

Placed Amongst Strangers – the Tenth Biennial Report (2001–2003) of the Mental Health Act Commission

Mat Kinton*

The Mental Health Act Commission's Tenth Biennial Report was laid before Parliament and published in December 2003. The report covers two years' activity – financial years 2001 to 2003 – monitoring the operation of the Mental Health Act 1983 as it relates to the detention and treatment of patients. In twenty chapters it deals with a range of issues pertinent to the care of mental health patients subject to compulsory treatment.

I will not attempt here to list systematically the points made by our report. Readers of this journal are likely already to have thumbed a copy of the report itself, or accessed it on the Commission website¹, and, if not, I hope that this article will encourage them to do so. Instead, I will seek to explain in more general terms the context and themes of the report, and what we would wish to see as its desired outcome.

The context of the report

Everybody with a concern in mental health services, particularly in relation to patients who may be compelled to accept treatment, has a general sense of the purpose of the Mental Health Act Commission. The legal remit of the Commission is stated in the Mental Health Act 1983, which requires the body to 'monitor the exercise of the powers and discharge of duties conferred or imposed' by that Act in respect of the detention of patients for psychiatric care and treatment². Mental health professionals who encounter visiting Commissioners will know that such 'monitoring' focuses primarily on meeting in private with such patients, as required by statute, and

* Senior Policy Analyst, Mental Health Act Commission 2 Mental Health Act 1983, s 120(1)

¹ www.mhac.trent.nhs.uk

includes the examination of documents and other evidence of practice in the use of the Act to detain and treat patients, culminating in a report to the hospital managers on the Commission's findings. The Commission's own gloss on this activity is that it is in the business of 'safeguarding the interests of detained patients'³. This is certainly the most apparent use of such a body, and one that can indeed be traced back to Government intentions when the Commission's establishment was suggested in the early 1980s⁴.

There is, however, an obverse aspect to the Commission's role as the defender of detained patients' interests. The Commission forms part of a framework of checks and balances that helps to legitimise what is otherwise a rather extended use of State power: the civil detention of mentally disordered people⁵. It is one of the means by which the State meets its obligation 'to know enough about its patient...to provide effective protection' to that patient⁶ (others are the Code of Practice, which provides guidance on the use of the powers that are monitored by the Commission, and the Mental Health Review Tribunal, whose remit is rather more sharply focussed on the legitimacy of continuing to subject individual patients to the general powers of the Act). Without these elements of patient protection, such healthcare interventions of the State could fail requirements of the European Convention on Human Rights (ECHR).

This Tenth Biennial Report may not be the last ever produced by the Commission in its current establishment – the eventual repeal of the 1983 Act upon which its existence depends is almost certainly too far away to expect a change in monitoring arrangements within the next two years – but it has been written under the assumption that we are upon the brink of potentially radical change in arrangements for monitoring the use of mental health legislation. In particular, Government has announced that it intends, upon the eventual repeal of the 1983 Act, to put such monitoring into the hands of the soon to be established Commission for Healthcare Audit and Inspection (CHAI). The Mental Health Act Commission is sympathetic to the need for such rationalisation of health service bodies, provided that the core statutory function and duties towards patients subject to care under the State's compulsion, including and especially visiting practices, are not lost in such arrangements. The proposals for the next Mental Health Act would create a conceptual shift in the role of the Tribunal, so that instead of functioning simply as an appeal body concerned with review and exit from compulsion, it will provide authority for compulsion. With this aspect of patient protection changed, some equivalent of the Mental Health Act Commission's monitoring function by a suitably independent and properly focussed body may be not only an ethical requirement for protecting vulnerable patients, but also necessary for the legitimacy of civil detention itself.

3 *Mental Health Act Commission, mission statement adopted in 1999. This statement has been criticised by some legal commentators (see, in particular Richard Jones (2003) Mental Health Act Manual, Eighth Edition, London: Sweet & Maxwell, page 467) as insufficiently precise in relation to the Commission's legal remit, but the Commission remains unapologetic in its focus.*

4 *Department of Health and Social Security, Home Office, Welsh Office, Lord Chancellor's Department (1981) Reform of Mental Health Legislation Cmnd 8405. London: HMSO, November 1981, para 34.*

5 *The Commission's remit does, of course, also extend to the use of the 1983 Act in a criminal justice context, whose legitimacy less obviously relies on any system of external safeguards. However, detention under the criminal justice powers of the 1983 Act takes place in hospital rather than prison, and is justified as treatment rather than punishment, so any clear distinction between civil and criminal justice use of the Act's powers is questionable.*

6 *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another; S v Airedale NHS Trust [2003] EWCA Civ 1036 at para 58.*

The core themes of the report: 'Placed amongst strangers'

We have taken as the title of the Tenth Biennial Report the words of John Perceval, who was committed to an asylum in the 1830s, and detained for a period of 18 months. Notwithstanding the emphasis on 'modernisation' in mental health services and developments in psychiatry in the last 170 years, it is remarkable how relevant Perceval's concerns are to detention under current mental health legislation⁷. The following passage from Perceval is an edited version of that which prefaces the report:

Instead of my understanding being addressed... I was... placed amongst strangers, without introduction, explanation or exhortation. Instead of great scrupulousness being observed in depriving me of my liberty or privilege, and of the exercise of so much choice and judgment as might be conceded to me with safety – on the just ground, that for the safety of society my most valuable rights were already taken away – on every occasion ... the assumed premise immediately acted upon was that ... my few remaining privileges to be infringed upon for the convenience of others. Yet I was in a state of mind not likely to acknowledge even the justice of my confinement...and jealous of any further invasion of my natural and social rights; but this was a matter that never entered into their consideration⁸.

In many ways the core themes of the Tenth Biennial Report are encapsulated in that statement. Noting the disempowerment of being forcibly removed into the company of others that is common to all detained psychiatric patients, Perceval complains that he is not involved in any decisions about his care and treatment, and uses the language of rights to set out his objections. However much we may think that healthcare for the mentally disordered has 'moved on' from Perceval's time, his words still describe the task of real 'modernisation' that has yet to be achieved.

The human rights challenge to mental health service provision.

The Commission's Ninth Biennial Report of 2001 was primarily addressed to mental health service providers and sought to contribute to a standards framework for the care and treatment of patients under the Act. We are pleased that many service providers continue to use the recommendations of that report in their own organisational risk assessments. Although about a third of the recommendations of the Tenth Biennial Report are similarly relevant to service providers, the report as a whole seeks to speak directly to Government and two-thirds of its recommendations are directly addressed to the Secretary of State for Health and his department. There are a number of reasons for this shift of emphasis, not least of which is the fact that, although the Commission's Biennial Reports have a wide readership for which they serve a number of purposes, they are in the first instance reports to Government, required by law to be set before Parliament by the Secretary of State⁹, and this report's publication falls within the parliamentary session during which it is likely the Government will introduce the latest draft of the Mental Health Bill.

7 This is not the only example of a historical precedent to contemporary concerns highlighted by the report. The report highlights a Lunacy Commission 'tribunal' hearing of a patient's appeal against detention in 1838 which, over two days and ending on a majority vote, debated and rejected the 'preventive' detention of a patient who, in today's legal terminology, would be classed as having a psychopathic disorder (see MHAC (2003) Tenth Biennial Report, p 83).

8 Perceval J (1840) *A Narrative of the Treatment*

*Experienced by a Gentleman, During a State of Mental Derangement; Designed to Explain the Causes and the Nature of Insanity, and to Expose the Injudicious Conduct Pursued Towards Many Unfortunate Sufferers Under That Calamity. A fuller version of this quotation, taken from Peterson D [ed] (1982) *A Mad People's History of Madness*, University of Pittsburgh 1982 p96-10, is at page 22 of the Commission's Tenth Biennial Report.*

9 Section 121(10) *Mental Health Act 1983*

The Commission takes the view that fostering a truly human rights based culture in the provision of mental health services involving compulsion will require positive action led by Government. The Human Rights Act 1998 has created a duty on all public authorities to operate their powers according to the principles and specific articles of the European Convention of Human Rights (ECHR)¹⁰. As a number of other bodies have already reported, including Parliament's own Joint Committee on Human Rights (which took evidence from the Mental Health Act Commission), insofar as this requires public authorities to be pro-active in their development of services that promote human rights principles, the 1998 Act has only partially been implemented, and, without intervention, the high-water mark of its effect in this respect may have been passed¹¹.

The Commission notes that the thrust of Government policy appears to be that health and social authorities should become more locally accountable, and that this implies a lessening of prescriptive guidance from central government. We agree with the aim of encouraging nursing, psychology and other professional leadership, and the fostering of grassroots pioneers in local services, to revitalise the notion of human rights as positive entitlements that are considered on a day-to-day level in service development. But, particularly in relation to the restriction of fundamental human rights as a health or safety measure on the authority of the State, the Commission views any divestiture of *responsibility* by Government as inappropriate, both in legal terms and in a wider ethical sense. For practitioners to attain the confidence to move beyond a defensive approach to human rights they must have the support of adequate and authoritative guidance on legal and practice issues. The Commission believes it to be the task of Government, in addition to ensuring that the legal framework provides the certainty and transparency required to meet ECHR principles, to provide such guidance.

During the writing of the Commission's report, these issues were tested by the Court of Appeal. The cases of *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust & Another* and *S v Airedale NHS Trust*¹² underlined the State's general responsibility for the treatment of those whom it has deprived of their liberty, as mentioned above. The *Munjaz* judgment was based upon the determination that the State is under a requirement to know enough about those it detains to afford them protection, and that the law allowing such detention must have transparency and predictability in its results, so as to avoid arbitrary use of powers and the disproportionate infringement of human rights. Where the law is insufficiently clear (as in the case of seclusion powers, which are nowhere mentioned explicitly in the 1983 Act), the judgment ruled that guidance such as that provided by the Government in its Code of Practice must be read as providing the necessary clarity for such powers¹³, and that the State, having provided guidance on the use of its powers to persons acting under its authority, must afford that guidance a status consistent with its purpose¹⁴. The immediate effect of this ruling was to raise the legal profile of the Code of Practice, in that practices that are not consistent with its guidance may fail ECHR requirements and be unlawful on such grounds. Practitioners are now required to follow the Code of Practice guidance

10 '... so far as it is possible to do so...' (section 3 Human Rights Act 1998)

11 *Joint Committee on Human Rights (2003) The Case for a Human Rights Commission: Sixth Report of Session 2002–03, Volume 1. HL Paper 67-1, HC 489-1. London, The Stationery Office, March 2003. Pages 6-7. See also Audit Commission (2003) Human Rights: improving public service delivery, London: Audit Commission, October 2003; British*

Institute for Human Rights (2002) Something for Everyone: The impact of the Human Rights Act and the need for a Human Rights Commission, London: British Institute for Human Rights.

12 [2003] EWCA Civ 1036. The case is reviewed by Anna Harding in this issue of the JMHL.

13 *Munjaz* paras 65, 74

14 *Munjaz*, paras 60, 71–6

unless they have good reasons not to do so based upon the clinical need of the patient concerned¹⁵. In the longer term, the ruling has perhaps set a precedent regarding governmental responsibilities that will be seen as a landmark human rights case.

Creating and maintaining a human rights focus in developing psychiatric services

There remains much to do to bring about a psychiatric service that fully respects human rights values. Patients are still compelled to reside on wards that are acknowledged by those responsible for them to be substandard, frightening and even dangerous. The majority of patients who are compelled to reside on such wards are subject to such compulsion for reasons of their own health or safety. It seems possible that the courts will, at some point, accept a human rights-based challenge to the lawfulness of such a detention on the grounds that the services provided under compulsion have neither addressed nor provided for the health or safety of the patient concerned.

The Commission understands and welcomes the apparent intention of Government to make mental health care 'a little less institutional and a little more diverse' through the provision of smaller inpatient units with closer links to the community¹⁶. It is easy to see how such a service could solve some of the most obvious problems inherent in acute inpatient care as presently organised. There are, however, particular and perhaps obvious risks inherent in having physically decentralised structures of smaller inpatient units operating powers of compulsion on behalf of the State. One such risk is the spreading of available medical and other expertise too thinly, so that no inpatient units could realistically have immediate access to a doctor when emergencies arise. Where patients are detained for their own safety, this may raise a similar ethical and potential legal dilemma to that faced by mental health professionals whose admission wards fall below acceptable standards under the current system. Under the proposals for future legislation, the increased demands on medical staff posed by the Tribunal system may exacerbate these difficulties at a time when 'legalism' and 'clinicalism' are likely to come increasingly into conflict.

A less obvious risk of decentralised structures, and indeed the potential converse of positive attempts to make the provision of mental health services 'patient-centred', is what a "less institutional" framework could mean for the practice of compulsion. The danger of emphasising the need for less formal structures of care is that these may disguise or detract from underlying realities of coercion. Throughout its existence, the Commission has expressed its concern over patients who, under current mental health legislation, are "*de facto*" detained in hospitals with none of the protections of the law, including Commission oversight and monitoring. We have similar concerns that, under envisaged structures of mental health care, and in the absence of sufficient central guidance and monitoring, laudable aims of less formality with greater immediacy of response and availability of appropriate care could lead, in practice, to the casual and unregulated application of powers of coercion. We believe that this would increase the dangers to patients, not only of arbitrary and unfair interference with their rights, but of dangerous or potentially abusive practice¹⁷.

15 In a departmental briefing post-Munjaz, the Department of Health stated "Although the declaration ... was limited to those parts of the Code that covered seclusion, the Department takes the view that the Court's analysis of the legal status of the Code is applicable to all aspects of it." Also see MHAC Guidance Note 1/04 'The status of the Code of Practice following the Munjaz judgment' available from the Commission and its web-site.

16 Professor Louis Appleby (National Director for Mental Health) giving evidence to the David Bennett inquiry [2003]. Inquiry transcript II.6-650.

17 The position of prisoners under present legislation is a telling example of the dangers of a 'casual' approach to compulsion. See Kinton, M (2002) Should we allow compulsory mental health treatment in prisons? in *Journal of Mental Health Law*, No 8, December 2002. University of Northumbria: Northumbria Law Press

A human rights culture in the coercion of psychiatric patients

The Commission acknowledges that a culture of human rights cannot be imposed upon services from above, but that Government nevertheless has an essential role in establishing the boundaries within which services work. By establishing such ground-rules, and by doing so with a particular regard to human rights issues, Government can at least partially fulfil its obligation to ensure that powers used in its name are implemented in accordance with principles of the European Convention.

Clearly, one consequence of this argument is the Commission's view that the next Mental Health Act needs to be clearer in its aims and thresholds for compulsion than was evident from the draft Bill published in 2002. The Commission argues for the next draft of future mental health law to express principles of use explicitly on the face of primary legislation. We continue to press for more clarity about specific powers and duties provided by the law. We would like, for example, to see statutory regulation of complex areas of patient management (including seclusion and restraint). We call for the judiciary's recent reading of the status of a Mental Health Act Code of Practice¹⁸ to be protected through primary legislation.

The Commission's report centres, of course, on our findings in relation to the exercise of the current law. Trends of use in the Act over the last twenty years are examined, and areas of current law are identified as insufficiently clear, requiring action or guidance from Government. We note for example that the use of section 3 has increased rapidly over the last ten years at the 'expense' of section 2, and that there appears to have been a rise in the use of emergency admissions during the last four years, following a long period in which the use of section 4 fell steadily. We also note the rise in second opinions to some 9,000 per annum, of which 3% (five patients per week) result in a significant change to the care plan under consideration.

We particularly call upon Government to address outstanding incompatibilities that have been declared between the Mental Health Act 1983 and the Human Rights Act 1998, and not to leave these to the uncertainties of a future legislative programme. We applaud Government initiatives in addressing inequalities in service provision to Black and minority ethnic patients, women and children, but urge continued effort in respect of these and other specific groups of patients who are additionally vulnerable in psychiatric services. We urge Government to allow flexibility in the implementation of its current and future Security Directions in relation to high secure care, and suggest that, in not doing so at present, Government is at risk of legal challenge based upon clear precedents in case law¹⁹.

¹⁸ see *Munjaz*

¹⁹ *In part, such a reading of case law is suggested by the Munjaz judgment's finding that Ashworth Hospital's seclusion policy was unlawful in its blanket departures from the Code of Practice irrespective of individual patient circumstances. In R (on the applications of 'P' and 'Q' and QB) v Secretary of State for the Home Department and another [2001] EWCA Civ 1151, the*

Court of Appeal required 'blanket' policies on matters that engage human rights issues to be flexible enough, through allowing exceptions to general rules, so as to ensure proportionality and compliance with ECHR requirements. See also Audit Commission (2003) Human Rights: improving public service delivery, London: Audit Commission, October 2003, p16.

Psychiatric services and the 'choice' agenda of Government reform

The current emphasis by Government on patient choice and participation in care has inherent dangers for those patients who are subject to compulsory care and treatment under mental health legislation. Patients who are denied choice in whether to engage with services – or when to disengage with them – are disadvantaged as 'consumers' of health care in any system where there is a contest for restricted resources. It is arguable that such disadvantages are already evident in mental health services' 'Cinderella' reputation, and by the historic under-funding of some acute psychiatric inpatient wards, where a high percentage of patients are detained under the Mental Health Act 1983. Government has, however, given a commitment to improve the patient environment on these acute wards, and shows a willingness to intervene in promoting better standards of care and treatment.

The potential disadvantages to psychiatric patients of the choice agenda may therefore be avoided with the correct safeguards and checks appropriate to public services. Furthermore, a renewed emphasis on patient choice and involvement in decision-making could provide the impetus for the cultural change required in the treatment of psychiatric patients that I touched upon above when discussing the core themes of the report and its title, *Placed amongst strangers*. Real choice for patients, whether they are detained or not, must be based upon their genuine involvement in drawing up their care plans and in making decision about their treatment options. Even within a context of compulsion, and even with patients whose mental capacity to make decisions is impeded by their illness, there is usually some scope for patients to exercise preferences if they are provided with appropriate opportunity and information.

We devote a chapter of the Tenth Biennial Report to outlining the concept of values-based practice as a means by which patients can be involved in treatment planning even within the context of compulsion²⁰. We are pleased that values-based practice has the support of Government and is being promoted by the National Institute for Mental Health in England (NIMHE). This should build upon existing policy structures: patient-involvement in care planning is, of course, already a key expectation of the Care Programme Approach (CPA), which was established over a decade ago and updated in 2000²¹. But despite many examples of good practice, CPA has still not yet been adopted properly and effectively across all mental health services. Commissioners too often report that they meet with detained patients who appear to have had little involvement in, and have scant understanding of, the details of their care plan, and certainly have not been provided with a written copy of it.

The choice agenda should also fuel ongoing work aimed at providing appropriate and responsive services that are culturally competent, sensitive to diversity of personal need and capable of providing effective treatment. No values-based practice can be indifferent to diversity issues, and the Commission is proud of its role bringing these into the foreground in mental health services policy²².

20 See Mental Health Act Commission (2003) *Tenth Biennial Report*, Chapter 5

21 Department of Health (2000) *Effective Care Co-ordination: Modernising the Care Programme Approach*. London, Stationery Office.

22 see NIMHE (2003) *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients*. Centre for

Ethnicity & Health, University of Central Lancashire; Mental Health Act Commission; NIMHE. London: Department of Health. This report flowed from the MHAC second 'national visit' of 1999. At the time of writing, consultation is underway on Government proposals in Department of Health (2003) *Delivering Race Equality: A Framework for Action*. Mental Health Services Consultation Document. London: Department of Health, October 2003.

In promoting patient involvement in care planning, Government (and the Commission or its successor body) will have the law on its side. The courts' reading of existing statutory powers of compulsion in mental health care in the light of ECHR principles has strengthened the legal necessity of taking patient's views into account in decision-making²³. The added legal weight given to the Code of Practice's guidance by the judgment in *Munjaz* reinforces the need of practitioners to have a proper regard to patients' views and mental capacity when providing treatment and care under the 1983 Act, and to keep appropriate records of determinations of a patient's mental capacity and discussions regarding consent to treatment in the patient's notes²⁴. In September 2003, just as our report went to press, the judgment in the case of *R (on the application of PS) v Dr. G and Dr. W* determined that even where statutory powers provided by the 1983 Act allow for the imposition of care and treatment against a patient's capacitated refusal, such imposition must be necessary according to the common-law tests of whether it is in the best interests of the patient if it is not to infringe human rights established under the European Convention²⁵. To demonstrate the necessity of their actions, professionals must take into account and give proper weight to the patient's views on treatment, defined to encompass nursing care and rehabilitation under medical supervision²⁶, including any alternatives to proposed interventions. Decisions taken by professionals will have to be increasingly sensitive to patients' views, and to patients' mental capacity when stating such views²⁷.

Such legal changes alone may provide a lever for changes in practice, if only through the adoption of minimum standards of consultation and recording as a form of defensive medico-legal practice. However, if services are encouraged to look beyond such a reactive approach, there are much broader opportunities for the establishment of a truly human rights based mental health service in the dying days of the 1983 Act.

23 e.g. *R (on the application of PS) v Dr. G and Dr. W* [2003] EWHC 2335 (Admin).

24 See *Mental Health Act Code of Practice*, Chapters 15 and 16.

25 See footnote 23 above. Also see (1) a review of the case by Peter Bartlett in this issue of the *JMHL*, and (2) MHAC Guidance Note 2/04 'Guidance for RMOs on PS' available from the Commission and its website.

26 see *Mental Health Act 1983*, section 145

27 The Commission does not, however, argue that capacitated refusals of consent should necessarily override future powers of compulsion. Chapter 4 of our report suggests that further thinking and agreement is needed over the different ways of understanding capacity in particular contexts and for particular purposes before mental incapacity should play a role different to that under the current *Mental Health Act* and its *Code of Practice*.