

The Separation of the Mental Health Act Commission's Functions: Inspectors, Visitors and Advocacy.

Margaret Clayton*

Introduction

This article is written in the week in which both the draft Mental Health Bill¹ and the Durham University Report on Independent Specialist Advocacy² have been published for consultation. All Commissioners are being consulted about both documents and it would clearly be premature to express any Commission views until we have all been able to digest their contents. We shall naturally have strong views on a number of issues, particularly the expressed intention to replace the White Paper's proposed Commission for Mental Health³ by a division of the new Commission for Health Inspection and Audit which will be responsible for scrutinising the proper application of the new Mental Health Act⁴.

My intention here is not to attempt to anticipate our considered response but instead to put the spotlight on a critical strategic issue which is not raised in either document and may otherwise be overlooked. This is the relationship between the concept of independent specialist advocacy services as set out in the Durham papers, the statutory functions of mental health advocates as described in the draft bill, and the amalgam of functions involved in the current visiting functions of the Mental Health Act Commission (MHAC). There is no intention of suggesting answers to

* *Chairman of the Mental Health Act Commission (December 1999 to present)*

1 *Department of Health (2002) Draft Mental Health Bill Cm 5538-1. London Stationery Office www.doh.gov.uk/mentalhealth*

2 *Barnes et al (2002) Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice. Executive Summary and Consultation*

Questions. University of Durham, available from www.doh.gov.uk/mentalhealth/advocacy

3 *Department of Health (2000) Reforming the Mental Health Act. Cm 50161. London, Stationery Office. p52-6.*

4 *See paragraphs 3.1 to 3.4 of Mental Health Bill – Consultation Document Cm 5538 – 111 Department of Health (2002). London Stationery Office.*

the questions raised. These will depend on consultation and consideration over time. The first part of the article, which is my sole responsibility, raises the general question. The second part describes, on behalf of the MHAC, how it has evolved since 1983 in a way which highlights the need for a close relationship between personal meetings with patients and a high level monitoring function. This combination may not be wholly compatible with an advocacy role.

Current Proposals

As the draft bill stands at present, there is no mention of how the current functions of the Mental Health Act Commission (MHAC) will be carried out under the new arrangements. The accompanying consultation document announces that the proper application of the Mental Health Act will become the responsibility of a specially established division of the new inspectorial commission and sets out some of its proposed scrutiny functions⁵. These accord well with many of the proposals the MHAC made in its submission on a successor body⁶, providing in particular a power for the new organisation to visit patients where there is cause for concern. The implication both in the consultation document and the Durham papers is that this power would be exercised through the independent advocacy service. Both sets of documents are, however, silent on the question of how the other functions encompassed in the current regular visiting role of the MHAC is to be covered.

The White Paper said that the role which Commissioners currently fulfil in alerting patients to their rights and responding to the many matters of concern raised by them would be taken over by a special advocacy service⁷. No comment was made at that stage on how the equally important function of using the concerns and experiences of all the individual patients to highlight general shortcomings in compliance with the Act would be carried forward. Similarly, there was no mention of the role which MHAC's current Commissioners play in feeding particular or general concerns back to local managers immediately so that remedial action can be taken without delay. Although MHAC visits are periodic and not all detained patients are visited, where they do take place staff as well as patients consistently stress their value. This role should therefore be built on rather than supplanted.

The draft bill makes provision for the approval (subject to regulations) of mental health advocates who will have statutory powers of access to patients and their records and a responsibility for providing the following help to patients:

- “s.159 (2). The help available under the arrangements must include–
- (a) help in obtaining information about and understanding–
 - (i) what medical treatment is being provided to the patient,
 - (ii) why it is being provided,
 - (iii) under what authority it is being provided,
 - (iv) what requirements of this Act apply in connection with the patient's treatment and what rights can be exercised by or in respect of him under this Act, and
 - (b) help (by way of representation or otherwise) in exercising those rights”.

5 *Ibid*

6 *MHAC (2000) A Successor to the Mental Health Act Commission. Available from www.mhac.trent.nhs.uk/successorbody.pdf*

7 *Department of Health (2000) Reforming the Mental Health Act. Cm 50161. London, Stationery Office. para 7.9.*

These powers and this responsibility could enable the advocates to carry out a large part of the core visiting function of current Mental Health Act Commissioners, provided that they are adequately resourced and properly regulated. They do not, however, include the responsibility mentioned above of bringing together in a generalised way the material relating to the impact of the legislation on individuals so that this can inform wider scrutiny of how the new Act is being implemented. There is similarly no indication that feedback and advice to local managers, which could be seen as compromising the advocacy role, would be one of the expected functions. There is therefore no indication that the whole range of functions of the existing visiting Commissioners will be covered.

The consultation document on Independent Specialist Advocacy in England and Wales is concerned with good practice for mental health advocacy, stressing that advocates are primarily listeners whose ultimate goal should be to enable service users to grow towards advocating for themselves wherever possible. The same document suggests that, if there were a good working relationship between the specialist advocacy services and the inspectorate, "the inspectorate could hear from specialist advocacy services that are alerted to concerns about care, treatment or the operations of mental health legislation". Although this role is not part of the conventional understanding of advocacy, it does not seem incompatible with the suggested model for special advocacy services, provided that the information given is either anonymised or given with the consent of the patient. This would reflect the current relationship between the MHAC and the Commission for Health Improvement and the National Care Standards Commission. The key point is that the advocacy would feed into the monitoring, just as the current visiting functions of the MHAC feed into both its own management and external inspectorial bodies.

The advocacy document also suggests, among other things, that the inspectorate might use the specialist advocacy service:

- to be the first line of independent advice and support for service users who approach the inspectorate direct with concerns, with the advocates only passing matters back to the inspectorate if they cannot deal with the issue,
- to contact service users who make complaints to the inspectorate, possibly offering support through the complaints process but not investigating the complaint.

These suggestions are included in a section of the Advocacy consultation documentation which is headed "Monitoring Body". The only consultation question on this subject included in the Executive Summary (Q.16) is how specialist advocacy services should be independently monitored and who should be responsible for the monitoring. It would therefore be very easy indeed for people who, quite reasonably, read one or other of the consultation documents in isolation from the other not to recognise that there are important questions to be examined here.

The fundamental question is perhaps whether any specific responsibility for approaching patients or undertaking any other activity on behalf of a third party is really compatible with the broader concept of advocacy set out in the Independent Special Advocacy document. Similarly, is a right of access to documentation, irrespective of the wishes of the patient, or a duty to provide information on statutory rights, compatible with advocacy? Should there perhaps instead be a distinction between:

- mental health advocacy services on the lines described more generally in that document, which are offered to all but provided individually only at the request of the patient, i.e. on behalf of the patient;

- people (referred to here as mental health visitors for the sake of a different title) who have specific statutory functions and rights of access which would not necessarily be compatible with speaking on behalf of the patient, but which include visiting every patient within a given time after detention/compulsion and ensuring access to mental health advocacy services, i.e. in the interests of the patient; and
- an inspectorate which has the right to ask statutorily approved mental health visitors to carry out certain functions on its behalf?

Put another way, there seems no difficulty in advocacy feeding, in general terms, into a monitoring/inspection function the qualitative material which enriches the quantitative evaluation. Similarly, it seems right that the monitoring/inspection function should have a right to request an individual approach to particular patients for specific purposes. The crucial issue is whether the latter right involves an imposition of power, with however beneficial a motive, which is incompatible with the whole concept of advocacy.

These questions are stated in a very open way because, as I have said, the Commission has not yet examined in detail or consulted its Commissioners on the two documents. The answers depend on details which are not explored at the present stage of consultation because they will presumably be handled in regulations or Codes of Practice. During the period in which implementation of the legislation needs to be worked out, much could be gained from examining other models, such as the Dutch one mentioned in the Durham papers, or the work which is being done on introducing advocacy at HM Prison, Forest Bank, Salford and how this will link with HM Inspectorate of Prisons and the prison Board of Visitors. What I am anxious to ensure is that those whose concern is with people who may be made subject to compulsion under the new legislation look carefully at the inter-relationship between the draft bill's reference to mental health advocates, the contents of the advocacy consultation documents, and the way in which the MHAC visiting functions enhance quantitative evaluation with qualitative information. To quote the MHAC's own Policy and Communications Manager:

“It would be a terrible irony if legislation providing a long overdue legal right of access to mental health advocacy also establishes a framework for advocacy and monitoring services which blurs the very real distinction between their roles with deleterious effects on the safeguards provided to patients”⁸.

Evolution of the Mental Health Act Commission

The remainder of this article gives a fairly simplistic overview of the evolution of the MHAC to try to show how the visiting function has gradually evolved to encompass functions which may be seen as inspectorial, but which we see as essentially rooted in individual visiting. The purpose is not to demonstrate that all the current functions cannot be carried out in any other way but to provide an understanding of how the quasi-inspectorial role has evolved from individual visiting and the value of the interplay between the two.

The White Paper which preceded the 1983 Act stated that: “ the proposed functions of the Commission will be separate to other inspectorial bodies; the Commission will not inspect and

⁸ *Mat Kinton (2002) Providing Mental Health Advocacy in a Patient-Centred NHS. The Mental Health Review 7:2, Pavilion.*

report on services and mental handicap in hospitals and units...[its] concern will be the particular problems which arise from detention of specific individuals in hospital rather than the general services which affect all mentally-ill and handicapped patients”⁹.

Meetings between individual patients and Commissioners have been the focus of the Commission's work from the outset and continue to be so. In 1999–2001, Commissioners met over 22,000 patients. The meetings have resulted in numerous specific improvements in compliance with the Act in locations visited. But also from the outset it was clear that it is impossible to meet several thousands of patients each year without drawing conclusions about the general delivery of services. The Commission's Biennial Reports have therefore always highlighted general service issues as well as providing more detailed cameos of the effect on individuals of compliance – or non-compliance – with the Mental Health Act. As the 1990s saw an increasing emphasis on the need for more effective management of health services in general, it became steadily more apparent that, in spite of the primary visiting/meeting function, mental health hospitals and related facilities were tending to rely on Mental Health Act Commission reports to feed back to them short-comings in their own service delivery in much the same way as a school, prison, or police service would look to reports from OFSTED or HM Inspectorates of Prisons or the Police to do so. The key differences have been, of course, that the Commission has had neither the powers nor the resources of a public inspectorate and there has been no health inspectorate to which its findings could be relayed.

This blurring of the distinction between a visiting and an inspectorial body was beginning to emerge even before 1990, when the Commission centralised its original regional structure in Nottingham, thus increasing central direction and control. In 1995/6 the visiting process was formalised by the introduction of policies and documentation which enabled particular experiences to be synthesised in a systematic way. Open recruitment and selection procedures were introduced, leading to a much enlarged body of Commissioners and more emphasis on consistent reporting back to local managers. At the same time, commissioning bodies and other quality assurance interests were included in the reporting back process. The core function on which all the reports are based has nevertheless continued to be meetings with individual patients to ensure that the Mental Health Act requirements are being properly complied with in relation to each person and to provide validation of the generalisations made in reports.

Since 1996, the Commission has continued to evolve in response to the needs of detained patients and those tasked to deliver services to them. A further major internal review in 1998/1999 and the recent creation of a number of new inspectorial or semi-inspectorial bodies led directly to the focus in the Commission's 9th Biennial Report on the need to improve management performance and to related changes in the Commission's visiting programme. The change in the focus of the Report and the developments in the visiting programme, which are briefly described below, were designed primarily to meet the problem that the same broad failures in compliance had been identified year after year without apparent improvement, but they also enhance the value of individual meetings with patients and provide a better basis for highlighting failures in compliance at all levels of management.

⁹ Department of Health and Social Security (1981) *Reform of Mental Health Legislation*. Cm 8405. London, Stationery Office. para 34.

Current and continuing position

What are these changes and developments? Put very simply, the 9th Biennial Report¹⁰ said that no matter how many patients are visited and how much new legislation is enacted, nothing much will change unless:

- there is a robust, properly funded infrastructure to provide the diverse, skilled and dedicated people needed to deliver proper services, and
- management at all levels takes responsibility for ensuring that legislative requirements and related policies are effectively implemented in relation to each individual patient.

The Commission has little influence over the first of these criteria. The recommendations in the Biennial Report and the changes in the visiting programme are, however, both aimed at the second. In February/March this year, the Commission hosted a series of ten travelling seminars at which we presented the Biennial Report and the changes in our visiting programme to over 300 Chairmen, Chief Executives and senior managers from Health Authorities, NHS Trusts and related private organisations. The essence of these changes (expressed here in a greatly over-simplified way) is that:

- the core focus continues to be on meeting with individual patients;
- whilst a general monitoring focus will be maintained on key areas of concern determined by the MHAC (e.g. in 2002–03, control and restraint, seclusion, and consent to treatment arrangements), additional local monitoring priorities will be targeted during the two year cycle of visits to every mental health hospital, depending on weaknesses identified by local management through its own self-assessment processes or in previous Commission reports;
- there will continue to be feed back to local managers at the end of each visit with action plans required for all identified areas of concern;
- the sum of these visits, together with the outcomes of individual patient visits, will be used to provide commissioning bodies and each NHS Trust or private equivalent with an overview of their effectiveness in compliance with the requirements of the 1983 Act;
- these overviews will provide relevant inspectorial bodies with evidentially-based and validated information to underpin and supplement their own work, while the consolidated results of all the work and the national monitoring of the specific issues identified as priorities by the MHAC itself will sharpen the focus on areas for national review or action.

In general, our new approach has been seen as a positive and helpful enhancement of what the MHAC already does. We have stressed that while our main aim is to help the patient by ensuring that managers “get it right first time”, this will also have the considerable benefit to local and other managers of enabling them to demonstrate to all the various bodies concerned that they have in hand effective arrangements to secure ongoing compliance with the legislative requirements. We are making all our monitoring forms available to managers on request to encourage them to check essential safeguards for themselves.

We know that many managers are already using the recommendations in the Biennial Report as a check-list to see how far they are addressing the key weaknesses identified in that Report. At the request of those who attended our seminars, we have also recently issued a checklist and reporting

¹⁰ MHAC (2001) *Ninth Biennial Report*. London, Stationery Office.

tool for optional use as an aide to help establish good arrangements locally. This may also help managers to respond to the Key Performance Indicator now introduced into the National Service Framework process by the Department of Health as a result of the Commission's urging in the 9th Biennial Report that compliance with the Act is an important ongoing duty which must be positively managed alongside other current priorities.

The main focus of all Commissioners is still on meeting with individual patients to hear their account of their experiences of service receipt, while also checking that their care and treatment is in accordance with the 1983 Act and that their clinicians and local management are aware of any shortcomings and concerns in relation to that particular patient. The new documentation enhances our ability to ensure that the lessons learnt from the experiences of individual patients can be brought together in a standard form which enables the Commission to provide a validated and comprehensive report for local management and commissioning bodies. This not only draws attention to particular cases where action is needed but also highlights whether those particular cases demonstrate or suggest wider failures in compliance with the Act.

The function of meeting patients is seen as essential to provide practical evidence as to whether the Act is being implemented in relation to individual patients in the way implied by more general monitoring tools. Only the patients themselves have the unique knowledge and understanding of what it is like to be compelled to remain in a particular situation and experience the feeling of others being in control of their lives. Such meetings are also vital to the well-being of individual patients, who often have no other independent person to whom they can turn for informed advice and help.

In spite of this emphasis on the importance of patient meetings, the change of style in the 9th Biennial Report, the subsequent emphasis on the need for management to make a more positive effort to ensure compliance with mental health legislation, and the clarification of the respective functions of meetings with patients and reporting/monitoring has led some commentators to assume that the Commission has abandoned its key role of keeping under review the operation of the Act as it relates to the detention of patients, or to patients liable to detention, under the Act¹¹. This is far from the truth. We see the situation rather as the continuation of a gradual evolution which recognises the need to ensure that the experiences of individuals continue to have a real impact on the technologically-based and quantitative approach to quality assurance which seems to characterise the beginning of the 21st century. There must continue to be a qualitative input to the quantitative monitoring. Nevertheless, the greater emphasis on general reporting can be seen as the beginning of a separation between the visiting and monitoring functions which requires careful consideration to be given to how the benefits of regarding them as two parts of one whole can be retained.

If this is to be achieved, personal experiences must be recorded and synthesised to focus on the specific action needed to remedy the more general defects in the service revealed by the failure to deliver in individual cases. And this identification of required action in turn needs greater powers to make sure that targeted action plans are produced and fulfilled. It may therefore be that the wheel has now come full circle and the time has come to separate the visiting functions yet again from the wider monitoring and inspectorial ones. Input to the new inspectorate from advocacy

¹¹ For example see Anselm Eldergill's review of the 8th Biennial Report, *Journal of Mental Health Law*, February 2002, pages 85–92.

services, PALS, and Community Health Councils could provide the qualitative flesh to the quantitative bones. The inspectorial function could be the key to ensuring the positive follow-up which the MHAC has had no power to achieve. But, as stressed in the first half of this article, the greater ability to monitor and enforce and the greater access by patients to advocacy services must not be allowed to undermine each other's integrity – there may still need to be a third element of statutorily based meetings with patients which provides the necessary link between them. How this might best be achieved remains to be seen.