



**Royal College of Psychiatrists: Proposed Amendments to the
Health and Social Care Bill at Grand Committee in the House of
Lords – Regular Visiting**

Amendments

Clause 48

BARONESS MURPHY

94 Page 24, line 31, at end insert—

"(6) The Commission shall in its annual report demonstrate that visits to relevant patients under section 120 of the MHA are sufficiently regular to fulfil the Commission's duty to ensure that the rights and welfare of those patients are safeguarded and promoted."

Schedule 3

BARONESS MURPHY

96 Page 116, line 42, at end insert—

"(4A) The arrangements made under subsection (3) must ensure that visits are sufficiently regular to ensure that the rights and welfare of the patients are safeguarded and promoted."

Purpose of the amendment

These amendments place in the Health and Social Care Bill a requirement that the visiting and interviewing of patients in private, as required in Schedule 3, is sufficiently regular to ensure the rights and welfare of those patients are safeguarded and promoted.

Summary

Some 45,000 people are detained on admission or following admission each year, and the Care Quality Commission must continue to, as the Mental Health Act Commission currently does, make regular unannounced visits to these people. This is a crucial tool in ensuring that patient's rights are protected, the potential for abuse is minimised, and appropriate care is provided at all times.

When discussing the continuation of the functions of the three bodies who are merging, the Government has expressed a preference for a 'light-touch' to regulating.¹

This is where decisions are left to the CQC to decide upon and are not prescribed in legislation. We believe that this should not apply to the visiting of people detained

¹ Lords Hansard 25 March 2008: Col 549.

under the Mental Health Act, who are a large and extremely vulnerable group, on wards which are 'tougher and scarier than they were a decade ago'²

If the Government fail to legislate on this issue, it will significantly damage the rights of detained patients, at a time where serious concerns have been expressed about in-patient mental health services. Furthermore, it would contravene the Optional Protocol to the Convention against Torture and other Cruel Inhuman and Degrading Treatment or Punishment (see below).

The reassurance from the Government that the CQC will continue the regular and frequent visiting of detained patients are not enough and the Royal College of Psychiatrists urge Peers to press the Government to ensure safeguards are written in to the legislation.

Why this visiting programme must be protected and enhanced

The role of the MHAC is not just to see that patients detained under the Mental Health Act are all being looked after properly, it is to ensure that the mental health legislation is being complied with. This is more than just their standards of care, it is about patients human and legal rights under the Mental Health Act.

The visiting programmes for those who have been detained under the mental health act are of particular importance for a number of critical reasons:

1) Patients detained under the Mental Health Act are not there by their own choice and are particularly vulnerable.

Patients detained under the Mental Health Act are in a different position from all other patients in that they are deprived of both their freedom to leave hospital when they wish and their freedom to make their own decisions about their treatment. They may also be subject to seclusion, control and restraint as part of their treatment for mental disorder.

The MHAC currently has only the equivalent of 15 whole time staff in its Commissioner body yet comes across abuses of patients and misuse of the law on a weekly basis.

2) The state of mental health in-patient services.

The conditions under which detained people live are little short of scandalous in a just society. The 12th Biennial MHAC Report 2005-7, shows the need for a rigorous regulatory framework to be maintained.

This report gives details of the increased pressure on admission wards, 37% of all wards visited by Mental Health Act Commissioners were running at over 100% occupancy, and a further 27% were at 100% occupancy. The busy acute wards 'appear to be tougher and scarier places than we saw a decade ago'.³ Many female patients reported fear for their safety and incidents of physical or sexual abuse.

² *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07

p17.

³ *Risks , Rights and Recovery* – Mental Health Act Commission Twelfth Biennial Report 2005-07

p17

Older patients including some suffering dementia have complained to us of feeling vulnerable and unsafe. They felt anxious witnessing the volatile behaviour by some of the more acutely ill younger patients and by the constant loud noise.

As the Commission points out:

Patients who are detained under Mental Health Act powers are placed in a quite different situation from many other NHS funded inpatients. They have not agreed to come into hospital and in some cases do not accept that need for admission, yet they may not discharge themselves from a ward that they find insupportable. They may experience no physical disability through their illness, and yet be confined, even by force, within a building with little access to exercise or fresh air. Ideally an acute inpatient ward should perform the positive function of asylum: a safe and supportive place that facilitates recovery. We have found wards that are unventilated and hot in summer but cold in winter; wards where there is little natural light; noisy and smoky wards; broken, worn and stained furniture, sticky floors and bad smells; vermin and cockroach infestation; peeling paint and graffiti; non-existent or broken lockable storage for patients' belongings. We have had cause to comment on broken and dirty toilet facilities, and on inadequate numbers of toilet and bathroom facilities.⁴

3) Unannounced visiting works

This unique role of regular, unannounced visiting is a highly effective way to monitor the use of the Mental Health Act, ensure that patient's rights are protected, the potential for abuse is minimised, and appropriate care is provided at all times.

The MHAC has noted that it is their regular, unannounced visiting that is the most effective:

'We will visit unannounced not only those services who give us cause for concern, but also those whose care and treatment of patients appears to be of a high standard. In this way we are able to see what services are really like on a day to day basis, and also have a less mediated access to detained patients in all types of service. We believe that the less our visits are viewed as special events by patients and staff alike, the better we are able to fulfil our remit.'⁵

4) The Optional Protocol to the Convention against Torture and other Cruel Inhuman and Degrading Treatment or Punishment (OPCAT) (2006)

The Optional Protocol to the Convention against Torture and other Cruel Inhuman and Degrading Treatment or Punishment (OPCAT) (2006) is an important addition to the UN Convention Against Torture (1984) and establishes an international inspection system for places of detention.

The objective of Article 1 of the Protocol is "to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or

⁴ Key findings about the use of the Mental Health Act 1983 – Mental Health Act Commission 2007 – p10.

⁵ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07 p260

degrading treatment or punishment". Article 1 describes important concepts, including the importance of preventive visits, undertaken on a regular basis.

Unannounced hospital visiting is an important part of the MHAC methodology, and one vital to its contribution towards fulfilling the UK's OPCAT requirements.

The Government position

During the passage of the Bill through the Commons and in 2nd Reading in the Lords, Parliamentarians have raised the importance of regular and frequent visiting of those who are detained under the Mental Health Act and the need for this to be continued by the CQC.

The Royal College of Psychiatrists are pleased that the Ministers in both houses have highlighted in particular how important it is that the visiting functions that are currently carried out by the Mental Health Act Commission continue with their current regularity.

During Second Reading in the Commons, the Secretary of State for Health said:

"I know that the MHAC places great emphasis on its visiting programme, covering each hospital and each ward that accepts detained patients. I expect the new commission to continue that approach."⁶

However, the view that has been put forward by the Government during the passage of the Bill in the Commons, which was echoed by Health Minister Lord Darzi in the Lords at Second Reading, is that legislating to ensure that visiting programmes are regular and frequent would constrain the flexibility of the regulator.

The Government prefers, as Lord Darzi put it in Second Reading, the 'light touch to regulation',⁷ with the majority of issues left to the Care Quality Commission to decide.

Whilst we are pleased that the Government envisage that, in areas of particular concern, visits would continue with their current regularity, we are not satisfied that these reassurances are enough.

The light-touch approach to regulation

The Royal College of Psychiatrists broadly supports the idea that many of the organisational decisions should be left to the Care Quality Commission to decide. If the Care Quality Commission is to be a flexible and effective organisation then it does not want to be overly constrained before it has even set up.

However, we do not accept that this approach can be used for the specific issue of visiting powers for those detained under the Mental Health Act. The legislation as currently drafted does not provide the adequate safeguards to ensure that the Government's obligations to people that are deprived of their liberty by law is met.

⁶ Commons Hansard 26 Nov 2008: Col 38

⁷ Lords Hansard 25 Mar 2008 : Col 549

Different remits

'As the Mental Health Act Commission, we are in a sense a very different beast to the other two organisations (Healthcare Commission and CSCI). We are not an inspectorate, we are a visitorial body.'

Lord Kamlesh Patel, Chair of the Mental Health Act Commission, Health and Social Care Bill – Public Bill Committee evidence session – Tuesday 8th January Col 4

The reason that the light-touch approach to regulation is not appropriate for the monitoring of those detained under the Mental Health Act is because of the fundamentally different tasks of the merging organisations.

The MHAC describe this as the difference between regulators who have a remit to assess the quality of care provided by organisations (Healthcare Commission and CSCI) and their remit, which is focused on the unique core task of protecting the rights of individuals.⁸

A light touch to regulating may well support the continuation and enhancement of the work of the Healthcare Commission and CSCI, who, as inspectorates, are committed to assessment methodologies based on sampling and self-assessment.

This approach, which the Care Quality Commission is likely to adopt, will rely more on unannounced visits as a reactive tool where they may be concerned about facilities. The Healthcare Commission has made it clear that it will make unannounced visits to wards where it sees a "cluster of concerns"⁹

This runs counter to the work of the MHAC who, as a visitorial body, have a specific rights-based remit dealing with those detained under the Mental Health Act.

The Commission visits each hospital/facility at least once every 12 months, and each ward with detained patients within those facilities at least once every 18 months. MHAC Commissioners visit all facilities, whether they have concerns or not, to monitor and safeguard against the abuse of legal powers.

The dangers of not legislating

We are extremely concerned about a situation where the frequency of visiting programmes is left to the organisational structure of the Care Quality Commission.

In a large regulatory body, where the priority is not just detained patients, but the all of health and social care, the importance of daily visiting will easily be lost. The Care Quality Commission is primarily based on an economic regulatory model and not a rights-based model.

⁸ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07 p 260

⁹ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07 p160.

This concern is highlighted by the MHAC:

'We do not believe that the internal monitoring mechanisms of detaining authorities should be relied on to determine whether to visit their detained patients, or even as uncorroborated evidence to determine the frequency of such visits'.¹⁰

Sampling and self-assessment, which are likely to be adopted by the CQC, are wholly inappropriate for the work for the monitoring of the Mental Health Act. The MHAC's 12th biennial highlights many cases where MHAC visits have 'shown considerable and dangerous gaps between self-assessment and reality'.¹¹

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Appendix A - The visitorial functions of the Mental Health Act Commission in detail

Lord Kamlesh Patel outlined the work of the MHAC with regards to visiting in his evidence to the Health and Social Care Bill Committee in the Commons:

'We have developed a methodology over the past 25 years in how we visit and interview detained patients. We have 109 public appointees, people from various backgrounds—health and social care, lay members and service users—all with expertise and experience of mental health law and how to relate to people detained under the Mental Health Act 1983. We visit at short notice or unannounced and we work with organisations. Unfortunately, on a small resource—I am talking about only 15 full-time equivalent staff, people work 24 days a year for us—we find up to three serious abuses of mental health law every single week. I could go through some examples later of fairly serious abuses of mental health law, so we need that visiting programme to continue.'¹²

Visiting services is an essential prerequisite for preventing the abrogation of patients' rights.

Mental Health Act Commission visits are ward based and require minimal support from provider staff. The Commission visits each hospital/facility at least once every

¹⁰ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07 p18

¹¹ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07 p18

¹² Health and Social Care Bill - Public Bill Committee - *Tuesday 8 January 2008*, Column 4

12 months, and each ward with detained patients within those facilities at least once every 18 months.

However these averages mask a wider range of visiting frequency, which is determined according to the level of risk. The documentation completed by Commissioners provides a standardised approach to visiting across all regions and informs a Visit Priority Rating (VPR) allowing Commissioners and Regional Directors to identify wards where, if resources allow,

Commissioners might visit above the usual minimum frequency. At each visit Commissioners meet with detained patients in private or in groups, check the documentation relating to detention and look at the care and treatment provided to detained patients. Where issues are raised, these are pursued on the day with ward staff or managers.

Commissioners leave a summary sheet with ward staff at the end of each visit recording any necessary action with agreed timescales which headquarters staff monitor or follow up, as necessary, by phone call or correspondence. Key issues arising from the visit may also be recorded on a patient poster for ward notice boards. Individual patient letters are written where actions have been taken in response to issues raised in individual interviews. When headquarters staff have received feedback from providers, they check with Commissioners whether the response is satisfactory or further action is required.

Mental Health Act Commission annual reports, written by Area Commissioners, are a summary of visiting activity undertaken by the Commission within a provider during a reporting cycle and identify significant issues raised by Commissioners during visits. Where issues are outstanding or provider responses have been unsatisfactory, this will be covered in the report.