Work of the Mental Health Act Commission

Letter to Mr William Bingley, Chief Executive, Mental Health Act Commission

Sir: We are writing this open letter on behalf of our colleagues in the Mental Health Services in the Paddington area of central London to express our concern over the recent changes in the work of the Mental Health Act Commission and to point out the adverse consequences of the procedures you have recently established to improve surveillance of the operation of the Mental Health Act. In view of your own intention to report serious breaches of the provision of the Act to a wide range of bodies, including the press, we are sure you would have no objection to our professional body, the Royal College of Psychiatrists, having a copy and for this letter (and your reply) to have general dissemination.

Your aim is a laudable one; to improve the safeguards given to patients and other relevant bodies so that the Mental Health Act is administered correctly. Unfortunately, the recent changes you have introduced, full and exhaustive visits at least once every two years, patient focused visits at least twice a year, targeted visits to examine specific statutory matters, and unannounced visits to ensure that we are not pulling the wool over your eyes during your planned visits, are all having such adverse effects on our practice that we feel that not only we in the service, but also patients themselves, are suffering. This may appear to be a surprising claim and we appreciate you will need evidence before agreeing with us. This comes under the headings: relevance, time, and anxiety.

Relevance

The Mental Health Act was passed in 1983 at a time when there was great concern about the rights of patients being abused by mental health services and the often long periods of detention under the provisions of the 1959 Act. Now we have intense pressures on our psychiatric beds and a policy of keeping hospital admissions to an absolute minimum, and equally strong pressures to keep close contact with patients with more severe mental illness after discharge. Patients admitted under the Act have their care constantly reviewed and the provisions removed whenever it appears safe to do so, and this review procedure is given much greater prominence than it was 13 years ago. Those that do remain detained under the Act increasingly are under Section 3 and remain out of hospital for increasing periods before finally being discharged. These are subject to a series of other statutory procedures, notably the Care Programme Approach, the Supervision Register and Supervised Discharge, and it is questionable whether the additional close review of our procedures now carried out by the Commission adds much of value to this already intensely bureaucratic process. The Mental Health Act is ripe for revision in the light of these new developments and it therefore seems a strange time to reinforce its operation.

Time

Most adult psychiatric units are malfunctioning at present through insufficient time to carry out their essential functions. All the additional tasks required of us as a consequence of recent reforms have been introduced without additional resources and, as our turnover of patients has also increased, there is no longer enough time to carry out the bare minimum to maintain a safe and effective service. We realise that the functioning of the service as a whole is not part of your remit but your members cannot have failed to notice these pressures. When we add to this the time required for your own visits, each one of which requires well over 50 hours of professional time, and the time necessary to carry out your requirements to the letter (a very appropriate metaphor as so many of these tasks require pedantic attention to written information), you will appreciate that this has been forcibly injected into a working week that cannot in all honesty be accommodated without being taken away from patient care.

Anxiety

Your letters are sent mainly to chief executives of trusts and district health authorities and disseminate widely through these organisations. You have been using increasingly strong language to reinforce your recommendations and your latest letter (23 September) indicates from 1 October 1996 you will adopt a new reporting procedure for issues of special concern. You describe the action to be taken for persistent serious breaches of the Mental Health Act,

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including the writing of a letter to the Secretary of State, reporting the matter in your Biennial Report, informing the press, and referring the matter to the Health Service Commissioner, General Medical Council or the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

These are strong actions and they have caused great anxiety to members of our nursing staff in particular. Our ward reviews are no longer preoccupied with the care of psychiatric patients; they have become nerve-wracked occasions in which the attending nurse sits shaking with bundles of forms waiting for the opportune moment to push each forward for completion with the fear of reprimand from on high, or even dismissal, if any of them fails to be completed. Patients admitted informally are given short shrift because so much attention has to be given to those who are detained.

What are these 'persistent and serious breaches of the Mental Health Act' that cause you so much concern? They include failing to complete consent to treatment forms that must use the language chosen by the Commission and give no latitude for clinical judgement in individual cases, leave forms being signed by doctors who are not the designated Responsible Medical Officers, and the absence of duplication of recommendations in the patients' notes that are also recorded on official section forms.

In the context of our present difficulties these issues are so minor they are piffling by comparison. If they are really to be enforced by your intended draconian action then we shall feel misunderstood and resentful and will increasingly be thinking of you as the Mental Health Act Inquisition.

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Mr Bingley's reply

Thank you for your letter which raises important questions and we welcome the opportunity to respond to them. The Mental Health Act Commission has always appreciated the importance of maintaining constructive relations with those who care for patients detained under the Act, and I hope this correspondence will contribute to that.

Our response to the points raised in your letter is as follows:

Mental Health Act Commission visits

The Mental Health Act Commission visit cycle, following our changes, is a minimum of one formal visit every two years (as opposed to one every year) and two patient focused visits per year (only one if there is a formal visit in that year). In addition, the Commission makes some targeted visits, especially if it is concerned about the implementation of a particular aspect of the Act or the Code of Practice. Incidentally, it may be helpful to point out that the latter is published by the Secretary of State and not the Commission. A small percentage of patient focused or targeted visits are unannounced. In our experience unannounced visits, in terms of constructive interplay between Commissioners and those who care for detained patients are among the most successful that we undertake. Ordinarily therefore, each hospital will be visited twice a year, the primary focus of at least one visit being to make contact with detained patients.

Relevance

While concern about patient abuse in hospitals (generated, for example, by the hospital inquiries of the late 1960s and the 1970s) was certainly a significant influence, it was not the only motive for the reform that culminated in the 1983 Mental Health Act. For example, among the first major concerns about the 1959 Act was the alleged misuse of Section 29, the short-term emergency admission section.

Overall, it is almost certainly true to say that people are generally detained for shorter periods than previously, although the number of people being admitted under the Mental Health Act is accelerating (an increase of 55% between 1989–1990 and 1994–1995) as is the number of detained patients residential in hospital on any one day. As I will not need to tell you, in some localities, especially London, the percentage of acute psychiatric admission beds occupied by detained patients has increased substantially over the past few years.

While we agree that the Mental Health Act needs review, it is not so obsolescent or irrelevant to the delivery of good quality care as to call into question the wisdom of securing its proper implementation. Moreover, I am not aware of any body of opinion calling for the removal of the rights of detained patients under Part IV of the current Act. The provisions of Section 58 of the Act (which apply to the administration of electroconvulsive therapy and also medication for mental disorder) lie at the heart of this Part of the Act. The Mental Health (Hospital, Guardianship

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and Consent to Treatment) Regulations 1983 (as amended) require the completion of Forms 38 and 39 in the circumstances prescribed by the Act. These statutory forms not only provide the legal authority to treat, they also record the outcome of the undertaking of a fundamental statutory safeguard. The Commission's interest is not just in the adequacy of the forms themselves (although in our experience, failure to complete them in accordance with Code of Practice guidance is not, infrequently, a pointer to some more fundamental problems) but in the activity of which they are the culmination. I would suggest that the regulations under Part IV, so far from being "piffling" as you call them, not only are but will (no doubt in some amended form) remain at the heart of the protection provided by a new Act as far as patients involuntarily in hospital are concerned. Equally, the proper understanding and implementation of Section 17 regarding leave for detained patients has assumed more, not less, importance in the light of current concerns and, as you know, has been highlighted in enquiries into some recent tragedies. Indeed, the Torbay Enquiry (The Falling Shadow: One Patient's Mental Health Care 1978–1993) not only criticised the unit concerned for its failure to use Section 17 properly, but it also took the Commission to task for having failed to identify the deficiency. Therefore until there is a new Act (and I would hazard beyond), people detained under the Act, Ministers and society generally, are entitled to have details of its provisions competently implemented and to have the Commission, in pursuit of its statutory responsibilities, ensure this is the case.

Time

The Mental Health Act Commission is aware of the enormous pressure under which many psychiatric services have to work. Indeed in its Fifth Biennial Report the Commission was one of the first organisations to draw public attention to such pressures. Many Commission members work for these very services and this, together with the fact that the Mental Health Act Commission visits over 600 mental health units a year, ensures that we not only "notice" such pressures (as you put it) but that purchasers and Ministers are constantly alerted to them.

The changes to the Commission's visiting pattern were, in part, made to relieve some of the pressure on staff that arises from our visits, especially in the preparation prior to them. All the Commission requires before a patient focused visit is a map, a plan of the hospital, the name of a senior manager who can be contacted during the day if necessary and a list of the wards and the details of detained patients in them. Full visits do require more preparation and on both Commissioners are acutely aware of the need to keep to a minimum the demands on staff time.

I am not quite sure what you mean by the "requirements", but I suspect it relates to the proper completion of statutory documentation. I cannot see the major resource implications, for example, of completing Form 38 in accordance with the guidance in the Code of Practice. Undertaking the activities of which they are a record, the seeking of valid consent, is of course more time consuming. I imagine, however, that you are not suggesting that this activity should in any way be curtailed, the proper undertaking of which is an integral part of patient care.

Anxiety

May I distinguish between the language used in our reports and the Special Procedure to which you refer.

I think it would be very difficult to demonstrate that the language deployed in our reports has recently got stronger. The Commission's Visiting Policy and our own quality monitoring encourages the preparation of competent, concise and balanced reports and criticisms, where necessary, that are fair, accurate and evidence based.

As I said in my letter of 1 October 1996, we anticipate the Special Procedure being used very rarely. It was created in part as a response to many representations we receive about the Mental Health Act Commission's lack of power to enforce its recommendations. In essence, all the Procedure does is to formalise what the Commission has always been able to do (and sometimes has) where serious matters remain unremedied. You ask about the "persistent and serious breaches of the Mental Health Act" referred to the Policy. It is difficult and probably undesirable to be specific about the sort of concerns that would be "serious" although it would need to be a matter central to the Commission's remit and severely detrimental to the rights and interests of a detained patient. "Persistent" is, I think, more self-evident, and in one sense provides a powerful clue as to why the Special Procedure will probably be used so rarely; the matters about which the Commission is concerned and to which it would have drawn explicit attention in its visit reports, and subsequent correspondence, will rarely have remained unremedied. Taking one of the examples in your penultimate paragraph, and to which I refer above, complying with the relatively undemanding guidance in the Mental Health Act Code of Practice about the completion of the statutory consent to treatment forms, seems so straightforward that we find it difficult to envisage the circumstances in which it would be necessary to invoke the Special Procedure.

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I am concerned about your reference to "nurses shaking with fear on ward rounds". If the Special Procedure was ever invoked in the sort of circumstances to which I refer above (i.e. Part IV or Section 17 of the Act) then it is helpful to recall that responsibility for implementation of these provisions of the Act falls upon the patient's responsible medical officer.

Shared interests

Not the least disappointing aspect of your letter is its underlying assumption that the Mental Health Act Commission has different objectives from those responsible for patient care. You appear to have misunderstood the range of the Commission's work which is as concerned with patients' interests as their rights. You will have noticed the regularity with which our reports comment on non-statutory issues such as bed pressures, ward environments, women's safety or staffing shortages. Such matters all contribute to the serious pressures to which you refer; conditions which are detrimental to patients are, in the Commission's view, equally detrimental to the professionals who have to work in them.

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