After the MHA Review: Priorities for future research on compulsory admissions

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Overview

1. Who am I?
2. Most pertinent issues in the Review from my point of view
3. The Long Term Plan for mental health
4. Reflections on research needs
Who am I?
Most pertinent issues in the Review from my point of view

1. Alignment of MHA Review & LTP e.g.:
   - Ambulances
   - Funding for crisis care
   - Funding for community care
   - Making acute inpatient care more therapeutic (revenue funding for staffing, and capital funding to improve the estate)

Choreography required, supporting DHSC to progress govt-led response to Review given mixture of legislative, policy, practice and implementation issues

2. Data black holes! E.g.:
   - NHS MHSDS – need to mainstream how MHA is viewed + DQ
   - S117 spend
   - S12 doctor availability
   - Police s136
   - AMHP data!
Most pertinent issues in the Review from my point of view

3. Evidence about why rates appear to be rising:
   - Lack of formal evidence?
   - What about logic? (Attribution, confounders..)

4. Risk!
   - Constant theme
   - How can we work across sectors and with coroners to crack this in clinical, AMHP and police practice?
5. **Workforce:**
   - CQC found lack of education among staff on new Code – shocking
   - How to standardise education and training on MHA?
   - Demographic composition of workforce to reflect patient population?
   - Recommendation on exploring links between staff experience and quality of care

6. **Digital:**
   - Practical, simple things to make information on e.g. rights readily available when someone is going into hospital for the first time?
   - How about a user-friendly video instead of an old bit of A4 black-and-white faded photocopier paper?
The LTP for (adult) MH

Crisis and acute
- 24/7 access to crisis services
- NHS 111 and ambulance
- Liaison services
- Non-medical alternatives to admissions
- Waiting times for emergency mental health services (Clinical Review of Standards)
- Therapeutic inpatient wards
- Reduction in length of stay

SMI community
- New models of integrated community care incl psychological therapies, physical health care, substance misuse, employment support, medicines management, co-morbid substance misuse
- Specialist services incl adult eating disorders, MH rehabilitation, personality disorder, EIP
- Testing 4 week waiting times in community settings (Clinical Review of Standards)
- Improving access to IPS
- Improving physical health checks for people with SMI

Suicide prevention
- Extend suicide prevention/reduction programme
- Postvention bereavement support
- Mental Health Safety Improvement Programme (part of wider new NHS patient safety strategy)
1. Ensure that anyone experiencing mental health crisis can call NHS 111 and access 24/7 age-appropriate mental health community support.

2. Continue ambition to ensure that all adult community crisis resolution and home treatment services are resourced and operating with high fidelity by 20/21.

3. Ensure that by 2023/24, 70% of Mental Health Liaison services in acute hospitals meet the ‘core 24’ standard for adults, working towards 100% coverage thereafter.

4. All children and young people will have access to 24/7 crisis, liaison and home treatment services by 2023/24.

5. Increase provision of non-medical alternatives to A&E such as crisis cafes and sanctuaries that can better meet needs for many people experiencing crisis.

6. Increase alternatives to inpatient admission in acute mental health pathways, such as crisis houses and acute day services.

7. Improve ambulance response to mental health crisis by introducing mental health transport vehicles (subject to future capital funding settlement), introducing mental health professionals in 111/999 control rooms; and building the mental health competency of ambulance staff.

8. Specific waiting times targets for emergency mental health services will for the first time take effect from 2020 (Part of wider clinical review of Standards).

9. Full coverage across the country of the existing suicide reduction programme.

10. Ensure the every area of the country has a suicide bereavement support service for families, and staff working in mental health services.
Ensuring inpatient care is therapeutic and purposeful

LTP wording: “For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. Purposeful, patient-orientated and recovery-focused care is the goal from the outset […] We will work with those units with a long length of stay and look to bring the typical length of stay in these units to the national average of 32 days.”

Proposed approach:

• Funding to improve MDT and should include AHPs (in particular OTs, psychologists, physiotherapists - very important for older people), and peer support workers

• View that new MDT staff should be part of community-based acute teams that in-reach onto wards, enabling therapeutic interventions more flexibly across both settings, whilst not delaying discharge or being used to bolster core ward staff numbers – the view is that this approach will reduce LoS whilst ensuring continuity of care pre and post discharge.
The detail: integrated primary and community care for adults & older adults with moderate to severe mental illnesses

We will establish new and integrated models of primary and community mental health care to support at least 370,000 adults and older adults per year who have severe mental illnesses by 2023/24, so that they will have greater choice and control over their care, and be supported to live well in their communities.

A new, inclusive generic community-based offer based on redesigning community mental health services in and around Primary Care Networks will include: improved access to psychological therapies, improved physical health care, IPS/employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance misuse.

This includes maintaining and developing new services for people who have the most complex needs including EIP, ‘personality disorder’, rehabilitation and adult eating disorders.

Through transforming the model of care and investing in new workforce we will be providing better care for people already receiving mental health support in the community, and increase access to these services over a 10 year period, including testing a new four-week waiting times standard for (generic adult and older adult) community mental health teams with a view to future roll-out. This testing of a potential future standard will form part of testing of the overall new model.

As part of improving the overall community offer, we will further increase the number of people with severe mental illnesses receiving physical health checks to an additional 110,000 people per year, and support an additional 35,000 people to participate in the Individual Placement and Support programme each year by 2023/24.
Reflections on research needs

• Perspective of working group membership for *Addressing rising detention rates - what interventions could reduce use of the MHA and compulsory admissions?*

• Need for systematic data collection – not just NHS
Reflections on research needs

Improved research and evaluation is needed to inform the design, commissioning and funding of services and interventions to tackle rising rates of detention.

Evaluations need to look at a broad range of outcomes and benefits, including the views and experiences of service users, families and carers. It is critical that a fresh approach to research considers a broad range of types of evidence and evaluations. This needs to go beyond the traditional reliance on RCTs, in light of the historical dearth of formal research and high-quality evidence, and the undue weight which can sometime be put on them.
Reflections on research needs

As far as is possible, research bodies should share iterative findings and learning from all MHA-related evaluations with services and professionals in real time to support continuous improvement and quality improvement approaches, thereby mitigating against the often very long lags in research that is in progress becoming applicable in practice and bridging the divide between researchers and practitioners.
Reflections on research needs

A new focus should include user- and carer-led research and qualitative experiential information; it is clear from what the review has heard that many service users, families and carers know from their individual perspectives what precipitates a crisis and what helps to avoid one. This knowledge should be respected, harnessed and nurtured in formal research as well as more informal means through which mental health providers and local authority professionals should seek to work with service users, families and carers within their local catchment areas to understand and address uses of the Act. This includes when considering how evidence and evaluation is funded and commissioned.