than an NHS hospital, which provides treatment or nursing (or both) for persons liable to be detained under The Act. The Act also provided that such independent hospitals should be registered under Part II of that Act, and should comply with such National Minimum Standards as may be published. The Care Standards Act 2000 superseded the Registered Homes Act (paragraph A2.3) and institutions registered under the earlier act as mental nursing homes were required to be registered as independent hospitals if they were taking patients liable to be detained.

Although NCSC retained responsibility for the registration and inspection of the independent hospitals, individual establishments were responsible for supplying data on detained patients to the Department, on form KP90. In April 2004 the NCSC functions covering private hospitals and clinics were transferred to the Healthcare Commission (which has in turn been superseded by the Care Quality Commission from April 2009). However, responsibility for supplying data on detained patients for the year 2003-04 remained with the individual establishments.

From 2008-09

Changes to the KP90 data collection form were required to take into account changes implemented by the Mental Health Act 2007. These were mandated by DSCN 26-2008 issued in November 2008 and approved by ROCR notification ROCR/OR/0015/FT6/002. This was also the third time that the

web based Omnibus data collection tool was used for the return. Both NHS and independent hospitals use the system. The DSCN which includes full details of the form can be downloaded here:

http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/index_html/?searchterm=KP90

Future data collection

The MHMDS has been changed so that it can potentially replace the KP90 as the data source for these statistics and this release includes parallel analysis which builds on work to date. Further work is needed and no change will be made without a full assurance process, ensure that outputs of comparable quality and scope can be produced.

Appendix 7: Related Reading

HSCIC information

Historical versions of this publication:

HSCIC Statistics on uses of the Mental Health Act 1983 ('The Act') (since 2005):
http://www.hscic.gov.uk/mentalhealth

Department of Health Statistics on uses of The Act (prior to 2005):
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalhealthcare/DH_4086494

Other documentation concerning this publication:

Omnibus guidance for completing the KP90 form:
http://www.hscic.gov.uk/datacollections/kp90

Consultation on the future of Mental Health Act 1983 statistics:
http://www.hscic.gov.uk/MentalHealthAct_stats_consultation

Paper on changes to these statistics (click link on left to 'Mental Health' area):
http://www.hscic.gov.uk/pubs/methchanges

Other recent statistics on uses of mental health legislation:

Guardianship under the Mental Health Act 1983:
http://www.hscic.gov.uk/catalogue/PUB14853

This report covers usage of Guardianship under the Mental Health Act, which allow limited powers to be granted to an appointed individual or authority to take decisions on a person's behalf, where those decisions would be in the person's best interest.

Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England); Annual Report 2013/14:
http://www.hscic.gov.uk/catalogue/PUB14825

Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England); Quarter 1 Return, 2014/15:
http://www.hscic.gov.uk/catalogue/PUB15475

Mental Health Bulletin; Annual Report from MHMDS Returns, England 2012/13:
http://www.hscic.gov.uk/catalogue/PUB12745

The Mental Health Bulletin includes counts of detained patients and people on CTOs during the reporting year)

Monthly Mental Health Minimum Data Set (MHMDS) Reports, England – February Summary Statistics and related information:
http://www.hscic.gov.uk/catalogue/PUB14125

This report includes a special feature on uses of The Mental Health Act in MHMDS.

Information on the Mental Health Minimum Data Set (MHMDS) and Mental Health and Learning Disabilities Data Set (MHLDDS):

Monthly MHMDS reports (including data quality metrics on Mental Health Act information):
http://www.hscic.gov.uk/mhmdsmonthly

MHMDS Dataset specification and guidance:
http://www.ic.nhs.uk/services/mhmds/spec

MHLDDS Dataset specification and guidance:

http://www.hscic.gov.uk/mhldds

Other statistics in this area

Uses of the Mental Health Act in Wales:
http://wales.gov.uk/statistics-and-research/admission-patients-mental-health-facilities/?lang=en

Uses of the Mental Health Act in Scotland:
http://www.mwcscot.org.uk/publications/statistical-monitoring-reports/

Mental Health statistics for Northern Ireland:
http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/mental_health_learning_disability.htm

Statistics of Mentally Disordered Offenders (England and Wales):
http://www.statistics.gov.uk/hub/crime-justice/offenders/mentally-disordered-offenders

These statistics are published annually by the Ministry of Justice and present information about mentally disordered offenders who were admitted under detention in or discharged from, hospital and were subject to restrictions on discharge under Part III of the Mental Health Act 1983 or the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991. These figures are not strictly comparable with figures in this publication as they are based on calendar years and there are also a number of definitional differences between the source datasets.

Count me in Census, 2010:
http://www.cqc.org.uk/sites/default/files/media/documents/count_me_in_2010_final_tagged.pdf

Information on the Mental Health Act 1983 and related legislation

Code of Practice: Mental Health Act 1983:
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4132161

Monitoring the use of the Mental Health Act:
http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf

Since April 2009, the Care Quality Commission (CQC) has been responsible for monitoring the use of the Mental Health Act in relation to those patients detained in hospital, placed on a community treatment order, or subject to guardianship. The report describes findings about the use of the Act, the areas where it is believed that improvement is needed and recommendations for achieving these improvements. It also looks at the appropriateness of prescribed treatment.

Police Custody as a 'Place of Safety': Examining the Use of Section 136 of the Mental Health Act 1983 (Independent Police Complaints Commission report):

http://www.ipcc.gov.uk/page/mental-health-police-custody

Amendments to the Mental Health Act as a result of the Health and Social Care Act 2012:

http://www.mentalhealthlaw.co.uk/Health_and_Social_Care_Act_2012

Amendments to the Mental Health Act as a result of the Mental Health (Discrimination) Act 2013:

http://www.mentalhealthlaw.co.uk/Mental_Health_(Discrimination)_Act_2013

Amendments to the Mental Health Act as a result of the Care Act 2014:

http://www.mentalhealthlaw.co.uk/Care_Act_2014

Resources for service users

CQC's guide to your rights under the Mental Health Act:
http://www.cqc.org.uk/content/your-rights-under-mental-health-act

CQC's guide to supporting people on CTOs:
http://www.cqc.org.uk/sites/default/files/documents/20120906_isl392_11_how_we_support_people_on_ctos_easy_to_read.pdf

The MIND guide to the Mental Health Act 1983:
http://www.mind.org.uk/help/rights_and_legislation/mental_health_act_1983_an_outline_guide
A booklet which sets out the main sections of The Act and outlines your rights if you are under these Sections.

Living with mental illness:
https://www.rethink.org/living-with-mental-illness
Web based information by the Rethink organisation for those living with mental illness.

More information on Deprivation of Liberty Safeguards

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1327

Other resources

Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales); July 2011

http://www.rcpsych.ac.uk/files/pdfversion/CR159x.pdf

Sections 135 and 136 of the Mental Health Act 1983 Good Practice Guidance
http://www.rcpsych.ac.uk/pdf/135%20136%20Good%20Practice%20Guidance.pdf

Metropolitan Police - operational guidance for police officers and staff responding to incidents involving someone with a mental illness
http://www.met.police.uk/foi/pdfs/policies/mental_health_policy.pdf
This is included as an example; similar documents for other forces can be found on the internet and local protocols may vary although all are governed by the Mental Health Act.

What must be considered when assessing the capacity of the patient to consent to medical treatment?
http://www.reach4resource.co.uk/what-must-be-considered-when-assessing-the-capacity-of-the-patient-to-consent-to-medication-treatment

Other changes to The Act were made as a result of the Health and Social Care Act 2012, the Mental Health (Discrimination) Act 2013, and the Care Act 2014; references are provided in the Appendix.

Appendix 8: Acknowledgements

Whilst ultimate responsibility for this report and its content rests with the HSCIC, we would like to acknowledge the valuable contributions of the following people and groups:

- Dr Tony Zigmond for technical assurance of the written report;
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- Participants of our Mental Health Act working group for their contributions to the refinement of Mental Health Act reporting terminology and developing recommendations from our Mental Health Act Statistics consultation results.

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For further information

www.hscic.gov.uk

0300 303 5678

enquiries@hscic.gov.uk