

The Mental Health Act Commission, Ninth Biennial Report, 1999–2001

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The Mental Health Act Commission's Ninth Biennial Report was laid before Parliament on 3 December 2001.

The report covers the Commission's activities during the two-year period from 1 April 1999 to 31 March 2001.

The Commission was established in 1983, as a Special Health Authority, following publication of the Boynton Report.¹ The report recommended the creation of such a Commission, the functions of which 'might include ... the independent investigation of more serious complaints (from whatever source).'

The Commission's statutory functions are much more limited than those exercisable by the Commissions in Scotland and Northern Ireland. Its main functions are to keep under review the way in which the powers and duties set out in the Mental Health Act 1983 are exercised in relation to people who are liable to detention; to arrange for persons to visit and interview detained patients; to investigate complaints within its jurisdiction; to perform the Secretary of State's consent to treatment functions under Part IV of the Act; and to review any high security hospital decisions to withhold post.

Positives

The biennial report is well presented and well written, and much of the credit here must go to Mat Kinton, one of the Commission's stars. It is a compassionate document, and gives an excellent summary of where mental health services stand. These features reflect the kindness, commitment and skill of its members, and of those who helped them to prepare the report. There is an excellent passage on the effects of the safety and security directions on patient care in the high security hospitals, and useful information about the Commission's survey of all ECT facilities in England and Wales. The output data published in the report provides incontrovertible evidence of the tremendous workload of under-paid but dedicated Commissioners.

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1 Report of the Rampton Hospital Management Review Team, Chair Sir John Boynton, October 1980.

MHAC ACTIVITY (1999/00–2000/01)
Patient visiting

Private meetings with document checks	13,042
Individual patients met informally	8,656
Individual patients met in group situations	895
Documents checked but patient not seen	11,285

Second-opinion (SOAD) activity

Medication only second opinions	11,794
ECT only second opinions	4,274
Medication and ECT second opinions	189
Neurosurgery (section 57) consent procedure (all granted)	9

Complaints activity

New complaints received 'and followed up'	747
Formal complaints 'raised or reviewed' during visits (none of which led to a full investigation by the Commissioner)	244

Patient deaths

Deaths of detained patients notified to the Commission	881
Number of inquests attended 127 Patient correspondence (section 134) Number of MHAC reviews/appeals (five appeals granted, and one in part)	15

Source: Mental Health Act Commission, Ninth Biennial Report, 1999–2001. Data represents two years' activity.

Reservations

Some of the main reservations, which necessarily are personal to some extent, concern the format of the report (specifically, the failure to concentrate on the statutory remit and the making of 75 recommendations); the failure to set out a clear position on the White Paper which defends legal standards and the need for effective safeguards; the continued failure to monitor the way in which Mental Health Review Tribunals use their powers; the amount of complaints activity; and a lack of outcome data.

Format of the report

According to the introduction, the Commission ‘believes that its focus must be on the implementation of the Act and the patients whose lives are affected by it.’

The main chapters are a distillation of the reports made after each Commission visit during the two years, and also take account of the work of Second Opinion Appointed Doctors. The object ‘is to provide an overview that shows how the implementation of the Act is affecting the people it aims to protect; helps the facilities visited to improve their own practice; draws attention to general areas of poor practice; and advises on possible remedies for some of the issues raised.’

According to the report, the way in which the main themes are addressed has enabled the Commission,

‘to make specific recommendations on the actions that we believe are needed to ensure that the Act is properly implemented. The Commission is not an inspectoral body, but our very wide knowledge of individual patient experiences under the various provisions of the Act puts us in a unique position to comment on implementation. Most of the comments and recommendations relate to the way in which any legislation needs to be implemented and will therefore be as relevant to new legislation as they are to the 1983 Act. We therefore make no apology for using this report to take the logical step from review to recommendation....’

Chapter 9 sets out the recommendations from Chapters 2–7, commenting on the wider mental health environment in which they are set. By ordering the recommendations in relation to those with the primary responsibility for implementing them, it is intended to help everyone concerned to work together to achieve higher levels of compliance with the Act and with any new legislation. We hope that the way in which we have been reviewing and changing our own practices during the past two years will make a significant contribution to better implementation of the Act.

In the present transitional period between the 1983 Act and the new legislation ... , the Mental Health Act Commission believes that it can best serve the interests of detained patients by highlighting in this report those aspects of the 1983 Act which our work suggests most need attention, both now and in future legislation. This is why, although previous Biennial Reports are valuable reference documents because they range widely over issues of interpretation of the Act, (e.g. summarising changes in legislation, significant law cases and differences of view between academics, lawyers and practitioners) we decided that this report should be a more narrowly focused, action-orientated document. We hope that the Secretary of State ... will find it a useful contribution to ongoing consideration of how best to meet the interests of patients subject to compulsion under mental health law.’

The report contains 75 recommendations in all. Contrary to what is said in the introduction, the majority (almost 60%) do not concern the MHAC’s statutory functions or the Mental Health Act. Most of them cannot therefore be said to be ‘intended to help everyone concerned to work together to achieve higher levels of compliance with the Act and with any new legislation.’ The Commission has always spent a lot of its time performing functions that Parliament did not establish it to perform, and this statement reads as a rationalization of its activity, possibly brought about by an increasing awareness of departmental anxiety about this fact.

Although the Commission ‘makes no apology’ for using the report ‘to take the logical step from review to recommendation,’ and claims that it is a ‘more narrowly focused, action-orientated document,’ there is a difference between recommendation and action. A good homicide inquiry

report may set out a manageable number of agreed actions specific to the service that has been reviewed, and an agreed timetable. In general, a few targeted recommendations contribute most of the service improvements there are to be had in the short to medium term, and the rest are either ignored or simply generate a lot of bureaucracy to little effect. Here, the Commission has generated 75 recommendations that require services to devise at least 98 staff-intensive, often bureaucratic, steps, many of which have nothing to do with the 1983 Act:

Undertake full review, keep under constant review, review practice, review systems, review policies, etc.	19
Develop protocols, standards and protocols, etc.	14
Audit, audit and analyse, adequate audit tools and flagging systems, monitoring and flagging systems, audit and review	13
Routine monitoring, regular monitoring, monitoring meetings, etc.	10
Exhortations to action	8
Devise standard forms	5
Collect data sets	4
Devise systems and policies	4
Make arrangements	4
Issue guidelines/ guidance	3
Consider, give consideration to, etc	2
Devise plan, action plan	2
Assess patient response	2
Commission research	1
Make new regulations	1
Undertake consultations	1
Develop programme	1
Develop service agreement	1
Develop new strategy	1
Have discussions	1
Provide explanations	1
Total	98

Assuming for a moment that this is a proper function for a Mental Health Act Commission, does this help professionals to provide better mental health services? The disadvantages are obvious: too many quality-assurance commissions, too much top-down guidance, too many codes of practice, confusion on the ground about what to prioritise, a feeling amongst staff that they are drowning in policies and procedures, the impossibility of meeting all targets, demoralisation, and so on. There is a general weariness about the endless raft of guidance and recommendations, and professionals opening their post may be seen ‘binning’ what they regard as the NHS equivalent of the innovations catalogue inserted in daily newspapers. This cannot be desirable, and it is perhaps illustrative that not a single person booked to attend a national one-day event arranged to publicise and discuss the recommendations made in the biennial report.

Some objection may also be taken to the content or quality of the recommendations. A number of them are frankly banal, some will be thought condescending by front-line staff, and others offer no help at all. For example,

‘All those involved with the care and treatment of detained patients should encourage multi-disciplinary liaison to develop protocols which balance the need for confidentiality against the need to share essential information.

The making of so many recommendations in a biennial report seems to be a bad mistake, the more so because so many concern matters outside the Commission’s remit.

White Paper on the Mental Health Act

For reasons that are not entirely clear, although they may be political, the White Paper on the Mental Health Act is not discussed in the report.² The Chairman does, however, express two opinions about the government’s proposals in her foreword.

Firstly, that the Commission ‘warmly welcomes the Government’s proposals to reform mental health legislation and to strengthen the safeguards available to those who are compelled to accept care and treatment for mental disorder.’

This is rather unnerving coming as it does from the head of that public body dedicated to upholding legal standards for people who are detained under mental health legislation. Why should the Commission welcome those proposals in a White Paper that erode many important safeguards against the poor or inappropriate use of compulsion:

- The absence of any definition of mental disorder means that who is dealt with as a mentally disordered person will no longer be subject to any legal restrictions.
- People may be detained in psychiatric units or subjected to compulsion in the community even if they have no conduct disorder, even if their condition is untreatable, and even if the only reason for intervening is dependency on alcohol or drugs, provided that professionals think this is in their ‘best interests’.
- Those detained under the 28-day order will not have an effective appeal, because if they ask for a hearing its purpose will be to determine whether a six-month order is required.

2 *Reforming the Mental Health Act. Part I: The new legal framework (Department of Health/Home Office, December 2000, Cm 5016–I); Reforming the Mental*

Health Act. Part II: High-risk patients (Department of Health/Home Office, December 2000, Cm 5016–II).

- The police may enter private homes without a warrant if advised by a mental health professional that a person within is in need of immediate care or control.
- There will no longer be a statutory duty to provide after-care to former involuntary patients, and they will, it seems, have no right to free after-care.
- Patients will no longer be visited by an independent Mental Health Commission, with power to investigate complaints of abuse or non-compliance with the law.
- Independent hospital managers, Community Health Councils, and independent inquiries will be abolished.
- Hospitals and homes will regulate and investigate themselves, subject only to a quality assurance visit from the Commission for Health Improvement every four years.
- An involuntary patient will no longer have a right to a binding, independent, second opinion on ECT or long-term medication.
- Non-medical involvement in compulsory procedures will no longer be mandatory, and decisions to detain a citizen may be made by three colleagues working for the detaining body.
- Nearest relatives, hospital managers, Health Authorities, NHS trusts, and local authorities will lose their power to discharge individuals from compulsion, and only the patient's clinical supervisor will have this power.
- It will no longer be possible for a patient to be discharged home by their spouse or partner, even if no one is in danger.

Secondly, the foreword states that 'although the Commission accepts that national regulatory bodies and local advocacy services may provide an adequate substitute for our current visiting functions, it is essential that Mental Health Act Commissioners continue to visit detained patients until satisfactory alternative arrangements are in place ...'

In truth, there is little to suggest that any of the newly established public bodies will provide an adequate substitute for specialist visiting, and this ought to be pointed out:

- The Commission for Health Improvement (CHI) is not independent of the Secretary of State, who may regulate how it performs its functions. This may be legitimate in the quality arena, but it is undesirable in the arena of individual legal rights.
- CHI's core functions focus on clinical governance and reviewing 'the arrangements made' by trusts for monitoring and improving the quality of health care (c.f. legal standards). It may investigate the provision or quality of 'healthcare' (c.f. legal standards).
- Because CHI is concerned with quality assurance mechanisms, rather than legal standards and protecting vulnerable individuals, it will only inspect NHS bodies every four years.
- Furthermore, because the CHI is concerned with quality assurance mechanisms, rather than legal standards and protecting vulnerable individuals, the regulations may only authorise the disclosure to it of information in in-patient medical notes and health records in very limited circumstances. Namely, if the information is disclosed in an anonymised form; or the individual consents to the information being disclosed; or the individual cannot be traced despite the taking of all reasonable steps.

- The new system for investigating adverse events that cause a member of the public to suffer is tightly controlled by the Secretary of State. Adverse events or incidents may only be independently inquired into with his consent. The motivation here can only be political, for no public interest is served.
- There is no indication that Patient Advocacy and Liaison Services (PALS) representatives will have access to patients' notes or statutory documents, or be legally qualified or otherwise competent to give a legal opinion, and any opinions would carry little weight and not be binding. It may be impractical to have a 'welcoming point' at every mental health unit or centre, and many services are provided outside hospital. It is not clear how the services will operate in high and medium secure facilities.
- Patients' Forums will replace Community Health Councils, and the Secretary of State may (but need not) require health service bodies to allow authorised forum members to inspect premises owned or controlled by them. Again, it is not clear how this will help to maintain legal standards, and the provisions seem designed with acute hospitals in mind. Which members (if any) will be authorised to inspect premises, and who will be excluded? How will members of high or medium secure hospital forums be appointed? Will patients in Broadmoor, or former patients, be entitled to inspect the premises? What does seem clear is that forum members will not have access to patients' notes or statutory documents, or be legally qualified, or have any statutory powers to police or enforce mental health legislation.

Fennell and Eldergill have summarised, and analysed, the proposals set out in the White Paper.³

Mental Health Review Tribunals

The 1983 Act provides that the statutory powers and duties which must be kept under review do not include any exercisable by the Court of Protection under Part VII. No such exception applies to the powers and duties exercised by Mental Health Review Tribunals under Part V.⁴ Furthermore, the Secretary of State is bound by statute to direct the Commission to perform on his behalf this function of keeping under review the way in which these statutory powers and duties are discharged.⁵ Consequently, the Commission has no discretion and must review the workings of tribunals, insofar as they relate to detained patients. However, yet again, it has not.

Outcome data

Although the report includes data on the Commission's activity (outputs) during the two-year period, it contains little information about outcome, and this is a weakness. For example, what percentage of SOAD second-opinions led to the treatment plan being modified in accordance with the patient's reservations? How many complaints investigations undertaken by the Commission were upheld? How many of the scrutinised documents were invalid, and what action was taken? Without this information it is impossible to know whether or not the Commission is performing its functions effectively.

3 Fennell P., 'Reforming the Mental Health Act 1983: 'Joined up Compulsion'' (2001) *Journal of Mental Health Law*, 5–20; Eldergill, A., 'Reforming the Mental Health Act' (2001) *The Journal of Forensic Psychiatry*, 12-2, 379–397.

4 *Mental Health Act 1983*, s.120(7).

5 *Ibid.*, s.121(2)(b).

Complaints investigations

The statutory framework envisages that the Commission will fulfil its duty to keep the operation of the Act under review in two main ways. Firstly, by visiting detained patients and, secondly, by investigating complaints made by them or about the use of the Act. According to the report, 747 new complaints were received 'and followed up' during the two years, and 244 formal complaints were 'raised or reviewed' during visits (none of which led to a full investigation by the Commissioner). It seems that the Commission may not be fulfilling one of its two main statutory functions. However, we are not given the detailed statistics about its complaints activity found in previous reports, and so cannot know the precise situation.

NHS jargon

Although mostly well written, the report does resort to health service clichés and jargon ('pro-active', 'robust', 'rolling out', 'inform practice'). A 'holistic' approach is recommended for many problems.

Summary

The Biennial Report is, of course, essential reading, and it provides an excellent summary of where mental health services stand. That though is not the Mental Health Act Commission's function. It is to keep the operation of the powers and duties in that Act under review. It is not a National Health Service Act Commission or a Mental Health Services Commission. In this respect, the report has little new to say about matters within its statutory remit. Nor does it inform us in any detail about how these powers and duties are being exercised in practice, and what problems have been encountered.

*Copies of the Biennial Report can be obtained from The Stationery Office.
Tel: 0870 600 5522. Fax: 0870 600 5533. www.clicktso.com.*