

# A Successor Body to the Mental Health Act Commission

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*“The Mental Health Act Commission (MHAC) has a major role in protecting the interests of patients who are subject to the provisions of the 1983 Act. Its principal functions are to:*

- *appoint Second Opinion Appointed Doctors*
- *review treatments given under sections 57(2) or 58(3)(b) of the Act, ie treatment that requires a second opinion*
- *visit detained patients and investigate complaints*
- *keep under review the exercise of statutory powers relating to detained patients*
- *submit proposals for a code of practice*
- *look into matters relating to informal patients, when directed to do so by the Secretary of State, and*
- *report to the Secretary of State every two years on the operation of the Act.”*

This is the summary of the functions of the MHAC contained in the Green Paper on Reform of the Mental Health Act 1983. In this brave new world of the Modern NHS, with much enhanced arrangements for local quality assurance and clinical governance, the Commission for Health Improvement, the Commission for Care Standards, the National Institute for Clinical Excellence, the establishment of Patient Advocate and Liaison Services, and the numerous other ways of increasing patient participation which are outlined in the National Plan for England, is a successor body to the Mental Health Act Commission really necessary ?

The Commission’s response is an unequivocal “Yes”<sup>1</sup>.

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1 A full version of the paper “The Successor Body” is available on the Mental Health Act Commission website.

The Green Paper on Reform of the Mental Health Act listed some of the proposals made for a successor body by the Expert Committee and sought comments on them in the context of a statement that the functions of the MHAC successor body would be decided in the light of decisions on the shape of the new Mental Health Act. As well as commenting on the general proposals in the Green Paper, the Commission therefore submitted a separate response detailing its views on the necessity for a successor body and its possible functions.

This article highlights some of the main points made in the Commission's submission and speculates on possible additional functions which could substantially enhance the safeguards available to detained patients. The term 'detained patients' is used generically to include all mentally disordered patients who might be either detained or subject to a Compulsory Order under the Green Paper proposals. It does not speculate on any extension of remit to "de facto" detained patients or others for whom alternative future safeguards are not yet clear.

Before outlining some of the detailed arguments for a successor body, there are two main points to be made:-

- It is the very proliferation of statutory and other agencies with fingers in the same pie and the complexity of their relationships that make a successor body absolutely essential. Proliferation is not conducive to a holistic view across boundaries.
- The judicial role of deciding whether a patient should be made subject to compulsory care and treatment and whether continued use of such powers is justified is different from and should be separate from ensuring that the continuing care and treatment of such a patient complies with the legislation on a day to day basis. This paper is concerned with the second of these.

Both these points are returned to later in the article.

### **Need for a successor body**

The Commission believes that an independent successor body is essential because:-

- The State is under a particular obligation to protect the interests and human rights of those it places under compulsion for any reason, but particularly when mental disorder may reduce a person's capacity to protect him or her self.
- Separation from the NHS and the Department of Health is clearly necessary to fulfil this function if the safeguarding role is to have any credibility.
- Coercive powers imposed by the State for therapeutic reasons can be misused, even with benevolent intent.
- The general public needs to be reassured that all reasonable steps have been taken to prevent this and, more generally, to be confident that mental health legislation cannot be used for social engineering or political purposes.
- Other similar groups of people who are perceived as particularly vulnerable have separate bodies to safeguard their interests, regardless of other relevant checks on service standards and delivery, e.g. the Disability Rights Commission, Commission for Racial Equality, Equal Opportunities Commission.

## **Main Functions**

### *What should or could a successor body do?*

The Green Paper is clearly right in saying that it should not duplicate the functions of management or other quality assurance bodies. The primary role must be to safeguard the interests of people subject to compulsory care and/or treatment. This can only be satisfactorily achieved if all relevant agencies work closely together to achieve complementary objectives. The successor body therefore has a role in facilitating such co-operative working as well as in focussing on individual patients.

The Commission believes that the core work would fall under five main headings:-

- Visiting
- Monitoring
- Reviewing, including deaths and complaints
- Reporting and dissemination
- Acting as a focus for other bodies with an interest in mentally disordered patients.

### *Visiting*

Patients subject to any form of compulsion need to receive independent visits to see that they are:-

- receiving the treatment for which compulsion has been imposed,
- aware of their rights under mental health legislation or have been unable to understand genuine efforts to make them so,
- know how to make a complaint if they are dissatisfied with any aspect of their care or treatment,
- not being subjected to improper use of restrictive powers, e.g. seclusion, search, physical or mechanical restraints, withholding of post or other property, refusal of visits, or access to activities,
- not being abused or neglected, and
- not receiving treatment which has not been properly authorised.

The existing MHAC carries out this visiting function in all health facilities which contain detained patients. It may be argued that more consistently provided advocacy services or the newly suggested Patient Advice and Liaison Service (PALS) could take over this role, but both would have a much wider focus than the particular issues relating to detention and neither would necessarily be seen as fully independent of the facility in which they are based. There seems therefore a clear role here for the MHAC successor body. Whether this role is in direct provision, as at present; in training and possibly accreditation; or in some form of franchising of local services, will depend on the shape of other proposals in the forthcoming White Paper. What must be recognised is the need for a successor body function which ensures consistency and equality of visiting provision for detained people in either health or social service facilities and uses information gained from visiting to validate documentary evidence.

### *Monitoring*

Visiting individual detained patients is definitely not enough to ensure that their interests are safeguarded. The MHAC has been accused of being bureaucratic and over-concerned with documentation but unless careful and accurate records are kept of such matters as risk assessment, care plans, consent to treatment, the administration of drugs, use of seclusion and access to recreational facilities and fresh air, how can anyone be sure that such patients are not being abused? Close monitoring of documentation is also necessary to track whether the progress of an individual through the system complies with statutory requirements. This is going to be even more important than now if compulsion can apply outside as well as within residential facilities. It is only by a combination of meeting patients, either individually or in groups, checking their perceptions against their personal records, and setting these personal records in the context of consistent monitoring of particular aspects of care that a reasonably accurate picture can be obtained of how well any specified facility is managing its detained patients or how well any particular patient is being treated in his/her progress through the system

With the best will in the world, it is extremely unlikely that hard-pressed managers or any national body with a health/social services wide remit could ever give sufficient priority to detained patients to enable this kind of detailed monitoring to be undertaken. A separate independent body with a specialised remit is needed both to provide the necessary protection and to feedback information which would alert those with primary responsibility for quality assurance to the need for remedial action. This monitoring role would be even more valuable if combined with a general facilitative remit to enhance the ability of all concerned to work to common objectives in relation to detained patients. (See "Acting as a focus..." below)

### *Reviewing, including deaths and complaints*

Visiting and monitoring will inevitably disclose areas which merit close scrutiny across the board. Since much of the base material and necessary contacts will be readily available to the MHAC successor body itself, such scrutiny could either be undertaken in-house or commissioned. The MHAC has carried out several very useful thematic reviews, the most recent of which - on aspects of race and equal opportunities - is the subject of ongoing work with the University of Central Lancashire and the Sainsbury Centre. The successor body must have the right to do the same.

Within this general role, the reviews of deaths and complaints are of particular significance. The Commission already receives notification of all deaths of detained patients and reviews their circumstances. An MHAC report on the outcome of these reviews during the past three years is shortly to be published. This will show the advantage of a single body having a review function which enables the build up of expertise and, more importantly, the ability to identify common features and perhaps commonly required preventative action. To give this function to an independent body will provide the credibility which is all too often (however wrongly) perceived as missing in relation to deaths in other types of custody, such as police or prisons.

The review of complaints is more complex. There is already a hierarchy of arrangements for processing complaints on any aspect of health and social services. The MHAC currently has the power to investigate complaints from detained patients but very rarely does so, considering it more constructive to provide support and advice to complainants to assist them in obtaining a response through the relevant quality processes. About 650 such cases are dealt with each year. To attempt

a review or investigation in parallel with existing arrangements would be confusing and could be oppressive to the subject of the complaint, while to replace the normal process would diminish the accountability of those who are responsible for general quality assurance.

Nevertheless, there is little doubt that detained patients are more likely than others to be disadvantaged by the long drawn out processes of the standard complaints procedure and, at the very least, a successor body could give added protection by being able to monitor progress and draw attention to deficiencies. Whether this should be only in relation to complaints about detention or extend to any formal complaint made by a detained patient is for consideration - it can certainly be argued that the need for monitoring of all formal complaints is just as critical in assessing the quality of care for detained patients as of those relating only to their detention.

In its response to the Green Paper, the Commission suggested that its successor body should not have investigatory powers in relation to complaints but should offer information and advice and be consulted on membership and terms of reference for any independent investigation. This more general role would not prevent Commission members from being involved in any investigation but would help to assure the public that the process of setting up such an investigation was itself subject to independent scrutiny.

### *Reporting and Dissemination*

#### **Reporting**

One of the most important aspects of visiting and monitoring is alerting local management to issues of concern which can and should be readily remedied. The MHAC finds that considerable change can be achieved in individual facilities through this informal reporting process. This approach to supporting staff who are anxious to improve their service will be essential for a successor body, but it should also be required to report more serious concerns to higher managers and others such as service commissioners who are responsible for quality assurance. Such a requirement will not only enhance the quality assurance capacity but also provide the opportunity for publicity if more serious concerns are ignored.

#### **Publications**

The MHAC is convinced that analysing and publishing relevant data relating to all detained patients is one of the most valuable ways in which a successor body could contribute to an improvement of mental health services, both for detained patients and others who experience similar care and treatment. Apart from material aimed specifically to provide information for detained patients, we suggest that the three main needs are for:-

- A wide range of “brand” documents such as special reports, regular reviews, or bulletins that aim to disseminate good practice and draw attention to differences, trends or bad practice which may raise questions about the quality of services.
- A freely available and widely circulated annual report that would meet the needs of public accountability and provide an ongoing record of overall improvements in the performance both of the successor body and of the organisations and functions it will be monitoring.
- A regular statutory report to Parliament - not necessarily biennial - that would continue to provide the broader historical perspective currently supplied by the Biennial Report.

It is arguable that a MHAC successor body should also be responsible for producing relevant Codes of Practice. The Commission believes that this is a proper function of the department(s) with responsibility for the legislation but that the successor body should retain the current right to make proposals for such Codes, as well as having a right to be consulted on the Codes and on all legislation or Government publications relating to compulsion under mental health law.

### **Advice and training**

The MHAC answers numerous written and oral queries about the implementation of the 1983 Act. Mental health authorities and practitioners have greatly welcomed the Guidance Notes issued by the Commission and the training introduced last year on the new Code of Practice. New legislation will require much more such advice and training. The Commission believes that the successor body should have a specific remit to provide advice and guidance on legal issues and good practice as they relate to compulsion in relation to mentally disordered patients, with particular regard to human rights legislation. It will have to provide such advice to its own staff and Commissioners and could therefore provide it to a much wider range of people consistently and cost-effectively.

How such advice should be provided will depend to a large extent on how well-resourced a successor body is to be. A 24 hr. helpline could provide both general advice and a first source of help for individuals liable to be detained. A web-site on mental health law similar to the one recently provided by the Institute of Mental Health Law but now discontinued would be a valuable resource for statutory as well as voluntary bodies and individuals. There could be regular up-dates on issues affecting compulsion under mental health law, perhaps on a subscription basis. There are many possibilities. It is, however, self-evident that to have a single authoritative independent body as the focal point must be beneficial to all concerned in providing one clear centre of expertise.

The role of a successor body in training is more complex. There is a considerable demand for training in mental health legislation and much to be gained by having it provided (not necessarily exclusively) by an independent authority separate from each of the related disciplines. This would ensure consistency of training across disciplines, facilitate multi-disciplinary involvement, which is particularly crucial to the care and treatment of detained patients, and prevent the excessive re-invention of wheels. It would, however, be essential not to intrude on professional training and to ensure close co-operation with all the relevant professional organisations. Relevant examples are training for Second Opinion Appointed Doctors (already undertaken by the MHAC), doctors appointed under section 12 of the 1983 Act, those who give independent advice to Tribunals, and Approved Social Workers.

Training of people who have not necessarily received any professional training in mental health matters creates less difficulty. These might include non-executive directors of health or social service bodies, administrators, volunteers in various capacities such as advocates or PALS, or other voluntary bodies lobbying or providing services for those with mental disorder.

**Acting as a focus for other bodies concerned with mentally disordered patients.**

Most of the proposals made above underline the need for detained patients to be recognised as a sub-set of vulnerable individuals whose needs should be examined holistically regardless of where they are placed or who is directly responsible for them. There is otherwise a very real danger that they will not be a high enough priority for any of the agencies concerned with their care for significant improvements to be made.

Resource constraints and different professional objectives make it difficult for any of these agencies - whether statutory or voluntary - to take a lead in trying to draw together the many complex threads of the issues surrounding compulsory care and treatment. This is why the development of a successor body to the MHAC with a clear remit to do this would be so valuable.

How the successor body would achieve closer inter-agency and multi-disciplinary working will be dependent on the shape of the arrangements which will be revealed in the forthcoming White Paper. The possibilities are many. They range from providing a common source of information, advice and training in mental health legislation, as already suggested, to the facilitation of inter-agency and multi-disciplinary conferences, seminars or meetings to:-

- identify and establish boundaries to avoid duplication of demands on patients, carers or staff,
- co-operate in the arrangement of visits/inspections for the same reason,
- discuss significant cross-boundary issues relating to detained patients,
- develop common priorities/targets for improvement,
- develop common standards for quality assurance,
- explore problems of confidentiality and professional ethics which may inhibit the transfer of information to the benefit of the patient,
- exchange best practice and identify reasons for differences revealed by the successor body's monitoring function.

“Joined up” working of this kind would have implications for the many patients who, although not subject to mental health legislation, are often managed in the same facilities and encounter very similar problems.

**Additional functions**

*Relationship with Tribunals*

With the exception of the facilitating role just mentioned, the functions already described largely maintain and enhance existing functions of the MHAC. At the beginning of this article an unsubstantiated assertion was made that the judicial function of deciding whether compulsion should be applied and whether its continuance was justified should be separate from assuring ongoing compliance with mental health legislation. There is room for disagreement here, since it is not inconceivable that one independent agency should be responsible for managing both the judicial and the monitoring functions, providing that the two roles were clearly differentiated. This would, however, run contrary to the general constitutional separation between judicial and administrative or executive functions and the possibility is not further considered here.

On the assumption that the tribunal suggested in the Green Paper will have a much more pro-active

role in establishing that a patient should be detained than the existing Mental Health Review Tribunal, there is little doubt that the number of expert opinions required from doctors will increase. The Commission's submission on a successor body suggested that such a body should recruit and train all doctors required either as members of or expert witnesses to the tribunal, as well as continuing to appoint, train and monitor the performance of Second Opinion Appointed Doctors involved in consent to treatment safeguards. This would underline the independence of second opinions and advice as well as enabling the knowledge and skills base of the successor body to be effectively utilised. The maintenance of a common database would facilitate the avoidance of duplication of functions and ensure the best use of scarce medical resources, thus contributing to the achievement of common objectives.

The number of other professionals required to give expert advice to the tribunal will also increase if the Green Paper proposals are implemented, as will the number of patients requiring legal representation. The successor body could have a similar function in relation to other professionals as to doctors. Legal representation could also be facilitated by the successor body directly engaging/appointing legally trained people throughout the country to be available for detained patients or maintaining lists of people who have been franchised by the Lord Chancellor's Department (or by the successor body itself) or simply establishing direct links with local bodies already involved with providing adequate legal representation.

### **Powers of the successor body**

Much of what is suggested above depends on the ability of the successor body to provide consistent, comprehensive and reliable information. The effectiveness of the existing MHAC is limited by the fact that it has no statutory powers to require information or to enforce its recommendations. In its submission to the Department of Health, the Commission suggested that to give the successor body enforcement powers could undermine service providers' managerial responsibilities or priorities or conflict with the responsibilities of other bodies with wider quality assurance roles. We therefore suggested that the successor body should instead have a broad range of statutory rights and duties such as:-

- the right to receive notification of all admissions to, extensions of and discharge from compulsory powers and of a range of other matters relating to detained patients, e.g. deaths, untoward incidents, formal complaints,
- the right of access to detained patients and their records,
- a duty to discuss with local managers matters of concern relating to their management of facilities or detained patients and to report to senior managers any matters requiring their attention,
- a duty to draw to the attention of the Secretary of State and/or the appropriate professional, regulatory or managerial body any cases, trends or practices relating to detained patients which it considers requires their action,
- a duty to publish from time to time such material arising from its remit as might contribute to the improvement of services to mentally disordered people subject to compulsion.

Rights and duties of this kind should provide the successor body with the information and mechanisms necessary to give authority to its activities without duplicating or overlapping with the responsibilities of others.



### **Structure and organisation of a successor body**

Structure follows function. It would therefore be premature to speculate on how the successor body might best be structured and organised to fulfil its functions. What must be recognised, however, is that if it is to fulfil the kind of enhanced role which is suggested in this article, it will need to be more self-evidently independent and differently resourced than at present.

The existing MHAC is a Special Health Authority. In its paper on the successor body, the Commission rejected this status because of the connotation that it is part of the NHS and responsible for the delivery of a health service, whereas it is independent and concerned with a wider range of services which it does not deliver itself. Similarly, the Commission argued that the successor body should be staffed by people from a wide range of disciplines, including full-time professionals, rather than solely by civil servants seconded from the Department of Health (although the latter would be amongst those included in the staff). These views are pertinent whatever functions are allocated.

If the successor body is to have the standing and authority necessary to carry out the full range of functions described, the Commission believes that it must have a stronger senior management structure to support the high level Chief Executive who has recently been appointed. More importantly, it should be a statutory Non-Departmental Public Body headed by people of national standing and credibility in the professions with which it will need to engage. It will require a modern infrastructure based on modern technology and the ability to adapt swiftly and effectively to changing circumstances.

All this will be a small price to pay for ensuring that one of the most vulnerable groups of people in our society have the additional safeguards and support which they need and that the staff and management who strive to look after them are helped to do so in a positive and constructive way. We cannot afford to lose the Mental Health Act Commission. The Government would be foolish to miss the opportunity to enhance its usefulness to all concerned.