



Royal College of Psychiatrists: Proposed Amendment to the Health and Social Care Bill at Grand Committee in the House of Lords - Expertise

Amendment

Schedule 3

BARONESS MURPHY

97 Page 117, line 22, at end insert—

"() The regulatory authority shall ensure that persons exercising functions under subsection (3) have relevant expertise to ensure the protection of the civil, legal and human rights of patients detained or treated under the Mental Health Act 1983 and patients deprived of their liberty under the Mental Capacity Act 2005."

Purpose of the amendment

This amendment will require the Care Quality Commission (CQC) to provide for staff who undertake functions under the Mental Health Act 1983 to have the relevant expertise to perform those functions effectively.

Reason for the amendment

The Royal College of Psychiatrists believe that this amendment is required to ensure that the Care Quality Commission retains the necessary specialist mental health expertise and that carrying out the functions under the MHA 1983 are given sufficient statutory weight and will not be weakened due to competing functions of the Care Quality Commission.

It will also ensure that all CQC staff are properly trained at appropriate levels. At present the Commissioners who carry out the visiting functions are highly qualified, trained and are generally consultants.

We believe that a specialist mental health team or department within the CQC should be established, which incorporates the present MHAC staff and Commissioner Team.

It is essential to the effective monitoring of mental health care that the CQC has an expert body of appropriately trained staff equivalent to the current body in the MHAC.

Specialist functions require expert staff

The functions of the CQC under Section 120 of the Mental Health Act are to 'keep under review and, where appropriate, investigate the exercise of powers and the discharge of duties conferred or imposed by this Act so far as relating to the detention of patients or their reception into guardianship or to relevant patients'.

The CQC has a duty to visit and interview patients in private and produce and inspect any records relating to the individual patients. Commissioners who are medical practitioners have a right to examine patients.

This contrasts markedly with the CQC 'Quality of Health and Social Care' functions in Chapter 3 of the Bill. Under Chapter 3, the Commission must conduct reviews, assess Trusts' performances following the reviews, and publish a report.

As opposed to the individual focus of the CQC functions under the Mental Health Act, the review required by Chapter 3 is focussed on 'overall' provision of care and exercising of functions.

Protecting individual rights

Patients detained under the Mental Health Act have a wide range of rights, which must be protected. These are their right to liberty under Article 5 of the ECHR, their right to private and family life (Article 8) and potentially both the right to life (Article 2) and the right to be free of inhumane and degrading treatment (Article 3). The legal cases under the MHA regularly involve consideration of these rights. These all affect their care and treatment while they are detained.

Where a person is deprived of liberty it is vital that those monitoring the services on behalf of the state have a thorough understanding and appreciation of:

- 1) The unique circumstances of detained patients.
- 2) The services in which patients are detained and compulsorily treated.
- 3) The laws under which detention and deprivation of liberty occur.

This is because the tasks that will be undertaken are not bureaucratic or organisational; they are rights-based and involve protecting vulnerable people who have been detained compulsorily, against their will.

The Commissioner Role

The Government has not yet made it clear whether the Commissioner role will be maintained in the same way in the Care Quality Commission. The importance of retaining this unique specialist role and not moving to other models of inspection has been underlined by the MHAC:

'The MHAC has watched developments in the Healthcare Commission since 2004 with some concern. In that body there have been changes from a specialist professional model of inspection for mental health services to a more generic model whereby not all inspectors assessing mental health services have a relevant background, and inspectors with specialist mental health expertise may also be deployed in inspections of other settings.'¹

Optional Protocol to the Convention Against Torture (OPCAT)

An additional reason that this amendment is necessary is that without giving statutory weight to the required expertise, the UK will fail to meet its requirements under the Optional Protocol to the Convention Against Torture (OPCAT).

Under the Optional Protocol to the Convention against Torture (which was adopted by the UN General Assembly in 2002 and entered in to force in June

¹ *Risk, Rights, and Recovery* –Mental Health Act Commission Twelfth Biennial Report 2005-07
p 259

2006), the UK is required to establish a National Preventative Mechanism (NPM). This is a system of regular visits to places of detention by independent expert bodies, in order to prevent torture and other forms of ill-treatment.

If functions relating to monitoring patients deprived of their liberty are carried out by CQC staff without the expertise mentioned in the paragraph above, OPCAT requirements will not be met.

The MHAC has written that: 'a model of generic inspection without a strong emphasis on training in these areas and sufficient experience would not meet the requirements of the Optional Protocol.'²

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Appendix A - Current Expertise of the MHAC

The MHAC currently has 103 Commissioners working in small teams within a Commission Visiting Area (CVA). CVAs are organised into four Mental Health Act Commission regions, each overseen by a full time Regional Director.

The roles of Local and Area Commissioners are different: Area Commissioners, usually one for each CVA, take the lead in establishing and maintaining good working relationships with senior managers within key agencies and preparing an annual report for each mental health service provider.

In addition one or two Local Commissioners within each area work independently, visiting services, interviewing detained patients, checking documents and lawfulness of detentions, and discussing issues of concern with patients/service users.

Where there is a high number of detained patients, the team may be larger; the maximum in any CVA is two Area Commissioners and three Local Commissioners.

Each Regional Director has responsibility for Commissioners in their area, and provides a high profile credible presence of the Commission at regional level.

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