Acknowledgements

The Commission wishes to thank the staff of the Health Authorities, Social Services Departments, NHS Trusts, Private Providers and High Security Hospitals throughout England and Wales who have been so willing to co-operate with Commissioners during their visits and the Board Members and staff who have taken action on Commission Visit Reports in order to improve their service to detained patients. We have greatly appreciated their assistance and courtesy.

This report is based on the knowledge and experience of Commissioners, taken from their visit reports, from contributions from each Commission visiting team and from many individual Commissioners. These major inputs are gratefully acknowledged.

The main writer of this report was the Commission's Communications Manager, Mat Kinton, guided by an editorial board consisting of Margaret Clayton (Commission Chairman), Paul Hampshire (Chief Executive) Dr Geoff Roberts (mental health consultant and Commission Member), and Christopher Heginbotham (Chief Executive, Eastern Region Specialised Commissioning Group) who acted as an independent adviser. We thank Mr Kinton, in particular, for his skill in bringing together the many strands of the Commission's work so effectively.

Farewells

The Commission extends its warmest thanks to the following key members of staff and/or the Board who have already left the Commission or will be leaving this year. All have made considerable contributions to our work and to this report.

William Bingley, who became the Commission's Chief Executive in 1991, left at the end of January 2000 to take up an academic appointment. He is now Professor of Mental Health Law at the University of Central Lancashire.

Jeff Cohen, who was employed by the Commission from 1996, lately as Head of the Policy Unit (and was a Commission member prior to that employment), left at the end of January 2001 to set up his own mental health consultancy service.

Professor Richard Williams, Professor of Mental Health Strategy at the Welsh Institute of Health and Social care in the University of Glamorgan and a Consultant Child and Adolescent Psychiatrist in the Gwent Healthcare NHS Trust, who became Vice-Chairman of the Board in 1996, leaves at the end of his second term of appointment in September 2001.

Gordon Lakes CB MC, ex-Deputy Director-General of the Prison Service, who has been a Commissioner since 1991, led the Visiting Team at Ashworth for three years, and was Acting Chairman from August 1998 to November 1999, will also be leaving at the end of his permitted terms of appointment at the end of December 2001.

Mental Health Act Commission Ninth Biennial Report

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Chairman's Foreword

The two years covered by this report have seen significant advances in the framework within which mental health services are provided and a very positive commitment by both the Department of Health and the National Assembly for Wales to the improvement of these services. Nevertheless, the issues raised by my predecessor in his foreword to the Eighth Biennial Report remain substantially unchanged. As this report shows, there are still huge variations in the quality of provision made for detained patients. A high proportion of these patients would not need to be detained if satisfactory health and social care were available for them in the community. Many patients who are detained do not receive care and treatment in accordance with the guidance given in the Code of Practice, and a number are treated unlawfully through inattention to the requirements of the Act. There is often scant regard to the principle of reciprocity in compulsion.

The Commission warmly welcomes the Government's proposals to reform mental health legislation and to strengthen the safeguards available to those who are compelled to accept care and treatment for mental disorder. Neither increased funding nor reforming legislation will, however, achieve the improvements required or tackle inequalities in provision. Both need to be underpinned by a robust infrastructure which ensures that diverse, skilled and dedicated people are available in sufficient numbers to provide the close relational safety and security essential to a therapeutic approach to any kind of mental disorder.

Similarly, providing a better legislative framework and more staff will not ensure improvements unless skilled managers are able to help staff translate policy into practice in relation to each individual patient. The right of every individual patient to be treated as an individual without discrimination, stigma or stereotype must be paramount.

The Department of Health and National Assembly for Wales have recognised these needs in the raft of plans to enhance the recruitment and training of the wide range of professionals involved in mental health and social care, and in the introduction of new regulatory bodies. The main message in this report is that self-regulation and strong systems within mental health care are the key to unlock the potential of all of these initiatives, particularly in relation to detained patients. This is true as much for the existing Act as for future legislation. The comments and recommendations made in this report therefore highlight the Commission's intention to focus on these matters in the current biennial period.

The comments and recommendations of this report are based on the knowledge and experience gained from the two-year rolling programme of visits by Commissioners to all NHS Trusts and Registered Mental Nursing Homes that detain patients under the Act. Our development plans recognise the key importance of these visits and we have no intention of reducing them as a result of our stronger focus on effective systems. I take this opportunity to pay tribute to the skills of the Commissioners and Secretariat who give unstintingly of their time and energy in examining whether the interests and rights of patients are being properly observed.

The development of the detailed legislation necessary to give effect to the broad principles in the White Paper on reforming the Act will provide a more appropriate opportunity than a Biennial Report to pursue issues of concern about how patients are likely to be affected by the proposed changes. The White Paper is not therefore discussed in this report. Preparation of the report has, however, highlighted two points which must be emphasised here. The first is that the drafting and implementation of the new legislation will need a high degree of consultation with practitioners and careful phasing if the gaps between policy and practice that are identified in the Report are to be closed. The second is that, although the Commission accepts that national regulatory bodies and local advocacy services may provide an adequate substitute for our current visiting functions, it is essential that Mental Health Act Commissioners continue to visit detained patients until satisfactory alternative arrangements are in place and their knowledge and experience should be utilised in the new arrangements.

Finally, although I am responsible, on behalf of the Commission, for the submission of this report to the Secretary of State, I did not become Chairman until December 1999. Mr Gordon Lakes CB MC was therefore Acting Chairman for the first eight months covered by this Report. This was a particularly difficult role because of the significant changes which were taking place both inside and outside the Commission. I cannot speak too highly of the skill and dedication with which Mr Lakes fulfilled the role, nor of the generosity with which he has offered me the benefit of his experience and knowledge in succeeding him. In particular, he has reinforced my own commitment and that of all Commissioners to our Mission Statement *"Safeguarding the interests of all people detained under the Mental Health Act".* This is what reviewing the implementation of the Act is all about.

Miss M A Clayton
Chairman

Rhagarweiniad y Cadeirydd

Mae'r ddwy flynedd a gwmpesir gan yr Adroddiad hwn wedi gweld cynnydd arwyddocaol yn y fframwaith y darperir gwasanaethau iechyd meddwl o'i fewn ac ymrwymiad cadarnhaol dros ben gan yr Adran Iechyd a Chynulliad Cenedlaethol Cymru fel ei gilydd tuag at welliant yn y gwasanaethau hyn. Er hyn, mae'r materion a godwyd gan fy rhagflaenydd yn ei ragarweiniad i'r Wythfed Adroddiad Dwyflynyddol yn parhau i fod heb eu newid yn sylweddol. Fel y mae'r Adroddiad hwn yn dangos, y mae amrywiadau anferthol yn ansawdd y ddarpariaeth a wneir ar gyfer cleifion dan orchymyn. Ni fyddai cydran uchel o'r cleifion hyn angen eu rhoi dan orchymyn pe byddai gofal iechyd a chymdeithasol boddhaol ar gael ar eu cyfer yn y gymuned. Nid yw llawer o'r cleifion sydd dan orchymyn yn derbyn gofal a thriniaeth yn unol â'r cyfarwyddyd a roddir yn y Côd Ymarfer, ac fe gaiff llawer ohonynt eu trin yn anghyfreithlon drwy ddiffyg talu sylw i ofynion y Ddeddf. Yn aml parch prin a delir i'r egwyddor o gilyddoldeb mewn gorfodaeth.

Mae'r Comisiwn yn croesawu'n gynnes gynigion y Llywodraeth i ddiwygio deddfwriaeth iechyd meddwl a chryfhau'r mesurau diogelwch sydd ar gael i'r rhai hynny a orfodir i dderbyn gofal a thriniaeth ar gyfer anhwylder meddwl. Ni bydd cynnydd mewn cyllid na deddfwriaeth ddiwygiol fodd bynnag, yn cyflawni'r gwelliannau sy'n angenrheidiol nac yn mynd i'r afael â'r anghyfartaledd sy'n y ddarpariaeth. Mae angen i'r deubeth gael eu cynnal gan rwydwaith cryf sy'n sicrhau bod digon o bobl amrywiol, medrus ac ymroddedig ar gael i ddarparu'r diogelwch perthynol clòs a'r diogelwch sy'n hanfodol ar gyfer dull gweithredu therapiwtig at unrhyw fath o anhwylder meddwl.

Yn yr un modd, ni bydd darparu gwell fframwaith deddfwriaethol a rhagor o staff yn sicrhau gwelliannau os na bydd rheolwyr medrus yn gallu cynorthwyo'r staff i drosi polisi yn ymarfer parthed pob un claf unigol. Rhaid i hawl pob un claf unigol i gael ei drin fel unigolyn heb wahaniaethu, stigma na stereoteip fod o'r pwys mwyaf.

Mae'r Adran Iechyd a Chynulliad Cenedlaethol Cymru wedi cydnabod yr anghenion hyn mewn peth wmbredd o gynlluniau i fwyhau recriwtio a hyfforddi ystod eang o bobl broffesiynol sy'n ymwneud â iechyd meddwl a gofal cymdeithasol, ac mewn cyflwyno cyrff rheoleiddiol newydd. Prif neges yr Adroddiad hwn yw mai hunanreoliad a systemau cryfion o fewn gofal iechyd meddwl yw'r allwedd i ddatgloi potensial yr holl fentrau hyn, yn enwedig parthed cleifion dan orchymyn. Mae hyn yr un mor wir am y Ddeddf bresennol ag y mae ar gyfer deddfwriaeth y dyfodol. Mae'r sylwadau a'r argymhellion a wneir yn yr Adroddiad hwn gan hynny'n amlygu bwriad y Comisiwn i ganolbwyntio ar y materion hyn yn y cyfnod dwyflynyddol presennol.

Mae'r sylwadau a'r argymhellion sy'n yr Adroddiad hwn wedi eu sylfaenu ar yr wybodaeth a'r profiad a enillwyd o raglen dreiglol ddwy flynedd o ymweliadau gan y Comisiynwyr a'r holl Ymddiriedolaethau GIG a Chartrefi Ymgeledd Meddwl Cofrestredig sydd â chleifion dan orchymyn yn unol â'r Ddeddf. Mae ein cynlluniau datblygol yn cydnabod pwysigrwydd allweddol yr ymweliadau hyn ac nid oes gennym unrhyw fwriad i'w cwtogi o ganlyniad i'n canolbwyntio cryfach ar systemau effeithiol. Rwyf yn manteisio ar y cyfle hwn i dalu teyrnged i fedrau'r Comisiynwyr a'r ysgrifenyddiaeth sy'n rhoi'n hael o'u hamser a'u hegni mewn archwilio os yw buddiannau a hawliau'r cleifion yn cael eu cadw'n gywir ai peidio.

Fe fydd datblygiad y ddeddfwriaeth fanwl sy'n angenrheidiol i ddwyn i fod yr egwyddorion bras sy'n y Papur Gwyn ar ddiwygio'r Ddeddf yn darparu cyfle mwy priodol nag Adroddiad Dwyflynyddol i fynd ar ôl materion sy'n achosi pryder ynglŷn â sut y mae'r cleifion yn debygol o gael eu heffeithio gan y newidiadau arfaethedig. Nid yw'r Papur Gwyn gan hynny'n cael ei drafod yn yr Adroddiad hwn. Mae'r paratoad ar gyfer yr Adroddiad, fodd bynnag, wedi amlygu dau bwynt y mae'n rhaid eu hamlygu yma. Y cyntaf yw y bydd y drafftio a gweithredu'r ddeddfwriaeth newydd angen graddfa uchel o ymgynghori gyda'r ymarferwyr a chyflwyno cam wrth gam gofalus os yw'r bylchau rhwng polisi ac ymarfer a nodwyd yn yr Adroddiad hwn i gael eu cau. Yr ail yw, er bod y Comisiwn yn derbyn y gall cyrff rheoleiddiol cenedlaethol a gwasanaethau eiriolaeth lleol ddarparu gwasanaeth amgen digonol i'n swyddogaethau ymweld presennol, mae hi'n hanfodol bod y Comisiynwyr Deddf Iechyd Meddwl yn parhau i ymweld â chleifion dan orchymyn hyd nes y bydd trefniadau amgen boddhaol mewn bod ac fe ddylid defnyddio'u gwybodaeth a'u profiad yn y trefniadau newydd.

Yn olaf, er fy mod yn gyfrifol, ar ran y Comisiwn, am gyflwyno'r Adroddiad hwn i'r Ysgrifennydd Gwladol, ni ddeuthum yn Gadeirydd tan fis Rhagfyr 1999. Mr Gordon Lakes CB MC gan hynny oedd y Cadeirydd Dros Dro am yr wyth mis cyntaf a gwmpesir yn yr Adroddiad hwn. Roedd hon yn swyddogaeth neilltuol o anodd oherwydd y newidiadau arwyddocaol a oedd yn digwydd y tu mewn a'r tu allan i'r Comisiwn. Ni allaf roi canmoliaeth rhy uchel i fedr ac ymroddiad Mr Lakes wrth gyflawni'r swydd, na'i haelioni i mi wrth iddo gynnig ffrwyth ei brofiad a'i wybodaeth wrth i mi ei olynu. Yn arbennig, y mae wedi atgyfnerthu f'ymrwymiad i fy hunan ac ymrwymiad yr holl Gomisiynwyr tuag at ein Datganiad Cenhadaeth "*Safeguarding the interests of all people detained under the Mental Health Act".* Dyma beth yw hanfod adolygu gweithredu'r Ddeddf.

Miss M A Clayton
Cadeirydd.

1 Introduction

1.1 The Mental Health Act Commission (the Commission) is a Special Health Authority whose main role is to keep under review the implementation of the Mental Health Act 1983 (the Act) as it relates to patients who are detained, or liable to be detained, under the Act in England and Wales. In the first issue of its Corporate Strategy and Business Plan, the Commission adopted the mission statement '*Safeguarding the interests of all people detained under the Mental Health Act'* to summarise its own interpretation of its statutory functions.

1.2 The Commission is required to publish a report on its activities every second year. This must be sent to the Secretary of State, who must lay a copy before each House of Parliament. This report relates to the two years from 1st April 1999 to 31st March 2001.

1.3 Because the Commission believes that its focus must be on the implementation of the Act and the patients whose lives are affected by it, the main part of this report (Chapters 2 - 7) concentrates on the findings and implications of our rolling programme of visits to all hospitals and nursing homes which hold detained patients. This programme enables us to meet with detained patients, review patients' records, examine the policies and systems which relate to them, and report to service providers on our findings in relation to the operation of the Act. Detailed information about the organisation of the Commission and its staff, the work we do and the use made of the finance allocated to us as a public body is given in Chapter 8.

Chapters 2 - 7: The Implementation of the Act

1.4 The contents of Chapters 2 - 7 are a distillation of the reports made after each Commission visit in the period under review, and also take account of the work of Second Opinion Appointed Doctors. Our object in these Chapters is not to name and blame but to provide an overview which:

- shows how the implementation of the Act is affecting the people it aims to protect;
- helps the facilities visited to improve their own practice;
- draws attention to general areas of poor practice; and
- advises on possible remedies for some of the issues raised.

Commissioners see so many individual examples of both good and poor practice that it can be invidious to select any for particular attention. Specific references to individual service providers are therefore limited to a relatively few examples of good practice. In making this extremely selective use of a few specific examples, we hope to avoid an unproductive focus on relative performance. Instead, we aim to encourage all readers to consider how far the issues considered and the recommendations made are relevant to their own working practices and circumstances.

1.5 The way in which the main themes in Chapters 2 - 7 are addressed has enabled us to make specific recommendations on the actions we believe are needed to ensure that the Act is properly implemented. The Commission is not an inspectorial body but our very wide knowledge of

individual patient experiences under the various provisions of the Act puts us in a unique position to comment on implementation. Most of the comments and recommendations relate to the way in which any legislation needs to be implemented and will therefore be as relevant to new legislation as they are to the 1983 Act. We therefore make no apology for using this report to take the logical step from review to recommendation.

The Commission in Wales

1.6 Chapters 2 - 6 relate, in general, to both England and Wales. Chapter 7 recognises that mental health policy and practice in Wales are largely determined by the Welsh National Assembly and mentions briefly the main differences in strategy and policy. Most of the comments and recommendations in Chapters 2 - 6 apply as much to Wales as to England but this Chapter highlights the few areas in which there are significant differences. As the two national healthcare services develop, the Commission hopes that each may learn from the best practice of the other.

Commentary and Summary of Recommendations

1.7 Chapter 9 summarises the recommendations in Chapters 2 - 7, commenting on the wider mental health environment in which they are set and explaining how grouping the recommendations in relation to those with the primary responsibility for implementing them is intended to help everyone concerned to work together to achieve higher levels of compliance with the Act and with any new legislation. We hope that the way in which we have been reviewing and changing our own practices during the past two years will make a significant contribution to better implementation of the Act.

The Organisation and Work of the Mental Health Act Commission

1.8 Chapter 8 sets out the organisational and financial details of the Commission both as the background to and validation of all that precedes it and also to demonstrate our compliance with the requirements of public sector accountability. In carrying out the functions of the Commission, we are aiming to follow the same principles of self-assessment and self-regulation which we emphasise as essential in the concluding chapter.

Conclusion

1.9 In the present transitional period between the 1983 Act and the new legislation which has been promised in the Government's White Paper on "Reforming the Mental Health Act"[1], the Mental Health Act Commission believes that it can best serve the interests of detained patients by highlighting in this report those aspects of the 1983 Act which our work suggests most need attention, both now and in future legislation. This is why, although previous Biennial Reports are valuable reference documents because they range widely over issues of interpretation of the Act, summarising changes in legislation, significant law cases and differences of view between academics, lawyers and practitioners, we decided that this report should be a more narrowly

[1] **Reforming the Mental Health Act**. HMSO Cm. 5016-11, 2000

focused, action-orientated document. We hope that the Secretary of State, to whom the report is submitted in accordance with the Act, will find it a useful contribution to ongoing consideration of how best to meet the interests of patients subject to compulsion under mental health law.

2 Rights and Respect

Protecting Patients' Rights and Encouraging Autonomy

2.1 All mental health services should be provided within the context of the guiding principles of the Mental Health Act Code of Practice. These include requirements that patients should be treated:

- with respect for their individuality and diversity;
- in the least controlled and segregated manner possible; and
- in such a way as to promote their self-determination to the greatest practicable degree consistent with their own personal needs and wishes[2].

This section focuses on some practical ways in which services can uphold these principles.

Stigma

2.2 Behaviour is determined more by values, ethos and attitudes than by exhortation or examples of good practice. The Commission is convinced that it will not be possible to achieve the quality of services which we should be offering to detained or other mentally ill people until there is a fundamental change in attitudes towards such people.

2.3 We warmly welcome the Government's campaign to end discrimination against those with mental health problems[3]. We strongly endorse the Declaration of Intent published by the Royal College of Psychiatrists as part of their "Changing Minds" campaign, which is reproduced in full in **Appendix A** to this report. Everything in this and the following Chapters should be read in the light of our commitment to ensure that detained patients, in particular, are not doubly disadvantaged by the stigma attached to their illness.

Recommendation 1

The Department of Health and the National Assembly for Wales should take every opportunity to challenge inaccurate representation of mentally ill people, in the media and elsewhere, based on stigmatising attitudes and stereotypes.

Providing Information to Patients and Relatives

2.4 It is a statutory duty on hospital managers to provide certain information to detained patients about their circumstances in relation to detention, consent to treatment, rights of appeal and other matters as soon as they can practicably do so[4]. Detailed guidance on the discharge of this duty is given in Code of Practice (Chapter 14) and the Memorandum to the Act (para 297).

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[2] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. see *Chapter One: Guiding Principles*

[3] Mind out for mental health – a campaign co-ordinated by the Department of Health to stop discrimination. Mindout@forster.co.uk

[4] **Mental Health Act 1983**, Section 132.

2.5 The Commission recognises the difficulties in explaining legal matters to patients whose mental state may preclude the understanding or retention of such information. It is therefore important that services are sensitive to the capacity of each individual patient and that rights are explained, as far as possible, in a way that the patient understands. It will often be necessary to make repeated attempts to achieve this.

2.6 The Commission's experience shows that, where patients do not understand their legal position and rights, this is often a result of poor practice in providing communication at an appropriate level and checking that this has been understood. Examples of staff being unable to identify when and by whom individual patients' rights were explained, even by reference to the patient's notes, were found in almost a quarter of units visited by Commissioners. The introduction of systems to record and monitor the provision of information to patients has been an important factor in improving performance in this area for many service providers.

Recommendation 2

Service providers should ensure that a system of verification using a standardised form is used to record that information has been given to patients about their legal position and rights under the Act. The form should have space for recording:

- **the name of the person giving the information;**
- **the date that the information was given;**
- **whether the patient understood the information;**
- **subsequent attempts to give the information; and**
- **the planned date for the next attempt.**

2.7 Hospital managers have a duty to provide written information to a patient's Nearest Relative, unless that patient objects to them doing so. Guidance on these duties is given at Chapter 14 of the Code of Practice.

Recommendation 3

Hospital Managers should ensure that patients' wishes in relation to Sections 132(4) and 133 are ascertained and recorded, and that information is provided to the Nearest Relative if the patient has not objected.

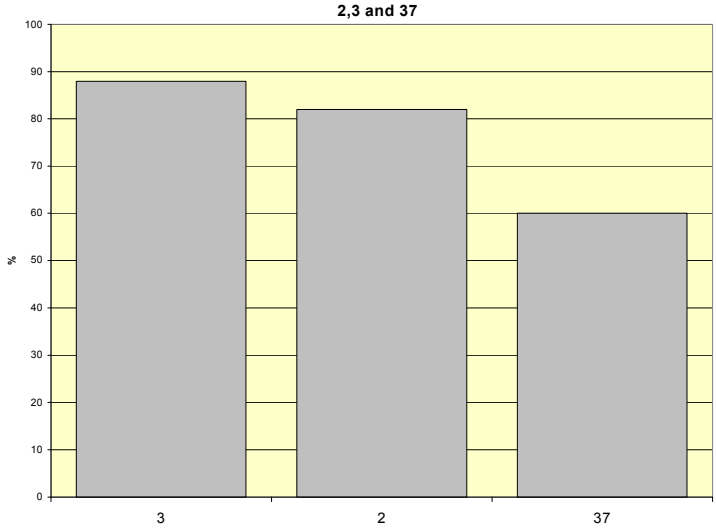
MHAC research on the giving of information on patients' rights

2.8 In 1999/2000 we gave a specific focus on our visits to the ways in which Hospital Managers were discharging their statutory duty to ensure that detained patients are afforded real opportunities to understand their legal status and rights. One finding of this exercise was the considerable proportion of units that failed to keep records of the communication of patients' rights (see paragraph 2.6 above). Another focus was the provision of such information in appropriate written forms.

2.9 Figure 1 shows the percentage of the 2,193 units visited that had available copies of English-language leaflets on Sections 2, 3 and 37. Although the figures are fairly high, it is alarming to

reflect that, despite the legal and good practice requirements on units to provide information under Section 132, 180 units could not provide a Section 2 leaflet and 263 had no Section 3 leaflets.

Figure 1 - Availability of English Language Patient Leaflets on Sections 2,3 and 37



2.10 We are also concerned to have found that nearly half of the units visited (49%) had no leaflets available in any language other than English, and only 9% were equipped with any information in braille.

Recommendation 4

Hospital managers should ensure that the Department of Health's patient information leaflets on the Mental Health Act are available on all units in an appropriate range of languages and formats.

2.11 The Commission supports the Law Society's recommendations[5] on the further development of standards in the giving of information, which include the following:

- The Department of Health's leaflets should be re-designed into a more user-friendly format and should include more specific advice on the procedures for applying to a Tribunal, such as a tear-off application form contained within each leaflet.
- The leaflets should set out the criteria for compulsory detention and the grounds on which the Tribunal would allow discharge.
- Staff should be trained on how to explain to patients their rights. Merely repeating what is already written on the leaflet is inadequate.
- There must be access to oral explanations through independent interpreters.
- An obligation should be placed on hospital managers to ensure that the information is repeated after a specified period of time (eg. 10 days) has elapsed since admission.

[5] Law Society (2000), **Comments on the Review of Tribunals Consultation Paper.** London, Law Society September 2000

Recommendation 5

The Department of Health should ensure that patient information leaflets on the Mental Health Act 1983 are available in formats appropriate to the following groups of patients:

- **children and adolescents;**
- **deaf patients;**
- **blind patients;**
- **deaf/blind patients;**
- **patients with learning disabilities**

see recommendations 65 (paragraph 6.44), 66 (6.54) and 69 (6.64)

2.12 We will be reviewing the Commission's own patient information leaflets over the next period, giving particular attention to whether other formats would be more appropriate for particular groups of patients.

Patients' access to legal advice and Tribunals

2.13 The right of patients to an independent review of their detention by a Mental Health Review Tribunal is an important safeguard. Patients have a right to be legally represented at the Tribunal to ensure that their case is fully and fairly put forward. Appropriately trained solicitors are franchised by the Legal Services Commission, which produces regional lists to publicise the solicitors' availability.

Recommendation 6

Hospital managers should ensure that each ward is issued with a copy of the Legal Services Commission list of franchised solicitors to assist in the process of representation at Mental Health Review Tribunals.

Voting rights of patients

2.14 The Commission was pleased to note the changes in law introduced in the Representation of the People Act 2000, which widened the franchise to all patients detained under Part II of the Act or on remand.

2.15 We have previously commented on the need for hospital managers to ensure that detained patients are assisted in exercising their right to vote in elections[6]. We therefore particularly welcome the publication of the Explanatory Notes to the Representation of the People Act 2000, available from the Stationery Office[7], and commend these to Hospital Managers who are unclear about the current legal position relating to the enfranchisement of detained patients.

[6] Mental Health Act Commission (1997) **Seventh Biennial Report.** London, Stationery Office. Paragraph 3.1.3.

Patient Involvement

Capacity and Consent to Treatment

2.16 The general principle that patients should be treated and cared for in such a way that promotes, insofar as is possible, their self-determination and responsibility[8] underlies the Code of Practice's specific recommendations on consent to treatment. All staff working with detained patients should be familiar with the guidance on medical treatment at Chapter 15 of the Code. The GMC, Royal College of Psychiatrists and UKCC have also produced specific good practice guidelines for relevant professionals[9].

2.17 It is of paramount importance that patients are treated lawfully. Common errors in completing authorisations for treatment and the Commission's recommendations for ensuring that these are avoided are given at paragraphs 2.63 – 2.67 below. The following paragraphs deal with the need to ensure that patients' capacity is properly ascertained and that capable patients are given the opportunity to give informed consent.

2.18 For all detained patients, it is the responsibility of the Responsible Medical Officer (RMO) to evaluate fully whether the patient has the capacity to give informed consent to the treatment. The basic principles of informed consent are defined in the Code of Practice as the voluntary and continuing permission of the patient to receive a *particular* treatment, based on an adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not 'consent'.

2.19 Commissioners often see patients who are reticent to raise issues of concern about their medication because their only contact with their RMO is at ward rounds with the whole clinical team present. Patients should be offered the opportunity of discussing their medication with their RMO on a one-to-one basis.

2.20 Despite the wide availability of guidance on consent to treatment issues, we remain disappointed at the prevalence of bad practice that we encounter on visits:

- There is often no entry in the medical notes of the discussion during which consent to treatment was sought and obtained, nor any reference to the patient's capacity to consent, as required by the Code of Practice (paragraphs 16.11, 16.13 etc).

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[7] **Explanatory Notes, Representation of the People Act 2000, Chapter 2** (2000). Stationery Office (ISBN 0-10-560200-0) £5.95.
[8] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. paragraph 1.1
[9] General Medical Council (1999) **Seeking Patients' Consent: The Ethical Considerations**; Royal College of Psychiatrists (2000) **Council Report CR83: Good Psychiatric Practice 2000**; UKCC (1998) **Guidelines for Mental Health and Learning Disabilities Nursing – a guide to working with vulnerable clients.**

- Where there are such entries, these are frequently insufficient. The General Medical Council's 'Good Medical Practice"[10] states that doctors must " keep clear, accurate and contemporaneous records which report the relevant clinical findings, the decisions made, the information given and any drugs or other treatment provided." Entries such as, "S…. consents to his treatment regime" and "consent to treatment completed" are inadequate.

- Commissioners frequently see patients who are deemed to be consenting but whose medical and nursing notes throw doubt on their capacity to do so. To give one example from many, Commissioners on a visit to an NHS Trust in May 1999 found one patient being given six different forms of medication on the purported authority of a Form 38 (on which his RMO had certified his consent), despite a clear statement by the same doctor on the renewal of detention Form 30, completed days after the Form 38, that he had no insight into his condition and despite a number of references in the medical notes to his reluctance and even refusal to take the medication prescribed. Where the Commission finds such practice it draws it to the attention of hospital managers and expects immediate remedial action.

Recommendation 7

Hospital managers should arrange for effective audit, monitoring and flagging systems to be in place to ensure that all detained patients' capacity to consent to treatment is assessed and reviewed regularly from their admission, that treatment is regularly discussed with patients, that they should be given the opportunity of having those discussions on a one to one basis and that such discussions are recorded, as required by Chapters 15 and 16 of the Code of Practice.

(see also recommendation 7, para 2.20)

2.21 A few service providers have managed to achieve uniformly high standards of practice in the recording of the discussion with the patient concerning capacity and consent. This has been achieved through both the commitment of medical staff to ensuring that patients are treated with respect for their legal and human rights, and the use of audits and clear flagging systems. Many wards at the three High Security Hospitals show excellent practice (see Chapter 5.21) and some other service providers have maintained excellent standards and introduced innovative practices (see paragraph 2.67).

Good Practice Example

Manchester Mental Health Partnership have designed a form to record the determination of each patient's capacity to consent. The form also records the nature of the proposed treatment and reminds staff to record findings separately in the patient's case notes.

Contact Mrs M Worsley, Director of Adult Services, Barlow House, Minshull St, Manchester M1 3DZ Tel :0161 2331627

2.22 Some services do not invite patients to be present at "ward-rounds" and similarly designated interdisciplinary discussions of their treatment. We believe that patients should, as a matter of

[10] General Medical Council (1998) **Good Medical Practice**. London, GMC

course, be included in such inter-disciplinary discussions. Paragraph 15.7 of the Code clearly states that, wherever possible, patients should be enabled to be involved in their care plan and to express agreement or disagreement with it. Where patients are reluctant to join in such meetings, or it is considered inappropriate for them to do so, every effort should be made to meet with the patient on a one-to-one basis to discuss plans being made. These attempts should be recorded.

Patient Advocacy

2.23 We recognise the important role played by advocacy schemes in helping staff and patients communicate more effectively. Representatives of advocacy services often meet with Commissioners on their visits to hospitals and have made an increasingly valuable contribution through sharing their experience of local issues. Nevertheless, while there are clear examples of good practice in the provision of such services across England and Wales, there are problems with the quality of some services, both in defining advocacy and in delivering advocacy services. We continue to note the general lack of access for patients from black and ethnic minority groups to appropriate advocacy service provision (see Chapter 6.31).

2.24 We are glad to record the Commission's representation on the Project Advisory Group for the study of good practice in mental health advocacy, which Durham University is undertaking under contract to the Department of Health. We look forward to discussions on the Government's proposed statutory advocacy service. The establishment of the Royal College of Psychiatrists' Carers and Users Experience Survey (CUES) initiative, which systematically reviews the experience of mental health patients and their carers, is a welcome move. With the pilots at the North Mersey, Warrington Community and Sheffield Trusts complete, the move to patients as participants in their care is set to progress.

Recommendation 8

The Department of Health should issue guidelines on good practice in the provision of advocacy services as soon as possible, in advance of whatever is decided on the special advocacy service proposed for the forthcoming legislation.

Complaints by patients and other people

2.25 The Commission has a general and discretionary remit to investigate complaints. Our complaints policy[11] provides that, as a general rule, formal complaints should have been considered at a local level through the NHS complaints procedure prior to the Commission undertaking any investigation itself. However, we deal with patients' concerns and complaints in other ways than through formal investigation.

2.26 At the most basic level, Commissioners on a visit to mental health facilities always talk to patients, either at their request or in a general discussion. Relatively minor individual complaints, such as the removal of particular possessions or the refusal of particular requests, are dealt with

by negotiation with managers on the spot and the patient is informed of the outcome immediately. Many general complaints and concerns are raised in such discussions, e.g. on access to fresh air, regularity of showers/baths, access to activities, which can both be followed up immediately with local managers and logged for consideration as matters to be raised as of wider concern. Sometimes the volume of complaints on a particular aspect of service reveals very serious shortcomings, e.g. as in the application of the Security Directions in the High Security Hospitals (see Chapter 5), which can be resolved only by changes of policy at a high level.

2.27 The Commission does help patients to make formal complaints through the NHS complaints procedure, by offering advice and guidance on the procedure and, where appropriate, monitoring the complaint's progress through the system (see Chapter 8.24). The use of the NHS complaints procures, introduced in 1996, has made it much easier for patients to have their complaints acknowledged and, in good examples, addressed, but some patients still feel that they are not being listened to. Hospital managers should ensure that staff are alert to this potential problem, and also that the sometimes lengthy and cumbersome processes which have to be followed can cause exceptional stress for patients who are already suffering from a mental illness and may well contribute to deterioration in their condition.

Recommendation 9

Hospital managers should closely monitor the handling of all complaints, both to ensure minimum delay and to note the quality implications of the subject of the complaint.

Recommendation 10

Complaints managers should ensure that complaints made by detained patients are not regarded less seriously than those from other patients, and should be sensitive to the potentially adverse effects on the progress of such patients of delays in handling complaints.

2.28 We recognise the difficulties posed by vexatious and unreasonably persistent complainants to many hospitals' complaints services, and commend the Health Service Ombudsman's advice and suggestions on local policies to deal with this[12].

2.29 Where the Commission believes that a formal complaint needs an instant reaction which cannot be provided through the NHS complaints process, or where, exceptionally, a complaint is made by a member of staff about the way in which a service is being provided, a Commissioner may investigate the matter immediately and provide a full written report to the Commission and the managers concerned. For example, at the end of this reporting period we intervened in such a way to examine and report on the conditions in which a learning disabled patient with profound behavioural difficulties was being cared for by one NHS Trust. Our report and recommendations

[11] **Mental Health Act Commission Policy on Complaints**[…full title] available from the Commission offices on request.
[12] Health Service Ombudsman (2001) **Health Service Ombudsman's Annual Report 2000-01**, London, Stationery Office *para 1.4 page 14*

were immediately implemented by the hospital managers, ending two months of very unsatisfactory service provision. Fortunately, the number of these exceptional cases is relatively small. They nevertheless highlight the need for a continuing provision for exceptional interventions, both now and under the new mental health legislation.

Recommendation 11

The Government should ensure that the new mental health legislation provides the Commission's successor body with an exceptional, discretionary power to investigate complaints or whistle-blowing allegations where appropriate.

Patient Confidentiality

2.30 In most cases, mental health services' respect for patient confidentiality is exemplary. The extent to which services have embraced the Department of Health's Guidance[13] and the subsequent Caldicott recommendations on patient confidentiality is encouraging. We welcome the development of the Mental Health Minimum Data Set[14], which should ensure that appropriate information is collated in retrievable form for managers and clinicians.

2.31 However, Commissioners do encounter rare examples of poor practice on their visits. One ward was found to use a "patient information whiteboard" in the nursing office, which was clearly visible to the ward through the office window. The Board displayed personal information about patients, including unflattering assessments of their presentation and propensities. Commissioners insisted that this practice be discontinued.

2.32 The Commission urges hospital managers to be continually vigilant to ensure that confidential patient information is handled and stored appropriately.

2.33 It is essential that a holistic approach to responsibility for the welfare of patients is fostered by the judicious sharing of information between agencies. For this reason, we have recommended statutory provision for such information sharing and welcome the Government's commitment to this in the White Paper[15]. We consider that clear protocols (requiring, for example, the transfer of information only to named individuals), proper safeguards and careful monitoring are essential to ensure that the advantages of a holistic approach are not outweighed by abuses of confidence.

Recommendation 12

All those involved with the care and treatment of detained patients should encourage multi-disciplinary liaison to develop protocols which balance the need for confidentiality against the need to share essential information.

[13] Department of Health (1996) **The Protection and use of Patient Information – Guidance from the Department of Health**
[14] NHS Information Authority (2000) **Mental Health Minimum Data Set; Using the MHMDS**. London, Stationery Offfice
[15] **Reforming the Mental Health Act 1983, Part 1: The new legal framework** (2000). Stationery Office. para 5.33 –5. 34

Upholding the safeguards of the Act

2.34 The Mental Health Act's framework for compulsion provides a number of structural safeguards against its powers being used arbitrarily or incorrectly. By ensuring that the Act is administered properly and to the best practice standards attainable, services can not only ensure that they act within the law, but can contribute to the protection of the patients that they deal with.

2.35 The duties of hospital managers under the Act are summarised and discussed at Chapter 22 of the Code of Practice. One vital duty, which hospital managers should delegate to properly trained and competent staff, relates to the receipt and scrutiny of documents. Clear guidance on the actions required of such delegated staff is given at Chapter 12 of the Code. The Commission expects all hospital managers to have suitable systems in place to ensure that the Act is operated lawfully and appropriately at all times.

2.36 The following section considers some of the problem areas in the administration of the Act that have been of concern to the Commission

Concerns over the use of holding powers

2.37 The Commission has expressed its concern in the last three Biennial Reports about the relatively high number of patients who agree to enter hospital on a voluntary basis but then have been prevented from leaving under Section 5(2). The purpose of Section 5(2) is to hold a patient whilst a full assessment is made of whether a longer-term detention under the act is appropriate. There continues to be a high use of this power (see figure 2, Chapter 3.2).

2.38 There are a number of reasons for the use of Section 5(2). There is certainly the desire of clinicians to take the views of patients into account; to avoid the use of compulsion at the point of admission when it is possible to do so; and to treat patients, as the Code requires, in the least restrictive way possible. There is also the convenience of avoiding the assessment process required for formal admission under Sections 2 or 3. High use of Section 5(2) may also be an indication that in-patient wards have become places where patients who require treatment have to be coerced to stay.

Recommendation 13

The Department of Health should commission research to examine the possible reasons for the nationally high use of Section 5(2), particularly with a view to investigating whether physical and / or therapeutic environment is an influencing factor.

2.39 Section 5(2) authorises the detention of the patient for up to 72 hours but should be used for the shortest time possible. Commissioners often find delays in arranging assessments of patients detained under this holding power.

Recommendation 14

Hospital managers should arrange for the routine collation of detailed statistics on the use of Section 5(2), including the time taken to complete assessments, for audit purposes.

2.40 We are also concerned about the practice of keeping the holding power in reserve in case the patient tries to leave the ward. It is not uncommon for a psychiatrist to leave instructions on the ward that a patient should be "put on a 5(2) if he or she attempts to leave". This amounts to de facto detention, where the patient is denied the safeguards of the Act. It also blurs the distinction between informal and detained patients and could lead to all patients feeling under coercion to stay in hospital (see Chapter 4.20).

Recommendation 15

All providers should ensure that risk assessments of informal patients take account of the likelihood of and risks involved in their leaving the ward, and if both are high, an assessment for detention under the Act should be considered.

Recommendation 16

Nursing and medical staff must ensure that all patients who are not detained under the Act should have a clear understanding of their legal status.

The use of Sections 2 and 3

2.41 We welcome the Government's proposal that new legislation should set a single route of entry to the system of compulsion. This will have the advantage of being simpler and more easily understood by both patients and professionals, with all patients being entitled to the same rights of multi-disciplinary assessment and independent review. In the meantime, debates continue as to the appropriate use of the Mental Health Act 1983 powers provided by Sections 2 and 3. In our Eighth Biennial Report, we commented upon debates around whether it was appropriate to use Section 2 or Section 3 when compulsorily admitting patients to hospital, and what the threshold for such admissions should be[16].

2.42 The fundamental criterion for admission under Section 3 is more rigorous than that for Section 2, in that admission to hospital for treatment must be certified as *necessary* for Section 3, whereas a patient can be admitted for assessment under Section 2 on the grounds that such admission is *warranted for at least a limited period*. To meet the stricter criterion for Section 3 admission, the

[16] Mental Health Act Commission (1999) **Eighth Biennial Report**. London, Stationery Office. p75-78

Code of Practice suggests that Section 3 should normally be used for patients already known to and recently assessed by the clinical team, whether or not they have had any previous compulsory admissions to hospital[17].

2.43 The Commission has heard of a number of disputes being raised over the legal interpretation of Sections 2 and 3, particularly since the coming into force of the Human Rights Act. We remain of the view that practitioners should continue to follow the guidance given in Chapter 5 of the Code of Practice in relation to when it is appropriate to use either Section 2 or Section 3 to compulsorily admit a patient to hospital. Although, to date, there have been no legal challenges under the HRA to the use of Sections 2 or 3 *per se*, practitioners should remember that, even if such a challenge were made successfully, domestic law can only be reinterpreted through case law or changed through Parliament. We are alarmed at the proliferation of scare-stories about elements of current legislation being potentially in breach of the ECHR, particularly where these persuade practitioners not to follow the requirements of the current law and Code of Practice.

Extending the detention of Section 2 patients

2.44 Commissioners often find examples where assessments to detain Section 2 patients further under Section 3 are only undertaken at the imminent expiry of the Section 2 detention order. It is unacceptable that this should occur routinely, as it can prevent full discussion and consultation as required by Chapter 2 of the Code of Practice, and also preclude General Practitioners from being available to carry out the second medical examination.

Recommendation 17

Hospital and social services managers should ensure, through audit and review, that, if a patient detained under Section 2 appears to require further detention, Section 3 assessments are arranged at the earliest opportunity and undertaken according to the requirements of the Code of Practice.

Reviewing and discharging detentions under Sections 2 and 3

2.45 Patients should be discharged from civil detention orders as soon as it is clear that detention is no longer justified. This is a requirement of both the Code of Practice (Chapter 1.1) and Article 5 of the ECHR, following the ruling in Winterwerp v Netherlands [1979] that detention must only continue for as long as the persistence of the mental disorder upon which it was based.

[17] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. Paragraph 5.3a

Recommendation 18

Hospital managers, through audit and review, should ensure that:

- **the detention of each patient is kept under constant review by the clinical team;**
- **decisions on the continuation of detention are based upon clinical need and not administrative convenience;**
- **detentions are not allowed to lapse, but are actively rescinded unless a decision is made to renew detention; and**
- **RMOs have access to a suitable form to rescind detentions, a copy of which is given to the patient upon discharge.**

2.46 Hospital managers should ensure that their duties in relation to informing Nearest Relatives of a patient's discharge are met (see paragraph 2.4 above).

Approved Social Worker (ASW) Issues

The important role of ASWs

2.47 The Code of Practice describes the role of ASWs in assessing patients for possible admission under the Act as one of co-ordinating both the assessment itself and the implementation of any decision to admit. The role is also widely seen as providing a safeguard against unnecessary admission by bringing in a balancing, non-medical view of the best interests of the patient[18] and the need to use the least restrictive alternative available to provide care[19].

2.48 The ASW's role is therefore complex and, at times, beset with problems of both practice and principle. However, we continue to believe that ASWs play a vital role in the administration of the Act. If an equivalent role in new legislation is to be undertaken by a wider professional group (such as community-based nurses), we urge the Government to consider how the benefits of the current structure might be protected.

Urgent Admissions where there is no bed

2.49 The common problem of ASWs finding no beds available when conveying a patient to a hospital for urgent compulsory admission was raised in our Eighth Biennial Report[20]. We advised that the ASW should remain with the patient while a bed is organised, taking the view that, where the hospital has been identified by a Health Authority as a place that will admit patients in emergencies, it is reasonable to expect the hospital to find a bed for the patient, even though Section 140 does not place a legal duty on it to do so.

[18] see Campbell, Wilson, Britton, Hamilton, Hughes & Manktelow (2001); *The Management of Approved Social Workers: Aspects of law, policy and practice.* **Journal of Social Welfare and Family Law** 23(2)20 for a literature review on the functions of ASWs.
[19] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. para 1.1
[20] Mental Health Act Commission (1999) **Eighth Biennial Report**. London, Stationery Office. p 87

2.50 Some providers have identified strategies to deal with this difficult situation:

Good Practice Example

Following discussions with local social services and consultation with the Commission, Wakefield and Pontefract Community NHS Trust identified a holding area and additional staff cover at Fieldhead Hospital where an ASW can wait with a patient if no bed is immediately available. The patient is formally admitted to the hospital upon arrival at this waiting area, so that nursing staff are able to hold the patient if he or she attempts to leave. If it proves impossible to identify a bed within the hospital, it is then legally possible (although clearly undesirable) to grant Section 17 leave to a temporary bed in another hospital. [DN insert contact details]

The Commission's ASW report checklist

2.51 When ASWs admit patients to hospital under the Act, they are required to leave an outline report giving reasons for admission, any practical matters about the patient that the hospital should know and, where possible, the telephone number of a social worker who can be contacted for further details[21].

2.52 The Commission has provided all social services departments with a checklist of all issues that we consider should be included in ASW reports, and we use this checklist to scrutinise samples of such reports on its visits. This checklist covers the following areas:

- Patient's spoken language and ethnicity;
- Record of interview with patient;
- Name of the person appearing to be Nearest Relative, and the process of his/her identification;
- Whether the Nearest Relative was notified of the application and given information on patient's rights, with reasons if not notified or consulted;
- Records of discussions with recommending doctors and other parties;
- Reasons for the decision to make the application and alternatives considered;
- Comments on risk to the patient or other peoples' safety, or to patient's health;
- Comment on any avoidable delay in assessment/admission process;
- Information relating to possibility of children visiting;
- Any other practical matters that the hospital needs to know; and
- The name and number of the Local Authority contact person.

A full copy of the checklist is available upon request from the Commission.

Recommendation 19

Social service authorities should develop forms for ASWs to complete on the admission of a patient to hospital under the Act, to ensure that the above information is left with the receiving hospital.

Nearest Relative issues

2.53 The requirement that ASWs must consult with a patient's Nearest Relative as a part of the statutory assessment process, regardless of the wishes or best interests of the patient[22], was the subject of a legal challenge to the Mental Health Act 1983 in this period[23]. We raised this issue in 1997[24] and welcome the Government's decision to concede that this requirement of the Mental Health Act breached the right to respect for private and family life contained in Article 8 of the ECHR. As part of a 'friendly settlement', the Government agreed to pay JT damages and to make changes in the law.

2.54 At the time of writing, it is unclear whether these changes are to be made as part of the review of the Mental Health Act or whether they are to be introduced beforehand. The outcome of the case has caused some confusion over how to implement the Act's requirements in the meantime.

2.55 Commissioners have noted a number of applications for detention recording that either the patient or the Nearest Relative had objected to the statutory consultation. It was not clear from these comments whether, in some cases, the ASW had actually contacted the Nearest Relative as required by the Act. We advise that such contact should be both made and recorded to ensure the lawfulness of the patient's detention. Neither the wishes of the patient nor of the Nearest Relative can obviate these legal requirements, regardless of the settlement in JT v UK, until and unless domestic law is changed (see paragraph 2.43 above).

2.56 The Commission is aware of the argument proposed in Richard Jones' *Mental Health Act Manual (Sixth edition **1-119**)* that consultation with the Nearest Relative can be avoided if it would be likely to have an adverse effect on the patient's situation, given that the Act only requires such consultation where "practicable". We do not support this interpretation of the Act, despite its attraction and the requirement to interpret legislation in accordance with Convention rights, as we consider that 'practicable' refers to the availability of the Nearest Relative and not to the repercussions that consultation might have on the patient.

Recommendation 20

Standard formats should be developed for ASWs' reports which ensure that details of how the Nearest Relative was identified and consulted are included. This will enable hospital administrators to include these issues in their scrutiny of admission documents and ensure that the papers are legally valid.

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[21] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. para 11.13
[22] **Mental Health Act 1983** Section 11(3) and (4).
[23] ***JT v United Kingdom*** Application No 26494/95, European Court of Human Rights, 30 March 2000
[24] Mental Health Act Commission (1997) **Seventh Biennial Report** London, Stationery Office p 189-90

GP and Section 12 Approved Doctor issues

2.57 Standard 3 of the National Service Framework states that any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs. This is even more essential for those whose mental illness may make them subject to compulsion. The local milestone: " A duty doctor, Section 12 approved, and approved social worker must always be available for mental health emergencies" is of key significance for such patients.

2.58 We have recorded in several Biennial Reports that the arrangements to secure the services of Section 12 approved doctors are not working satisfactorily[25]. Much time and money is wasted in fruitless attempts to find Section 12 approved doctors who are available and willing to assess patients for compulsory admission to hospital.

2.59 In the Eighth Biennial Report, we called for a national solution which would include making Section 12 duties more financially rewarding and which would build in other incentives around the education and training of GPs to become approved. We welcome the work currently being undertaken by the British Medical Association to survey a large percentage of consultants and other doctors to discover and address the reasons for the shortage and lack of availability of Section 12 doctors. Recent advice on the making of recommendations under the Mental Health Act, issued to GPs by the Department of Health, may also improve the situation.

2.60 We are engaging with the Department of Health, the Royal College of Psychiatrists and the police to ensure that a solution to the lack of availability of Section 12 doctors is positively pursued.

2.61 We have suggested the following specific measures to the Department of Health:

- inclusion of a clause in the contract of consultant psychiatrists requiring them to be approved under Section 12;
- ensuring that all medical students involved in training in psychiatry are made aware of the need for and importance of more Section 12 doctors;
- making the entry requirements for approval more flexible so that GPs who can show that they have sufficient knowledge and experience in psychiatry are eligible to apply;
- making the Section 12 approval training available to all interested GPs before any commitment to become approved;
- encouraging Primary Care Groups / Trusts to aim to increase the number of GPs in their area who are approved under Section 12;
- similarly to encourage Primary Care Groups / Trusts to require co-operatives operating out-of hours services in their area to guarantee the availability of at least one Section 12 doctor at all times;

[25] Mental Health Act Commission (1999) **Eighth Biennial Report**, p 82-4; MHAC (1997) **Seventh Biennial Report**, p 56 –8; MHAC (1995) **Sixth Biennial Report** p 83-4. London, Stationery Office.

- streamlining the system of payment to ensure that fees are paid promptly by the area in which the assessment is carried out, rather than being passed from one health authority to another;
- inviting Chief Constables to require forensic medical examiners to become approved.

Recommendation 21

The lead Health Authority responsible for the approval of doctors under Section 12(2) in each region, in partnership with the other relevant services, should ensure that :

- **there is systematic high level collation of data from ASWs on the numbers of telephone calls made, the time taken to locate a Section 12 Approved doctor and the sharing of workload between doctors so that baselines and targets for improvement can be established;**
- **regular monitoring meetings between Health Authorities, Trusts, Social Services and Police are held to ensure that targets are met;**
- **intensive, possibly modular, training courses are established to enable a wider range of GPs to carry out the assessment function with confidence; and**
- **approved training courses are monitored to ensure both quality and consistency.**

2.62 There is no reason why increased flexibility in the approval criteria for the appointment of Section 12 Approved Doctors should lead to any diminution in the standard of assessments, provided that the situation is properly monitored and existing inter-regional variations in standards are overcome. There is, however, no doubt that neither Standard 3 of the National Service Framework nor the local milestone mentioned at paragraph 2.57 above will be met unless something positive is done to address the shortage of Section 12 Approved Doctors.

The Administration of Particular Treatments (Part IV of the Act)

2.63 Our concerns over the evaluation of patients' capacity to give informed consent and discussions between RMOs and their patients over proposed treatments are detailed at paragraphs 2.16 - 2.22 above. Concerns over RMOs' completion of statutory forms authorising such treatment, subsequent to their having made an evaluation of patients' capacity and consent status, are also frequently raised on Commission visits. This is disappointing, particularly given the clear guidance provided at Chapter 16 of the Code of Practice, which should be familiar to any member of staff involved in the operation of Part IV of the Act[26].

2.64 Commissioners frequently encounter practice that potentially renders the administration of some or all of a patient's prescribed medication unlawful. Where they do so they draw this to the attention of hospital managers, recommending that they take immediate remedial action, inform the patient of the position and assist the patient in obtaining legal advice if he or she wishes to do so.

[26] Department of Health and Welsh Office (1999) **Mental Health Act Code of Practice**. London, Stationery Office. para 16.3.

2.65 Commissioners may question the lawfulness of the administration of treatment when, for example:

- The medication for mental disorder being administered is different, in relation to either type of drug, number of drugs in each BNF category, or upper limit of dosage authorised on Form 38 or 39;
- Drugs are described incorrectly on Forms 38 (i.e. with reference to the wrong BNF category);
- The initial three-month period of detention has expired without a Form 38 or 39 being completed to authorise continued treatment with medication for mental disorder; or
- Patients appear to have withdrawn their consent but are still being treated on the questionable authority of a Form 38.

2.66 Commissioners will raise issues of good practice when, for example:

- Forms 38 do not state an upper dosage limit, or the number of drugs authorised in any BNF category described;
- Forms 38 have been completed by a doctor who is neither the current RMO nor a SOAD;
- Forms 38 have not been regularly reviewed.

2.67 Where we have noted improvements in the administration of Part IV of the Act, this is usually due to the introduction or refinement of audit tools and flagging systems to record and trigger specific actions ensuring compliance with good practice and the law (see, for example, Chapter 5.21 on High Security Hospitals).

Recommendation 22

All service providers should have adequate audit tools and flagging systems to record and trigger specific actions ensuring compliance with the consent to treatment provisions of the Act. **(see also recommendation 7, para 2.20)**

Recommendation 23

A copy of the relevant statutory Form 38 or 39 should be kept attached to patients' medicine charts and pharmacists should be asked to check against this authorisation before dispensing medication for patients.

Compliance with CPA guidance and Section 117

2.68 Guidance on implementing the Care Programme Approach is given in *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach*[27]. This builds upon the National Service Framework for Mental Health's specific standards (Standards Four and Five) aimed to ensure that services for people with severe mental illness are effective. These include requirements that patients detained under the Act, well as informal patients:

[27] Department of Health (2000) **Effective Care Co-ordination: Modernising the Care Programme Approach.** London, Stationery Office. www.doh.gov.uk/pub/docs/doh/polbook/pdf

- receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk;
- have a copy of a written care plan which is regularly reviewed; and
- have a written aftercare plan agreed on discharge, which sets out the care to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

2.69 Although the the NSF standards extend the expectation of pre-discharge planning to *all* patients, those subject to Section 117 of the Act have a statutory entitlement to aftercare. Patients with such entitlement should therefore be clearly identified in patient records, particularly as funding questions may arise during discharge planning.

2.70 Clear and detailed guidance on aftercare planning and discharge is given in the Mental Health Act Code of Practice (Chapter 27). Given the frequent failures to comply with aspects of this guidance, the following points are often highlighted by Commissioners on visits:

- The planning arrangements for aftercare should start when the patient is admitted to hospital, rather than only being addressed when imminent discharge is envisaged.
- Some discussion of aftercare needs must take place prior to any Mental Health Review Tribunal or hospital managers' hearing, so that suitable aftercare arrangements can be implemented if the patient is discharged, even if the care-team does not expect discharge to result from the hearing.
- Multi-disciplinary Section 117 meetings should be held and documented before a patient can be granted any substantial period of leave under Section 17.

Recommendation 24

All relevant agencies should take particular note of discharge planning requirements for patients subject to Section 117 of the Act

2.71 We still find many examples of poor practice on visits, although examples of the effective use of the Care Programme Approach and fulfillment of statutory duties under Section 117 are increasingly in evidence. Where this is so, marked benefits have been noted in relation to patients' relations with their RMOs and care-teams. The Commission will continue to check CPA documentation on its visits and to encourage service providers to comply with the Code of Practice's advice.

2.72 In a number of examples encountered on Commission visits, even where high quality Care Programme Approach documentation was evident, the effectiveness of the Care Programme Approach for individual patients' care was hampered by lack of co-operation from outside agencies, or lack of appropriate facilities for patients to go to when discharged from hospital. In particular:

- Some social service authorities seem reluctant to accept their statutory duties in relation to Section 117: the Commission was informed that one authority would only do so after judicial action had been threatened.
- Many care-teams reported that the transfer or discharge of patients was held back due to lack of social care provision and suitable housing accommodation. A typical example was recorded on a Commission visit to Southampton Community Services NHS Trust in March 2000, where managers and staff all reported to Commissioners that the lack of throughput through the unit, a lack of funding for community placements and a shortage of suitable accommodation outlets were a significant and constant problem. Managers suggested that fifteen to twenty of the patients detained in one unit would have been discharged were it not for these difficulties.
- The independent sector has reported difficulties in getting relevant agencies, such as social services or referring hospital consultants for Out of Area Treatments, to attend planning meetings, partly due to the fact that many of its patients are out-of-area placements from NHS facilities. The Commission has encouraged independent sector facilities to seek rapprochement with such agencies and to allow flexibility over the scheduling of such meetings, but it has been reported that some agencies have indicated that they are too busy even to attend six-monthly meetings. We are very concerned that such attitudes could hamper the transfer or eventual discharge of patients from out-of-area independent sector placements.

2.73 The provisions for new joint health and social care trusts and for pooled budgeting arrangements under the Health Act 1999 offer the potential for problems of this kind to be minimised. Meanwhile, the Commission condemns the widespread derogatory term of 'bed blockers' to describe patients whose discharge is hindered by a lack of provision over which the patient has absolutely no control.

Monitoring the Independent Sector

2.74 The Commission visits and monitors the application of the Mental Health Act in all Registered Mental Nursing Homes (the term encompasses all hospital provision in the independent sector) that are licensed to detain patients under the Act. In some of the smaller homes that may only occasionally provide care for detained patients, the operation of the Act can be difficult because of lack of administrative support, training and experience, as well as uncertainty over who can fulfil the role of hospital managers under the Act. Many smaller homes' medical cover is also provided part-time by General Practitioners, with psychiatric input being provided on a part-time basis by a psychiatrist, often from a local NHS Trust. The former may not have the necessary experience of the Act, and neither may have sufficient time, to ensure that good practice is always observed. Difficulties in liaison with referral bodies and social services, particularly when

patients are received into nursing homes for Out of Area Treatment, continue to be a problem. We discussed these problems in our Seventh and Eighth Biennial Reports[28].

2.75 Under current legislation, services in the independent sector that are able to take detained patients must be registered under Part II of the Registered Homes Act 1984 by local Health Authorities. The process of registration itself should be an opportunity to ensure that such homes are able to comply with the requirements of the law and the Mental Health Act Code of Practice. The Commission works alongside local authority registration units providing advice and assistance in this matter, but has repeatedly pointed to the lack of legislative regulations or standards concerning the use of the Mental Health Act that registration units could apply, as well as to the lack of an effective and focussed sanction that could be brought to bear on failing service providers.

2.76 We welcome the Government's acknowledgement that the Registered Homes Act 1984 and the systems established to police it are no longer suited to the patterns of mental healthcare provision. We are therefore pleased that the Care Standards Act 2000 has provided for the establishment of the National Care Standards Commission (NCSC), one of whose duties will be, when it takes up its regulatory work in April 2002, to set standards for registration of private and independent services providing care to patients detained under the Mental Health Act.

2.77 In its response to the House of Commons Health Committee's call for Mental Health Act Commission representation at a national level on the new regulatory body[29], the Government has given assurances that the successor body to the Commission under new mental health legislation will have complementary functions to other bodies, including the NCSC[30]. In the meantime, we hope that the Government will give its full support to collaborative working between the Mental Health Act Commission and NCSC to ensure that the experience of the former informs regulation of the independent sector in both the short and long term.

[28] Mental Health Act Commission (1997) **Seventh Biennial Report** London, Stationery Office p74 – 76. Mental Health Act Commission (1999) **Eighth Biennial Report** London, Stationery Office p106 – 110

[29] House of Commons Health Committee, **Fifth Report of Session 1998-99 on the Regulation of Private and other Independent Health Care** (HC 281-I), July 1999 (para 75).

[30] Department of Health (1999) **The Government's Response to the Health Committee's Fifth Report on the Regulation of Private and other Independent Healthcare**. Cmnd 4540. London, Stationery Office. (Page 6).

3 Quality and Standards of Care

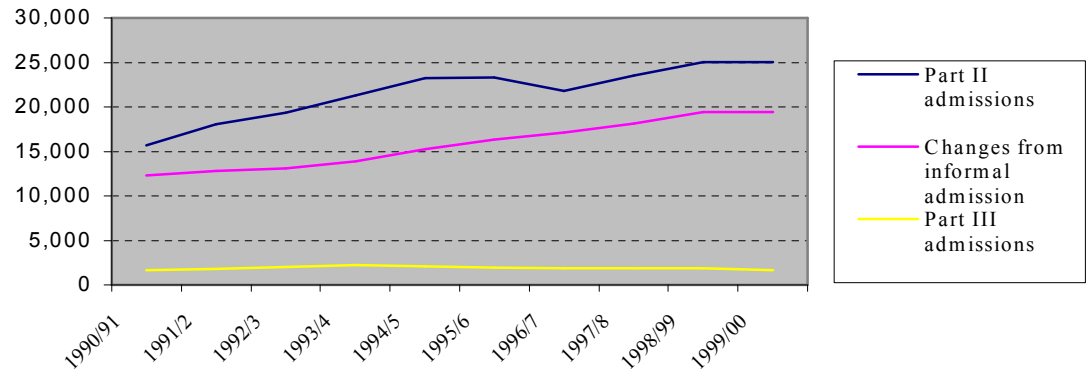
The Infrastructure of Mental Health Services

Admission trends

3.1 Over the last decade there has been an increase in the numbers of patients detained under the Act (see figure 2 below). This increase has occurred during a time when there has been a reduction in the number of beds and an increase in the use of community-based facilities and outpatient treatment for those patients whose mental disorder can be managed away from an institutional setting. This means, however, that a high proportion of psychiatric in-patients is now detained. In a simultaneous visit to a large representative sample of acute units in 1996[31], the Commission found that nearly one third of the patients in acute units were detained. In some areas this proportion reached over 90%. This makes the role of the Commission, whose remit is limited to monitoring the use of powers and discharge of duties in relation to patients who are liable to be detained, all the more central in the overview of inpatient mental health services.

3.2 Under present legislation, compulsory treatment can only be administered in hospital. It seems likely that this may be a deciding factor in the instigation or continuation of a significant proportion of detentions under the present Act. We welcome, cautiously, the proposal that new legislation will break the link between compulsory treatment and detention in hospital[32], particularly in that it may shorten the time that some patients are required to stay in hospital.

Figure 2: Admissions under the Mental Health Act



(Due to the availability of data, the above table relates to admission in England only. Changes from Places of Safety detentions are not included.)

[31] Mental Health Act Commission and Sainsbury Centre (1997) **The National Visit. A one-day visit to 309 acute admission wards by the Mental Health Act Commission and Sainsbury Centre for Mental Health**. London, Sainsbury Centre for Mental Health.
[32] Department of Health (2001) **Reforming the Mental Health Act.** London, Stationery Office. para 2.13 et seq

3.3 A discussion of the use of holding powers (shown as "changes from informal admission" in the above table) can be found at Chapter 2.37. Further discussion of admission data in relation to ethnicity is at Chapter 6.9.

Bed Pressures

3.4 Standard Five of the National Service Framework sets out the expectation that any patient who is assessed as requiring mental health care away from their home should have timely access to an appropriate hospital or alternative bed, in the least restrictive environment and as close to home as is possible.

3.5 We continue to be concerned that the pressures on inpatient beds reported in our last four Biennial Reports continue to hamper achievement of this objective, resulting in :

- delays in acute admissions;
- patients being moved during their admission;
- sending patients on leave, often to poor living environments and with inadequate community support and supervision (sometimes shifting the burden of care and responsibility onto relatives or carers who may be ill-equipped to cope), so as to free beds for other admissions;
- staff time being diverted from direct patient care to find alternative placements;
- patients being transferred to expensive and distant out-of-area placements, away from family and other supporters;
- inappropriate patient mix on admission wards, in that patients of a wide range in age and diagnosis sharing facilities (e.g. elderly or depressed patients being cared for alongside young men with drug or alcohol problems);
- and lack of appropriate aftercare planning, both through pressures on staff time and because of logistical problems due to patients' movements within mental health services.

3.6 These pressures, and their effects on patient care, are frequently noted by Commissioners during visits. Many services are operating at well over 100% capacity and sending patients on leave to generate 'free' beds. Our experience is that high bed occupancies and lack of free beds hampers patient movement across all services, from low security to the High Security Hospitals. The National Service Framework for Mental Health recognises that up to a third of all inpatients would be better placed elsewhere and that there are gaps in medium secure and low secure long-stay provision, intensive care and supported community daycare[33]. The Government has accepted that a holistic approach to relieving pressures on such services is needed, but this could be

[33] Department of Health (1999) **A National Service Framework for Mental Health**. London, Stationery Office, p 49.

hampered by the extent of the problem not being accurately reflected in national statistics, given that patients who are on leave are not uniformly counted in bed-occupancy figures.

Recommendation 25

The Department of Health should ensure that national statistics on bed occupancy take account of detained patients who are on leave from inpatient beds, so that available beds and bed occupancy can be monitored more meaningfully.

3.7 A number of mental health services have attempted to deal proactively with the problem of bed pressures, with some encouraging results. Common to most attempts is an increased focus on community-based and outreach services, so as to reduce the numbers of patients requiring admission to hospital under compulsion and to facilitate the discharge of patients who could leave hospital if appropriate services in the community were available. We welcome the following Government initiatives included within the NHS Plan that should enhance such services:

- Proposals for 50 early intervention teams for the effective support and treatment in the community of young people experiencing the first sign signs of psychosis.
- The establishment of 335 crisis resolution teams, aimed at providing home-based services to people currently admitted to hospital.
- The establishment of 220 assertive outreach teams across the country to provide active support to people with mental health problems whom traditional services have found hard to engage.

3.8 In the ongoing development of mental health services it is essential that commissioners of health care monitor bed occupancy and ensure that safe standards are applied. We encourage all mental health services to adopt proactive bed management strategies:

Recommendation 26

Where shortage of beds appears to be adversely affecting services, service commissioners and providers should jointly consider and agree:
Short-term action: local reviews of all current inpatient stays with a view to clearly identifying the purpose of admission, anticipated length of stay and action required to achieve discharge.
Longer-term action: the establishment of systems & policies that lead to an increase in planned rather than emergency admissions, closer involvement of care co-ordinators during in-patient stays, and greater use of inpatient staff in providing advice to community staff where admission is being considered;

- **a review of policies and procedures around admission, assessment care planning and discharge;**
- **closer work between community and inpatient teams;**
- **the provision of staff training in CPA & risk management for both community and in-patient staff; and**
- **consideration of whether inadequacies in community provision are leading to admissions that could have been prevented with earlier intervention.**

Staffing issues

3.9 Most mental health services visited by the Commission report recruitment and retention problems causing shortages of suitably trained staff who are experienced in the care of people with mental health problems. The effects of such staffing shortages are bound to have a wide-ranging effect on such hospitals' service through the increased pressure on existing staff and an overall reduction in the quality of patient care. In the worst cases, the Commission has been informed of potentially dangerous ward environments due to the numbers of staff available.

3.10 We therefore welcome the establishment by the Government of the Mental Health Workforce Action Team (WAT), set up to explore the practical solutions necessary to help deliver the workforce issues around the National Service Framework for Mental Health and the NHS Plan. In their Final Report[34], the WAT sets out the issues around recruitment and retention of staff, as well as issues around education and training, setting these elements in the context of the wider workforce issues. We are pleased to note the many references to examples of good practice as well as the recommendations made to improve recruitment and retention in particular. The Mental Health Task Force has also given clear guidance on how best to implement the WAT report and we look forward a joint approach being taken by all the bodies mentioned to make improvements in the current position.

3.11 The WAT already report that good examples can be found of services engendering workforce plans centred around the NSF standards and Health Improvement Plans. Such workforce plans identify workforce profiles and future staffing needs, including recruitment, retention and training needs. We are particularly pleased to note examples of inter-agency working in setting up such plans to encompass both health and social services, and private and voluntary services as well as the NHS.

3.12 However, serious difficulties are faced in many areas of the service at present, all of which have very regrettable effects on patient care. We recognise that problems caused by understaffing increase the pressures on the service and can lead to:

- less time available for therapeutic interactions between staff and patients;
- strain on patients' therapeutic relationships with staff, particularly with temporary or frequently changing medical staff;
- restrictions on patients' attendance at therapeutic activities, and free access to fesh air, etc;
- poorer compliance with the Care Programme Approach requirements regarding personalised care programmes, proper risk assessments and pre-discharge planning;
- poorer compliance with the safeguards of the Act, particularly with regard to consent to treatment, leave arrangements, etc.

[34] Workforce Action Team (2001) **Mental Health National Service Framework (and the NHS Plan) Workforce Planning, Education and Training Underpinning Programme: Adult Mental Health Services: Final Report by the Workforce Action Team**. London, Stationery Office. www.doh.gov.uk/nsf/mentalhealth.htm

3.13 Nevertheless, more imaginative approaches may help mental health services manage more effectively:

Recommendation 27

All local mental health service managers faced with staffing problems should consider the following examples of best practice identified by Commissioners:

- **providing greater access to support and supervision to staff;**
- **wider use of psychologists and other professionals in ward-based activities, particularly at trainee level;**
- **bringing therapists (including art or drama therapists) onto wards on a sessional basis;**
- **encouraging patients and staff to contribute to ward activities through sharing their skills in activity groups; and**
- **providing training to staff in behaviour management, particularly de-escalation techniques.**

3.14 One particular area that requires particular attention is the shortage of consultant psychiatrists that is felt throughout mental health services. Many services report their reliance on locums and temporary cover for consultant vacancies. This can make the maintenance of therapeutic relationships between patients and doctors difficult. It can also threaten the establishment or continuation of good practice in operating the Act, through a lack of thorough knowledge and experience of the Mental Health Act and the establishment where it is applied.

Essential environmental requirements

3.15 Although issues relating to patient safety, including suicide prevention and mixed sex accommodation in mental health units, are discussed at Chapter 4 of this report (see Chapter 4.11 – 4.22), it cannot be over-emphasised that acceptable standards in detained patients' surroundings are a precondition of a safe and therapeutic environment. This is recognised by various reports, including the Sainsbury Centre's *Acute Problems*[35] and the Government-sponsored *Review of Security at the High Security Hospitals*[36].

3.16 The Commission's Eighth Biennial Report contained many references to an inadequate standard of physical environment for inpatients with wards which:

- were poorly furnished and badly decorated;
- lacked privacy for patients;
- minimal standards of security for patients' belongings;
- caused concern for patient safety.

[35] Sainsbury Centre for Mental Health (1998*)* **Acute Problems: A survey of the quality of care in acute psychiatric wards**. London, Sainsbury Centre for Mental Health pp20

[36] Department of Health (1999) **Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital.** Cm 4149-11. London, Stationery Office [DN page numbers? Is this the right report?]

3.17 In visits to all mental health units that detain patients under the Act, Commissioners encounter a wide variety of environmental standards. Some units manage to be bright, clean and cheerful, whilst others, regrettably, continue to provide bleak conditions for patients. We welcome the Government's announcement of a £30m refurbishment programme over the next two years, targeted in the first year to wards identified as being the most run-down.

3.18 There is a danger that environmental issues, such as décor, or access to fresh air and activities, rank fairly low amongst the many priorities that unit managers have to contend with. But for many detained patients, especially those housed on acute wards, being confined in unpleasant surroundings with few opportunities for respite or relief can be profoundly anti-therapeutic, contributing to management problems (see Chapter 4.32 - 4.34) and undermining attempts to provide a safe environment for vulnerable people (see Chapter 4.11 *et seq.*).

Recommendation 28

All service commissioners and providers should ensure that the general environmental quality of inpatient facilities are subject to locally agreed, systematically monitored standards.

Recommendation 29

Where remedial action is required in relation to general environmental quality, at whatever level, this should be the subject of an agreed action plan with resources needed for implementation clearly identified.

3.19 We have noted some imaginative and sensitive approaches to ensuring that patients feel happier with their environment:

Good Practice example

Patients being relocated from one hospital site to another in Cardiff and Vale NHS Trust were involved in choosing the décor and furnishings for their new wards. This process has been a success in so far as the new environment has had a recognisably beneficial effect on the way in which patients treat their surroundings, staff and each other. We understand that Cardiff and Vale NHS Trust are now extending this approach across its other mental health units.

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Patients' access to fresh air

3.20 In many units, particularly but not exclusively those providing medium and high secure care, patients' access to fresh air remains a problem. The former Special Health Services Authority (SHSA) specified a minimum standard for patients in the High Security Hospitals to have access to fresh air for 10 hours per week during summer months and four hours per week in winter. Sadly, even this minimal level is not always attained.

3.21 Many units do not have any substantial and secure outside area. This is particularly the case of a number of medium-secure units in urban settings. In many such cases, staff shortages or shift patterns appear to limit the availability of nursing staff to accompany those patients who cannot be allowed unescorted leave.

3.22 The patients in many medium and high secure care wards can be young and active people, for whom cramped indoor conditions exacerbate frustrations and lead to management problems. Regardless of the nature of the patients, however, access to fresh air should be regarded as a basic human need and taken very seriously by hospital managers and staff alike.

Recommendation 30

Service Commissioners and providers should agree and monitor specific standards for access to fresh air for all detained patients.

Patient activity and facilities

3.23 In a report published early in this biennial reporting period, the Department of Health's Standing Nursing and Midwifery Committee stated *'users, carers and professionals agree that in-patient units are becoming increasingly custodial in their atmosphere. Our work suggests that users in acute care often feel that they are being deprived of therapeutic activity, have much less contact with nurses than they would wish, and at times feel unsafe.* [137]'

3.24 The experience of the Commission is that whilst this is a true reflection of care standards in many instances, there is no reason why services in acute and other care cannot be improved.

3.25 On visits, Commissioners pay particular attention to the levels of patient activity on and off wards. On a number of visits, some of which are unannounced, patients are observed sitting in lounges or bedroom areas with little of no discernable focus of activity and no obvious interaction with staff. Whilst it would be unrealistic for us to suggest specific standards, all too often we encounter bored patients whose only recreational activities are smoking and television. Patients often speak of their need for more recreational activities, including access to sports facilities, such as gymnasium, keep-fit or yoga sessions; a better variety of reading matter; cooking or craft activities; drama or art therapy workshops, etc.

[37] Department of Health (1999) **Addressing Acute Concerns: report by the Standing Nursing and Midwifery Committee**. London, Stationery Office. June 1999

Recommendation 31

Hospital managers should consider addressing the provision of patient activities and facilities by:

- **ensuring that all patients are aware of opportunities on offer, both through publicly displayed information and individual discussion with patients as a part of their care plan;**
- **using monitoring and user-surveys to identify needs and opportunities in providing activities;**
- **considering the use of voluntary or other agencies, or of existing contracted staff within the Trust to bolster available activities on a sessional basis; and**
- **employing or designating an activities co-ordinator.**

The provision of therapeutic interventions

3.26 The precise definition of therapeutic interventions can be a problem, specifically for hospital managers' audits and monitoring of service standards. We have noted that some services have adopted classifications for this purpose , based on the following distinctions:

Type A interventions include low-key approaches such as craftwork, current affairs discussions, etc.

Type B interventions have a defined therapeutic purpose and include social skills training, relaxation therapy and less intensive forms of group therapy.

Type C interventions have a pre-defined therapeutic methodology and specific targeted therapeutic goals such as a victim empathy group, or individual dynamic psychotherapy.

3.27 Patients often inform Commissioners that they feel that they are provided with inadequate therapeutic interventions, such as psychological therapy or counselling, and that their treatment appears to be limited to being administered medication. While we recognise the value of pharmacological treatment for serious mental disorder, such impressions appear to be profoundly anti-therapeutic for patients and raise concerns about the reality of multi-disciplinary working.

3.28 The Health Select Committee report on Mental Health Services recognised that there is a shortage of psychologically-based treatments in the NHS, but that it is not known whether this is primarily due to the shortage of professionals able to deliver them, lack of awareness among those responsible for purchasing mental health services as to their benefits, or cost[38]. We welcome the Government's action in relation to staffing; education and training; and clinical decision support systems, which we hope will move the NHS towards addressing this problem.

3.29 We particularly welcome the publication in February 2001 of Department of Health guidance on *Treatment Choice in Psychological Therapies and Counselling*[39]. While recognising that the

[38] Department of Health (2000) **The Government's Response to the Health Select Committee's Report on Mental Health Services**. London, Stationery Office, October 2000. Page 17

[39] Department of Health (2001) **Treatment Choice in Psychological Therapies and Counselling : Evidence-based Clinical Practice Guideline**. www.doh.gov.uk/mentalhealth/treatmentguideline

guidance does not extend to the treatment of all patients who are likely to be detained under the Act (especially given the exclusion of psychotic disorders from the scope of the guidelines, despite the National Service Framework for Mental Health's recognition that there is a growing evidence of the effectiveness of psychological therapies for schizophrenia[40]), we expect that all service commissioners and providers will adopt the key implementation points and audit criteria suggested by the guidelines in assuring that the services that they pay for and provide are in accord with evidence-based practice.

Recommendation 32

Mental health service commissioners and providers should agree specific standards for the provision of recreational, educational and therapeutic activities and monitor their availability, taking account of patients' views.

3.30 The Commission has undertaken some preliminary studies of access to psychology and psychotherapy within the High Security Hospitals over the last year, initial results of which are presented at Chapter 5.15 – 5.20 of this report.

Survey of ECT Facilities

3.31 The way in which patients are treated while undergoing what can be the distressing experience of Electro Convulsive Treatment (ECT) is a good indicator of how seriously service providers take their responsibility of care. During 2000/2001 Commissioners made a survey of all ECT facilities in England and Wales, using a standardised form based partly on criteria published by the Royal College of Psychiatrists and partly on Commissioners' experience. The full results of this survey became available only at the end of the period covered by this report and will be described in a comprehensive analysis to be published in due course. A preliminary examination of the results has been carried out with the help of one of the staff of the Royal College of Psychiatrists; a brief summary of this is given below.

3.32 Commissioners interviewed an informed member of staff at 230 sites and visited the ECT suite or other facility to verify certain elements of the information given. 48 standardised questions were asked, covering the main areas shown in the figure 3 (see Chapter 7.23 for a similar breakdown for Wales alone).

[40] Department of Health (1999) **A National Service Framework for Mental Health**. London, Stationery Office. p 46

Fig 3

Item	Percent (n=230 sites surveyed in England and Wales)
The Arrangements for ECT Possession of a dedicated ECT suite, comprising 3 or more rooms, including a separate waiting room and recovery room	**68**
A Policy for ECT Clinics which were able to show the surveyor either a copy of the Royal College of Psychiatrists Handbook or a copy of the hospital's own ECT policy	**95**
A Named Consultant Psychiatrist ECT clinics with a named consultant psychiatrist who visits regularly	**73**
Recovery and Resuscitation ECT Clinics that have, in practice, a nurse in the recovery room who is trained in Basic Life Support, Cardio-pulmonary Resuscitation and who attends refresher courses in resuscitation regularly	**64**

3.33 In 18 instances, the facilities visited scored very highly in each of the main criteria surveyed and in another 30 instances they appeared to comply substantially. Good practice was identified in many of these cases and will be highlighted in the forthcoming special publication.

3.34 At the other end of the scale, the survey indicated that there were substantial departures from best policy, practice or training in about 20% of cases. This does not necessarily mean that any individual patient is being adversely affected, but it does imply an unacceptable standard of service. The Commission will be writing to the relevant Chief Executives asking them to review their policies and practice in the light of the findings.

3.35 At this stage of analysis and follow-up, it would not be appropriate to make any specific recommendations. During the summer and autumn of 2001, we will be reviewing the survey as a prelude to further discussions and consideration of the findings with the ECT Committee of the Royal College of Psychiatrists. The intention is to publish a fuller picture of policy and practice relating to ECT administration thereafter.

4 Safety and Security

A Safe and Therapeutic Environment

4.1 The National Service Framework for Mental Health requires local health and social care communities to provide safe hospital accommodation for those who need it (Standards Five and Seven). We welcome the Government's emphasis on patient safety in the White Paper on *Reforming the Mental Health Act* and related initiatives.

4.2 Patients are detained under the Act on the justification that this is necessary for their own health, for their safety or for the protection of others. There is very little evidence that prevailing standards of security for detained patients have caused any disproportionate risk to members of the public, but we are concerned that patients' own safety is not always adequately protected by the actions of mental health services and can be compromised by their omissions. The key issues of concern are highlighted in this chapter.

Protecting patients from inappropriate placements

4.3 Among the greatest risks to the safety of detained patients are:

- fear of hospitals which prevents them from seeking early help
- fear of other patients which prevents them from benefiting from treatment
- self-harm which is often increased by a poor environment, boredom, and loss of hope aggravated by being with patients who are more vulnerable than themselves.

These are matters frequently cited by patients and others in meetings with Commissioners. A major cause is the way in which people enter the acute care system and an inappropriate mix of patients in confined conditions (see Chapter 3.4 *et seq*.).

Places of Safety

4.4 The way in which mentally ill people who need to be taken to a place of safety by the police are treated is a cause of ongoing concern. Police stations continue to be the most common location used as places of safety, despite repeated emphasis on the undesirability of this in every Biennial Report issued by the Commission and guidance in the Code of Practice (paragraph 10.5) and the Memorandum to the Act (paragraph 315). People who are thought likely to be mentally ill should be treated as individuals whose greatest need is a sensitive response which does not itself catalyse the violent reactions for which the patient is then blamed.

4.5 Section 135(6) of the Act does not restrict places of safety to police stations or hospitals but allows for them to be " a mental nursing home or residential home for mentally disordered persons or other suitable place, the occupier of which is willing temporarily to receive the patient". The Government's policy on a more holistic and primary care based approach to those with acute

episodes of mental illness provides an excellent opportunity for health, social and voluntary services to work together locally to provide a much wider range of such places of safety.

Good Practice Example

Enfield Community Care NHS Trust used their Day Hospital to provide a Section 136 service which was set up as the result of work by a multi-disciplinary Working Party. This has now developed into a specially designed suite which is part of a larger Emergency Reception Service run by Barnet Enfield and Haringey Mental Health NHS Trust. In 2000, 32 people were taken directly to the suite under Section 136 and successfully assessed for their future care needs. Significant numbers of others were brought informally to the Unit by the police for assessment.

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4.6 One of the our key objectives over the next two years is to encourage such co-operation by monitoring the use of Section 136 on a country-wide basis and liaising with the police to see if more consistent policies and training can be provided on their response to people who appear to be mentally ill in a public place. An imaginative multi-disciplinary approach towards these particular powers must be developed so that the person held receives a responsive service that meets their needs, reduces risks, and enables the services involved to resume their other responsibilities as soon as possible.

Ensuring appropriate outcomes

4.7 While the immediate purpose of an arrest under Section 136 will be the protection of the person concerned or of other people, the Act also provides that the purpose of the subsequent holding power is to enable the detainee to be examined by a doctor and interviewed by an Approved Social Worker so that any necessary arrangements for further care or treatment can be made. (Section 136(2)). The Code of Practice's guidance on this aspect of the Act (specifically at paragraphs 10.8a and 10.14a) has been widely misunderstood by services seeking to draw up Section 136 policies, and the Commission has been frequently approached to give an interpretation.

4.8 It is our view that, if the doctor who examines a person detained under Section 136 fails to detect any form of mental disorder whatsoever, that person should be discharged from detention under Section 136 immediately, as there can be no reasonable legal grounds for the holding power to continue. If however, the doctor concludes upon examination that the person appears to be suffering from a mental disorder as defined in Section 1(2) of the Act, whether or not of a nature or degree sufficient to justify detention under Sections 2 or 3 of the Act, the detention under Section 136 should continue until an Approved Social Worker has seen the person and a decision has been reached on the arrangements needed for further care or treatment. We emphasise that this should be the case even if, on examination, the doctor feels that neither further detention under the Act nor informal admission to hospital will be required. In this way the law seeks to

ensure that no mentally ill person held under Section 136 is discharged without some form of follow-up care.

4.9 We note that the above interpretation is reflected in the Police and Criminal Evidence Act Code of Practice (C, para 3.10) and is therefore a widely appreciated requirement for patients held in police stations.

Recommendation 33

Service providers, including the police, should ensure that their policies on Section 136 reinforce the need to wait for an Approved Social Worker to attend a person who is believed to have any kind of mental disorder as defined in the Act before discharging such a person and that the implementation of the policy is monitored.

Ensuring more appropriate placements

4.10 Better and more consistent police training and a wider range of places of safety should reduce the number of people who are inappropriately taken to police stations or busy hospitals where any aggressive reactions are likely to be triggered as much by fear and confusion as by any innate dangerousness. We therefore welcome the Government's proposals for:

- increases in early intervention;
- introduction of more crisis resolution teams;
- enhancement of community facilities and treatment;
- the provision of more specialised facilities for the most disruptive and dangerous patients; and
- more medium secure places.

Together these developments should all enable patients to be treated with more sensitivity and within a more appropriate patient-mix, so that the management problems which are exacerbated by poor environments, lack of activity and lack of hope may be reduced. This, in turn, should reduce the level of fear and the widely held belief that hospital settings are unsafe. Particular attention needs to be paid to the needs of specific patient groups, such as women (see chapter 6.33 – 6.39 below) .

Protecting patients in hospital

Environmental Safety and Security

4.11 All too often, references to environmental safety and security concentrate solely on removing opportunities for patients to self-harm or abscond. It is impossible to over-emphasise that these aspects must be seen as only part of a holistic approach to the care of patients. This must aim to ensure that the environment in which patients are cared for reduces the likelihood of them trying to self-harm or abscond by providing good standards of accommodation and catering, access to

activities and fresh air, and – most important of all – interaction with staff who regard them as individuals with particular personal needs and wishes.

4.12 Our concerns about these broad aspects of safety and security are discussed in Chapter 3. They can all be major causative factors in management problems, generating patients' distress, aggression and self-harm. While, therefore, the following paragraphs highlight physical aspects of safety, we stress that these must be underpinned by work on making hospital wards better places to be in.

Learning from Adverse Events

4.13 The Commission's contribution to helping services to learn from failure was acknowledged in the report of the expert group chaired by the Chief Medical Officer, *An Organisation with a Memory*[41], which recognised specifically that a very critical Commission visiting report was the catalyst for change in one troubled establishment The expert group was critical, however, of the fact that what it described as 'barriers to learning' should have prevented action at the unit prior to the Commission's intervention. We wholeheartedly agree with this analysis and condemn any approach which focuses on blame rather than on learning from mistakes as well as from good practice elsewhere.

4.14 We therefore welcomed the Government's acceptance of all the recommendations in *An Organisation with a Memory* [42], which should establish a system within the NHS ensuring that lessons from adverse events in one locality are learned across the service. This philosophy has particular relevance to "untoward incidents".

4.15 In February 2000 *The Report of the Review of Security at the High Security Hospitals* (the `Tilt Report', which is further discussed at Chapter 5) recommended that untoward incidents should be categorised according to the seriousness of outcome and in accordance with the Mental Health Act Commission's classifications. These classifications are as follows:

> **Class A Incidents -** Incidents that result in death or cause such serious harm that they place life in jeopardy. They include, but are not limited to, homicide, attempted homicide, sudden and unexpected death and suicide.
>
> **Class B Incidents -** Incidents that are not life threatening, but which acutely jeopardise the well-being of anyone involved. They include, but are not limited to, allegations of patient abuse or neglect, assaults, attempted suicide, unexplained injuries and serious errors of medication.
>
> **Class C Incidents –** Incidents which seriously affect, or have the potential to seriously affect, the health or psychological well-being of individuals involved. They include, but are not limited to, errors of medication (which may be Class B incidents), sexual improprieties, and sexual or racial harassment. Accidental injuries, assaults and acts of deliberate self-harm may amount to either Class C or Class D incidents depending on the severity of the outcome.

[41] Department of Health (2000) *An Organisation with a Memory: report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. London, Stationery Office . See page 33 for the example cited.
[42] See Department of Health (2001) *Building a Safer NHS for Patients: implementing An Organisation with a Memory*. London, Stationery Office. (www.doh.gov.uk/buildsafenhs/)

Class D Incidents - Incidents which result in no injury, or only very minor injury, and do not involve any blame on the part of any member of the staff of the relevant Trust.

Class E Incidents - Any other untoward occurrence.

Recommendation 34

Service commissioners and providers should agree:

- **standard classifications for incident reporting to be adopted in relation to all incidents involving detained patients;**
- **common management monitoring, audit and analysis of all untoward incidents falling within Class A, B and C to see whether any patterns emerge and what lessons can be learnt; and**
- **an arrangement for joint consideration of such patterns/lessons.**

4.16 We are glad to note that the need for separate notification of incidents involving patients detained under the Mental Health Act is recognised in the Government's plans for promoting patient safety[43]. We look forward to working with the newly established National Patient Safety Agency, which will implement and operate the overall system of data collection and analysis.

Learning from Patient Deaths

4.17 Standard Seven of the National Service Framework for Mental Health introduced a number of general expectations towards the reduction of suicides amongst the mentally ill. These have been further reinforced by the setting of a standard of zero suicides by inpatients from suspension from shower rails or hanging rails in wardrobes by 2002[44], as recommended in *An Organisation with a Memory*. The oversight of hanging rails within wardrobes as an opportunistic suicide risk has been a particular concern of Commissioners during the two years covered by this Report and we are pleased to note that it has been highlighted so specifically.

4.18 Shower and wardrobe rails nevertheless form only a proportion of the means whereby patients attempt suicide. The Commission published its report *Deaths of Detained Patients in England and Wales*[45] in March 2001. This report presented the findings of our review of every patient who died whilst subject to detention under the Mental Health Act during the three year period 1997-2000. Of 1,471 such deaths, 253 were reported to the coroner as being from unnatural causes. We were able to consider 208 inquest verdicts from this group.

4.19 A summary of the main findings and recommendations from this review is at **Appendix B** to this report. The outcomes, which all underline the need for constant vigilance and awareness on the part of staff, are being followed up separately. Only two particular aspects of the findings are

[43] Department of Health (2001) *Building a Safer NHS for Patients; implementing An Organisation with a Memory*. London, Stationery Office www.doh.gov.uk/buildsafenhs/ p 39

[44] Department of Health (2001) *Building a Safer NHS for Patients; implementing An Organisation with a Memory*. London, Stationery Office. p 54

[45] Mental Health Act Commission (2001) *Deaths of Detained Patients In England and Wales: A report by the Mental Health Act Commission on information collected from 1 February 1997 to 31 January 2000*. Mental Health Act Commission. Summary available at www.mhac.trent.nhs.uk. Copies of the report are available from the Commission for £7.95 + £1 p&p.

highlighted here because of their significant implications for safety and security. The first is that the assumption that most deaths which are categorised as hanging relate to a suspension or drop from a high point which fatally damages the central nervous system or other vital structures in the neck may be misleading. The nature of the ligatures used in our detailed study suggests that many instances of so-called hanging could be due to strangulation, where a much less robust ligature pulled tight around the neck may cause asphyxiation, reflex cardiac inhibition leading to arrest, or failure of blood supply to the brain. Strangulation of this kind requires neither a fall from a height nor the suspension of the body from a load-bearing point.

4.20 This finding implies that advice on the prevention of suicide requires continued attention to be paid, where there is a substantial risk of suicide, to the removal of a wider range of ligatures than at present, including some seemingly harmless items such as shoe-laces, dressing gown cords and belts. It also requires greater attention to the opportunities provided by some integral components of a normal ward environment such as freestanding cupboards or wardrobes, doorframes, bed frames and low level piping. Perhaps even more importantly, the finding has implications for the nature of observation, since it is much easier to see whether someone is hanging from a height than whether a supine figure is attached to a fixture which might be causing strangulation. The need to train staff in resuscitation techniques appropriate to strangulation also becomes very relevant in the light of this finding.

Recommendation 35

Hospital managers should note the findings of the Mental Health Act Commission report on the deaths of detained patients (see Appendix B):

- **in assessing the physical risks in the ward environment,**
- **in considering the training to be given to staff on the management of episodes of strangulation; and**
- **in considering the physical health of patients on admission.**

4.21 The second finding to which we wish to draw particular attention relates to the location of suicides among detained patients. Of the 168 inquest verdicts considered, 38 (23%) of the patients concerned killed themselves while on authorised leave and 64 (38%) were absent without leave. This has very significant implications for the management of Section 17 leave and for the prevention and management of patients absent without leave, both of which are considered below. That the remaining 151 patients whose deaths were considered at inquest were neither on leave or AWOL should give rise to concerns about the safety of inpatient units.

4.22 We hope to work closely with the Director for Mental Health, Professor Louis Appleby, in pursuing the issue of patient deaths in the light of the publication of the first five-year report of the National Confidential Inquiry[46] and of the work that continues to be done within Professor Appleby's Department at Manchester University on Sudden Unexplained Deaths.

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[46] Department of Health (2001) **Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness**. London, Stationery Office.

Section 17 Leave

4.23 The finding that one in five suicides occurs while the patient is on authorised leave suggests that the management of Section 17 leave could be improved. We recognise that detaining authorities must balance the need to encourage self-reliance and normalisation against the risks involved in greater freedom for patients and has noted many examples of good practice in this. Nevertheless, Commissioners continue to see far too many examples of poor practice in the granting of Section 17 leave.

Recommendation 36

Hospital managers should ensure that sole discretion for the granting of authorised Section 17 leave is NOT left to the supervising nurse alone but is approved ONLY:

- **following consultation with involved professionals to ensure that the patient's needs for health and social care are fully assessed and addressed by the care-plan (see Code of Practice, paragraph 27.5), all of which should be recorded in the patient's clinical record;**
- **following a detailed risk assessment which is similarly recorded;**
- **with carefully considered contingency plans, including contact telephone numbers;**
- **with clearly set down parameters, including the time of return;**
- **with clearly set down supervision arrangements;**
- **with a copy of the Section 17 leave form given to the patient, and to the carer, if appropriate.**

4.24 Monitoring the use of Section 17 against these requirements will be a high priority for the Commission during the next two-year period.

4.25 Commissioners have noted a number of examples where Section 17 leave forms state that patients have been allowed leave when "escorted" by family members or friends. The implication of such a statement is that the patient would be in the legal custody of relatives while on leave (thus also implying that relatives would have specific legal powers and responsibilities to detain and convey if the patient breaks the leave conditions). In these circumstances Commissioners question whether delegating such legal responsibility to relatives or friends is appropriate or even intended. Managers are reminded that whenever a patient is to be escorted by someone other than a member of staff, that person must be given written authority by the hospital managers (Section 17(3)). In the absence of such authority it would be more appropriate to use the term "accompanied" rather than "escorted".

Section 18 and Patients Absent Without Leave (AWOL)

4.26 In our Seventh Biennial Report we emphasised the importance of clear policies to enable staff to take appropriate action when a patient goes absent without leave[47]. It is unacceptable to note that some service providers have still to develop and implement policies to deal effectively with

[47] Mental Health Act Commission (1997) **Seventh Biennial Report**. London, Stationery Office. pp51

this, as required by the Code of Practice (paragraph 21.5). This failure is even more regrettable in view of our finding that one third of the deaths by suicide mentioned above occurred when the patient was absent without leave.

Recommendation 37

Hospital managers should ensure that AWOL policies and procedures clearly indicate:

- **when the patient should be regarded as AWOL;**
- **who has responsibility to return the patient;**
- **which staff are authorised under Sections 137 and 138 to act to take a patient into custody, convey or detain;**
- **what the expectations are of the police in terms of finding and returning patients; and**
- **who should take charge of the AWOL procedure, and how they should determine:**
  - **who should undertake a local search and the extent of the local search;**
  - **when a wider search should be undertaken and by whom and what areas should be searched;**
  - **when to contact the police;**
  - **when to contact the carers or relatives.**

4.27 Patients who are absent without leave are frequently located in a different area from that served by their detaining authority. There is no nationally agreed protocol for arrangements to return such patients, although it is clearly the responsibility of the detaining authority to arrange the conveyance of a patient back to hospital. One of a number of examples which Commissioners have found of the kind of problem this causes was of a patient who had been detained at a registered mental nursing home for "out of area" treatment. The referring NHS Trust had not made clear to the registered home that the patient had a history of absconding and had not discussed the risks that this presented with those who would be responsible for the patient's detention. Consequently, proper arrangements were not made to avoid the patient going AWOL and, when she did do so, the nursing home was ill-prepared, both in terms of having clear policies and in having experienced and available staff, to arrange for her safe return. No significant harm came to the patient in this instance, but it could easily have done so.

Good practice example.

Wirral and West Cheshire Community NHS Trust have adopted procedures that could serve as a useful model for other Trusts. The main points of this protocol are as follows:

- **The responsibility for the safe return of an AWOL patient rests with the detaining authority.**
- **Transport should be by ambulance, with an escort of staff from the detaining authority in accordance with identified risks.**
- **Where a detaining authority cannot arrange immediate transport, the service provider in whose area the patient has been located should take the patient into custody pending such arrangements. The detaining authority must provide faxed authorisation for this, and should also provide copies of the patient's detention papers.**
- **The police should only be involved in either custodial or transportation arrangements where absolutely necessary.**

Contact: XXXXXX Wirral and West Cheshire Community NHS Trust, St Catherine's Community hospital, Church Road, Birkenhead, Merseyside, CH42 OLG. Tel: 0151 678 7272

Recommendation 38

The Department of Health should ensure that national protocols are established, encompassing all service providers, to ensure clarity and accountability in all instances where a patient is located out of area, whether by arrangement or because the patient has crossed boundaries without the knowledge of the detaining authority.

Safety in the Administration of Medication

4.28 In considering the administration of medicine, the greatest attention is usually paid to matters of consent, whereas what is just as important for the safety of the patient and others is that the appropriate drugs or other medicines are being prescribed and administered. This can have a significant effect not only on the safety of patients, but also on their ability to function well on leave or discharge. The role of Second Opinion Appointed Doctors (SOADS) is crucial to this aspect of treatment where consent has not been given, but in all cases the administration of medication should be subject to rigorous clinical scrutiny. The Commission encourages Hospital Managers to use the expertise of pharmacists as one such safeguard.

Recommendation 39

A pharmacist should check that:
- **Forms 38 have been authorised by the RMO;**
- **that they are accurately reflected in the medication chart, and:**
- **that they comply with the RCP guidance**

before releasing any prescription. This also provides a useful check on any combination of medications which might be counter-productive.

Pharmacists should also check medication charts against Forms 39 where issued.

4.29 The Royal College of Psychiatrists has issued advice on dosages above the British National Formulatory (BNF) limits which should be adhered to by all psychiatrists[48]. In this connection, it is particularly important that RMOs and nursing staff are aware of aspects of the patient's past history and behaviour, or changes in current behaviour, weight or other relevant factors, which might affect his/her response to the prescribed medication. Good record-keeping is essential to such an awareness.

Recommendation 40

All service providers should obtain a copy of the Royal College of Psychiatrists' guidelines on doses above BNF upper limit for distribution to their staff.

[48] Royal College of Psychiatrists Council Report CR26: consensus statement on the use of high-dose antipsychotic medication. A useful and readily available summary of this statement is reproduced at the beginning of Chapter 4.2 of each edition of the British National Formulary.

4.30 The generally high standard of medical record keeping is often commented upon by Commissioners during their visits but poor practice is sometimes found in the wider aspects of the administration of medication. It is the responsibility of the Responsible Medical Officer (RMO) to keep clear, accurate, and contemporaneous patient records which report relevant clinical findings, decisions made, information given to the patient and drugs or other medication prescribed. Good clinical governance is needed to ensure that the relevant information is accurately transferred to the medication charts used by those who administer the medication and that nurses check that what they are giving accords with the RMO's original decisions.

4.31 The Commission has published guidance to nurses on the administration of medication and the Act[49] which has been endorsed by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

Recommendation 41

Hospital managers should ensure that clear policies on the prescription and administration of medication have been agreed and that compliance is regularly audited.

Particular Management Problems

4.32 Patients who are compelled to enter or remain in hospital under the Mental Health Act 1983 may, perhaps more than any other patient group, behave in such a way as to disturb others around them, or to present a risk to themselves or to those charged with their care.

4.33 The very fact of compulsion, coupled with the severity and type of mental disorder being experienced by some detained patients, is likely to be a significant causative factor in this problem behaviour. However, as emphasised above and in Chapter 3, the following often very evident causes can all too easily be overlooked:

- an unsuitable mix of patients;
- boredom and lack of environmental stimulation;
- too much stimulation, noise and general disruption;
- overcrowding;
- antagonism, aggression, or provocation on the part of others;
- influence of alcohol or substance abuse; and
- the rewarding of undesirable behaviour by attention.

4.34 Many of these factors can be eliminated or reduced by effective management policies. During their visits Commissioners have witnessed a wide variety of good practice in this respect. In dealing with patients needs, however, it is important to remember that the key to successful

[49] Mental Health Act Commission (2001) *Guidance Note 2/2001: Nurses, the Administration of Medicine for Mental Disorder and the Mental Health Act 1983*. Available from the Commission or at www.mhac.trent.nhs.uk.

intervention lies with the staff, whose own needs must not be overlooked. A typical example of the many adverse effects of failures in the infra-structure (see Chapter 3.9 *et seq.*) is of one ward where Commissioners found that 50% of the E grade nursing staff had left during the past three month period and that the Deputy Ward Manager was on sick leave after an assault by a patient. This had resulted in tremendous pressure on nursing staff, who were all doing extra shifts. The Ward Manager, as an example, was doing three extra shifts during the week of the visit, adding 17.5 hours to her normal 37.5 hour week. This is good for neither staff nor patients.

Violence against staff

4.35 One of the key components adding to the pressures on staffing levels (see Chapters 3.98 et *seq.*) appears to be the increasing problem of violence and aggression directed towards staff by patients. We therefore welcomed the launch of the high profile *Zero Tolerance* campaign by the Department of Health in October 1999, and are extremely pleased to note the resources now available on the NHS Zero Tolerance Zone website[50]. We commend this website to all mental health service managers, whether they work within the NHS or the independent sector. The site contains resources specific to mental health services, giving good practice examples and contacts, and the facility for case studies to be submitted by e-mail.

4.36 We are glad to note that the campaign's focus extends to a consideration of the causative factors for patient violence, and recommends risk-assessment and prevention as well as methods of dealing with aggression when it occurs.

4.37 We are also pleased to note the establishment of the National Task Force on Violence Against Social Care Staff[51] in September 1999 and the Minister's acceptance and endorsement of their interim report in March 2000. The National Action Plan, rolled out from January 2001, aims to introduce measures designed to promote the safety of all social welfare workers. We welcome and support the work of the National Task Force and hope that the Department of Health will give full consideration to its recommendations.

Seclusion

4.38 Commissioners make a practice of visiting any patient in seclusion on the day of their visit and monitoring the use of seclusion will be a high priority for the Commission during the next two years.

4.39 The Code of Practice describes seclusion as the supervised containment of a patient in a room which *may* be locked (paragraph 19.16). Seclusion may be used only for the containment of severely disturbed behaviour that is likely to cause harm to others, and should not be used for any other purpose. We deplore the practice of secluding patients under other guises, such as "cooling-off", particularly when such practices are not recorded or monitored as episodes of

[50] website address: www.nhs.uk/zerotolerance
[51] website address: www.doh.gov.uk/violencetaskforce

seclusion. The definition of 'seclusion' is not dependent on whether the door to the room is locked or even closed.

Recommendation 42

Hospital managers should audit the use of seclusion regularly to ensure that it is properly used.

Where the use of seclusion appears excessive, a seclusion reduction plan should be produced which includes monitoring the effects of any change in management regime on the attitude and behaviour of patients.

4.40 Commissioners frequently encounter the following particular areas of concern in relation to the proper use and recording of seclusion:

- **Poor design of seclusion rooms.** Facilities that are structurally inappropriate continue to be used. Commissioners have drawn attention to rooms with blind spots, inwardly opening doors (enabling patients in seclusion to prevent access to the room) and dangerous fittings, such as sharp corners and even ligature points.
- **Poor access to seclusion rooms.** Particularly when seclusion facilities are shared between non-connected wards or sited away from the wards that they service, getting patients into seclusion can be a dangerous and demeaning task. Commissioners have encountered facilities where, for example, patients requiring seclusion had to be taken down two floors through a busy part of a main hospital, or down dangerous staircases and through several sets of doors.
- **Poor regard for privacy and dignity** A number of seclusion rooms fail to provide dignified facilities. Many of these are barely furnished, if at all. One particularly poor example had only a cardboard potty for toilet facilities and broken air-conditioning. Another room had one way glass that prevented the patient from seeing out but allowed the rest of the ward to see in.
- **Poor documentation of observations** Commissioners often criticise the recording of observations. Records are often cramped and illegible, or simply fail to record that medical and nursing reviews are being carried out in accordance with the guidance in the Code of Practice (paragraph 19.20).
- **Poor recording of reasons for seclusion** For example, one record stated only that "behaviour has become increasingly chaotic and unpredictable, aggressive and wanting to leave the ward". Entries in the seclusion register should be clear and in accordance with the grounds for seclusion stated in paragraph 19.16 of the Code of Practice.
- **Use of seclusion facilities for other purposes**, blurring the distinction between seclusion and other situations. One facility was used as the seclusion room, a "time-out" room post-medication and an occasional bedroom for a patient who wished to sleep away from the clamour of the ward. The limitations of the ward area should not allow for the seclusion room to be used as a bedroom, quiet room or time out area.

- **Problems with the prompt attendance of a doctor,** if the doctor is not involved in initiating seclusion. The Code of Practice requires the immediate attendance of a doctor if seclusion if for more than five minutes (paragraph 19.19).

Where Commissioners encounter such problems on visits they will continue to expect immediate remedial action by the hospital managers.

4.41 A different kind of example of poor practice is failure to recognise relatively minor matters which may have an adverse effect on the sensory impact of seclusion. One such example is not knowing the time, which may also cause confusion for the patient. Respect for the individual should ensure that, wherever possible, seclusion rooms have a clock visible to the patient.

Recommendation 43

Hospital managers should take all the current areas of concern identified by the Commission into consideration when auditing their arrangements for seclusion

4.42 In our Eighth Biennial Report we provided detailed guidance on seclusion practice that was intended to be read alongside the broader guidance in the Code of Practice. This guidance, which is summarised in figure 5 below, is now endorsed by the NHS Zero Tolerance Campaign[52]. Services that use seclusion should ensure that their policies address these issues.

[52] Department of Health (2001) **NHS Zero Tolerance Zone. Managing Violence in Mental Health. Resource Sheet Update: Seclusion**, www.nhs.uk/zerotolerance/mental/seclusion.htm

Fig 5 : Advice on Seclusion from the Commission's Eighth Biennial Report

Periodic reviews of seclusion (as required by the Code of Practice, para 19.21) should :

- Include an assessment of the mental state of the patient, being alert to the potentially harmful psychological consequences of seclusion, such as:
  - feelings of increased despair and isolation;
  - anger;
  - worsening of delusions and hallucinations; and
  - the effects of sensory deprivation.
- Include an assessment of the physical state of the patient, taking account of:
  -level of consciousness;
  -respiration rates; and
  -pulse rates,
- If practicable, particularly if the patient has been administered psychoactive drugs, the patient's temperature and blood pressure should also be recorded.

For all patients in seclusion, care must to taken to ensure adequate intake of food and fluids (particularly in terms of avoidance of dehydration) and urinary output monitored.

Patients in seclusion should retain as much of their *own* personal clothing as is compatible with their personal safety, but shoes, boots (and laces), belts and ties, dressing gown cords and jewellery can present particular dangers.

The 'care and support' provided to a patient after an episode of seclusion (Code of Practice para 19.17) should include, at the earliest possible safe moment, an opportunity to discuss the events leading to seclusion and the seclusion itself with the clinical team. Whilst such a discussion should be tailored to the individual patient, staff should seek to:

- assess any adverse effects of seclusion;
- recognise with the patient that seclusion can be traumatic;
- explain why it was necessary to institute seclusion;
- seek the patient's views (particularly in terms of possible alternatives to seclusion);
- jointly consider future alternative means by which the patient may express anger without recourse to violence; and

record any comments or complaints that the patient wishes to make.

4.43 We are pleased to note that some Trusts, such as Portsmouth Healthcare NHS Trust, do not use seclusion at all. Many other services have reduced their use of seclusion significantly. Rampton Hospital is an excellent example of the way in which a range of management responses is used to avoid the use of seclusion.

Good practice example

Reduction in Seclusion in the Men's Intensive Care Ward, Rampton Hospital Authority

Over the last two years, the men's Intensive Care Ward at Rampton Hospital has reduced incidences of seclusion by 76%, and the average duration of seclusion episodes by 85%.

This achievement has resulted from a number of factors, some of which are highlighted below:-

Leadership - Adjustments in the balance of clinical and managerial skills have facilitated the implementation of revised seclusion policies and procedures. The Commission has noted that the ward manager's management style, clinical skills and commitment to education has been a crucial element in the personal development of each member of the nursing team.

Monitoring - New policies ensured that all confinements of patients in locked or unlocked facilities were classified as seclusion and carefully recorded and reviewed by ward staff and multi-disciplinary teams.

Use of alternative management techniques - Commissioners have observed the effective use of de-escalation techniques on the ward.

Nursing skills - The Commission has noted improved care plans, named nurses having regular one-to-one sessions with patients, and regular nursing reviews. The increase in the number of qualified staff has undoubtedly improved standards of care.

Attention to patient mix - The number of patients on the ward was reduced by one third. This has reduced overcrowding, over-stimulation of patients through noise and general disruption, and poor patient mix. As a consequence, there is now a greater turnover of patients.

Attention to environment - Efforts have been made to create a non-institutional environment. The ward has been refurbished, paying close attention to décor arrangement of furniture. The daytime area has been arranged into smaller sitting areas with furniture arranged to facilitate communication. Areas affording privacy are designated for specific activities such as the occupational therapy room, interviewing room and telephone area. There is access to an open space under supervision.

Attention to patient activities - Two occupational therapists have been employed, enabling individualised and patient-focussed programmes to be developed in consultation with patients and their named nurses.

Contact: XXXXX Rampton Hospital , Retford, Nottinghamshire, DN22 OPD Tel: 01777 248 321

4.44 We hope that the above achievements can be extended to women patients at Rampton Hospital. At Ashworth Hospital, the Commission and Women in Secure Hospitals (WISH) approached the hospital managers over the practice of denying access to sanitary protection products to women held in seclusion. After discussion, it was agreed that the practice is not acceptable and women who would be deemed at risk if secluded with sanitary protection are now nursed 2:1 as an alternative. We hope that the experience of this change of policy and practice will aid the hospital in its review of seclusion procedures for all women patients, and further help to reduce the use of seclusion and encourage the exploration and implementation of alternative strategies. Issues specific to women's services are discussed further at Chapter 6.33 – 6.39).

The use of Control and Restraint

4.45 The Commission recognises that physical interventions to control and restrain patients' aggressive and dangerous behaviour are sometimes necessary in the interest of the safety of patients and staff. The Code of Practice gives clear and specific guidance on the use of control and restraint (paragraphs 19.6 - 19.14), which the Commission expects to be followed at all times.

4.46 In our Eighth Biennial we reported our concern over the increasing use of misleading terminology such as "care and responsibility" or "care and reassurance" that cloaks the nature of control and restraint.[53]. It is likely that this increases the frustration of patients who have been subjected to control and restraint, who will often perceive the intervention as an exercise in power. It also short-circuits discussion between patients and staff over the events that led to control and restraint and the actions of staff. Such discussion is essential as a learning opportunity for both patients and staff.

Recommendation 44

Hospital managers should ensure that care and support is available to patients who have been subject to control and restraint interventions, in addition to the visit to the patient by a senior officer which is required at paragraph 19.13 of the Code of Practice.

4.47 Our report on *Deaths of Detained Patients* (see paragraph 4.17 *et seq.* above) noted 22 cases in which restraint had been used before death. In the 17 cases where an inquest had been completed at the time of writing, two deaths had occurred while the patient was being restrained and in four cases restraint had been used during the preceding twenty-four hours. It is clearly very important in such cases to establish immediately how far, if at all, the use of restraint may have contributed to a simultaneous or subsequent death.

4.48 In this reporting period we have noted a number of uses of the police in full riot gear in response to situations of wards where patients are detained. Such uses may have been entirely justifiable, but their incidence remains a concern. Further concerns were raised by the well-publicised incident leading to the Sines Report[54], where two teams of staff wearing riot-gear, including balaclavas under helmets with visors, were used for an internal transfer within a High Security Hospital. Such incidents, as well as our findings about deaths following or during control and restraint, reinforce the need for rigorous monitoring and evaluation of the use of these powers, which should always be a last resort.

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[53] Mental Health Act Commission (1999) **Eighth Biennial Report** London, Stationery Office. p 225

[54] Sines D (1999) **Independent Investigation into Complaints Raised by Ian Stewart Brady Relating to His Transfer to Lawrence Ward and Re-feeding at Ashworth Hospital**.

Recommendation 45

Hospital managers should ensure that each use of control and restraint techniques is immediately reviewed, with regular audits to ensure that poor practice is eliminated and management and training lessons are learnt.

4.49 Any initial attempt to restrain aggressive behaviour should, as far as the situation will allow, be non-physical. Where physical restraint is used, it is essential that any staff involved are adequately trained. A lack of training in control and restraint techniques is a common finding on Commission visits. We are very encouraged at the work being undertaken by the British Institute of Learning Disabilities (BILD), whose practice guidelines for physical interventions in relation to adults and children with Learning Disability and/or Autism should be published later this year[55], and the Royal College of Nursing (RCN), whose working party is considering principles of good practice for control and restraint training[56]. The RCN's work, which will aim to establish generic guidance for the curricula and content of training courses, is particularly welcome given our concerns, stated in our last two Biennial Reports[57], over the proliferation of unregulated training courses which often give conflicting advice in this field. We have been involved in the UKCC's work relating to "the recognition, prevention and therapeutic management of violence in mental health care", the consultation document of which was published in January 2001. We look forward to the publication of the definitive document later in 2001.

4.50 The Code of Practice recommends that any training provider in control and restraint techniques should be suitably qualified, having completed a course designed for health care settings that has "preferably" been validated by either the English National Board or Royal College of Nursing Institute (paragraph 19.9). In our response to the Green Paper on the Reform of the Mental Health Act (**Appendix E**, paragraph 37) we urged the Government to introduce statutory regulation of the powers to exercise control and restraint. Such regulation should encompass both the initial provision of training to staff and requirements for refresher training.

Recommendation 46

New legislation should include provision for the regulation of the power to exercise control and restraint.

Locking of wards

4.51 The Code of Practice recognises that some services require secure environments and will therefore operate locked wards. Usually such services will be in the medium or high security sector, and locked wards may be necessary in the professional judgement of the RMO or may

[55] See www.nhs.ukzerotolerance/mental/physical/htm
[56] See www.nhs.uk/zerotolerance/mental/principles.htm

even be a requirement of a court. Guidance on locked wards and secure areas, which stresses the importance of a proper consideration of each affected patients' individual circumstances and needs, is found at paragraphs 19.28 – 19.29 of the Code of Practice.

4.52 For most services operating at a lower security level, the Code suggests that staffing levels should be sufficient to prevent the need to lock wards, individual rooms or other areas. However, the Code also states that the nurse in charge of any shift, who is responsible for the care and protection of patients and staff and the maintenance of a safe and secure environment, has discretion to lock the ward door if the behaviour of patients makes this necessary. The Code gives precise guidance on the correct procedure to be adopted if this circumstance arises (paragraph 19.25). We have found, nevertheless, that some lower security services seem reluctant to allow staff this discretion, which is clearly of considerable relevance to the finding mentioned above (paragraph 4.21) that one third of detained patient suicides occur whilst the patient is absent from hospital without leave.

4.53 By contrast, we continue to find wards that appear to be kept continually locked as a result of the inadequate number or management of staff, rather than because of any inherent management problems of the patients. This is a misuse of the power of compulsion, especially since some of the patients on these wards will not be detained under the Mental Health Act.

4.54 Some units, particularly those based in cities, lock wards to keep intruders out rather than to keep patients in. Where there are issues such as illicit drug dealing around the hospital (see paragraphs 4.55 – 4.61 below) or theft of items from the ward, services may have little choice but to impose some such form of security. Such measures should never impede the free movement of patients whose clinical needs do not warrant such restrictions.

4.55 The contrast between those places where wards are not locked when they should and those where they are locked when they should not be underlines the need to balance the need for patient and staff safety against the need to ensure maximum autonomy for patients. This in turn reinforces the responsibility of management for establishing clear policies on the locking of wards.

Recommendation 47

Service providers should ensure that there are clear service-wide policies on the locking of wards and that compliance is regularly audited. The frequency of locking of doors on non-secure wards should, in particular, be scrutinised to establish whether this indicates problems with day to day practice or with inadequate staffing. In both instances, the appropriate remedial action should be taken.

[57] Mental Health Act Commission (1997) **Seventh Biennial Report** p 168, Mental Health Act Commission (1999) **Eighth Biennial Report** p 226

Drugs and alcohol misuse

4.56 On numerous occasions nursing staff draw the Commission's attention to the problem of drug and alcohol abuse on wards and the extreme difficulty of caring for patients with widely differing needs and expectations. The problems identified range from the effect of disturbed and aggressive behavior on the care and treatment of quieter patients and the difficulties in preventing street drugs entering the ward to the inappropriate use of seclusion facilities for the admission of intoxicated patients. Staff on acute wards have frequently reported that a large proportion of emergency admissions are drug related. The incidence of drug misuse appears to compound the amount of aggression experienced by staff, and in some instances by patients, and adds very significantly to the pressures ordinarily experienced in acute wards.

4.57 Many health services operate policies whereby all patients who enter their facilities are asked to sign contracts or declarations stating that they will not use drugs or alcohol whilst rresident there, and agree to the searching of their possessions or the taking of blood, urine or breath samples where there is suspicion of possession of drugs or alcohol. Such contracts can be useful as a way to reach an understanding with patients about the expectations of their behaviour whilst in the care of the service, although it is unclear what, if any, effective sanctions are available to a detaining authority if the patient is compelled to enter and remain in such care by the Mental Health Act.

4.58 In many cases an appropriate response of affected hospitals is to review their security, ensuring that the personal safety of staff and patients is as good as possible and reducing opportunities for bringing drugs and alcohol on to the premises. Some measures that should be considered on safety grounds where a patient is suspected or known to be using drugs or alcohol are: increasing observation levels; restricting leave; searching property, limiting or supervising visits; and transfer to higher security. Such measures should only be taken as a result of objective, multi-disciplinary risk-assessment on the basis of clinical need, and never as punitive sanctions[58].

4.59 In our Sixth, Seventh and Eighth Biennial Reports we raised concern over the lack of effective guidance given to service providers on the difficult issues surrounding substance misuse and its control and management amongst detained patients[59]. Although we have repeatedly highlighted the widespread lack of policy guidance on this issue, both at a national level and in the individual policies of hospitals, we must do so once again. All too often, hospital staff are not provided with effective policy guidance on what actions they can or should take when they suspect or know of substance misuse.

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[58] Williams, R and Cohen, J (2000) ***Substance use and misuse in psychiatric wards; a model task for clinical governance?***; in **Psychiatric Bulletin 24**, 43-46. See also Cohen, J, Runciman, R and Williams, R (1999) ***Substance Use and Misuse in Psychiatric Wards*** in **Drugs: education , prevention and policy** Vol 6, No 2 1999. Carfax Publishing.

[59] Mental Health Act Commission (1995) **Sixth Biennial Report** . London, Stationary Office p105 – 107; Mental Health Act Commission (1997) **Seventh Biennial Report**. London, Stationary Office. p 166 – 167; Mental Health Act Commission (1999) **Eighth Biennial Report**, London Stationery Office p231 - 4

4.60 A number of hospitals have created their own local policies and some of these are commendable, although their preparation would have been eased by central guidance:

Good Practice Example

Tameside and Glossop Community and Priority Services NHS Trust operate a locally-produced *Policy for the Management of Illicit Drug Use Incidents in Mental Health Services,* which is linked with the hospital's health and safety policy. The policy sets out actions expected of staff when faced with a variety of situations involving patients or visitors, and includes guidance on what staff can and should do when taking possession of illicit substances, whether through confiscation or other means.

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4.61 At the time of writing, elements of this policy were being reviewed on the advice of the Trust solicitor. Whilst all policies should be reviewed periodically, the need for this review indicates how useful centralised guidance from the Department of Health would be.

Recommendation 48

The Department of Health should consider issuing guidance on the management of illicit-drug related incidents with a particular focus on mental health services caring for detained patients. Such guidance should clearly set out:

- **expected actions where there is a suspicion of illicit drug use or supply, or of alcohol consumption, whether by patients or visitors;**
- **expected actions where there is knowledge of illicit drug use or supply, or of alcohol consumption, whether by patients or visitors;**
- **powers of staff to search for and confiscate illicit drugs or alcohol;**
- **reassurance on the powers of staff to handle and dispose of illicit drugs that come into their possession;**
- **expected arrangements with police services over issues relating to illicit drugs; and**
- **expectations of service agreements between mental health services and drug and alcohol teams in relation to patients presenting with dual diagnosis or co-morbidity.**

Recommendation 49

Mental health service providers should ensure that

- **clear policy guidance on the management and prevention of incidents involving alcohol and illicit drugs is available to staff; and**
- **that they have written service agreements with drug and alcohol teams for the joint management of patients with dual diagnosis or co-morbidity.**

A Systematised Approach to Risk Management

4.62 Nearly every item to which attention is drawn in this Chapter has emphasised the importance of clear policies to protect both patients and staff and the need to introduce rigorous monitoring and audit processes to ensure that they are adhered to. A systematised approach to risk

management is at the heart of all the recommendations made. This involves the proper assessment of risks and the devising of strategies to minimise them in every area of management, whether relating to the environment, the allocation of patients, their care while in hospital and their grant of leave or discharge, or to the health and safety of staff. [60]

4.63 We urge detaining authorities to adopt a stringent and pro-active risk management culture in all mental health units. Risk assessment is not simply a paper exercise but an essential tool to enable managers, staff and patients to feel more safe in a hospital environment and to have the confidence to take reasonable risks. The feeling of safety and confidence is one of the main constituents without which a truly therapeutic environment cannot be established. Commissioners find in all too many instances that risks are assessed in a haphazard and non-objective way, or not at all. There is therefore no chance of either managers or staff learning to incorporate risk assessment into their way of thought and behaviour so that it becomes second nature rather than an impediment to positive action.

Recommendation 50

Service providers should ensure that a full risk management strategy is introduced for all their services and that appropriate training, recording and audit are provided to ensure compliance with it. Such a strategy should include evaluation of the adequacy of existing arrangements and the need for additional measures, common systems for incident reporting, regular review systems to re-assess the risks, and a continuing programme of staff development in the assessment of risk.

Some of the main matters which must be taken into account are:

- **environmental risks, including those from equipment and to staff as well as to patients**
- **risks from patients of harm to self or others, including not only the nature of the illness or overt threats, but also objective assessments of family history, criminal record, substance misuse, absconding, trigger points, who is most likely to be harmed and how, and other relevant factors**
- **need to ensure that information is systematically recorded and passed on immediately when a patient moves to another location, is allowed leave or is discharged, as well as being made readily available to all relevant staff.**

[60] United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) Guidelines for Mental Health and Learning Disabilities Nursing. London, UKCC p22.

5 High Secure Care after the Fallon Inquiry

5.1 The issues raised in relation to inpatient care throughout this report are almost all relevant to the three High Security Hospitals serving England and Wales (Ashworth, Broadmoor and Rampton hospitals), as is evidenced by the use of illustrative practice vignettes from these hospitals in other chapters. The merger of Broadmoor and Rampton Hospital Authorities with their respective local NHS Trusts gives a clear sign that high security services can no longer be considered in isolation from mainstream psychiatric hospital care. We welcome this assimilation as a positive move towards an integrated service where institutions providing all types of security can learn from and teach each other. We also recognise that this process may present a challenge in terms of protecting gains in good practice prior to the mergers, and in ensuring that senior management of the new Trusts maintain a close involvement with the High Security Hospitals as institutions.

5.2 The last two years have been a period of considerable change, specific to the High Security Hospitals, stemming from the report of Sir Peter Fallon's inquiry into the Personality Disorder unit at Ashworth Hospital[61]. In response to a recommendation made in this report, the Government commissioned a review of security at the three hospitals, culminating in the report by Sir Richard Tilt[62] and the subsequent issue and implementation of new Security Directions for the hospitals[63].

5.3 These matters are of such consequence to the care of the patients in the hospitals that they are dealt with specifically in this chapter.

Inappropriate placements in high secure care

5.4 The Tilt Report's recommendations on security at Ashworth, Broadmoor and Rampton hospitals (see paras. 5.21 onwards below) were acknowledged to be made on the assumption that these hospitals provide care and treatment to patients who require conditions of high security. The report itself recognised that this was not the case in relation to roughly a third of the hospitals' population, as 436 patients were in the hospitals' transfer/ discharge system at the time of the review [64]. The report stated that

> *we regard it as inappropriate, both from a civil liberties and efficient use of resources viewpoint, for a patient who can safely be accommodated in less secure conditions to remain in a high security setting for lengthy periods*[65].

[61] Department of Health (1999*) Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital*. Cm 4149-11. London, Stationery Office
[62] Department of Health (2000) *Report of the Review of Security at the High Security Hospitals*. London, Stationery Office
[63] The Safety and Security in Ashworth, Broadmoor and Rampton Hospitals Directions 2000 www.doh.gov.uk/hospitaldirections
[64] Report of the Review of Security at the High security hospitals p. 11
[65] Report of the Review of Security at the High Security Hospitals p. 12

5.5 The very first recommendation of the report was that the additional funding (£25 million) already identified to deal with the problem should be deployed over the period 2000 – 2003, to "be used in the first instance to facilitate the movement of patients no longer needing high secure care"[66]. The report concluded that the movement of such patients would be "a crucial step towards ensuring that the hospitals are really fulfilling their true purpose of providing a service for people who require high security psychiatric care at the time when they genuinely need it"[67].

5.6 At the end of April 2001, over two years from the publication of the Tilt Report, figures available to the Commission indicated that there were 349 patients in the transfer/discharge system within the High Security Hospitals. While we accept that transfer and discharge from the hospitals is a careful process, and that some patients officially included in these lists may not be ready for immediate transfer, this is still 27% of the total patient population of the three hospitals. This does not take account of the numbers who are not yet on the list because there is no realistic hope of finding them alternative accommodation (see paragraph 5.8 below).

5.7 The high proportion of patients who are ready to move to lower security levels and the integration of the High Security Hospitals with local NHS Trusts have a particular significance with regard to Broadmoor, where £29m has been committed to build a new perimeter wall. We hope that, since both these changes may affect the use to be made of the site for patients requiring high security, this decision may be reconsidered in the light of other pressing priorities highlighted in this Chapter.

The Effects of Bed Pressures on the Movement of Patients from High Security Care

5.8. The intended destinations of most patients who are ready to leave the high security sector are medium secure places. All three High Security Hospitals continue to report difficulties in locating available places. It is therefore probable that, in addition to the patients who are formally counted as being within the transfer/discharge system, there is a further group of patients who are not included because there is no realistic prospect of finding a suitable alternative facility to admit them[68]. As a result it is likely that neither the Tilt Report nor the Commission has accurately reflected the true number of patients in these hospitals who could safely be transferred out.

5.9 Much more needs to be done to facilitate the freer movement of patients within psychiatric services. The problem must be approached holistically, as it is clear that the silting up of beds across the whole of mental health services is hampering the movement of patients within and across all security-levels. The bed-pressures across the service (see Chapter 3.4 – 3.8) are such that patients who require a level of security other than the one in which they reside often have to wait an unacceptable length of time to be allocated a place.

[66] Report of the Review of Security at the High Security Hospitals p. 47
[67] Report of the Review of Security at the High Security Hospitals p. 12
[68] Report of the Review of Security at the High Security Hospitals p. 11

5.10 There remain significant funding difficulties in effecting transfer from high secure to medium secure beds. Most NHS medium secure units are intended for shorter-stay patients and may not, for example, have the facilities or expertise to take personality disordered patients. This leaves forensic services largely dependent on the independent sector and Out of Area Treatment funding from their patients' health authorities for longer-term placements. In a number of instances, health authorities have been reluctant to provide such funding. In this context, we are particularly concerned to learn that a number of medium secure units have explicitly stated that they will not accept patients with personality disorder from Ashworth Hospital and that this is increasing transfer delays for this group of patients. We will continue to express our concern on these issues to the relevant regional authorities and will press for action in individual cases.

5.11 For patients waiting to move to lower levels of security, transfer delays hold up their effective treatment, infringe their civil liberties and create tensions in the management of the facilities. This is particularly relevant in the case of High Security Hospital patients awaiting transfer, given the changes in culture at these hospitals in the wake of the Fallon Inquiry.

Bed Pressures within the High Security Hospitals

5.12 All three High Security Hospitals are experiencing bed pressures within their hospitals, leading to delays in admissions and in the movement of patients already admitted within the hospitals themselves.

5.13 In the case of patients residing in low and medium-secure care who require admission to higher security services, the lack of available beds has led to dangerous situations for the patients, staff and, potentially, the general public. The nursing of such patients greatly increases the burden on staff and other resources in low and medium-secure units, often to the detriment of other patients' care. On occasion, the only way in which low-secure units can manage such patients is through 1:1 or 2:1 nursing, or even the use of seclusion for long periods. Such treatment of patients is far less humane and effective, and results in a far greater curtailment of the patient's liberty, than that which would be available to the patient in an appropriately structured and secure environment (see Chapter 3.4 *et seq.* on bed pressures in general services).

5.14 Throughout the current reporting period we have remained concerned about the pressure on beds within the High Security Hospitals. As the hospitals are almost invariably full and have waiting lists, there is little flexibility in the system. We remain concerned about the inability of the hospitals to provide appropriate clinical pathways for patients admitted to their care:

- At the beginning of their treatment, patients frequently remain on admission wards for anything up to year after their admission case conference. As a consequence, the commencement of treatment programmes is often delayed and the patient-mix on the admission wards is such that meaningful therapeutic activity is almost impossible.

- If a patient becomes particularly ill and requires treatment on one of the intensive care wards, their original bed is not always retained. Patients are consequently stranded on the intensive care wards much longer than their clinical need would require.

- The patient-mix on many types of ward is too often dictated by available space rather than clinical appropriateness.

- The limited specialist services within the hospitals that work with issues of addiction have long waiting lists. As many of the index offences of patients are in some way linked to the abuse of drugs or alcohol, we urge continued effort to address these issues in all three hospitals (see paragraphs 5.19-5.21 below).

5.15 There is clearly a vicious circle here, with some patients remaining in high security beds because beds are not available at a lower level of security and others being held in lower security than their illness warrants because all the high security beds are filled. We recognise that geographical considerations do not allow for simplistic solutions but we believe that there should be a concerted effort within each NHS Region to see how far it would be possible to make a better match between beds and individual patients. This could well reveal that the shortage of beds is less extreme than it may appear. Meanwhile there needs to be some move to increase flexibility within the high secure hospitals.

Recommendation 51

NHS Regional Offices, Regional Commissioning Bodies (DN Proper name ?) and Health Authorities should investigate the possibility of reviewing all patients in a particular area who are considered inappropriately placed at their current level of security to see how far patient exchanges might reduce mis-match and bed pressures.

Recommendation 52

While the Commission recognises the pressure on high security beds, the possibility of maintaining a number of vacant places should be explored as a way to benefit both patient care and throughput efficiency of the High Security Hospitals.

Staffing shortages within the High Security Hospitals

5.16 All three High Security Hospitals have problems in maintaining adequate levels of medical and nursing staff.

5.17 The struggle to maintain continuity of Responsible Medical Officer cover in the High Security Hospitals is of grave concern. The hospitals are environments where continuity of care is of utmost importance to patients, not least because their chances of being recommended for transfer or discharge may be dependent on an effective alliance between them and their RMO. Some patients have indeed complained that the frequent changes in the consultant responsible for their care has resulted in an over-cautious approach to their rehabilitation. Whilst we have

found no firm evidence to support the patients' view, the perception itself should be seen as a matter of concern to the hospitals.

5.18 Nursing shortages loom large over many of the management problems within the hospitals. It is acknowledged by the hospitals' management that staffing shortages can prevent patients' access to activities and fresh air (see also Chapter 3.20 – 3.30). Commissioners have noted staff working additional shifts to cover the basic requirements of the hospitals. Such staffing issues are of great concern, given their adverse effects on patient care and the provision of a safe and therapeutic environment (see Chapter 4).

The provision of therapeutic interventions within the High Security Hospitals

5.19 At the end of this reporting period the Commission undertook initial research on the provision of therapeutic interventions across the three High Security Hospitals. A number of concerns have emerged at this early stage of our work, particularly in relation to:

- A lack of routinely collated information to enable audit of therapeutic interventions;
- Patients waiting for long periods before psychological assessments are initiated; and
- Patient waiting for long periods to access specialist treatments for specific problems, such as sex offending, alcohol and drug abuse, arson, self-harming and anger management.

5.20 We are also concerned at the increasing cessation of mixed-gender activities and therapies within the hospitals (see Chapter 6.37).

5.21 A high proportion of patients within the High Security Hospital system have particular requirements relating to psychological therapies. It is also the case that restricted patients' failure to engage in psychological therapies, for whatever reason, will be taken into account by the Home Office in considering requests for leave, transfer or discharge. For these reasons, a full range of therapeutic activities and interventions should be a part of every High Security Hospital patient's treatment options. We will be working with the hospitals over the next reporting period to address these issues.

Recommendation 53

High Security Hospital managers should instigate routine monitoring of non-pharmacological therapeutic interventions and audit for gaps in their provision.

Consent to Treatment in the High Security Hospitals

5.22 Notwithstanding the difficult circumstances described above, we are pleased to be able to report significant improvements in the quality of records and practices in relation to patients' consent to treatment in all three High Security Hospitals. In our Seventh Biennial Report we reported serious shortcomings in all three hospitals with regard to ascertaining and certifying patients'

consent[69]. In our Eighth Biennial Report[70] we noted that, with some exceptions, this area still required attention and improvement. It is now the case that bad practice is the exception to an overall improvement across all three hospitals. These improvements have resulted from the auditing of consent documentation and the commitment of medical staff to instill better practices (see also Chapter 2.16 – 2.22, 2.63 – 2.67).

Effects of the Safety and Security Directions on Patient care

An increasing custodial focus?

5.23 Revised Safety and Security Directions have been in force at all three High Security Hospitals from November 2000. We recognise the need for an increased focus on both relational and physical security in the light of the Fallon Inquiry report and the subsequent review of security by Sir Richard Tilt and his team (see paragraphs 5.2 – 5.7 above) and support the strategic goal of these interventions in the management of the hospitals.

5.24 Over the last seven months both staff and patients at the High Security Hospitals have expressed concern to the Commission at some aspects of the implementation of the Directions.

5.25 We are concerned that the implementation of the Security Directions should not impose overly time-consuming and restrictive practices in the hospitals at the expense of therapeutic interactions between staff and patients. These concerns are heightened by the blanket application of the Directions, with a devastating result for some patients, particularly women, those undergoing rehabilitation and those who have lived in the hospitals for many years. We are particularly concerned at the depersonalising and institutionalising effect of some of the measures taken. Some of the many matters raised by patients and/or staff are highlighted in the following paragraphs.

5.26 **Searches**. While recognising the importance of searches as a tool in maintaining appropriate levels of security, both patients and staff point out the large amount of time they consume at the expense of time spent talking to patients, the effect on therapeutic relationships and the huge administrative overhead attached to recording the process.

Recommendation 54

High Security Hospital managers should review searching procedures and documentation to ensure that the Security Directions are being implemented sensibly and that staff time is used appropriately. The review should consider whether staffing levels are sufficient to provide quality care to patients given the demands of the Security Directions.

[69] MHAC (1997) Seventh Biennial Report p87
[70] MHAC (1999) Eighth Biennial Report p158

5.27 **Property restrictions**. Commissioners have learned from many patients of the distress of losing access to many of those possessions which previously helped sustain their individuality. The diminished number of possessions that patients may keep in their room continues to cause resentment. Women patients complain of not being allowed to keep sufficient toiletries to look after their own personal hygiene. Other patients have particularly mentioned access to books, recorded music and clothes. One patient waited for five weeks in the autumn of last year for his pullovers to be released from storage; another was told, having requested his CD player from storage in November, to expect it to be returned to him in February. The mechanism for retrieving items from the property section appears to be somewhat convoluted and time-consuming. We consider that the Patients Possessions Policies are insufficiently flexible, particularly in that the same level of restriction applies on wards on which there are patients near to discharge as on wards where there are patients of 'high dependency'.

Recommendation 55

High Security Hospital managers should monitor the time taken to approve the release of patients' personal possessions from storage, and the time taken post-approval for items to be delivered to patients. Agreed standards should be set and improvement targets initiated.

5.28 **Restrictions on patients' use of computers.** Commissioners have learned from many patients of the adverse consequences of losing access to their computers. Patients have lost old and entirely harmless machines. One patient had to abandon his Open University Course, while many lost access to an activity which gave them constructive use of their evenings and weekends. Broadmoor Hospital has made commendable efforts to compensate for this loss by the creation of a computer network in the Education Centre, but even this is limited to term-time access and dependent upon staff being available to escort patients to the facility.

Recommendation 56

High Security Hospital managers should consider ways to improve patients' access to computers, particularly in their leisure-time.

5.29 **Restrictions on bringing food into the hospital.** We remain concerned at the interpretation of this Security Direction, which has, in addition to stopping relatives from bringing food to patients on their visits, led to bans on patients buying-in takeaway food from previously trusted providers, patients being restricted to an authorised shopping list on therapeutic shopping, Occupational Therapists being prevented from bringing in special items for therapeutic cooking programmes, and staff being prevented from providing edible prizes for patient raffles.

Recommendation 57

High Security Hospital managers should review their implementation of the Security Directions relating to the importation of foodstuffs to the hospitals, to ensure that they do not result in unintended and undesirable consequences.

5.30 In an environment where matters of rules, power and control are often so overtly part of the agenda, some impositions seem counter-therapeutic and make the work of the clinical team much more difficult. We are particularly concerned to hear of instances where impositions appear to be pettily bureaucratic, such as:

- one hospital's restrictions on access to shampoo because of its minimal alcohol content, which was widely regarded as demeaning to the whole security debate;
- a patient who had purchased a present for his mother, who visits him at weekends, was told that he would have to send the present to the stores for his mother to collect. The stores are only open during the week.
- the removal of a patient's established access in leisure time to materials (paint and varnish) for pursuing his hobby of painting model soldiers, despite nursing staff's offer to supervise his access and use of such materials.

5.31 In some cases, however, staff have found ways to make the new rules less onerous for patients. Ward staff at Ashworth Hospital keep patients' recorded music items in a locked cupboard on the wards, so that patients have more ready access to them.

Recommendation 58

High Security Hospital managers should keep the implementation of the Security Directions under constant review, ensuring that they are imposed in appropriate ways that cause no unnecessary detriment to patient care.

5.32 In some areas the Security Directions have been approached as a positive opportunity to improve the care of patients in a better-structured environment. Commissioners visiting Cherwell Ward, Broadmoor Hospital, in May 2000 were impressed with the sense of energy, direction and purpose that seemed to have been instilled as a result of the locking-off of patient bedrooms during the day. This, and the consequent job of getting patients up in the morning, had been approached by the clinical team as a positive move towards greater activity and not simply an end in itself. Nursing staff had been deployed from the relatively unproductive task of 'monitoring the gallery' to more useful forms of patient contact.

5.33 There is a real danger that the implementation of the Security Directions could distract from a holistic approach towards safety and security in the High Security Hospitals. Action to promote a safe and therapeutic environment (see Chapter 4) needs to be continually addressed within the hospitals to make the Security Directions meaningful, particularly with regard to:

- increasing the availability to all patients of therapeutic interventions and activities, including psychological treatments (see paragraphs 5.19 –5.21 above);
- ensuring that women patients in the hospitals are not disadvantaged in terms of facilities and access to activities;

- continued attention to environmental risk assessment and management, avoiding the assumption that safety and security can be assured by implementation of Security directions alone; and
- ensuring that the Care Programme Approach is effectively implemented for all patients across the three hospitals.

5.34 We hope that, as new systems and policies are embedded and developed in the hospitals, there can be an increased focus on the individual needs of patients based on individual risk-assessments, in line with good mental health practice, rather than blanket restrictions. This is all the more vital if decent and humane care is to be provided to the many patients who appear to have been disadvantaged by the imposition of the Safety and Security Directions, especially those who are awaiting transfer out of the hospitals, or who no longer really require very high levels of security.

Childrens' Visiting

5.35 The revised Code of Practice, published in March 1999, required all hospitals to have written policies on the arrangements for the visiting of patients by children, drawn up in conjunction with local social services authorities. Visits by children should consequently only be allowed where it is decided that such a visit is in the child's best interest, and such decisions should be regularly reviewed (paragraph 26.3).

5.36 This revision was made as it became clear that lax arrangements for such visits had put a young girl at severe risk on her visits to the Personality Disorder Unit at Ashworth Hospital. Specific directions for high security services[71] followed, in response to the report on these events by Sir Peter Fallon. General guidance on the Code's advice in relation to other psychiatric services was published later.[72] The general guidance emphasised that "in the vast majority of cases, the issue of whether or not a child should visit will be straightforward, and in these cases, policies should aim to encourage and facilitate contacts between children and adults which are considered to be in the child's interest" [73]. We recommend that this be considered as applicable across all services, including the High Security Hospitals.

5.37 We accept that security lapses such as those investigated by the Fallon Inquiry should never be allowed to happen again, and are supportive of measures that will ensure that this is the case. However, as with many aspects of the Security Directions, we are concerned that a rigid application of regulations and procedures across patient categories, rather than in response to patients' individual needs as set out in their care plans, compromises the hospitals' ability to

[71] HSC 1999/160, revised by HSC 2000/027.
[72] Department of Health (1999) *Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children.* HSC 1999/222: LAC (99)32,
[73] Department of Health (1999) *Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children.* HSC 1999/222: LAC (99)32 p3

provide patient-centred care in the context required by both the Mental Health Act Code of Practice and the National Service Framework for Mental Health.

5.38 In February and March 2001, the Commission undertook special visits to consider services provided to women patients at the three High Security Hospitals. The visits focussed on a number of issues, including arrangements for visiting by children.

5.39 Commissioners found that women patients' experience of the new visiting arrangements was the single issue that caused most distress. The new rules were described as tortuous, incomprehensible and unfair, with many women who had previously had happy and uncomplicated visits from their children or grandchildren now finding these restricted by delays and bureaucracy. A number of women patients who have been transferred from prison were surprised and disappointed to find that opportunities and facilities for their childrens' visits were greatly reduced in hospital. One woman had waited for over seven months before seeing her children, because of hold-ups in the approval process. Another patient had asked not to see her grandchildren rather than put them through what she perceived as the "ordeal" of assessment. One woman patient told a Commissioner that "the new rules make you feel like a child abuser". There was a widespread resentment that measures designed to protect against a repeat of the actions of some male patients in one hospital had produced such an effect on all patients.

5.40 The hospitals themselves are not responsible for all of the causes of delay in visiting arrangements. All three hospitals report delays in assessments by social services authorities local to the patients' families. One local authority informed Rampton Hospital that other casework precluded any such assessment in the foreseeable future. We hope that this situation will be improved by the Department's guidance that such assessments should now be fully completed within 35 days. The hospitals themselves have limited administrative time to chase up responses. We have found that uniform data on delays was not available, and have advised that it should be properly collected and monitored.

5.41 The requirement for extra vigilance during visits has, in some instances, limited the number of visits that can be arranged in each week. Although new visiting facilities are being developed at Broadmoor and Rampton hospitals, shortages of appropriately trained staff have also been cited as a limiting factor. Many patients have complained that problems in providing staff to escort or supervise visits have led to their two-hour visiting slots being significantly reduced. We hope that the hospitals will give urgent attention to these matters.

5.42 The requirement that children should be searched before and after visits has caused understandable distress to patients and to the children themselves. Rampton Hospital conducts such searches on children under the guise of a game called "hunt the sweet", so as to alleviate their embarrassment or stress. We hope that, for as long as it is considered necessary to search children, the hospitals will make every effort to do so in as appropriate and sensitive a manner as possible.

5.43 Supervision on visits can seem obtrusive to patients and their families. One patient spoke of the impossibility of having any meaningful discussion with her teenage daughter whilst a social worker, probation officer and two escort staff looked on. Patients also resent the ban on them preparing food for their visitors, or on their visitors bringing any food into the hospital (see paragraphs 5.29 above).

Recommendation 59

High Security Hospital managers should review the implementation of the Security Directions with regard to the visiting of patients by children in the light of the Commission's concerns. Consideration should be given to whether certain patients are unfairly disadvantaged by the blanket imposition of all new visiting arrangements, and whether such arrangements serve any useful purpose and may be counter-therapeutic.

Recommendation 60

The Department of Health should consult with senior managers in the three High Security Hospitals to see if the adverse effects of the Security Directions can be minimised in any way.

6 Addressing the needs of a diverse group of patients

The Challenge of Diversity

"No injustice is greater than the inequalities in health which scar our nation".

(NHS Plan 2000[74])

6.1 Since its inception and first Biennial report in 1985, the Commission has continually raised concerns with respect to the inadequate level of care and treatment afforded to particular groups of patients[75]. The requirement to meet these needs whilst respecting the individuality of every patient both in care plans and in the day to day running of inpatient units is becoming increasingly challenging as mental health services for detained patients are experiencing growing diversity in the patient population and greater awareness of the need to tackle inequalities.

6.2 The Code of Practice requires that people to whom the Act is applied should "be given respect for their qualities, abilities and diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics" (paragraph 1.1).

6.3 The National Service Framework for Mental Health contains the principle that people with mental health problems can expect services *"to be well-suited to those who use them and non-discriminatory"*. Particular expectations of services in relation to disabled patients are also raised through the Disability Discrimination Act 1995[76]. The Race Relations (Amendment) Act 2000 requires public authorities to promote good relations across all their activities and specific guidelines for the NHS are being developed by the Commission for Racial Equality.

6.4 This is further reinforced, and welcomed by the Commission, in the vision of a health service designed around the needs of the patient, as described in the NHS Plan[77]. As the then Acting Commission Chairman said in his opening remarks to the Commission's National Visit 2:

"How society relates to those of its members from minority ethnic groups is a measure of its value and standards. Nowhere is this more relevant than in the provision of health and social care for those with mental health problems - especially under compulsion."[78]

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[74] Department of Health (2000) **The NHS Plan**. London, Stationery Office

[75] See, for example, Mental Health Act Commission (1999) **Eighth Biennial Report** p234 - 261

[76] See Department of Health (1999) **Doubly Disabled: Equality for disabled people in the new NHS**. HSC 1999/093

[77] Department of Health (2000) **The NHS Plan**. London, Stationery Office

[78] Warner et al (2000) **Improving Care for Detained Patients from Black and Minority Ethnic Communities Preliminary Report - National Visit 2**. Sainsbury Centre for Mental Health

6.5 This Chapter concentrates on some particular areas of service provision where additional effort must be made to allow this vision to be realised. We also suggest, at Chapter 6.15 - 19 below, one approach through which service commissioners and providers may take practical steps to address diversity in a holistic fashion.

Black and minority ethnic patients

6.6 There is a widespread perception that mental health services do not have sufficient understanding of the complex and diverse religious, cultural and traditional needs of Black and minority ethnic people and that this constitutes institutional racism as defined by the Macpherson Report (1999) on the Stephen Lawrence Inquiry:

> *"…the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin"*.

6.7 From our First Biennial Report, published in 1985, we have continually drawn attention to the disproportionate numbers, and the inadequate care and treatment of patients from certain Black and minority ethnic groups who are detained. We have also raised concerns about the adequacy of the service response to Black and minority ethnic groups in general.

6.8 The Government acknowledged that many of the issues raised in the Macpherson report have relevance for the NHS[79] and subsequently made a number of announcements on race equality within the NHS. Perhaps understandably, these have initially concentrated on the clearly identifiable issues relating to staffing and racial harassment. Although welcome initiatives to increase the numbers of Black and minority ethnic members of NHS Boards and schemes and to teach all Board members about the need for equality and diversity in service delivery were announced in 1997, there is clearly still much to do to ensure that Black and minority ethnic mental health service users receive appropriate care from the NHS.

6.9 In February 2001, the Royal College of Psychiatrists' Council endorsed a set of recommendations that included the setting up of an Ethnic Issues Committee to work with the College in ensuring that its members receive appropriate training in cultural sensitivity and are aware of the possibility of discrimination when applying the Mental Health Act. As this report goes to press, the pages of the *Psychiatric Bulletin* have been opened to a debate over the extent and effects of institutional racism in British Psychiatry[80]. Indeed, our own collection of data on the ethnicity of patients admitted under the Act for the past four years, though not scientifically rigorous, supports the notion that certain Black and minority ethnic groups are disproportionately detained within psychiatric settings (see figure 6 below).

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[79] HSC 1999/060 (12 March 1999): **Tackling Racial Harassment in the NHS – a Plan for Action**.

[80] Shashidaran S P *Institutional Racism in British Psychiatry* & Cox J L *Commentary: Institutional Racism in British Psychiatry*. **Psychiatric Bulletin** 25:7 July 2001 p244-249

Figure 6 : Mental Health Act by Ethnicity in England and Wales[81]

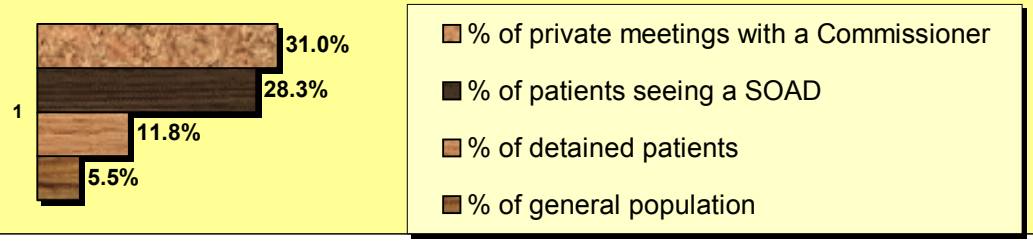
Ethnic Group	Mental Health Act Data				Census Data
	1996/7 (n=29,426)[1] %	1997/8 (n=33,552)[2] %	1998/9 (n= 35,097)[3] %	1999/2000 (n=40,024)[4] %	%
White	84.0	83.3	85.0	88.2	94.5
Black Caribbean	5.4	6.2	5.2	3.6	0.9
Black African	2.7	2.5	2.4	1.7	0.4
Black other	1.8	2.0	1.5	1.1	0.3
Indian	1.7	1.6	1.4	1.5	1.5
Pakistani	1.3	1.0	1.4	1.2	0.9
Bangladeshi	0.4	0.6	0.4	0.4	0.3
Chinese	0.3	0.3	0.3	0.2	0.3
Other groups	2.4	2.5	2.4	2.1	0.9

1 ethnicity not known (1996/7) = 2,102 – not included in table
2 ethnicity not known (1997/8) = 1,505 – not included in table
3 ethnicity not known (1998/9) = 1,204 – not included in table
4 ethnicity not known (1999/2000) = 5,029 – not included in table

(n.b. the growth in "ethnicity unknowns" has possibly distorted the residual analysis shown)

6.10 Figure 7 shows that not only is there a disproportionate detention rate of Black and minority ethnic people under the Act but also that, having been detained, the rate at which they are referred to the SOAD service and the number requesting the support of a Commissioner are incrementally higher still.

Figure 7: Increasing Proportionate Uses of Services for Detained Patients by Black & Minority Ethnic Groups 1999/2000



6.11 This analysis adds a new dimension to data previously reported separately and heightens the need for research into the possibility of institutional racism both pre and post detention.

[81] based on information supplied to the Commission by 269 establishments out of a possible 281 respondents.

6.12 In respect to our collection of in-patient data, we make no claim to be adding significantly to research studies already undertaken on the use of the Act on ethnic minorities. In fact, we support the view published in the Department of Health-sponsored publication *Assessing Health Needs of People from Minority Ethnic Groups*[82] that hospital in-patient statistics alone are inadequate as epidemiological data, and that research into the wider aspects of ethnicity and health provision, including the take-up of services in the community, must take place if real planning and health targeting can occur.

6.13 It is not merely enough to provide training programmes, or to employ one or two token Black staff, or to produce an equality of opportunity policy, or to provide a 'special pot' of money to tackle what are - in the final analysis - fundamental components of an effective mental health service. None of these areas are mutually exclusive and that it is crucial to have a holistic, multi-dimensional approach, and not instigate activities in isolation. Services need to have clear strategic programmes coupled with long-term mainstream funding.

The Commission's strategic approach: the Equal Opportunities Programme

6.14 As early as 1996 (two years prior to the Macpherson report), the Commission recognised that institutional racism was an issue that needed addressing within its own structures, policies, practices and day-to-day operations. In recognition of this and the need to develop and implement a more proactive response to the fundamental issues of inequality, and to demonstrate to external agencies the implementation of sound principles of equality into our own internal policies and practices, we developed a long-term strategic Equal Opportunities Programme (EOP). In our Seventh Biennial Report (1997) we published an EOP statement (see Figure 8 below) and a set of clear goals identifying specific areas of implementation.

Figure 8: The Commission's Equal Opportunities Programme

Five Key Goals Set:

- To be committed to the identification of unequal and discriminatory services in the mental health field;
- To establish an effective monitoring & quality assurance system;
- To set specific foci for commission activities – e.g.: women's issues and race and culture;
- To build in Equal Opportunities awareness into the development of members and staff;
- To increase the number of under-represented groups amongst staff, Commission members and appointees.

These measures aim to enhance public understanding of the Mental Health Act Commission's commitment to Equal Opportunities.

6.15 In our Eighth Biennial Report we highlighted the key activities that took place under phase one of the EOP strategy[83]. Two central achievements included the training of 98% of all Commissioners in issues of race and culture, and the undertaking of National Visit 2, which looked at nationwide

[82] Shashidaran & Commander (1998) *Mental Health* in Rawaf & Bahl (eds) **Assessing Health Needs of People from Minority Ethnic Groups.** London, Royal College of Physicians.
[83] Mental Health Act Commission (1999) **Eighth Biennial Report**. London, Stationery Office p 20 - 22

provision of ethnic monitoring, interpreting services and strategies to deal with racial harassment. Phase two of the Commission's strategy was to establish consultation exercises within Black and minority ethnic communities, both as a way of addressing the recruitment issues within the Commission and to hear such communities' perceptions of service provision for detained patients. A summary of the findings from the National Visit 2 and details of the National Consultation Exercises is given in **Appendix C** below: in this chapter we have concentrated on the lessons for services that have emerged from these exercises and from the Commission's general experience of visiting hospitals.

The Commission's Regional Consultation Exercises

6.16 The Commission's Regional Consultation exercises took place over this Biennial reporting period around three geographical areas: Greater Manchester, the West Midlands and the North East of England. The exercises were structured through interviews and focus-groups involving approximately 50 organisations (including Black and minority ethnic community members, mental health service providers, police and probation officers and voluntary organisations) in each region, followed by a local seminar in which the Commission discussed its role and remit and attendees could explore mental health service issues through workshops facilitated by local Black and minority ethnic groups.

6.17 The exercises highlighted five key areas:

- Mental health services for Black and minority ethnic communities;
- Detention under the Mental Health Act 1983;
- Race equality initiatives;
- Ethnic monitoring; and
- Services for women.

Details of the way in which the consultations and seminars were prganised and particular findings from them are given in **Appendix D** to this Report.

6.18 Building services to meet the needs of and to support diversity amongst patient populations requires consultation and working with the voluntary sector and other stakeholders in such services, such as Black and minority ethnic communities. We were particularly pleased to note that our consultation exercises were used by service providers as a platform for further local development in building contacts with such organisations and groups. For example, in Manchester, the local authority and mental health service commissioners organised a follow-up seminar which was attended by eighty local people and led to a number of specific goals for improved partnership working in that area.

6.19 We view our national consultation exercises as a model of the engagement of Black and minority ethnic communities, mental health service users, service providers and commissioners. The findings from this project will contribute to forging true partnerships between people from Black and minority ethnic communities and the providers of mental health services and other relevant organisations, on both local and national levels. In this way, the challenge of delivering mental

health services that consistently and effectively meet the needs of diverse communities can be addressed. Developing these partnerships will require strategic thinking; commitment from all parties especially statutory authorities and other providers; and the development and cherishing of local networks.

Recommendation 61

Service commissioners and providers should consider the consultation model used by the Commission when planning their own strategies to address diversity amongst their own patient populations. This model could be adapted and applied to the planning services for any identifiable groups of patients, including each of those that are the subject of this Chapter, and not only to Black and minority ethnic groups.

Services for Black and Minority Ethnic Groups - what is to be done?

6.21 Over the years, we have suggested many policy and practice measures to address the diverse needs of Black and minority ethnic groups, including the provision of translated leaflets and appropriately sensitive environments taking into account patients' dietary, religious and cultural backgrounds. The issues of ethnic monitoring, racial harassment and the provision of and access to interpreters have been consistently raised as matters requiring urgent attention. Although some of these measures have met with positive change, service development in these areas has remained ad hoc, patchy and piecemeal.

6.22 We believe that the key to improvement in this whole area is Board leadership in producing a long-term, proactive, strategic equality programme that addresses all aspects of inequality. This programme should be endorsed and driven by the Board and senior management of the organisation and be developed with clear action points, providing realistic timescales and led by senior identified staff. The Race Relations (Amendment) Act provides a useful list of the key areas of focus[84].

6.23 The strategic programme should produce clear policies, procedures and guidelines in all aspects of service delivery together with robust monitoring, implementation and review procedures. The programme should include the following:

- the development of innovative methods of effective and meaningful consultation and active involvement of community and user groups in developing and delivering policy and practice;
- the recruitment, retention and training of staff;
- the establishment of partnerships with a wide variety of groups;
- the regular dissemination of information;
- increased initiatives in respect of prevention, education and early access particularly within primary care services;
- the raising of awareness of the stigma and discrimination faced by users;
- access to trained and qualified interpreters
- clear unambiguous polices with respect to racial harassment

[84] Home Office (2001) **Race Relations (Amendment) Act 2000 New laws for a successful multi-racial Britain: proposals for implementation.** London Home Office. Chapter 6.

Above all there should be clear procedures for actively identifying and responding to individual patients' needs.

6.24 Central to the success of any such programme is the need to acknowledge the diversity of individuals and communities. It is necessary to recognise the differences between well-established communities (who have up to four generations living in the UK), and those who are newly arrived with a variety of additional health and social care issues. There is also a fundamental need to collect and analyse ethnic monitoring data so that this information can feed directly back into the monitoring and evaluation process.

Recommendation 62

Service commissioners and providers should engender clear strategic equality programmes, endorsed and driven by the Board and senior management of the service provider and allocated mainstream funding, taking account of the suggestions presented at paragraphs 6.22 – 24 above.

6.25 While we are firmly of the view that services cannot successfully address the needs of Black and minority ethnic groups, or indeed any minority group of patients, without a strategically holistic, multi-dimenional approach with long-term mainstream funding, certain issues must be addressed within such an approach and, where such an approach is slow in starting, should be addressed immediately. These are highlighted in the following paragraphs.

6.26 **Racial harassment** is a serious problem and occurs in all sectors. Racial harassment not only includes physical attacks on people but also verbal abuse and any other form of behaviour that deters people from using or participating in a particular service. It is important that all service providers should have clear policies and procedures to deal with inter-patient racial harassment and of racial harassment of patients by staff. These should require staff to intervene when harassment is apparent, and to ensure that the victim of racial harassment is not further disadvantaged by any such intervention. Following the National Visit 2 we found that three quarters of the units visited in England had no such policies. All too often we learn of patients who have been subject to racial harassment being isolated from the environment where harassment is taking place, whilst the perpetrators go unchallenged and unaffected by their actions. As well as the obvious injustice of such an approach, this can cause or exacerbate problem behaviour from the patient who has been subject to the harassment, leading to an escalation of the problem and further alienating that patient.

6.27 In one well-publicised case that we have followed closely during this reporting period, this approach had tragic consequences. David Bennett was a young black man who, when acting out in response to racist taunting from fellow patients, was isolated from those patients and subsequently died whilst struggling under restraint. The lack of a clear racial harassment policy was recognised by the coroner as being one factor in the events that led to his death.

6.28 **Ethnic Monitoring** remains patchily implemented, although it is has been a mandatory requirement since April 1995. The need for and advantages of ethnic monitoring may be a training issue

amongst staff where ethnicity is neither routinely nor accurately determined. Some services have developed innovative practices, whereby patients are given a list of statements of ethnicity in various languages and asked to indicate which statement applies to them.

6.29 With some exceptions, data from ethnic monitoring is not being put to good use. One of the main reasons for requiring such information is to enable ward staff to identify patients' ethnicity so that appropriate action is taken to provide care in a culturally appropriate framework, taking account of **linguistic, cultural and religious needs**. This information, and the views of the patients as to their specific needs, should be an integral part of their care plans.

Good Practice example

A number of services have produced guidance for staff on the requirements and observances of different religions. One good example is that produced by the Chaplaincy at Aintree Hospital, "cultural and religious needs of patients", which provides information for staff on the key issues and special considerations for 15 religious groups, including guidance on diet and expectations for washing and other day-to-day facilities. The guide emphasises that patients should always be asked about their preferences rather than these being assumed.

(Contact: *Chaplaincy Department, University Hospital, Aintree, Longmoor Lane, Liverpool L9 7AL. Tel: 0151 529 3195*), which covers a wide range of religions.

6.30 **Interpreting services** are widely used, but two-thirds of wards visited on the National Visit 2 and many service providers engaged in the national consultation exercises had used patients' relatives or friends for this purpose in the recent past. Nearly a half of wards visited in this reporting period only had patient information leaflets in English, despite their availability in a number of other languages (see Chapter 2.8 – 2.10).

6.31 Links with Black and minority ethnic groups should extend, wherever possible, to contacts with **culturally appropriate advocacy groups** and voluntary organisations.

6.32 We reiterate the need for over-arching strategies to cover all these points. We welcome the on-going development of guidance of Codes of Practice in relation to the NHS and the Race Relations (Amendment) Act 2000, and hope that the duties imposed by that Act on public authorities will serve as a useful lever to ensure race equality in access to services and treatment. Through our focus on this area of work and its programme of activities over the past four years, we have laid solid foundations for addressing the requirements of the Race Relations (Amendment) Act 2000. We will continue to build on our established equality programme over the next two years to ensure that we meet the new duties, and will be actively looking for similar compliance and a general sensitivity to the special needs of patients from Black and minority ethnic backgrounds in services that we visit.

Women Patients

Safety, Privacy and Dignity in mixed environments

6.33 Women patients are normally in a minority on any mixed ward at any given time[85]. This is particularly the case in acute care and in some medium secure units. It is of paramount importance that women patients are able to feel safe and retain their privacy and dignity on such units, and the Commission welcomes the Government's action to ensure this.

6.34 The NHS Executive issued EL(97)3 on the 24 January 1997, requiring health authorities to set local performance targets with Trusts within their boundary, to deliver the following objectives:

- Ensure that appropriate organisational arrangements are in place to secure good standards of privacy and dignity for hospital patients;
- Achieve fully the standard for segregated washing and toilet facilities across the NHS; and
- Provide safe facilities for patients in hospital who are mentally ill which safeguard their privacy and dignity.

Central monitoring arrangements within the NHS Executive have been tracking the progress in achieving these objectives from an original target of 95% implementation by 2002. The first annual report on this monitoring (1999) showed a 93% expectation and urged greater effort.

6.35 As well as finding some units that have yet to comply with the Directive at all, Commissioners also find some that have complied with the basic requirements to provide gender-differentiated toilet and washing facilities, yet do so in a way that still does not afford women patients the safety and security that they should be able to expect. In particular, women-only washing and toilet facilities may be provided, but these are placed within wards in such a way that women have to pass male sleeping areas at night to reach them. Other services have not yet managed to protect women patients adequately from harassment or even serious danger. For example, in some services women are provided with individual rooms that are not furnished with patient-operated locks that can be overridden by staff, even though they share corridor access with mens' rooms.

6.36 The National Service Framework for Mental Health states that "while accommodation for social and therapeutic activities will usually be mixed, Government wants to ensure that single sex day space is always provided" (page 50). It is now a requirement that newly built units must provide secure day rooms for women patients only. Older hospitals may have to adopt more imaginative solutions, but it is not acceptable that the only women-only spaces in mental health units can be patients' bedrooms and bathrooms.

[85] MHAC (1999) Eighth Biennial Report, para 10.57

Good Practice Example

West Hampshire NHS Trust facilitated a working party comprised of staff and patients to address the concerns raised over womens' safety and access to facilities on a particular unit. The working party was charged with:

- **evaluating the delivery of care to women patients at the unit and identifying shortfalls and examples of good practice, taking account of the differing needs of women on each of the wards and using questionnaires or other means to ascertain the views of all patients and staff;**
- **formulating an audit tool to establish and monitor base-line standards; and**
- **making policy recommendations on all of these issues, including recommendations for evidence based practice in the care of women.**

The group was also linked to another in-house group setting standards and looking at quality assurance for all of the patients within the unit.

The Commission commends this as an imaginative approach to addressing issues of women's care.

Contact Jayne Dollery, CBT Nurse Specialist, Ravenswood House MSU, Fareham, Hampshire SO51 7ZA Tel 01329 836000

6.37 We would not wish to see these guarantees for womens' safety and security resulting in the creation of entirely segregated hospitals. Commissioners have found that some services, whether by design or inadvertently, appear to be losing sight of the continued need for women and men patients to engage in social and therapeutic activities in a mixed environment. This could lead not only to a lack of normalcy in hospital environments, but also to a serious diminution of activities and therapies available to the often small group of women living in such environments. We have particular concerns over this issue at the three High Security hospitals, following strong representation from both patients and staff at the hospitals (see Chapter 5.18 – 5.20).

6.38 In the coming period we will continue our involvement with the UKCC in developing standards of care for women in secure environments. The Commission looks forward to the outcome of this project, which will involve a wide range of interested parties.

Recommendation 63

Service commissioning bodies and service providers should agree and monitor services for women patients to ensure that such patients can:

- **Lock bedroom doors, using a system capable of being overridden by staff in emergency;**
- **Have a choice of a female key-worker;**
- **Be in contact with other women;**
- **Have the opportunity to take part in women-only therapy groups and social activities, but have the choice of taking part in mixed groups where appropriate;**
- **Engage safely in a full range of such activities, even where their number is small compared to the hospital population;**
- **Have physical health-checks on admission;**
- **Have access to a female doctor for medical care;**
- **Have access to a female member of staff at all times; and**
- **Be assured of adequate supervision at night.**

6.39 Issues relating to women and seclusion are discussed at Chapter 4.44 above.

Children and adolescents

6.40 In our last two Biennial Reports we have expressed our concern over the uneven provision of services for children and adolescents who are detained under the Mental Health Act[86]. We welcomed the inclusion in the 1998 National Priorities Guidance[87] of an objective to improve the provision of appropriate, high-quality care and treatment for children and adolescents through building up locally based child and adolescent mental health services (CAMHS). The Government has reported significant investment in the period covered by this report towards meeting all the objectives set by the National Priorities Guidance, also taking account of the recommendations of the Audit Commission's Children in Mind report[88]. Work also continues at a national policy level, and the Government has announced its intention to publish a Children's National Service Framework, encompassing CAMHS, in 2003/4[89]. An All-Wales Strategy for CAMHS was also in preparation at the end of this reporting period.

6.41 However, the difficulties faced by mental health services in responding adequately to the needs of detained children mean that a great deal of work remains to be done. Inpatient service provision for distressed children and adolescent patients remains problematic across England and Wales. We are particularly concerned about those cases where adolescents are admitted through necessity to adult units, or where, through a lack of facilities, they are not admitted when at their most vulnerable.

6.42 Even in the best circumstances, children admitted to adult wards are likely to be isolated and unhappy, and their social, educational and emotional needs are unlikely to be met. In some cases, the facilities in which children are detained are so poorly suited to accommodate them that service providers are reluctantly forced to take extreme measures. In this reporting period Commissioners met with one 14 year old girl who was being nursed one-to-one in her own room and in the corridors of a central London Hospital, because she was seen as vulnerable if housed on the overcrowded wards. The hospital had reluctantly agreed to admit her for a few days whilst suitable accommodation was located, but, eight weeks from admission, no such place had been found. Whilst staff were doing their best in such a situation, the girl's detention amounted to little more than containment of dubious therapeutic value and was potentially extremely damaging to her own morale and to that of staff and other patients. Many less dramatic but no less concerning examples could be given.

6.43 One problem faced by services is the relative infrequency of admission of children and adolescents under the Act. In visits to CAMHS and general services in this reporting period Commissioners met with slightly more than 200 detained children and adolescents, which it estimates to be roughly one

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[86] Mental Health Act Commission (1997) **Seventh Biennial Report** London, Stationery Office p187-8, Mental Health Act Commission (1999) **Eighth Biennial Report** London, Stationery Office p 247 - 250

[87] Department of Health (1998**) Modernising Mental Health Services: National Priorities Guidance 1999/00 – 2001/02.** LAC(98)22

[88] Audit Commission (1999) **Children in Mind.** Oxford, Audit Commission Publications.

[89] See www.doh.gov.uk/nsf/children.htm

fifth of all the children and adolescents detained in this period. The Commission surveyed all hospitals and Registered Mental Nursing Homes that detain patients on the numbers of admissions of children and adolescents under the Act in this reporting period. The results (based upon 230 responses out of 281 establishments) are presented in Figure 9 below.

Fig. 9 Children and Adolescents admitted under the Mental Health Act, 1/4/99 – 31/3/01

	TYPE OF WARD ADMITTED TO				
	Adult male	Adult female	CAMHS male	CAMHS female	**TOTAL**
Children (under 16 years)	71	46	150	193	**460**
Minors (16-18 years)	307	200	58	57	**622**
TOTAL	**378**	**246**	**208**	**250**	**1082**

6.44 When it is unavoidable to admit children or adolescents to adult wards, strategies such as that reported in the Eighth Biennial Report[90] in relation to Gwent Healthcare NHS Trust can ensure that as the best possible arrangements are made. In essence the arrangements, which are agreed in protocol form and can be brought into action on the admission of any child or adolescent patient, are as follows:

- One unit is identified as the most appropriate placement for children and adolescents in emergencies;
- That unit has access to a pool of bank nurses trained to care for children and adolescents;
- Daily assessment by a child psychiatrist or a designated junior is arranged;
- An on-call child psychiatrist is available for queries and advice out of hours; at other times an identified clinical services manager provides this service; and
- Staff caring for the patient are treated as a part of the ward tem and rotated, to avoid isolation of either staff members or the patient.

At Chapter 7.26 we note that all Welsh facilities that provide inpatient psychiatric care for children and adolescents are required to meet standards set by the Health Advisory Service 2000, including having explicit protocols relating to the admission of young people to adult mental illness units. We hope that the all services will consider whether such strategic arrangements should be agreed within their localities, and that the Department of Health will consider making this a requirement for all English services.

[90] Mental Health Act Commission (1999) **Eighth Biennial Report**. London, Stationery Office p 249

Recommendation 64

All mental health services providing care to children and adolescents detained under the Act should have agreed working and referral arrangements with appropriate medical and psychiatric expertise in CAMHS.

Recommendation 65

The Department of Health should consider the need for England to have standards and protocols for the care of mentally ill minors detained in adult units, as already exists in Wales

6.45 We look forward to working with the Department of Health in discussions over the formulation of the Children's National Service Framework. Our review of our own information leaflets (see Chapter 2.12) will consider formats that will be accessible to children.

Recommendation 66

The Department of Health should consider formats for its information leaflets on the Mental Health Act that will be accessible to children.
(see recommendation 5, Chapter 2.11)

Commissioner and SOADs' visits to detained children

6.46 At the end of this reporting period, the Commission Board agreed that, as all Mental Health Act Commissioners have significant contact with child and adolescent patients, and have legal authority to meet with them in private as well as access to their records, two Commissioners would be present at any private meeting with such patients unless one of those Commissioners had been police-checked.

6.47 We have also initiated the establishment of a small panel of SOADs with expertise in child psychiatry, so as to ensure that suitable safeguards under Part IV of the Act are provided to child and adolescent patients. Such SOADs will also be police-checked.

Deaf Patients

6.48 Approximately one in every 1000 of the population is deaf, using "sign" as their preferred language[91]. Despite normal intelligence, the ability of people with early profound deafness to understand spoken or written English, and therefore lip-reading or the written word, is limited. Given the centrality of communication to every aspect of psychiatric practice, such people can be seriously disadvantaged by the general lack of appreciation of these considerable difficulties.

[91] Pathfinder Mental Health Services NHS Trust [n.d.] **National Deaf Services: Mental Health Services in Sign Language for Deaf Adults, Children and Families.** London, Pathfinder Mental Health Services NHS Trust. p 1

6.49 Deaf patients have been reported to be grossly over-represented in mental hospitals as a result of poor diagnosis, miscommunication and misguided treatment programmes[92]. The three national specialist mental health services for deaf people are neither commissioned nor resourced to provide intensive care. In a few cases, deaf patients requiring detention under the Act may be treated in a neighbouring facility to one of the national centres, so allowing for some input from the national centre to their care, but, if no bed is available locally, they may be deprived of any significant input from the national centres.

6.50 Problems in services for deaf mentally ill patients, particularly in crisis situations, were brought into sharp focus by the publication of the report from the Inquiry into the care and treatment of Daniel Joseph in September 2000[93]. We were pleased to note the Government's acceptance of the recommendations of this Inquiry, which included the development of a nationally co-ordinated strategy for deaf people with mental health problems, a review of the commissioning of sign-language interpreters in health and social services and increased priority for the specialist services for deaf people on the NHS Executive agenda.

6.51 We welcome the expected publication of the Consultation Paper *Modernising Mental Health Services for People who are Deaf*[94] and look forward to working with the Department of Health in the development of a national strategy for deaf people.

6.52 Article 5(2) of the European Convention of Human Rights provides a right to anyone deprived of their liberty to be informed promptly of the reasons for this deprivation "in a language which he understands." We believe that deaf patients are especially vulnerable to failures to secure this right, which may be symptomatic of the many disadvantages faced by such patients who do not come into early and appropriate contact with the three national specialist mental health services for deaf people.

6.53 The importance of acknowledging and dealing with problems in communication, including deafness, is specifically referred to in the Code of Practice (see guiding principles, paras 1.3 – 1.7). In circumstances where there is doubt as to whether oral/aural and written methods of communication are adequate, the assistance of either a local authority Social Worker with Deaf People or a voluntary agency worker with the deaf must be sought.

6.54 In our review of the appropriateness of our own information leaflets for particular groups of patients (see Chapter 2.12), we will consider the unique communication needs of the Deaf community. We urge the Department of Health to similarly review its information leaflets on the Mental Health Act.

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[92] Pathfinder Mental Health Services NHS Trust [n.d.] **National Deaf Services: Mental Health Services in Sign Language for Deaf Adults, Children and Families.** London, Pathfinder Mental Health Services NHS Trust. p2

[93] **Report of the Independent Inquiry Team into the Care and Treatment of Daniel Joseph** (2000) Commissioned by Merton Sutton & Wandsworth and Lambeth, Southwark & Lewisham Health Authorities. April 2000.

[94] In preparation at the time of writing.

Recommendation 67

The Department of Health should consider formats for its information leaflets on the Mental Health Act that will be accessible to deaf patients whose first language is BSL. (see recommendation 5, Chapter 2.11)

Elderly patients

6.55 At the end of this reporting period the Government published the National Service Framework for Older People[95]. We welcome the setting of these standards, particularly Standard Seven, promoting access to integrated mental health services to ensure effective diagnosis, treatment and support; Standards One and Two promoting anti-discrimination and person-centred care; and Standard Four ensuring that care in hospital will be provided appropriately by properly trained staff.

6.56 We also welcome the publication of guidelines for implementing the medicine-related aspects of the NSF for Older People[96]. We hope that this can set the groundwork for further and more comprehensive guidelines on the use of medication for mental disorder with older people.

6.57 Two particular cases of deaths of elderly detained patients have caused us concern in this period:

- A frail 79 year old man with a confusional state was admitted to a psychiatric ward under section 2 for assessment of his condition. His haemoglobin was noted to be 25% and he was transferred to the general care of an elderly ward. His psychiatric records were not transferred with him. After he had become agitated and assaultative towards staff, he was given a prescribed rapid tranquillisation combination of drugs in a dosage more suitable to an active fit young man. When he woke up, he was unsteady on his feet and fell on several occasions sustaining injuries to his head. He later died from a large skull fracture.

- A 76 year old woman was admitted to a psychiatric ward for assessment under Section 2. She was noted to be eating and drinking little over the ten-day period before she died of dehydration, but little or no specific action seems to have been taken to address the problem.

6.58 In both cases Commissioners attended the inquests with Properly Interested Person status and pursued matters with the Trusts concerned. In the second case, although an internal inquiry concluded that the standard of care was poor and changes were implemented to prevent a recurrence, an unannounced visit by a specialist nurse Commissioner two months later showed that

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[95] Department of Health (2001) **National Service Framework for Older People**. London, March 2001. www.doh.gov.uk/nsf/olderpeople.htm

[96] Department of Health (2001) **Medicines and Older People: Implementing the medicines-related aspects of the NSF for Older People**. London, March 2001. www.doh.gov.uk/nsf/olderpeople.htm

little had changed and that two patients were in imminent danger. These cases were brought to the attention of the Medical Director.

6.59 The dangers of services failing to take account of the particular needs of elderly patients are evident from these examples. In the first example, a general hospital ward mishandled psychiatric treatment with tragic consequences; in the second, a ward providing psychiatric treatment was failing to provide the most basic care needed to maintain patients' lives.

6.60 The service model outlined for mental health services in the NSF for Older People could help to ensure that these failures do not happen[97]. Specialist mental services should be multi-disciplinary and have agreed working and referral arrangements with, amongst others, dieticians and pharmacists. Specialist services are expected to provide outreach and advice services to other parts of the service.

Recommendation 68

Non-specialist services who care for elderly detained patients should look to the expectations placed on specialist services by the National Service Framework for Older People (p103 – 6) and try to meet those expectations as far as they are able.

Recommendation 69

All mental health services providing care to elderly detained patients should have agreed working and referral arrangements with appropriate medical and psychiatric expertise in the care of older people.

6.61 Commissioners all too frequently note particular problems in the care environments of elderly patients. A common problem is the management of urinary incontinence, as evidenced by strong urine smells in certain wards. Affected wards should review their management of this issue and check that floor-coverings are appropriate

6.62 Many older patients without mental capacity to give consent to their care and treatment, particularly those with dementia-related disorders, are not necessarily detained under the Mental Health Act. Being essentially compliant with their care and treatment, they are provided with this under common-law powers. It is widely acknowledged that such patients may be inappropriately prescribed neuroleptic drugs to treat behavioural complications of their disorder, sometimes with adverse effects on their cognitive state[98]. We welcome the Department's guidance on this, which applies to detained patients as well as informal ones[99]. However, there is, as yet, little overview of these and more general standards of care and treatment for patients who lack mental capacity but who are not

[97] Department of Health (2001) **National Service Framework for Older People**. London, March 2001. P 103-6

[98] Department of Health (2001) **Medicines and Older People: Implementing the medicines-related aspects of the NSF for Older People**. London, March 2001 p 15; Department of Health (2001) **National Service Framework for Older People**. London, March 2001. P99

[99] [99] Department of Health (2001) **National Service Framework for Older People**. London, March 2001. www.doh.gov.uk/nsf/olderpeople.htm p 99

detained under the Act. We discuss our concerns over such patients at paragraphs 6.68 – 6.69 below.

Needs of Patients with Learning Disabilities

6.63 The National Service Framework for Mental Health aims to enable people with Learning Disability to access mainstream psychiatric services in the same way as anyone else wherever possible. It recognises that this will require mainstream services to be more responsive to the needs of such patients. The NSF for Mental Health also recognises the need for specialist learning disability services, both to provide specialist treatment to learning disabled patients and to provide facilitation and support to mainstream services.

6.64 One of the challenges faced by all services that detain learning disabled patients is to provide information to such patients. This applies to fulfilling the statutory duty to provide detained patients with information on their legal situation and rights (Section 132) just as it does to providing suitable information to enable them to participate in their treatment to the fullest extent possible. We welcome the Government's assurance that it will take steps to ensure that mental health promotion materials and information are available in formats accessible to people with learning disabilities, including those from minority ethnic groups[100], and trusts that this will extend to patient leaflets on the Mental Health Act 1983. We will be similarly reviewing our own patient information leaflets (see Chapter 2.12).

Good practice example

Dr Anna Thomas, now working for Independent Community Living Ltd, has aided the Commission in producing a "Symbol" Mental Health Act Commission poster, aimed at people with mental impairment or reading difficulties, which has been a success in Learning Disabilities Units. Dr Thomas has also produced a pictorial information leaflet explaining Section 37 for patients in her own care, which other services may wish to adapt for their own use.

(Contact: Dr A Thomas, ICL ltd, Lys Ifor, Crescent Road, Caerphilly, South Wales CF83 1XY tel 029 2088 1994 fax 029 2085 3111)

Recommendation 70

The Department of Health should consider formats for its information leaflets on the Mental Health Act that will be accessible to patients with learning disabilities. Such formats could include pictoral or "symbol" text, or video.
(see recommendation 5, Chapter 2.11)

6.65 Relatively few patients in specialist learning disability units are detained under the Mental Health Act. Planned Commission visits to such units may be postponed due to the fact that there are no detained patients for Commissioners to see. Although Commissioners have encountered some excellent

facilities and services for this group of patients, they have also encountered some alarmingly poor services. The limit to the Commission's oversight of the many small units providing services for the learning disabled is of considerable concern.

6.66 In one particularly worrying example, a Commissioner visited a learning disability unit on world mental health day (10 October) 2000. Patients resident on the men's villa (none of whom were detained under the Act) were housed on a locked ward in appalling conditions. A strong smell of urine pervaded the ward, and patients had little or no available activities or access to fresh air. The Commissioner recorded that she was shocked at the conditions and aura of low expectation on the unit. It was even more disturbing that, as there were no detained patients on the ward, these conditions had come to the Commission's attention by chance.

6.67 We believe that there are important lessons to be learned from such examples about the need for regular visits to services where vulnerable patients are detained. These are discussed briefly below.

The vulnerable position of long-term mentally incapacitated patients

6.68 Every Commission Biennial Report (starting in 1985) has expressed concern at the de facto detention of mentally incapacitated patients[101], whether they are patients with learning disability, dementia or head-injuries. The judgement in R v Bournewood Community & Mental Health NHS ex parte L [1998) 3 AER[102] confirmed that, under the present law, it is acceptable for such patients to be kept informally in hospital where they are compliant with such action, even though this was described in the judgment of Lord Steyn as "an indefensible gap in mental health law". We remain extremely concerned at the lack of legal protection offered to such patients, not only with regard to the possibility that they may be held in hospital where such action is unwarranted or unlawful, but also because such patients are denied the protections offered to patients detained under the Mental Health Act regarding consent to treatment, aftercare and visitorial oversight by the Commission.

6.69 We acknowledge and welcome the Government's intention to provide safeguards in relation to the long-term mentally incapacitated[103], including bringing such patients within the remit of the successor body to the Commission. The experience of Commissioners (see Chapters 6.xx above) suggests that an important aspect of this protection must be a visitorial role, whether this is given to the successor body or to any other organisation with appropriate experience and expertise.

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[100] Department of Health (2001**) Valuing People: A New Strategy for Learning Disability for the 21st Century**. London, Stationery Office. p 66.

[101] Mental Health Act Commission (1985) **First Biennial Report** p 11; (1987) **Second Biennial Report** p50; (1989) **Third Biennial Report** p 35; (1991) **Fourth Biennial Report** p43; (1993) **Fifth Biennial Report** p.47; (1995) **Sixth Biennial Report** p 66; (1997) **Seventh Biennial Report** p 180-181 (1999); **Eighth Biennial Report** p 35, 254 –255. London, Stationery Office.

[102] see Mental Health Act Commission (1999) **Eighth Biennial Report**. London, Stationery Office p 33-35

Recommendation 71

The Commission urges the Government to consider ways in which long-term incapacitated patients can be protected while new legislation is awaited.

[103] Department of Health (2000) **Reforming the Mental Health Act: Part I The New Legal Frarmework**. London, Stationery Office. Chapter 6

7 The Commission in Wales

The National Assembly for Wales

7.1 The Mental Health Act Commission serves both England and Wales. Since we started work in 1983, there have often been differences in service provision and practice between England and Wales. This situation has been accentuated since 1999 by the creation of the National Assembly for Wales, the election of its members and its appointment of a Minister of Health and Social Services. These changes have significantly increased the importance of the Commission paying attention to differences in policy and practice while continuing to fulfil our main function of visiting patients to ensure satisfactory compliance with the provisions of the Mental Health Act 1983.

7.2 In recognition of this new situation, the Vice-Chairman of the Commission's Board, Professor Richard Williams, has taken the lead on Welsh matters which are of concern to the Commission and has established positive links between the Commission's Board and Members and staff of the National Assembly. Although Professor Williams will unfortunately be leaving the Commission at the end of September 2001, we intend to continue the practice of having a Board Member with this special focus.

7.3 In March 2001, the Commission held a Board Meeting at the Assembly building in Cardiff Bay. Board Members were able to discuss matters of mutual interest with the Minister, Jane Hutt AM, and the Chair of the Health and Social Services Committee, Kirsty Williams AM. The Commission's Board greatly welcomed this opportunity and were encouraged by the keen interest shown in the work of Commissioners. The Board intends to continue to hold at least one meeting a year in Wales to demonstrate its recognition of the differences between England and Wales.

Welsh Language Policy

7.4 The Commission has been active in developing its Welsh Language Policy in accordance with the requirements of the Welsh Language Act 1993. This policy, which has been endorsed by the Welsh Language Board and cited as a model of good practice, ensures that anyone who wishes to use the Welsh language in correspondence with or talking to Members or staff of the Commission may do so. Wherever possible, a Welsh-speaking Commissioner attends Commission visits in Wales and arrangements are made for any detained patient who wishes to speak to a Commissioner in Welsh to do so.

Mental Health Strategy and Policy in Wales

7.5 In reading Chapters 1 - 6 of this Biennial Report, it is important to recognise that many of the strategies and policies mentioned there do not apply to Wales. One example of this is "Modernising Mental Health". It is therefore necessary to distinguish between the NHS Framework for England and that for Wales. Wales has not adopted anything similar to the NHS Zero Tolerance policy which is

welcomed in Chapter 4.35, but we would strongly recommend that the National Assembly looks seriously at the possibility of doing so. The Commission for Health Improvement and the National Institute for Clinical Excellence both have responsibilities for aspects of mental health in Wales, but there is a separate Welsh Care Standards Commission.

7.6 We welcome the decision of the National Assembly to place mental health as one of its three top health priorities, as in England. In June 2000, two Welsh mental health strategy documents were issued for consultation. *"Everybody's Business"*[104], is groundbreaking as the first plan of its kind in the U.K. to cover the whole field of mental health services for children and adolescents. In Chapter 6.44, we commend such a strategy to England. We look forward to seeing the plan fully implemented and developed into practices which may serve as an example to mental health services in England as well as Wales.

7.7 The Commission was pleased to see detained patients specifically mentioned in the section on empowerment in *"Equity, Empowerment, Effectiveness, Efficiency"*[105], the draft strategy for adult services. This states that such patients should be encouraged to participate actively and willingly in their own care. Commissioners comment frequently on the beneficial effect which such involvement has on the health of the patients concerned. We understand that the National Assembly intends to develop a National Service Framework for Wales from the strategy.

7.8 Although the strategy plans which have emerged from these two consultation exercises have not yet been published, the Commission understands that the Minister, Jane Hutt, has confirmed them and that they will be launched in September this year. We look forward, in particular, to seeing how individual detained patients will be affected by those objectives which will address some of the issues covered in this report, such as:

- the development of advocacy services for all patients;
- the adoption of the Care Programme Approach for the first time in Wales;
- the improvement of discharge plans to include suitable support and follow-up.

All of these go towards the over-riding objective of providing mental health services in settings which are fit for purpose and which provide dignity and privacy. The importance which the Commission attaches to this objective is emphasised in Chapters 3 and 4 of this Report.

Structural Change

7.9 Prior to devolution, the Welsh Office reconfigured the NHS Trusts and, in April 1999, reduced them by almost one half. Wales now has no mental health or community Trusts – a significant difference compared to the development of some very large combined mental health and community Trusts in England. Similarly, in 1998, when Primary Care Groups were created in England with a view to the development of Primary Care Trusts independent of Health Authorities, in Wales, 22 Local Health

[104] **Child and Adolescent Mental Health Services. *Everybody's Business***. Consultation Strategy Document June 2000
[105] **Adult Mental Health Services for Wales: *Equity, Empowerment, Effectiveness*, *Efficiency***. Draft Strategy document June 2000

Groups were created as sub-committees of the five Health Authorities, each one co-terminous with one of the County Borough Councils and having local authority representation on its board.

7.10 Commissioners have not observed that these differences in structure have had any direct effect on the experiences of individual mentally ill patients in Wales, perhaps because the commissioning of mental health services has not yet been devolved to the Local Health Boards.

7.11 The consultation document *Improving Health in Wales- Structural Change in the NHS in Wales* (published in July 2001- after the period covered by this Report) proposes to replace all five health authorities by twenty-two Local Health Boards. These will be statutory bodies grouped under three Health Economy Teams (for North Wales, South and East Wales and Mid and West Wales). Although the Commission understands that the new system will pay particular attention to the commissioning arrangements for mental health services, we are concerned that already over-pressed managers and staff, heavily engaged in adapting to changes in management arrangements, may lose sight of the priority which should be accorded to mentally ill patients, especially those detained against their will.

The Commission's Activities in Wales

7.12 All visits to mental health facilities in Wales are carried out by one of the Commission's seven Commission Visiting Teams (CVT6). The Commissioners who are regular members of this team are highlighted in Appendix A. This Team covers the West Midlands as well as Wales and so its members have to be familiar with the structures of two health services and with two different approaches to mental health policy. Welsh Trusts that have borders with England and English Trusts which border on Wales similarly find themselves working with patients from both countries and with two structures and policies. The Commissioners are therefore able to appreciate the demanding challenges this duality poses for professionals and managers in those services and the need for greater recognition and better training to take account of the position.

Recommendation 72

Welsh Trusts with boundaries with England and English Trusts with Welsh boundaries should ensure that there is at least a nucleus of staff who know both systems well enough to offer advice as necessary to those who deal with cross-boundary patients.

7.13 During the two years under review, Commissioners visited every mental health facility in Wales which held detained patients on a rolling programme. Most units will have received at least three visits in the period. A total of 51 visits were made overall.

7.14 As explained in the Introduction to this Report (Chapter 1), we do not wish to name and blame but to provide an overview of how the implementation of the Act is affecting the people it aims to protect, to help the facilities visited to improve their own practice, and to draw attention to general areas of poor practice and advise on possible remedies. Commissioners are greatly impressed by the general level

of commitment and care shown by staff and managers on their visits. With very few exceptions, the general areas of poor practice which have been identified in Wales reflect those in England. The recommendations made in earlier chapters and the Commentary and Schedule of Recommendations in Chapter 9 therefore apply as much to Wales as to England. The following paragraphs accordingly highlight only those issues which we believe are of particular significance in Wales.

Rights and Respect

Doctors appointed under Section 12 of the Mental Health Act

7.15 Chapter 2.57 stresses the importance of Section 12 doctors and recommends a number of actions by Health Authorities to try to increase the number and availability of such doctors so that patients are not subjected to long delays in assessment. Commissioners in Wales have also identified problems over the availability and location of suitably approved doctors but our particular concern relates to the mechanisms for considering applications for Section 12 approval in Wales, the standards applied to applicants and the training required of them. We note that these all vary considerably amongst the health authorities in Wales. In particular, some health authorities require specific training but some require none.

7.16 The Commission takes the view that all patients are entitled to receive a common standard of assessment for detention and believes that there should be at least minimum national requirements for training. There may be concerns that raising the threshold for approval would reduce the number of doctors applying to be approved but experience in England suggests that many potential applicants feel re-assured by the offer of training. In this respect, we are glad to note that both the National Assembly for Wales and the Department of Health have made funding available to the Royal College of Psychiatrists towards the training of child and adolescent psychiatrists as Section 12 doctors.

Recommendation 73

In considering how responsibilities for approving Section 12 doctors should be exercised under the proposed restructuring, the National Assembly for Wales should review the current system for approving Section 12 doctors with a view to ensuring greater consistency and a minimum level of initial and ongoing training.

Approved Social Worker (ASW) Issues

7.17 Chapter 2 also highlights the important role of ASWs and the need for them to complete standardised forms to ensure that all the relevant information about a detained patient is left with the receiving hospital. Commissioners regularly scrutinise forms completed by ASWs in relation to individual patients and have been glad to note that, although the quality and comprehensiveness of such forms varies widely across Wales, there are several examples of good practice.

Quality and Standards of Care

Bed pressures

7.18 Commissioners frequently express concerns about the adequacy of facilities for acutely ill and disruptive patients, especially those who require medium secure beds. We nevertheless believe that it is difficult to establish whether there is a true shortage of secure beds in Wales without a detailed analysis of the extent to which patients are being kept unnecessarily in such accommodation because of the shortage of low secure beds.

Recommendation 74

The Specialist Health Services Commission for Wales should encourage a holistic assessment of bed needs across all security levels so that patients are not kept at a higher level of security than their condition justifies.

Staffing issues; shortage of psychiatrists

7.19 As in England, workforce issues are likely to be the key to the development of mental health services for patients of all ages. Commissioners report that there is a significant shortage of psychiatrists in Wales, although closer analysis suggests that the proportion of vacant posts is actually lower than in England. The position varies considerably across the country, with worrying numbers of vacancies in particular parts of Wales, and especially a shortage of forensic psychiatrists. We understand that although there are sufficient training posts in Wales to fill present and predicted consultant vacancies, the out-turn of trainees is not sufficient to fill those vacancies. We welcome the National Assembly's recognition of the problem and the initiative it has taken to review the situation.

Essential environmental requirements

7.20 Staffing issues naturally impact on delivery of the standard of care which should be provided. A number of in-patient facilities in Wales remain housed in old unsuitable buildings. Some progress has been made during the period under review in that a number of wards have been up-graded and refurbished while others, such as the Mid-Wales Hospital in Talgarth, have been relocated in completely new units. Particular concerns continue to be:

- the provision of single sex facilities for men and women;
- access to fresh air;
- lack of activity; and
- an inappropriate mix of patients on wards.

As an example of the latter, Commissioners visited one ward on which staff were caring for patients with conditions ranging from chronic psychosis and personality disorders to substance misuse and learning disabilities.

7.21 In spite of continuing concerns, we have been greatly encouraged by the positive response of Trusts which have sought to implement coherent ward management policies and by the many examples of

good practice which have been encountered in Welsh facilities. One such example, involving Cardiff and Vale NHS Trust, is highlighted at Chapter 3.19.

ECT in Wales

7.22 The Commission's study of ECT facilities is described at Chapter 3.31, where we report the figures from our initial analyses of the ECT survey combined for England and Wales. Fourteen of the 230 clinics reviewed were in Wales. A summary of the findings relating to these clinics is provided in Figure 10 below.

7.23 Three of the 18 clinics which were rated highly in the total survey were in Wales and another three Welsh facilities were in the group of 30 which complied to all requirements to a substantial extent. At the other end of the scale, one clinic had less than three rooms and at least one other departure from the standards expected. Although the proportion of ECT facilities scoring well in Wales was much higher than in England (40% compared with18%), the relatively small number of suites involved is obviously a relevant factor.

Figure 10

Item	Percent (n=14 sites surveyed in Wales)
The Arrangements for ECT Possession of a dedicated ECT suite, comprising 3 or more rooms, including a separate waiting room and recovery room	**79**
A Policy for ECT Clinics which were able to show the surveyor either a copy of the Royal College of Psychiatrists Handbook or a copy of the hospital's own ECT policy	**100**
A Named Consultant Psychiatrist ECT clinics with a named consultant psychiatrist who visits regularly	**93**
Recovery and Resuscitation ECT Clinics that have, in practice, a nurse in the recovery room who is trained in Basic Life Support, Cardio-pulmonary Resuscitation and who attends refresher courses in resuscitation regularly	**86**

7.24 As recorded in Chapter 3.35, a full analysis of the findings from this survey in both England and Wales will be published later in 2001.

Diversity: addressing the needs of diverse groups of patients

7.25 The difficulties highlighted in Chapter 6 in relation to small groups of diverse patients are in general similar in Wales to England. The problems of Black and minority ethnic groups are, however, more easily overlooked because only Cardiff reaches the national average for people from such minorities. Because the population is so much more dispersed in Wales, it is difficult to address the needs of

relatively isolated individuals. This is one of the reasons why the Commission, in consultation with the National Assembly for Wales, has decided to carry out a National Visit in Wales which will focus on the needs of Black and minority ethnic groups, following up some of the issues raised in our second National Visit to the whole of England and Wales.[106]

Children and Adolescents

7.26 One major difference between Wales and England is the creation of standards by the Health Advisory Service 2000 for the inpatient psychiatric care of adolescents in the NHS in Wales. All psychiatric facilities that admit young people are required to meet these standards. In particular, all mental health services must have in place explicit protocols covering the arrangements for and management of young people admitted to adult mental illness units. This includes specific items relating to child protection and the availability of staff who have been trained to work with children and are police checked. In Chapter 6.44 we recommend that the Department of Health considers the adoption of similar standards and protocols.

7.27 Commissioners have found that, in practice, problems in finding appropriate places for adolescents in Wales and in applying the protocols to adolescents in adult facilities are increasing because of the pressure on adult psychiatric units from the rise in numbers of adults who need urgent or emergency admission. The number of young people who need such help has also risen and yet we understand that the number of dedicated places for adolescents is proportionately less in Wales than in any NHS region in England. We therefore welcome the commitment in *"Everybody's Business"* to review this problem.

7.28 In Wales as in England, the Commission has recently required Commissioners who have not been police-checked not to hold any private meeting with a child or adolescent patient unless another Commissioner is present. A small panel of Second Opinion Appointed Doctors with expertise in child expertise is also being identified. The Commission will ensure that they are police-checked for attendance on such patients.

7.29 These observations underline the key importance, as stressed in Chapter 6, of ensuring that general strategies and policies for the protection of children are applied to this especially vulnerable group of children and adolescents.

Conclusion

7.30 In carrying out their functions during the past two years, Commissioners have noted very few significant differences in the implementation of the Mental Health Act 1983 between Wales and England. The development of different policies and strategies and perhaps of different legislation and priorities may alter this position over the years to come. This chapter has highlighted some of the

[106] Warner et al (2000) **Improving Care for Detained Patients from Black and Minority Ethnic Communities Preliminary Report - National Visit 2**. Sainsbury Centre for Mental Health

current differences. We will continue to note significant differences in the hope that this may encourage the better sharing of good practice throughout Wales and England.

7. Y Comisiwn yng Nghymru

Cynulliad Cenedlaethol Cymru

7.1 Mae'r Comisiwn Deddf Iechyd Meddwl yn gwasanaethu Cymru a Lloegr. Ers i'r Comisiwn ddechrau ar ei waith ym 1983, yn aml fe fu gwahaniaethau yn narpariaeth y gwasanaeth a'r arfer rhwng Cymru a Lloegr. Fe gafodd y sefyllfa hon ei amlygu ers 1999 oherwydd creu Cynulliad Cenedlaethol Cymru, ethol ei aelodau a phenodi Gweinidog Iechyd a Gwasanaethau Cymdeithasol. Mae'r newidiadau hyn wedi cynyddu'n arwyddocaol ar y pwysigrwydd i'r Comisiwn dalu sylw i'r gwahaniaethau mewn polisi ac arfer tra'n parhau i gyflawni ei swyddogaeth o ymweld â chleifion er mwyn sicrhau cydymffurfio boddhaol gyda darpariaethau Deddf Iechyd Meddwl 1983.

7.2 I gydnabod y sefyllfa newydd hon, mae Is-Gadeirydd Bwrdd y Comisiwn, Yr Athro Richard Williams, wedi rhoi arweiniad ar y materion Cymreig sydd o bryder i'r Comisiwn ac mae wedi sefydlu dolenni cyswllt cadarnhaol rhwng Bwrdd y Comisiwn ac Aelodau a Staff y Cynulliad Cenedlaethol. Er y bydd Yr Athro Williams yn anffortunus yn gadael y Comisiwn ddiwedd Medi 2001, mae'r Comisiwn yn bwriadu parhau gyda'r arfer o gael Aelod o'r Bwrdd sy'n meddu'r canolbwynt arbennig hwn.

7.3 Ym Mawrth 2001, fe gynhaliodd y Comisiwn Gyfarfod o'r Bwrdd yn adeilad y Comisiwn ym Mae Caerdydd. Roedd Aelodau'r Bwrdd yn gallu trafod materion a oedd o gyd-ddiddordeb iddynt gyda'r Gweinidog, Jane Hutt AC, a Chadeirydd y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol Kirsty Williams AC. Fe groesawodd Bwrdd y Comisiwn y cyfle hwn yn fawr iawn ac fe'u calonogwyd gan y diddordeb byw a ddangoswyd yng ngwaith y Comisiynwyr. Mae'r Bwrdd yn bwriadu parhau i gynnal o leiaf un cyfarfod y flwyddyn yng Nghymru i arddangos ei gydnabyddiaeth o'r gwahaniaethau sydd rhwng Cymru a Lloegr.

Polisi'r Iaith Gymraeg

7.4 Mae'r Comisiwn wedi bod yn weithredol mewn datblygu ei Bolisi Iaith Gymraeg yn unol â gofynion Deddf yr Iaith Gymraeg 1993. Mae'r polisi hwn, sydd wedi cael ei gymeradwyo gan Fwrdd yr Iaith Gymraeg a'i enwi fel model o ymarfer dda, yn sicrhau bod unrhyw un sy'n dymuno defnyddio'r iaith Gymraeg mewn gohebiaeth â, neu mewn siarad ag Aelodau neu staff y Comisiwn, yn gallu gwneud hynny. Pryd bynnag mae hynny'n bosibl, mae Comisiynydd Cymraeg ei iaith yn mynychu ymweliadau'r Comisiwn yng Nghymru ac fe wneir trefniadau i unrhyw glaf dan orchymyn sy'n dymuno siarad â Chomisiynydd yn Gymraeg wneud hynny.

Strategaeth a Pholisi Iechyd Meddwl yng Nghymru

7.5 Wrth ddarllen Penodau 1 - 6 o'r Adroddiad Dwyflynyddol, mae hi'n bwysig cydnabod nad yw llawer o'r strategaethau a'r polisïau a grybwyllir yno yn cymhwyso at Gymru. Un enghraifft o hyn yw "*Modernising Mental Health*." Mae'n angenrheidiol gan hynny i wahaniaethu rhwng Fframwaith GIG ar gyfer Loegr a'r un ar gyfer Cymru. Nid yw Cymru wedi mabwysiadu unrhyw beth sy'n debyg i bolisi

Goddefgarwch Sero'r GIG sy'n cael ei groesawu ym Mhennod 4.35, ond fe fyddem yn argymell yn gryf bod y Cynulliad Cenedlaethol yn edrych yn ddifrifol ar y posibilrwydd o wneud hynny. Mae gan y Comisiwn ar gyfer Gwelliant Iechyd a'r Sefydliad Cenedlaethol ar gyfer Ardderchowgrwydd Clinigol gyfrifoldebau am agweddau ar iechyd meddwl yng Nghymru, ond y mae Comisiwn Safonau Gofal Cymru ar wahân.

7.6 Yr ydym yn croesawu penderfyniad y Cynulliad Cenedlaethol i osod iechyd meddwl fel un o'i dri prif flaenoriaeth iechyd, fel y digwydd yn Lloegr. Ym Mehefin 2000, fe gyflwynwyd dwy ddogfen strategaeth iechyd meddwl Gymreig ymgynghorol. Mae *Everybody's Business* [107], yn torri tir newydd fel y cynllun cyntaf o'i fath yn y DG, i gwmpasu maes cyfan gwasanaethau iechyd meddwl ar gyfer plant a phobl ifanc. Ym Mhennod 6.34, yr ydym yn cymeradwyo strategaeth o'r fath ar gyfer Lloegr. Yr ydym yn edrych ymlaen at weld y cynllun yn cael ei weithredu a'i ddatblygu'n llawn mewn arferion a all weithredu fel enghraifft i wasanaethau iechyd meddwl yn Lloegr yn ogystal â Chymru.

7.7 Roedd y Comisiwn yn falch o weld cleifion dan orchymyn yn cael eu crybwyll yn benodol yn yr adran ar awdurdodi yn *Equity, Empowerment, Effectiveness, Efficiency*[108] , y strategaeth ddrafft ar gyfer gwasanaethau oedolion. Mae hon yn datgan y dylai'r cyfryw gleifion gael eu hannog i gymryd rhan weithredol ac un sydd o'u gwirfodd yn eu gofal hwy eu hunain. Mae'r Comisiynwyr yn gwneud sylwadau'n aml ar yr effaith llesol a gaiff ymwneud o'r fath ar iechyd y cleifion dan sylw, Yr ydym ar ddeall bod y Cynulliad Cenedlaethol yn bwriadu datblygu Fframwaith Gwasanaeth cenedlaethol ar gyfer Cymru o'r strategaeth.

7.8 Er nad yw'r cynlluniau strategaeth sydd wedi ymddangos o'r ddau ymarfer ymgynghori hyn wedi cael eu cyhoeddi hyd yma, mae'r Comisiwn ar ddeall bod y Gweinidog, Jane Hutt, wedi eu cadarnhau ac y byddant yn cael eu lansio ym Mis Medi eleni. Edrychwn ymlaen, yn neilltuol, at weld sut yr effeithir ar gleifion unigol dan orchymyn gan yr amcanion hynny a fydd yn ymdrin â rhai o'r materion a gynhwyswyd yn Rhan 1 yr Adroddiad hwn, megis:

- datblygiad gwasanaethau eiriolaeth ar gyfer yr holl gleifion;
- mabwysiadu'r Dull Gweithredu Rhaglen Ofal am y tro cyntaf yng Nghymru;
- pwysigrwydd y cynlluniau rhyddhau i gynnwys cefnogaeth addas a dilyniant.

Mae'r rhain i gyd yn cyfrannu at yr amcan pwysicaf o ddarparu gwasanaeth iechyd meddwl mewn lleoliadau sy'n addas i'r perwyl ac sy'n darparu urddas a phreifatrwydd. Mae'r pwysigrwydd y mae'r Comisiwn yn ei osod ar yr amcan hwn yn cael ei bwysleisio ym Mhenodau 3 a 4 yr Adroddiad hwn.

[107] **Child and Adolescent Mental Health Services.** ***Everybody's Business***. Consultation Strategy Document June 2000

Newid Strwythurol

7.9 Cyn datganoli, fe ailgyflunwyd Ymddiriedolaethau GIG gan y Swyddfa Gymreig ac, yn Ebrill 1999, fe'u cwtogwyd gan ymron i'r hanner. Nid oes gan Gymru erbyn hyn unrhyw Ymddiriedolaeth iechyd na chymuned. - gwahaniaeth arwyddocaol o'i gymharu â'r datblygiad mewn rhai Ymddiriedolaethau iechyd meddwl a chymunedol cyfunedig mawr iawn yn Lloegr. Yn yr un modd, ym 1998, pan grëwyd Grwpiau Gofal Cynradd yn Lloegr gyda'r bwriad o ddatblygu Ymddiriedolaethau Gofal Cynradd fyddai'n annibynnol o'r Awdurdodau Iechyd, yng Nghymru, fe grëwyd 22 Grŵp Iechyd fel is-bwyllgorau o'r pump Awdurdod Iechyd, pob un ohonynt yn ffinio ag un o'r Cynghorau Bwrdeistrefol Sirol ac â chynrychiolaeth awdurdod lleol ar ei fwrdd.

7.10 Nid yw'r Comisiynwyr wedi sylwi bod y gwahaniaethau hyn mewn strwythur wedi cael unrhyw effaith uniongyrchol ar brofiadau cleifion unigol ag afiechyd meddwl yng Nghymru, efallai oherwydd nad yw'r comisiynu gwasanaethau iechyd meddwl hyd yma wedi ei ddatganoli i'r Byrddau Iechyd Lleol.

7.11 Mae'r ddogfen ymgynghorol *Improving Health in Wales - Structural Change in the NHS in Wales* (a gyhoeddwyd yng Ngorffennaf 2001- ar ôl y cyfnod a gwmpesir yn yr Adroddiad hwn) yn cynnig disodli pob un o'r pump awdurdod iechyd gan ddau ar hugain o Fyrddau Iechyd Lleol. Fe fydd y rhain yn gyrff statudol wedi eu grwpio o dan Dimau Economi Iechyd (ar gyfer Gogledd Cymru, De a Dwyrain Cymru, a Chanol a Gorllewin Cymru). Er bod y Comisiwn ar ddeall y bydd y system newydd yn talu sylw neilltuol i'r trefniadau comisiynu ar gyfer gwasanaethau iechyd meddwl, yr ydym yn bryderus y gall rheolwyr a staff sydd eisoes wedi eu gorlwytho, ac â rhan drom mewn addasu i newidiadau mewn trefniadau rheolaethol, golli golwg ar y flaenoriaeth y dylid ei rhoi i gleifion ag afiechyd meddwl, yn enwedig y rhai hynny sydd dan orchymyn yn erbyn eu hewyllys.

Gweithgareddau'r Comisiwn yng Nghymru

7.12 Mae'r holl ymweliadau â chyfleusterau iechyd meddwl yng Nghymru yn cael eu cynnal gan un o saith Tîm Ymweld Comisiynol y Comisiwn (CVT6). Mae'r Comisiynwyr sy'n aelodau rheolaidd o'r tîm hwn yn cael eu hamlygu yn Atodiad A. Mae'r tîm hwn yn cwmpasu Gorllewin Canolbarth Lloegr yn ogystal â Chymru ac felly mae'n rhaid i'w aelodau fod yn gyfarwydd â strwythurau dau wasanaeth iechyd ac â dau wahanol ddull gweithredu tuag at bolisi iechyd meddwl. Mae Ymddiriedolaethau Cymreig sydd â ffiniau â Lloegr ac Ymddiriedolaethau Saesnig sy'n ffinio ar Gymru yn yr un modd yn eu canfod eu hunain yn gweithio gyda chleifion o'r ddwy wlad a chyda dau strwythur a pholisi. Mae'r Comisiynwyr gan hynny yn gallu gwerthfawrogi'r sialens anodd y mae'r ddeuoliaeth hon yn ei osod ar bobl broffesiynol a rheolwyr yn y gwasanaethau hynny a'r angen am fwy o gydnabyddiaeth a gwell hyfforddiant i ymdopi â'r sefyllfa.

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[108] **Cymru Gwasanaethau Iechyd Meddwl Oedolion ar gyfer Cymru *Equality, Empowerment*, *Effectiveness, Efficiency*** Dogfen Strategaeth Ddrafft Mehefin 2000

Argymhelliad

Fe ddylai Ymddiriedolaethau Cymreig sydd â ffiniau â Lloegr ac Ymddiriedolaethau Saesnig sydd â ffiniau â Chymru sicrhau bod o leiaf gnewyllyn o staff sy'n gwybod am y ddwy system yn ddigon da i roi cyngor fel y bo angen i'r rhai sy'n delio â chleifion traws-ffiniol.

7.13 Yn ystod y ddwy flynedd a oedd dan adolygiad, fe ymwelodd y Comisiynwyr yn ôl rhaglen dreiglol a phob un cyfleuster iechyd meddwl yng Nghymru a oedd yn cadw cleifion dan orchymyn. Fe fydd y rhan fwyaf o'r unedau wedi derbyn o leiaf dri ymweliad [109] yn ystod y cyfnod hwn. Fe wnaed cyfanswm o 51 o ymweliadau yn gyfangwbl.

7.14 Fel yr eglurwyd yn y Cyflwyniad i'r Adroddiad hwn (Pennod 1), nid ydym yn dymuno enwi a beio ond yn hytrach darparu arolwg o sut y mae gweithredu'r Ddeddf yn effeithio ar y bobl y mae'n fwriad ganddi eu hamddiffyn, i wella'r cyfleusterau yr ymwelwyd â hwy er mwyn gwella eu harfer hwy eu hunain, ac i dynnu sylw at ardaloedd cyffredinol o ymarfer sâl a chynghori ar ddulliau posibl i wella arnynt. Fe wnaethpwyd argraff dda ar y Comisiynwyr gan lefel gyffredinol yr ymrwymiad a'r gofal a ddangoswyd gan y staff a'r rheolwyr ar eu hymweliadau. Gydag ond ychydig iawn o eithriadau, mae'r meysydd cyffredinol o arfer sâl a ganfyddwyd yng Nghymru yn adlewyrchu'r rhai sy'n Lloegr. Mae'r argymhellion a wnaethpwyd mewn penodau cynharach a'r Sylwebaeth a'r Crynodeb o Argymhellion ym Mhennod 8 yn cymhwyso gan hynny yn gymaint at Gymru ag y mae at Loegr. Nid yw'r Penodau canlynol felly ond yn amlygu'r materion hynny y credwn eu bod o arwyddocâd neilltuol yng Nghymru.

Hawliau a Pharch

Doctoriaid a benodwyd o dan Adran 12 y Ddeddf Iechyd Meddwl

7.15 Mae Pennod 2 yn pwysleisio pwysigrwydd doctoriaid Adran 12 ac mae'n argymell nifer o ffyrdd y gall yr Awdurdodau Iechyd weithredu i geisio cynyddu nifer ac argaeledd Meddygon o'r fath fel na bo'r cleifion yn wrthrych oedi maith mewn asesiadau. Mae'r Comisiynwyr yng Nghymru wedi canfod anawsterau yng Nghymru yn ogystal gydag argaeledd a lleoliad meddygon a gymeradwywyd ond y mae ein pryderon neilltuol yn berthynol i'r peirianwaith ystyried ceisiadau ar gyfer cymeradwyaeth Adran 12 yng Nghymru, y safonau a gymhwysir at ymgeiswyr a'r hyfforddiant sy'n ofynnol. Yr ydym yn nodi bod y rhain i gyd yn amrywio'n helaeth ymysg awdurdodau iechyd yng Nghymru. Yn neilltuol, mae rhai awdurdodau iechyd yn gofyn am hyfforddiant penodol a rhai nad ydynt yn gofyn am ddim.

7.16 Mae'r Comisiwn o'r farn bod yr holl gleifion â'r hawl i dderbyn safon asesu gyffredinol ar gyfer gorchymyn ac yn credu y dylasai bod gofynion lleiaf yn bod yn genedlaethol ar gyfer hyfforddiant. Fe all bod pryderon y byddai codi'r trothwy ar gyfer cymeradwyaeth yn lleihau nifer y meddygon fyddai'n ceisio cymeradwyaeth ond mae'r profiad yn Lloegr yn awgrymu y byddai llawer o ymgeiswyr posibl yn teimlo'n fwy bodlon o gael cynnig hyfforddiant. Parthed hyn yr ydym yn falch o nodi bod Cynulliad Cenedlaethol Cymru a'r Adran Iechyd fel ei gilydd wedi gwneud cyllid ar gael i Goleg Brenhinol y

Seiciatryddion tuag at hyfforddi seicolegwyr plant a phobl ifanc fel meddygon Adran 12 (gweler Pennod 6.34).

Argymhelliad

Wrth ystyried sut y dylasid gweithredu'r cyfrifoldebau ar gyfer cymeradwyo meddygon Adran 12 yn ôl yr ail strwythuro arfaethedig, fe ddylai Cynulliad Cenedlaethol Cymru adolygu'r system bresennol ar gyfer cymeradwyo meddygon Adran 12 gyda'r bwriad o sicrhau mwy o gysondeb a lleiafswm o lefel hyfforddiant dechreuol a chyfredol.

Materion Gweithiwr/wraig Cymdeithasol Cymeradwyedig (GCC)

7.17 Mae Pennod 2 yn amlygu yn ogystal swyddogaeth bwysig GCCau a'r angen am iddynt gwblhau ffurflenni safonedig er mwyn sicrhau bod yr holl wybodaeth berthnasol ynglŷn â chlaf dan orchymyn yn cael ei adael gyda'r ysbyty derbyn. Mae'r Comisiynwyr yn archwilio'r ffurflenni a gwblhawyd gan GCCau yn rheolaidd yn berthynol â chleifion unigol ac maent wedi bod yn falch o nodi, er bod ansawdd a hollgynhwysedd ffurflenni o'r fath yn amrywio'n eang ledled Cymru, bod llawer o enghreifftiau o arfer dda.

Ansawdd a Safonau Gofal

Y pwysau am welyau

7.18 Mae'r Comisiynwyr yn aml yn mynegi pryderon ynglŷn â pha mor addas yw'r cyfleusterau ar gyfer y difrifol wael a chleifion trafferthus, yn enwedig y rhai sydd ag angen gwelyau diogelwch canolig. Yr ydym yn credu fodd bynnag ei bod hi'n anodd sefydlu pa un a oes prinder gwirioneddol o welyau diogel yng Nghymru heb ddadansoddiad manwl o'r graddau y cedwir cleifion yn ddiangen mewn llety o'r fath oherwydd prinder gwelyau diogelwch isel.

Argymhellion

Fe ddylai'r Comisiwn Gwasanaethau Iechyd Arbenigol dros Gymru annog asesiad holistaidd o anghenion gwelyau ar draws yr holl lefelau diogelwch fel nad yw'r cleifion yn cael eu cadw ar lefel diogelwch uwch nag y mae eu cyflwr yn cyfiawnhau.

Materion staffio; prinder seiciatryddion

7.19 Fel yn Lloegr, mae materion gweithlu yn debygol o fod yn allweddol i ddatblygiad iechyd meddwl ar gyfer cleifion o bob oed. Mae'r Comisiynwyr yn adrodd yn ôl bod prinder arwyddocaol o seiciatryddion yng Nghymru, er bod dadansoddiad mwy manwl yn awgrymu bod y gydran o swyddi gweigion mewn gwirionedd yn llai nag ydynt yn Lloegr. Mae'r sefyllfa'n amrywio'n sylweddol ar draws y wlad, gyda niferoedd sy'n achosi pryder mewn rhannau neilltuol o Gymru, ac yn arbennig prinder seiciatryddion fforensig. Yr ydym ar ddeall er bod digon o swyddi hyfforddi yng Nghymru i lenwi swyddi gwag ar gyfer ymgynghorwyr ar hyn o bryd ynghyd â'r rhai a arfaethir, nid yw'r nifer sy'n derbyn hyfforddiant yn ddigonol i lenwi'r swyddi gwag hynny. Yr ydym yn croesawu bod y Cynulliad Cenedlaethol wedi cydnabod y broblem a'r fenter a gymerodd i adolygu'r sefyllfa.

Gofynion amgylcheddol hanfodol

7.20 Mae materion staffio yn naturiol yn effeithio ar gyflenwi'r safon gofal y dylid ei darparu. Mae nifer o gyfleusterau cleifion mewnol yng Nghymru yn parhau i fod mewn hen adeiladau anaddas. Fe wnaethpwyd peth cynnydd yn ystod cyfnod yr arolwg oherwydd fe gafodd nifer o wardiau eu huwchraddio a'u hadnewyddu tra bod rhai eraill, fel Ysbyty Canolbarth Cymru yn Nhalgarth, wedi cael eu hadleoli i unedau cyfan gwbl newydd. Mae pryderon neilltuol yn parhau ynglŷn â

- darpariaeth cyfleusterau un rhyw ar gyfer dynion a merched;
- mynediad at awyr iach;
- diffyg gweithgareddau;
- a chymysgedd amhriodol o gleifion ar wardiau.

Fel enghraifft o'r pwynt olaf, fe ymwelodd y Comisiynwyr ag un ward ble roedd y staff yn gofalu am gleifion gyda chyflyrau a oedd yn amredeg o seicosis cronig ac anhwylderau personoliaeth hyd at gamddefnyddio sylweddau ac anableddau dysgu.

7.21 Er gwaetha'r pryderon sy'n parhau, fe gawsom ein calonogi'n fawr gan ymateb cadarnhaol yr Ymddiriedolaethau sydd wedi ceisio rhoi polisïau cydlynus rheolaeth wardiau mewn grym a chan y llu o enghreifftiau o arfer dda y daethpwyd ar eu traws mewn cyfleusterau Cymreig. Fe gaiff un enghraifft o'r fath, a oedd yn ymwneud ag Ymddiriedolaeth GIG Caerdydd a Bro Morgannwg, ei hamlygu ym Mhennod 3.19.

Therapi Electrogynhyrfol (ECT) yng Nghymru

7.22 Fe ddisgrifir astudiaeth y Comisiwn o ECT ym Mhennod 3.31 uchod, ble yr ydym yn rhoi adroddiad ar y ffigyrau o'n dadansoddiadau dechreuol o'r arolwg ECT a gyfunwyd ar gyfer Cymru a Lloegr. Roedd pedwar ar ddeg o'r 230 clinig a adolygwyd yng Nghymru. Fe ddarperir crynodeb o'r canlyniadau sy'n berthynol i'r clinigau hyn yn Nhabl Y isod.

7.23 Roedd tri o'r 18 clinig y rhoddwyd dyfarniad uchel iddynt yn yr arolwg cyfan yng Nghymru ac yr oedd tri chyfleuster Cymreig arall yn y grŵp o 30 a oedd yn cydymffurfio â'r holl ofynion i raddau sylweddol. Yn y pegwn arall, roedd llai na thair ystafell mewn un clinig ac yr oedd o leiaf un arall a oedd heb gyrraedd y safonau a ddisgwylid. Er bod y gydran o gyfleusterau ECT a oedd yn cyrraedd sgôr dda yng Nghymru yn llawer uwch nag yn Lloegr (40% o'i gymharu â 18%). mae'r nifer gymharol fechan o'r cyfleusterau dan sylw yn amlwg yn ffactor perthnasol.

Tabl Y

Eitem	**Canran** (n=14 safleoedd a arolygwyd yng Nghymru)
Y trefniadau ar gyfer ECT Yn meddu ystafelloedd ECT penodedig, sy'n cynnwys 3 neu fwy o ystafelloedd, gan gynnwys ystafell aros ar wahân, ac ystafell ddadebru	**79**
Polisi ar gyfer ECT Clinigau a oedd yn gallu dangos i'r archwilydd naill ai gopi o Lawlyfr Coleg Brenhinol y Seiciatryddion neu i bolisi ECT yr ysbyty ei hun	**100**
Seiciatrydd Ymgynghorol a Enwyd Clinigau ECT gydag arbenigwr seiciatryddol a enwir sy'n ymweld yn rheolaidd	**93**
Adferiad a Dadebriad Clinigau ECT sydd, yn ymarferol, â nyrs yn yr ystafell ddadebru sydd wedi'i hyfforddi mewn Cynnal Bywyd Sylfaenol, Adferiad Cardio-ysgfeiniol, ac sy'n mynychu cyrsiau gloywi mewn dadebru'n rheolaidd.	**86**

7.24 Fel y cofnodwyd ym Mhennod 3.35, fe fydd dadansoddiad llawn o ganfyddiadau'r arolwg hwn yng Nghymru a Lloegr fel ei gilydd yn cael eu cyhoeddi'n ddiweddarach yn 2001.

Amrywiaeth: ymdrin ag anghenion grwpiau amrywiol o gleifion

7.25 Mae'r anawsterau a amlygir ym Mhennod 6 parthed grwpiau bychain o gleifion amrywiol yn gyffredinol yn gyffelyb yng Nghymru ac yn Lloegr. Mae problemau lleiafrifoedd Duon ac ethnig fodd bynnag, yn haws eu hanwybyddu oherwydd mai dim ond Caerdydd sy'n cyrraedd y cyfartaledd cenedlaethol ar gyfer y cyfryw leiafrifoedd. Oherwydd bod y boblogaeth yn llawer mwy gwasgaredig yng Nghymru, mae'n anodd ymdrin ag anghenion unigolion sy'n weddol ynysig. Dyma un o'r rhesymau pam y mae'r Comisiwn, mewn ymgynghoriad â Chynulliad Cenedlaethol Cymru, wedi penderfynu cynnal Ymweliad Cenedlaethol yng Nghymru a fydd yn canolbwyntio ar anghenion lleiafrifoedd Duon ac ethnig, gan fynd ar ôl rhai o'r materion a godwyd yn ein hail Ymweliad Cenedlaethol â Chymru a Lloegr gyfan.[110]

Plant a phobl ifanc

7.26 Un gwahaniaeth mawr rhwng Cymru a Lloegr ydyw'r creu ar safonau gan y Gwasanaeth Iechyd Ymgynghorol 2000 ar gyfer gofal seiciatrig mewnol pobl ifanc yn y GIG yng Nghymru. Mae'n ofynnol ar i'r holl gyfleusterau seiciatrig sy'n derbyn pobl ifanc ddiwallu'r safonau hyn. Yn neilltuol, mae'n rhaid i'r holl wasanaethau iechyd meddwl fod â phrotocol pendant yn cwmpasu'r drefniadaeth ar gyfer, a'r rheolaeth ar, bobl ifanc sy'n cael eu derbyn i unedau iechyd meddwl i oedolion. Mae hyn yn cynnwys eitemau penodol parthed amddiffyn plant ac argaeledd staff sydd wedi cael eu hyfforddi i weithio gyda phlant ac wedi eu gwirio gan yr heddlu. Ym Mhennod 6.44 yr ydym yn argymell bod yr Adran Iechyd yn ystyried mabwysiadu safonau a phrotocolau cyffelyb.

7.27 Mae'r Comisiynwyr wedi darganfod, yn ymarferol, bod problemau mewn canfod lleoedd priodol ar gyfer pobl ifanc yng Nghymru ac mewn cymhwyso'r protocolau at y bobl ifanc mewn cyfleusterau i oedolion yn cynyddu oherwydd y pwysau sydd ar yr unedau seiciatrig gan y cynnydd yn y nifer o oedolion sydd angen derbyniad brys neu argyfwng. Mae nifer y bobl ifanc sydd angen cymorth o'r fath wedi codi'n ogystal, ac eto, yr ydym ni ar ddeall bod nifer y lleoedd penodol ar gyfer y bobl ifanc ar gyfartaledd yn llai yng Nghymru nag mewn unrhyw ranbarth GIG yn Lloegr. Yr ydym gan hynny'n croesawu'r ymrwymiad yn *Everybody's Business* i adolygu'r broblem hon.

7.28 Yng Nghymru fel yn Lloegr, mae'r Comisiwn wedi ei gwneud hi'n ofynnol i'r Comisiynwyr na chawsant eu gwirio gan yr heddlu i beidio â chynnal cyfarfod preifat gyda phlentyn neu berson ifanc sy'n glaf os nad oes Comisiynydd arall yn bresennol. Mae panel bychan o Ddoctoriaid Ail Farn a Benodwyd gydag arbenigedd plant hefyd yn cael eu nodi. Fe fydd y Comisiwn yn sicrhau eu bod wedi cael eu gwirio gan yr heddlu ar gyfer ymweld â chyfryw gleifion.

7.29 Mae'r sylwadau hyn yn tanlinellu pwysigrwydd allweddol, fel y'i pwysleisir ym Mhennod 6, o sicrhau bod y strategaethau a'r polisïau cyffredinol ar gyfer amddiffyn plant yn cael eu cymhwyso at y grŵp o blant a phobl ifanc sy'n neilltuol o hawdd eu niweidio.

Casgliad

7.30 Wrth iddynt gynnal eu swyddogaethau yn ystod y ddwy flynedd ddiwethaf, ychydig iawn o wahaniaethau arwyddocaol y mae'r comisiynwyr wedi eu nodi yng ngweithrediad Deddf Iechyd Meddwl 1983 rhwng Cymru a Lloegr. Fe all datblygiad ar wahanol bolisïau a strategaethau ac efallai ar wahanol ddeddfwriaeth a blaenoriaethau newid y sefyllfa dros y blynyddoedd sydd i ddod. Mae'r bennod hon wedi amlygu rhai o'r gwahaniaethau presennol. Fe fyddwn yn parhau i nodi gwahaniaethau arwyddocaol yn y gobaith y gall hyn annog gwell rhannu ar arfer dda ledled Cymru a Lloegr.

8 The Organisation and Work of the Commission

8.1 Earlier chapters of this report have stressed that the findings and recommendations are all founded on our work during this reporting period. In support of that assertion, this Chapter gives a brief summary of how the Commission is organised and the main areas of work which have not only contributed to the contents of the Report but have ensured that the interests of detained patients are not overlooked in a wide range of circumstances. Some details relating to the Commission's work, and in particular its governance and financial management, are briefly discussed below. Full financial details can be found in the **Appendix G** to this Report.

8.2 This Chapter is followed by a commentary and schedule of the recommendations discussed in previous chapters and evidenced by the work and activities described below.

The Function of the Commission

8.3 The Mental Health Act Commission is a Special Health Authority whose functions are set out in Section 121 of the Mental Health Act 1983 and subsidiary legislation. The Commission's primary responsibility is monitoring the application of the Mental Health Act as it relates to the care and treatment of detained patients in England and Wales. We discharge this function mainly by visiting such patients and checking that the legal requirements for their detention appear to have been met. On such visits we also look at the arrangements and procedures which ensure that detained patients' care and treatment is provided in accordance with the Act and the Code of Practice. All reviews of arrangements and procedures are validated by testing them in operation and checking that staff are aware of and comply with their obligations under the Act. Broader responsibilities relate to the appointment of Second Opinion Appointed Doctors and neurosurgery panels, reviewing deaths in detention and dealing with complaints about the implementation of the Act.

8.4 The Commission's functions are fulfilled in the following ways:

- a programme of visits by teams of Commissioners to all hospitals or nursing homes caring for detained patients;
- the appointment by the Commission of a panel of Second Opinion Appointed Doctors (SOADs) who visit and give a second opinion on certain treatments for patients who are unable or unwilling to give consent (Section 58);
- appointing multi-disciplinary panels to consider the authorisation of neurosurgery for mental disorder for consenting patients, whether or not they are detained (Section 57);
- advice on, monitoring and sometimes investigation of complaints by detained patients;
- monitoring of deaths of detained patients, including review of any enquiry reports and attendance at some inquests;
- considering appeals against the withholding of postal packets from (and, since the introduction of new Security Directions, internal mail from and telephone calls by) patients in the High Security Hospitals;

- giving advice on policy and practice, based on established views or where necessary following discussion amongst groups of Commissioners with relevant professional expertise; and
- offering training on aspects of the Mental Health Act and Code of Practice for service providers and others concerned with the implementation of the Act.

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Commission Membership

8.5 The Commission consists of a Chairman, Vice-Chairman and up to 180 Commissioners, all of whom are appointed by the Secretary of State after open competition and formal interview. A list of all those who have been Commissioners in the period under review is given in **Appendix H**. Those who have served on the Commission's Board during the period of this report are indicated on this list. Additionally, the Commission's Chief Executive and Chief Financial Officer are executive members of the Board.

8.6 Figure 11 below analyses Commission membership by gender and shows the representation of members from Black and Minority Ethnic groups. Figures are shown as at March 2000 and March 2001 to illustrate current trends in membership.

Figure 11: Commission Membership Profile & Changes 2000/01

Analysis	Numbers @ March 2000				Numbers @ March 2001			
By Source	**Male**	**Female**	**Total**		**Male**	**Female**	**Total**	
White	**73**	**68**	**141**	***82.9%***	**75**	**59**	**134**	***77.9%***
Black & Minority Ethnic Groups	**18**	**11**	**29**	***17.1%***	**22**	**16**	**38**	***22.1%***
Total	**91**	**79**	**170**		**97**	**75**	**172**	
	53.5%	***46.5%***		***100.0%***	***56.4%***	***43.6%***		***100.0%***

8.7 One success of the efforts to improve our profile with Black and minority ethnic groups (see Chapter 6.14 and Appendix D) is reflected in the fact that membership from these groups has risen from 17% at 1 April 1999 to 22% by 31 March 2001. During the same period, the proportion of members who are female decreased slightly, but with a much higher number now drawn from Black and minority ethnic populations. Overall, therefore, the male/female membership balance of members drawn from Black and minority ethnic communities is now more reflective of the overall gender balance. We believe that this analysis demonstrates our commitment to the diversity that has been emphasised in Chapter 6.

8.8 Similarly, the diverse professional backgrounds of our Commissioners mirrors our belief in a multi-disciplinary approach, both to our own services and to mental health services in general. Nearly half

our Commissioners have a nursing or social work background; 15% are lawyers, 11% are consultants or GPs and 26% come from other disciplines, such as psychology, pharmacy or mental health administration, or from non-professional backgrounds. Many of our Commissioners from all backgrounds are or have been service users or carers.

Second Opinion Appointed Doctors (SOADs)

8.9 Doctors who have been acting as SOADs between 1999 and 2001 are listed in **Appendix I**. Figure 12 below provides a breakdown of gender and ethnicity for SOADs appointed by the Commission.

Figure 12: SOAD Panel Profile Of Active SOADs and Changes 2000/01

	Numbers @ March 2000				Numbers @ March 2001			
Source	**Male**	**Female**	**Total**		**Male**	**Female**	**Total**	
Black & Minority Ethnic Groups	**34**	**2**	**36**	***23.1%***	**57**	**5**	**62**	***33.9%***
Other	**94**	**26**	**120**	***76.9%***	**96**	**25**	**121**	***66.1%***
Total	**128**	**28**	**156**		**153**	**30**	**183**	
	82.1%	***17.9%***		***100.0%***	***83.6%***	***16.4%***		***100.0%***

8.10 The escalation of SOAD demand since 1997/98 (see paragraph 8.18 *et seq.* below) has made SOAD recruitment a priority issue for the Commission during this period. The SOAD panel has increased significantly throughout the period, with SOADs from Black and minority ethnic groups now providing one third of the panel membership. Although the total number of female SOADs has increased, the proportion of SOADs who are female has fallen slightly to one in six.

8.11 The recruitment drive also took account of the fact that a large proportion of the SOAD panel is made up of older doctors, with a significant reliance on SOADs who are past retirement age. This potentially signals future difficulties and efforts have been made to encourage applications from younger age groups. However, whilst the majority of new appointments are now under 55 years of age, it remains difficult to recruit working consultant psychiatrists to the SOAD panel and one in five SOADs are currently over retirement age.

Commissioner and SOAD Visiting Activities

Visiting Activities

8.12 Commissioners are divided into seven Commission Visiting Teams (CVTs), covering different geographic areas. Each of the High Security Hospitals also has a dedicated team. The CVTs work to a two-year programme, during which time every Trust or Registered Mental Nursing Home in their area

which holds detained patients is visited at least three times. The Commission will visit establishments where there are particular difficulties or large numbers of patients more often. The primary purpose of the visits is to meet patients currently detained, to check their documentation and to validate in practice that arrangements ensure that they are being treated in accordance with the provisions of the Act and the Code of Practice. This inevitably raises many of the general issues highlighted in Chapters 2 - 7 above.

8.13 Figure 13 summarises key visiting activity during the reporting period and compares this to the previous period. The number of visits made each year cannot easily be compared because we record them by number of Trusts rather than by number of facilities visited. The major reconfiguration of Trusts which has occurred recently therefore means that where there may previously have been one visit to a Trust managing two facilities, one visit to a large amalgamated Trust may now cover, say, eight or nine facilities.

8.14 In comparison to the previous period, in this reporting period there has been a substantial increase in all patient related activity. Whilst private meetings are driven by patient requests and can, in some years, show a reduction, all other areas are managed by Commissioners and show by far the largest gains. Translated into more personal measures, and after allowing for patients seen more than once, the following patient contact frequencies are estimated:

- At the High Security Hospitals, all patients meet a Commissioner and have their rights protected by document checks at least once in any year: and
- At other providers, on average Commissioners meet with about 1 in 15 of all detained patients in private and they check documentation of or meet informally with a further 1 in 6 of all such patients.

It is this high level of contact that gives us confidence regarding the depth of knowledge that Commissioners have about services to detained patients and the strength of evidence that underlies the conclusions and generalisations made in the preceding chapters of this report.

Figure 13 – Visiting Activity

Details of Patient Contacts and Documentation Checks	1997/98 to 1998/99	1999/2000 to 2000/01	Increase
Direct Patient Contacts			
- Private Meetings with Document Checks	12394	13042	5.2%
- Individual Patients Met Informally	6580	8656	31.6%
- Individual Patients Met in Group Situations	742 *	895	20.6%
- Total Direct Patient Contacts	**19716**	**22593**	**14.6%**
Documentation Checks			
- Documents Checked but Patient Not Seen	7910 *	11285	42.7%
- Total Document Checks	**20304**	**24327**	**19.8%**

* Data not collected in 1997/98, therefore estimated at 1998/99 activity levels

8.15 Because of the wide range of services involved in the provision of care to detained patients, at least one of the visits to each Trust is used by Commissioners to seek the views of others who are involved with those patients. The most significant of these is Social Services, which are visited separately at least one in every two-year period to ensure that they too are properly fulfilling their functions under the Act. Additionally, when Commissioners undertake a full visit to a Trust, they invite representatives of users and carers, Patient Councils or similar bodies, relevant voluntary organisations, including advocacy services, and other statutory services such as the police and ambulance service to attend a general discussion so that concerns relating to the treatment of the patients can be fully discussed.

8.16 During the course of each visit, Commissioners raise issues about particular patients with the staff who are directly responsible for them and in so doing are able immediately toresolve many difficulties. At the end of each visit, there is a meeting with senior managers from the Trust or Nursing Home at which Commissioners discuss their findings. This is followed by a formal written report to the Chief Executive which comments on what Commissioners have found and, where necessary, suggests remedial action. Commissioners see their visits as not only providing safeguards for the patients but also offering support to staff and managers who often find the observations and guidance of an outside expert body of considerable assistance.

8.17 The visits and meetings described in the preceding paragraphs have been the primary source of evidence for the general and specific points made throughout this report. The need to synthesise what is learned from the experience of individual patients and validation work based on more focussed and better documented surveys of how the Act and Code of Practice are being implemented has led to the

changes in our administrative and visiting arrangements which are described in paragraphs 8.34 – 8.37 below.

SOADs

8.18 SOAD activity is demand-led. Although the Commission can and does initiate a small number of visits by using our powers to withdraw previous certificates, for which purpose we review the treatment of all patients subject to treatment under Section 58 for a certain period of time[111], the large majority of SOAD visits are initiated by requests from individual patients' RMOs. Fluctuations in the number of SOAD visits is therefore wholly outside the control of the Commission. The Commission responds to these requests by allocating SOADs on a rotational basis linked to proximity to the hospital or nursing home in which the patient is receiving treatment.

8.19 Figure 14 shows that, following the significant increase in demand in 1998, the number of requests for Second Opinions has remained relatively stable.

Figure 14: SOAD Activity 1997/98 to 2000/01

	1997/98	%Change	**1998/99**	%Change	**1999/00**	%Change	**2000/01**
Medication Only	**4,732**	29.2%	**6,116**	-5.8%	**5,761**	4.7%	**6,033**
ECT Only	**2,197**	1.5%	**2,229**	-2.7%	**2,169**	-3.0%	**2,105**
ECT and Medication	**74**	6.8%	**79**	27.8%	**101**	-12.9%	**88**
	7,003	20.3%	**8,424**	-4.7%	**8,031**	2.4%	**8,226**

Section 57 activity: neurosurgery for mental disorder

8.20 During this reporting period we arranged visits to consider the authorisation of neurosurgical procedures for the treatment of mental disorder in relation to nine patients (seven in 1999/2000, two in 2000/01). The Commission's role in this matter is to appoint a multi-disciplinary panel to consider whether the patient is giving fully informed, valid consent and whether the treatment can be given[112]. In one case, the appointed panel deferred their decision, requesting that the patient's records and aftercare plan be fully completed, before certifying that the operation could go ahead. All nine operations were eventually certified to go ahead.

Matters requiring particular attention

8.21 In addition to patient visits and document checks (see paragraph 8.12 above), we selected four aspects of implementation for structured scrutiny during the period under review. Three of these were

[111] See Section 61, Mental Health Act 1983.
[112] See Section 57, Mental Health Act 1983

monitored by detailed questionnaires and interviews with staff completed in every ward visited. These related to:

- the provision of information on patients' rights
- contact with Responsible Medical Officer
- knowledge of and contact with named nurse

8.22 The information gained from these surveys is still being collated and analysed, but an initial analysis of information provided to patients on their rights under the Act is discussed at Chapter 2.8 – 2.10.

8.23 The fourth area of special investigation was ECT, which was based on facilities rather than wards. The initial findings from this exercise are discussed in Chapters 3.31 - 3.35 and 7.22 – 7.24.

Complaints

8.24 The Complaints Co-ordinator is a Commissioner who oversees the administrative arrangements for dealing with complaints made directly to the Commission. During the two years under review, 747 new written complaints were received and followed up by the Commission and 244 formal complaints were raised or reviewed during visits. None of these led to a full investigation by the Commission (see Chapter 2.25 *et seq.)*.

Deaths of Detained Patients

8.25 All hospitals and Registered Mental Nursing Homes are required by the Commission to notify us of the death of a detained patient within 72 hours of the event. A panel of experienced and specially trained Commissioners is available to attend inquests, with Properly Interested Person Status where appropriate, and/or to follow up any subsequent Commission concern with service providers. In the two years under review, we were notified of 881 deaths and attended 127 inquests. In February 2001 we published a report, *Deaths of Detained Patients in England and Wales*[113], analysing information collated as a result of these activities (see Chapter 4.17 *et seq.* and **Appendix B**).

Section 134 – Reviewing Withheld Mail / Telephone calls

8.26 The Commission is empowered to consider appeals over the withholding of patients' mail in the High Security Hospitals[114]. We undertook fifteen such reviews in this period and, after consideration of all the circumstances, directed in five cases that the withheld item should be released to the mail's intended recipient. In one further case, we directed that part of the withheld item should be released.

8.27 Although the High Security Hospital Safety and Security Directions (see Chapter 5) provided the Commission with a power to review the withholding of internal mail and telephone calls from the 30 November 2000, no requests for such a review were made of the Commission from that time to the end of the reporting period.

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[113] Mental Health Act Commission (2001) **Deaths of Detained Patients in England and Wales; A Report by the Mental Health Act Commission on Information Collected from 1 February 1997 to 31 January 2000**. Details of how to obtain the report are given in Appendix X

[114] See Section 134, Mental Health Act 1983

Advice on Policy and Practice

8.28 The Commission's Secretariat provides help and informal advice to services and patients, utilising the expertise of Commissioners where appropriate. We estimate that, annually, we deal with some 2000 such queries by telephone and 400 by letter. The Commission also publishes advice and guidance on aspects of the implementation of the Act. A list of published guidance is given in **Appendix K**.

Public Consultations

8.29 The period from 1999-2001 was a particularly busy one in terms of the formulation of national policy. We played a significant role in offering policy advice on matters relating to detained patients. Our main inputs were as follows:

- **Expert Committee on the Review of the Mental Health Act 1983**
  We provided a detailed response to the Expert Committee's consultation in 1999.
- **Reponse to the consultation paper on "Managing Dangerous People with a Severe Personality Disorder"**
- **Response to the consultation paper on "Reforming the Mental Health Act"**
  The responses to these two documents set out clearly the Commission's position on the main consultation issues. Since these documents were not published, the Summary of the Commission's Views from the each of them is reproduced in full in **Appendices E and F**. We were pleased to note that the proposals in both Parts of the subsequent White Paper accorded very closely to the views we had expressed.
- **Submission of a separate document to the Department of Health giving the Commission's detailed views on a successor body.**
  The proposals for a Commission for Mental Health closely follow the Commission's suggestions, with particular regard to greater monitoring capability and increased ability to analyse findings and offer support and advice. We shall maintain an ongoing dialogue with the Department about the need to ensure that the omission of a visiting function from the remit of our successor body will be adequately covered by the arrangements proposed in the White Paper.
- **Submission of evidence to the Home Affairs Select Committee on Regulating Private and Voluntary Healthcare and a response to the subsequent consultation paper.**
  We were glad to see that the establishment of the Care Standards Commission drew particular attention to the need to focus on mentally people in private care facilities.

Equal Opportunities

8.30 The Commission's Equal Opportunities Strategy, launched in 1997, is discussed at Chapter 6.14. This reporting period saw the launch of phase two of the strategy: the Commission's Regional Consultation Exercises. Three multi-disciplinary events were organised by the Commission in collaboration with the University of Central Lancashire during the period, each preceded by consultation interviews and seminars in which Commissioners met with representatives of the Black and minority ethnic

community, voluntary organisations, service providers and other relevant groups. The lessons for services that emerged from these exercises are also discussed at Chapter 6.21 *et seq*., while a synopsis of the reports now published on these three events is provided in **Appendix D**.

8.31 During the period under review, we have established an Equal Opportunities Advisory Group consisting of experienced Commissioners from each of the visiting teams, whose remit is to provide ongoing advice to the Board on wider equal opportunities issues, disseminate relevant information to their teams, assist in monitoring the impact of our Equal Opportunities Programme, both internally and externally, and help to develop relevant monitoring tools. These Commissioners will be closely involved in carrying forward the next stage of our work in this area (see Chapter 6. 14).

External Training

8.32 Following the issue of the revised Code of Practice in 1999, the Commission developed training on the application of the Code which was offered to all service providers. 157 days of such training were delivered by a panel of specially selected and trained Commissioners to 126 service providers.

8.33 The demand for and appreciation of this training were so high that a further set of training modules were developed concentrating on particular aspects of good practice and the Mental Health Act. From May 2000 to the end of the reporting period 83 further days of training were provided to 65 services by Commissioners. The level of satisfaction expressed by service providers for this training is high and there is an ongoing demand for it.

Administration and Corporate Governance

Administrative Support

8.34 Commissioners, SOADs and the Board are supported by a Secretariat consisting of an average of 31 staff, led by a Chief Executive who is accountable to the Chairman and the Commission Board. The Commission is grateful for the commitment and goodwill of the staff, who have coped with an exceptionally difficult period despite significant vacancies and changes at senior level. The period under review has been difficult not only because there have been many changes in national policies and structures but also because the Commission itself has been undergoing considerable administrative changes.

Corporate Strategy and Business Plan

8.35 At the end of the last biennial reporting period, the Commission undertook a review of its central organisational structure and associated costs.[115] The changes suggested by that review could not be implemented immediately because of significant vacancies and changes in staffing, but the work has been carried forward steadily since then. In 2000/2001, the Commission put forward to the Department of Health a Corporate Strategy and Business Plan which showed that, even after re-investing the savings identified to be available, its functions in relation to detained patients could not properly be fulfilled without substantial new investment. Both the Department of Health and the

[115] Mental Health Act Commission (1999) **Eighth Biennial Report** London, Stationery Office p19 - 20

National Assembly of Wales have now allocated additional resources for 2001/2002. These new funds will enable the employment of a more professional administrative and support staff structure and allow for the development of our Information Technology strategy (see paragraph 8.37 below).

Review of Visiting Practice

8.36 A major part of the Corporate Strategy was the development of current visiting activities to ensure that, while the commitment to visiting patients was wholly maintained, better arrangements could be made regarding validation checks and the follow-up of action by Trusts and Nursing Homes on issues of concern raised during visits. At Commission Conferences late in 2000 and Workshops early in 2001, all Commissioners were involved in developing detailed plans for organising visits and feed-back to service providers in ways which would help everyone concerned to improve the services to detained patients. This work is ongoing, with a further Commission Conference in September 2001, leading to discussions with stakeholders at strategic, management and operational level early in 2002. Service users and carers will be involved in these discussions and the publication of this Biennial Report will be a significant contribution to them.

Increased Support for Commissioner Activities

8.37 Both the Central Cost Review and the Review of Visiting Practice showed that better use could be made of the professional skills of Commissioners if the staff at the Commission's Secretariat could be strengthened, particularly at senior level, and if better technological tools were available to enable more sophisticated data input and analysis. As a result of the additional resources mentioned in paragraph 8.35 above, we are, at the time of writing this report, in the process of recruiting staff to provide the additional support needed to ensure that the evidential base and follow up to all our visits can be more systematised and consistent while simultaneously reducing the time which Commissioners need to spend on administration. Additional skilled staff are also being recruited to develop a technological infra-structure which will enable the Commission to record and analyse its data more efficiently and to communicate more effectively with all the relevant stakeholders in mental health services.

Corporate Governance

8.38 The Commission is almost wholly funded by the Department of Health and the National Assembly for Wales and is therefore accountable for its use of public monies. We are also required to conform to the corporate governance requirements applicable to all public bodies. During the period under review, we have undertaken a full review of all our corporate governance policies and documentation and have improved arrangements for planning, managing and accounting for expenditure.

Financial Management

8.39 During the reporting period, the Commission's financial management was subject to the scrutiny of a Finance and Audit Committee and external audit. Our total expenditure in 1999/2000 was ???? and in 2000/2001 it was ???? Efficiency savings were achieved in each year without any detriment to the visiting programme and budget underspends on other Commission activities helped offset an

unfunded deficit on SOAD fees and expenses. The Commission has no control over expenditure on SOAD fees since it is dependent wholly on the demand for second opinions and wishes to make clear that, without unfunded overspends in this area, a balanced outturn would have been reported in both years. **Appendix G** summarises expenditure, relevant notes and the balance sheet of the Commission extracted from the accounts as certified for presentation in this report by the statutory auditor. A full set of the accounts is available on application to the Commission.

Conclusion

8.40 We hope that this relatively brief description of the way in which the Commission has been developing demonstrates our commitment to the self-assessment and self-regulation processes which we are commending to others throughout this report. During the next biennial reporting period we shall not only have to maintain this positive development of the Mental Health Act Commission, but also consider and advise on the arrangements which will be necessary to make a smooth transition to the proposed Commission for Mental Health. We believe that the action which is currently being taken to strengthen our infrastructure and enhance our current visiting capacity will help us to do this without any adverse effect on our ongoing capacity to monitor the implementation of the existing legislation. We hope that the Commentary and Schedule of Recommendations in the following chapter will provide a useful tool for us to do so in full co-operation with policy makers, service commissioners and service providers.

9 Commentary and Schedule of Recommendations

9.1 This chapter puts the comments and findings in the preceding chapters in the context of the wider mental health environment and comments on the implications of this environment for them. It also groups the recommendations in a way which we hope will be useful to those who are responsible for implementing the Act in general and, in particular, to the mental health facilities which we shall be visiting during the next two years.

Mental Health Strategy

9.2 National policy on mental health has developed more quickly and more dynamically since the period covered by the Eighth Biennial Report than at any time in the history of state intervention in mental illness. The recognition of mental illness as one of the three top healthcare priorities of the present Government - on a par with cancer and cardiac illnesses - is a step whose importance is difficult to over-estimate. This major Governmental thrust is reinforced and emphasised by the bringing into effect of the Human Rights Act 1998, which puts a new and different stress on the recognition of individual rights.

9.3 The Commission's comments and recommendations are intended to be read in the context of the following major Government documents and the emerging strategies of the National Assembly for Wales:

- *Modernising Mental Health Services*
- *The National Health Service Plan*
- *The NHS Framework and Standards*

9.4 These documents (see **Appendix J** for a list of background documents to this report) set a clear strategy for the future development of mental health services and provide leadership and a sense of direction which the Commission greatly welcomes. In particular, we welcome the recognition that acutely ill patients do not necessarily have to be in residential care but can be treated within the community if the health and social services infra-structure can be made sufficiently robust. Any changes which reduce the number of patients initially admitted to hospital under the Act or re-admitted constantly because of their alleged "failure" to cope outside must be in the overall interests of the patient.

9.5 In our view, full implementation of this strategy, together with a continued commitment to the removal of stigma, will be key factors in reducing the number of detained patients so that the quality and standard of their care can begin to match the requirement of reciprocity in relation to such detention.

Structural Changes

9.6 The structural changes which directly affect mental health are far-reaching. In England, they include:

- establishment of Primary Care Trusts;

- amalgamation of many Acute and Community Mental Health Trusts;
- development of joint Health and Social Care Trusts; and
- integration of High Secure Hospitals with broader-based Trusts

Of less direct impact but nevertheless of relevance is the forthcoming major reduction in the number of Health Authorities and changes in the configuration and role of the National Health Service Executive Regional Offices. Similar structural changes are under way or proposed in Wales.

9.7 These are valuable foundation stones for the positive development of mental health care services in the 21st century and should clearly contribute to the development of the integrated infra-structures necessary to give effect to our recommendations on the care of detained patients. The Commission nevertheless wishes to emphasise that structural change needs to be phased and managed so that:

- mental health priorities are maintained throughout the period of change;
- the changes do not adversely affect individual patients;
- there is ongoing and effective implementation of the Mental Health Act;
- significant recommendations relating to improvements in practice can still be achieved; and
- there is a properly planned and integrated approach to how the structural changes interact with each other and the patients whom they affect.

Regulatory Changes

9.8 In parallel with these structural changes, the Government has set up or announced a number of new bodies with responsibilities for ensuring the delivery of services in different contexts or from different perspectives:

- *Commission for Health Improvement*
- *National Institute for Clinical Excellence*
- *Care Standards Commission*
- *National Patient Safety Agency*

9.9 This increase in regulatory bodies should similarly improve the likelihood of patients in general receiving the standard of service they are entitled to expect. None of them is, however, specifically concerned with detained patients, who are unlikely to be high in their priorities because of stronger demands from elsewhere in the National Health Service. Our particular concerns in relation to detained patients are that:

- boundaries may not be sufficiently clearly defined to prevent duplication of demands on those who are managing facilities with detained patients;
- responding to such demands may distract service managers from their core functions; and
- managers may assume that greater regulation diminishes their own responsibility for performance management.

We are sure that the Director for Mental Health will be well aware of the first two risks in carrying out his co-ordinating role in relation to the delivery of the Mental Health Plan. One of our aims in making the recommendations in this report is to help managers address both the second and the third risks by

signalling ways in which self-regulation may be made so effective that external regulatory action becomes a quality re-assurance process rather than a primary safeguard.

Managing in a Period of Uncertainty

9.10 The Commission recognises the strains which strategic, structural and regulatory changes are placing and will continue to place on the managers and staff of facilities which provide services to detained patients. We regularly observe their commitment and see the efforts they make to meet the needs of their patients in the face of practical difficulties caused by shortages of staff, money and/or alternative placements. We understand and empathise with these difficulties and hope that the points made above will help to reduce any adverse effects of change. None of this can, however, allow us to overlook the extent to which detained patients are disadvantaged by failure to implement the various provisions of the Act and the guidance in the Code of Practice.

9.11 The recommendations made throughout this report are all based on good practice which Commissioners have seen on visits to facilities where detained patients are held. Good practice in one area of implementation of the Act does not, of course, mean that it exists across all areas in any particular facility. We nevertheless believe that the good practice established by many managers and staff has general relevance and can be applied elsewhere to maintain and improve existing services in a constantly changing environment.

9.12 Where good systems are in place and well understood, managers and staff are better able to work together in the interests of the patients. Those who can demonstrate by regular monitoring of such systems that they are implementing the provisions of the existing legislation are far less likely to come into conflict either with regulatory bodies or with the provisions of the Human Rights Act. The less time that managers spend in responding to criticisms of their service, the more they have to spend in ensuring that the services for which they are responsible are properly delivered. Good management enhances the confidence of staff and frees them to spend more time with patients.

9.13 We do not therefore share the view that good management systems are a bureaucratic end in themselves. We believe that good systems are major cogs to connect the engine of policy to the wheels of practice so that detained patients actually receive the service intended by the legislation and related guidance. In the following paragraphs, we comment on how the way in which our recommendations are presented is intended to help managers at different levels to create and oil such cogs.

Grouping of recommendations

9.14 The summary of recommendations that follows has been divided into four sections:

- Strategic recommendations for action at national or regional/Health Authority level.
- Recommendations for agreed action between service commissioners and service providers.

- Recommendations for action by those with direct responsibilty for service delivery (i.e. local hospital managers, whether NHS or independent sector; High Security Hospital Managers; and social service managers).
- Recommendations for action at an operational level.

9.15 The terms used in these divisions are deliberately generic because of the structural changes mentioned above. During the next few years, for instance, "service commissioners" may be Health Authorities, Primary Care Trusts, or possibly other new specialised agencies with a strategic responsibility. Similarly, "service providers" may be Primary Care Trusts, Mental Health NHS Trusts, Health and Social Care Trusts or various private agencies, any of whom may be "hospital managers" within the definition of the Mental Health Act 1983 (i.e. anyone with direct responsibility for managing a facility which has the authority to hold detained patients[116]). All these terms may differ between England and Wales. The recommendations listed and the comments made will apply regardless of the nomenclature.

Strategic Action

9.16 The number of recommendations for strategic action is small because they are intended only to highlight particular concerns of the Commission which are not already specifically addressed in the current range of strategic proposals.

9.17 We hope that focussing on a few key areas may not only highlight the issues of particular relevance to detained patients but also help to identify areas which would serve as a useful basis for discussion between the various new regulatory bodies. Discussions on the need for national protocols on out of area placements (recommendation 39) or for the care of children in adult units (recommendation 64) could, for instance, help to establish boundaries and areas of co-operation between regulatory bodies which will ensure positive corporate working. We should be glad to facilitate or be involved in any such discussions.

Action between Service Commissioners and Providers

9.18 The recommendations under this heading are similarly limited because the main intention is to emphasise the need for those who commission services to work closely with service providers to establish policies and systems which apply as widely as possible to a range of providers. This will help to establish more consistent levels of care for patients as well as enabling commissioning bodies to establish monitoring and audit systems which will help to reveal best practice. The areas selected are those of particular concern to the Commission which we shall be closely monitoring during the next biennial period.

Action by those with direct responsibility for service delivery

9.19 By far the largest number of recommendations is intended for action by those with direct responsibility for the delivery of services. These are the managers with whom Commissioners have the most contact

[116] see Mental Health Act 1983, Section 145. (The definition given at paragraph 9.15 above is a précis of the statutory definition).

when visiting detained patients and establishing how far they are being treated within the terms of the Act and the Code of Practice.

9.20 The recommendations here are a clear indication of the issues which we shall be following through on our visits during the next two years. As implied in paragraph 9.10 above, we are well aware that many of the recommendations will be regarded as adding to administrative burdens rather than improving the service to patients. The key point which we wish to underline is that good systems and effective monitoring and feed-back can provide valuable support to those who are at the interface with patients and allow them to concentrate better on the staff/patient relationship. We believe that it is the nature of this relationship which ultimately determines the therapeutic value of detention.

Action at an operational level

9.21 Finally, there are a few recommendations intended specifically for those at the interface with patients. We have been especially selective here because we believe that it is for managers to determine operational requirements and that the recommendations for managers will translate readily into such requirements. The three issues which we have highlighted are ones which observation leads us to conclude are particularly likely to be overlooked unless staff at operational level take a personal interest in them.

Performance Management

9.22 Our recommendations have deliberately not been prioritised. We wish to emphasis that there is good and bad practice in all the facilities we visit and that we are constantly impressed by the quality and commitment of the managers and staff we meet. In our view, it is for them to examine the recommendations so that they may decide which are already being satisfactorily fulfilled and which areas need to take priority in improving their own service delivery. Self-assessment and Commission Visit Reports should both contribute to this process. High priority areas will depend on weaknesses identified, and may differ even within individual providers.

9.23 Similarly, we have not included any specific recommendation relating to performance management in the provision of mental health services. We assume that service providers wish to achieve good services in the first instance rather than having shortcomings identified by others. That is certainly the impression we have gained from the positive response which most providers make to the various matters raised by Commissioners at the end of each visit. “Getting it right first time” requires a rigorous process of self-assessment and improvement at local level, with commissioning and regulatory bodies undertaking regular monitoring and auditing functions. Our recommendations are intended to make a positive contribution to this process and it is with that in mind that we shall be looking to see how far they have been implemented during our visits over the next biennial period.

9.24 Finally, although most of our recommendations are resource neutral, and others could lead to overall savings, we recognise that many will have staffing or financial implications. At commissioning and local management levels, it is therefore essential that action plans are supported by a realistic assessment of resource needs and of how such resources will be provided. At a strategic level, the

total resource requirement needs to be clearly identified and given high priority in the light of the Government's commitment to mental health as one of its top three priorities for both England and Wales.

Conclusion

9.25 The Commission itself is in the same position as other bodies concerned with mental health services in facing the challenges and opportunities which the current far-seeing agenda for mental health reform poses. We have the great advantage of a single focus on patients who are detained or liable to be detained under the Mental Health Act but this in itself touches on the most difficult issues which face us all. We therefore intend to do all we can to help facilitate the many changes mentioned at the beginning of this Chapter. At the same time we shall continue to ensure that the implementation of the 1983 Act and the Code of Practice are given the priority they deserve by drawing attention to those aspects which fall far short of what is expected. The right of detained mentally disordered patients to be treated with the same respect and humanity as every other free member of society must be safeguarded.

Schedule of Recommendations

Strategic Recommendations for Action at National and Regional / Health Authority level.

References to the Department of Health should be taken as relating also to the National Assembly of Wales where appropriate.

Recommendation 1 **(Chapter 2.3)**
The Department of Health and National Assembly for Wales should take every opportunity to challenge inaccurate representation of mentally ill people, in the media and elsewhere, based upon stigmatising attitudes and stereotypes

Recommendation 5 **(Chapter 2.11)**
The Department of Health should ensure that patient information leaflets on the Mental Health Act 1983 are available in formats appropriate to the following groups of patients:

- **children and adolescents;**
- **deaf patients;**
- **blind patients;**
- **deaf/blind patients; and**
- **patients with Learning Disabilities**

(see also Recommendations 66 (para 6.44), 67 (6.54) & 68 (6.64))

Recommendation 8 **(Chapter 2.24)**
The Department of Health should issue guidelines on good practice in the provision of advocacy services as soon as possible, in advance of whatever is decided on the special advocacy service proposed in the new legislation.

Recommendation 11 **(Chapter 2.29)**
The Government should ensure that the new mental health legislation provides the Commission's successor body with an exceptional, discretionary power to investigate complaints or whistle-blowing allegations where appropriate.

Recommendation 13 **(Chapter 2.38)**
The Department of Health should commission research to examine the possible reasons for the nationally high use of Section 5(2), particularly with a view to investigating whether physical and / or therapeutic environment is an influencing factor.

Recommendation 21 **(Chapter 2.61)**
The lead Health Authority responsible for the approval of doctors under Section 12(2) in each region, in partnership with the other relevant services, should ensure that :

- **there is systematic high level collation of data from ASWs on the numbers of telephone calls made, the time taken to locate a Section 12 Approved doctor and the sharing of workload between doctors so that baselines and targets for improvement can be established;**
- **regular monitoring meetings between Health Authorities, Trusts, Social Services and Police are held to ensure that targets are met;**
- **intensive, possibly modular, training courses are established to enable a wider range of GPs to carry out the assessment function with confidence; and**
- **approved training courses are monitored to ensure both quality and consistency.**

Recommendation 25 **(Chapter 3.6)**
The Department of Health should ensure that national statistics on bed occupancy take account of detained patients who are on leave from inpatient beds, so that available beds and bed occupancy can be monitored more meaningfully.

Recommendation 38 **(Chapter 4.27)**
The Department of Health should ensure that national protocols are established, encompassing all service providers, to ensure clarity and accountability in all instances where a patient is located out of

area, whether by arrangement or because the patient has crossed boundaries without the knowledge of the detaining authority.

Recommendation 46 **(Chapter 4.50)**
New legislation should include provision for the regulation of the power to exercise control and restraint.

Recommendation 48 **(Chapter 4.61)**
The Department of Health should consider issuing guidance on the management of illicit-drug related incidents with a particular focus on mental health services caring for detained patients. Such guidance should clearly set out:

- **expected actions where there is a suspicion of illicit drug use or supply, or of alcohol consumption, whether by patients or visitors;**
- **expected actions where there is knowledge of illicit drug use or supply, or of alcohol consumption, whether by patients or visitors;**
- **powers of staff to search for and confiscate illicit drugs or alcohol;**
- **reassurance on the powers of staff to handle and dispose of illicit drugs that come into their possession;**
- **expected arrangements with police services over issues relating to illicit drugs; and**
- **expectations of service agreements between mental health services and drug and alcohol teams in relation to patients presenting with dual diagnosis or co-morbidity.**

Recommendation 51 **(Chapter 5.15)**
NHS Regional Offices, Regional Commissioning Bodies (DN Proper name ?) and Health Authorities should investigate the possibility of reviewing all patients in a particular area who are considered inappropriately placed at their current level of security to see how far patient exchanges might reduce mis-match and bed pressures.

Recommendation 52 **(Chapter 5.15)**
While the Commission recognises the pressure on high security beds, the possibility of maintaining a number of vacant places should be explored as a way to benefit both patient care and throughput efficiency of the High Security Hospitals.

Recommendation 60 **(Chapter 5.43)**
The Department of Health should consult with senior managers in the three High Security Hospitals to see if the adverse effects of the Security Directions can be minimised in any way.

Recommendation 65 **(Chapter 6.44)**
The Department of Health should consider the need for England to have standards and protocols for the care of mentally ill minors detained in adult units, as already exist in Wales.

Recommendation 71 **(Chapter 6.69)**
The Commission urges the Government to consider ways in which long-term incapacitated patients can be protected while new legislation is awaited.

Recommendation 73 **(Chapter 7.16)**
In considering how responsibilities for approving Section 12 doctors should be exercised under the proposed restructuring, the National Assembly for Wales should review the current system for approving Section 12 doctors with a view to ensuring greater consistency and a minimum level of initial and ongoing training.

Recommendation 74 **(Chapter 7.18)**
The Specialist Health Services Commission for Wales should encourage a holistic assessment of bed needs across all security levels so that patients are not kept at a higher level of security than their condition justifies.

Recommendations for Agreed Action between Service Commissioners and Service Providers

Recommendation 26 **(Chapter 3.8)**

Where shortage of beds appears to be adversely affecting services, service commissioners and providers should jointly consider and agree:

Short-term action: local reviews of all current inpatient stays with a view to clearly identifying the purpose of admission, anticipated length of stay and action required to achieve discharge.

Longer-term action: the establishment of systems & policies that lead to an increase in planned rather than emergency admissions, closer involvement of care co-ordinators during in-patient stays, and greater use of inpatient staff in providing advice to community staff where admission is being considered;

- **a review of policies and procedures around admission, assessment care planning and discharge;**
- **closer work between community and inpatient teams;**
- **the provision of staff training in CPA & risk management for both community and in-patient staff; and**

consideration of whether inadequacies in community provision are leading to admissions that could have been prevented with earlier intervention.

Recommendation 28 **(Chapter 3.18)**

All service commissioners and providers should ensure that the general environmental quality of inpatient facilities are subject to locally agreed, systematically monitored standards.

Recommendation 29 **(Chapter 3.18)**

Where remedial action is required in relation to general environmental quality, at whatever level, this should be the subject of an agreed action plan with resources needed for implementation clearly identified.

Recommendation 30 **(Chapter 3.22)**

Service commissioners and providers should agree and monitor specific standards for access to fresh air for all detained patients.

Recommendation 32 **(Chapter 3.29)**

Service commissioners and providers should agree specific standards for the provision of recreational, educational and therapeutic activities and monitor their availability, taking account of patients' views.

Recommendation 34 **(Chapter 4.15)**

Service commissioners and providers should agree:

- **standard classifications for incident reporting to be adopted in relation to all incidents involving detained patients;**
- **common management monitoring, audit and analysis of all untoward incidents falling within Class A, B and C to see whether any patterns emerge and what lessons can be learnt; and**
- **an arrangement for joint consideration of such patterns/lessons.**

Recommendation 61 **(Chapter 6.20)**

Service commissioners and providers should consider the consultation model used by the Commission when planning their own strategies to address diversity amongst their own patient populations. This model could be adapted and applied to the planning services for any identifiable groups of patients, including each of those that are presented in Chapter 6 of this report, and not only to Black and minority ethnic groups.

Recommendation 62 **(Chapter 6.24)**

Service commissioners and providers should engender clear strategic equality programmes, endorsed and driven by the Board and senior management of the service provider and allocated mainstream funding, taking account of the suggestions presented at 6.12 – 29 above.

Recommendation 65 **(Chapter 6.38)**

Service commissioning bodies and service providers should agree and monitor services for women patients to ensure that such patients can:

- **Lock bedroom doors, using a system capable of being overridden by staff in emergency;**
- **Have a choice of a female key-worker;**
- **Be in contact with other women;**
- **Have the opportunity to take part in women-only therapy groups ands social activities, but have the choice of taking part in mixed groups where appropriate;**
- **Engage safely in a full range of such activities, even where their number is small compared to the hospital population;**
- **Have physical health-checks on admission;**
- **Have access to a female doctor for medical care;**
- **Have access to a female member of staff at all times; and**
- **Be assured of adequate supervision at night.**

Recommendation 64 **(Chapter 6.44)**

All mental health services providing care to children and adolescents detained under the Act should have agreed working and referral arrangements with appropriate medical and psychiatric expertise in CAMHS.

Recommendation 68 **(Chapter 6.60)**

Non-specialist services who care for elderly detained patients should look to the expectations placed on specialist services by the National Service Framework for Older People (p103 – 6) and try to meet those expectations as far as they are able.

Recommendation 69 **(Chapter 6.60)**

All mental health services providing care to elderly detained patients should have agreed working and referral arrangements with appropriate medical and psychiatric expertise in the care of older people.

Recommendations for Action at Local Hospital Management Level (including private providers).

Recommendation 2 **(Chapter 2.6)**

Service providers should ensure that a system of verification using a standardised form is used to record that information has been given to patients about their legal position and rights under the Act. The form should have space for recording:

- **the name of the person giving the information;**
- **the date that the information was given;**
- **whether the patient understood the information;**
- **subsequent attempts to give the information; and**
- **the planned date for the next attempt.**

Recommendation 3 **(Chapter 2.7)**

Hospital managers should ensure that patients' wishes in relation to Sections 132(4) and 133 are ascertained and recorded, and that information is provided to the Nearest Relative if the patient has not objected.

Recommendation 4 **(Chapter 2.10)**

Service providers should ensure that the Department of Health's patient information leaflets on the Mental Health Act are available on all units in an appropriate range of languages and formats.

Recommendation 6 **(Chapter 2.13)**

Hospital managers should ensure that each ward is issued with a copy of the Legal Services Commission list of franchised solicitors to assist in the process of representation at Mental Health Review Tribunals.

Recommendation 7 **(Chapter 2.20)**

Hospital managers should arrange for effective audit, monitoring and flagging systems to be in place to ensure that the capacity of each detained patient to consent to treatment is assessed and reviewed regularly from the time of admission, that treatment is regularly discussed with patients, that they should be given the opportunity to discuss such treatments on a one-to-one basis and that such discussions are recorded, as required by Chapters 15 and 16 of the Code of Practice.

(see also recommendation 22, Chapter 2.67)

Recommendation 9 **(Chapter 2.27)**

Hospital managers should closely monitor the handling of all complaints, both to ensure minimum delay and to note the quality implications of the subject of the complaint.

Recommendation 10 **(Chapter 2.26)**

Complaints managers should ensure that complaints made by detained patients are not regarded less seriously than those from other patients, and should be sensitive to the potentially adverse effects on the progress of such patients of delays in handling complaints.

Recommendation 12 **(Chapter 2.33)**

All those involved with the care and treatment of detained patients should encourage multi-disciplinary liaison to develop protocols which balance the need for confidentiality against the need to share essential information.

Recommendation 14 **(Chapter 2.39)**

Hospital managers should arrange for the routine collation of detailed statistics on the use of Section 5(2), including the time taken to complete assessments, for audit purposes.

Recommendation 15 **(Chapter 2.40)**

All providers should ensure that risk assessments of informal patients take account of the likelihood of and risks involved in their leaving the ward, and if both are high, an assessment for detention under the Act should be considered.

Recommendation 17 **(Chapter 2.44)**

Hospital and social services managers should ensure, through audit and review, that patients who are detained under Section 2 but thought to require a further period of detention are assessed for detention under Section 3 at the earliest opportunity, and that such assessments are undertaken according to the requirements of the Code of Practice.

Recommendation 18 **(Chapter 2.45)**

Hospital managers should ensure, through audit and review, that:

- **the detention of each patient is kept under constant review by the clinical team;**
- **decisions on the continuation of detention are based upon clinical need and not administrative convenience;**
- **detentions are not allowed to lapse, but are actively rescinded unless a decision is made to renew detention; and**
- **RMOs have access to a suitable form to rescind detentions, a copy of which is given to the patient upon discharge.**

Recommendation 22 **(Chapter 2.67)**

All service providers should have adequate audit tools and flagging systems to record and trigger specific actions to ensure compliance with the consent to treatment provisions of the Act.

(see also recommendation 7, para 2.20)

Recommendation 24 **(Chapter 2.70)**

All relevant agencies should take particular note of discharge planning requirements for patients subject to Section 117 of the Act.

Recommendation 27 **(Chapter 3.13)**

All local mental health service managers faced with staffing problems should consider the following examples of best practice identified by Commissioners:

- **providing greater access to support and supervision to staff;**

- **wider use of psychologists and other professionals in ward-based activities, particularly at trainee level;**
- **bringing therapists (including art or drama therapists) onto wards on a sessional basis;**
- **encouraging patients and staff to contribute to ward activities through sharing their skills in activity groups; and**
- **providing training to staff in behaviour management, particularly de-escalation techniques.**

Recommendation 31 **(Chapter 3.25)**

Hospital managers should consider addressing the provision of patient activities and facilities by:

- **ensuring that all patients are aware of opportunities on offer, both through publicly displayed information and individual discussion with patients as a part of their care plan;**
- **using monitoring and user-surveys to identify needs and opportunities in providing activities;**
- **considering the use of voluntary or other agencies, or of existing contracted staff within the Trust to bolster available activities on a sessional basis; and**
- **employing or designating an activities co-ordinator.**

Recommendation 33 **(Chapter 4.9)**

Service providers, including the police, should ensure that their policies on Section 136 reinforce the need to wait for an Approved Social Worker to attend a person who is believed to have any kind of mental disorder as defined in the Act before discharging such a person and that the implementation of the policy is monitored.

Recommendation 35 **(Chapter 4.20)**

Hospital managers should note the findings of the Mental Health Act Commission report on the deaths of detained patients (see appendix B):

- **in assessing the physical risks in the ward environment;**
- **in considering the training to be given to staff on the management of episodes of strangulation; and**
- **in considering the physical health of patients on admission.**

Recommendation 36 **(Chapter 4.23)**

Hospital managers should ensure that sole discretion for the granting of authorised Section 17 leave is NOT left to the supervising nurse alone but is approved ONLY:-

- **following consultation with involved professionals to ensure that the patient's needs for health and social care are fully assessed and addressed by the care-plan (see Code of Practice, paragraph 27.5), all of which should be recorded in the patient's clinical record;**
- **following a detailed risk assessment which is similarly recorded;**
- **with carefully considered contingency plans, including contact telephone numbers;**
- **with clearly set down parameters, including the time of return;**
- **with clearly set down supervision arrangements; and**
- **with a copy of the Section 17 leave form given to the patient, and to the carer, if appropriate.**

Recommendation 37 **(Chapter 4.26)**

Hospital managers should ensure that AWOL policies and procedures clearly indicate:

- **when the patient should be regarded as AWOL;**
- **who has responsibility to return the patient;**
- **which staff are authorised under Sections 137 and 138 to act to take a patient into custody, convey or detain;**
- **what the expectations are of the police in terms of finding and returning patients; and**
- **who should take charge of the AWOL procedure, and how they should determine:**
  - **who should undertake a local search and the extent of the local search;**
  - **when a wider search should be undertaken and by whom and what areas should be searched;**
  - **when to contact the police;**
  - **when to contact the carers or relatives.**

Recommendation 40 **(Chapter 4.29)**

All service providers should obtain a copy of the Royal College of Psychiatrists' guidelines on doses above BNF upper limit for distribution to their staff.

Recommendation 41 **(Chapter 4.31)**

Hospital managers should ensure that clear policies on the prescription and administration of medication have been agreed and that compliance is regularly audited.

Recommendation 42 **(Chapter 4.39)**

Hospital managers should audit the use of seclusion regularly to ensure that it is properly used. Where the use of seclusion appears excessive, a seclusion reduction plan should be produced which includes monitoring the effects of any change in management regime on the attitude and behaviour of patients.

Recommendation 43 **(Chapter 4.41)**

Hospital managers should take all the current areas of concern identified by the Commission into consideration when auditing their arrangements for seclusion

Recommendation 44 **(Chapter 4.46)**

Hospital managers should ensure that care and support is available to patients who have been subject to control and restraint interventions, in addition to the visit to the patient by a senior officer which is required at paragraph 19.13 of the Code of Practice.

Recommendation 45 **(Chapter 4.47)**

Hospital managers should ensure that each use of control and restraint techniques is immediately reviewed, with regular audits to ensure that poor practice is eliminated and management and training lessons are learnt.

Recommendation 47 **(Chapter 4.53)**

Service providers should ensure that there are clear service-wide policies on the locking of wards and that compliance is regularly audited. The frequency of locking of doors on non-secure wards should, in particular, be scrutinised to establish whether this indicates problems with day to day practice or with inadequate staffing. In both instances, the appropriate remedial action should be taken.

Recommendation 49 **(Chapter 4.61)**

Mental health service providers should ensure that

- **clear policy guidance on the management and prevention of incidents involving alcohol and illicit drugs is available to staff; and**
- **that they have written service agreements with drug and alcohol teams for the joint management of patients with dual diagnosis or co-morbidity.**

Recommendation 50 **(Chapter 4.63)**

Service providers should ensure that a full risk management strategy is introduced for all their services and that appropriate training, recording and audit are provided to ensure compliance with it. Such a strategy should include evaluation of the adequacy of existing arrangements and the need for additional measures, common systems for incident reporting, regular review systems to re-assess the risks, and a continuing programme of staff development in the assessment of risk.

Some of the main matters which must be taken into account are:

- **environmental risks, including those from equipment and to staff as well as to patients**
- **risks from patients of harm to self or others, including not only the nature of the illness or overt threats, but also objective assessments of family history, criminal record, substance misuse, absconding, trigger points, who is most likely to be harmed and how, and other relevant factors**
- **the need to ensure that information is systematically recorded and passed on immediately when a patient moves to another location, is allowed leave or is discharged, as well as being made readily available to all relevant staff.**

Recommendation 72 **(Chapter 7.12)**

Welsh Trusts with boundaries with England and English Trusts with Welsh boundaries should ensure that there is at least a nucleus of staff who know both systems well enough to offer advice as necessary to those who deal with cross-boundary patients.

Recommendations specific to High Security Hospital Managers

Recommendation 53 **(Chapter 5.21)**
HSH managers should instigate routine monitoring of non-pharmacological therapeutic interventions and audit gaps in their provision.

Recommendation 54 **(Chapter 5.26)**
HSH managers should review searching procedures and documentation to ensure that the Security Directions are being implemented sensibly and that staff time is used appropriately. The review should consider whether staffing levels are sufficient to provide quality care to patients given the demands of the Security Directions.

Recommendation 55 **(Chapter 5.27)**
HSH managers should monitor the time taken to approve the release of patients' personal possessions from storage, and the time taken post-approval for items to be delivered to patients. Agreed standards should be set and improvement targets initiated.

Recommendation 56 **(Chapter 5.28)**
HSH managers should consider ways to improve patients' access to computers, particularly in their leisure-time.

Recommendation 57 **(Chapter 5.29)**
HSH managers should review their implementation of the Security Directions relating to the importation of foodstuffs to the hospitals, to ensure that they do not result in unintended and undesirable consequences.

Recommendation 58 **(Chapter 5.31)**
HSH managers should keep the implementation of the Security Directions under constant review, ensuring that they are imposed in appropriate ways that cause no unnecessary detriment to patient care.

Recommendation 59 **(Chapter 5.38)**
HSH managers should review the implementation of the Security Directions with regard to the visiting of patients by children in the light of the Commission's concerns. Consideration should be given to whether certain patients are unfairly disadvantaged by the blanket imposition of all new visiting arrangements, and whether such arrangements serve any useful purpose and may be counter-therapeutic.

Recommendations specific to Social Service Managers

Recommendation 19 **(Chapter 2.52)**
Social service authorities should develop standard forms for ASWs to complete on the admission of a patient to hospital under the Act, to ensure that all the relevant information is left with the receiving hospital.

Recommendation 20 **(Chapter 2.56)**
Standard formats should be developed for ASWs' reports which ensure that details of how the Nearest Relative was identified and consulted are included. This will enable hospital administrators to include these issues in their scrutiny of admission documents and ensure that the papers are legally valid.

Recommendation 24 **(Chapter 2.68)**
All relevant agencies should take particular note of discharge planning requirements for patients subject to Section 117 of the Act.

Recommendation 33 **(Chapter 4.9)**
Service providers, including the police, should ensure that their policies on Section 136 reinforce the need to wait for an Approved Social Worker to attend a person who is believed to have any kind of

mental disorder as defined in the Act before discharging such a person and that the implementation of the policy is monitored.

Recommendations for Action at Operational Level

Recommendation 16 **(Chapter 2.40)**
Nursing and Medical staff must ensure that all patients who are not detained under the Act have a clear understanding of their legal status.

Recommendation 23 **(Chapter 2.76)**
A copy of the relevant statutory Form 38 or 39 (Consent to Treatment) should be kept attached to patients' medicine charts, and pharmacists ahould be asked to check against this for authorisation before dispensing medication for patients.

Recommendation 39 **(Chapter 4.28)**
A pharmacist should check that:

- **Forms 38 have been authorised by the RMO;**
- **that they are accurately reflected in the medication chart, and:**
- **that they comply with the RCP guidance**

before releasing any prescription. Pharmacists should also check medication charts against Forms 39 where issued.

APPENDICES

Appendix A

The Commission is a signatory to the following declaration of intent of the Royal College of Psychiatrists' *Changing Minds* campaign.

every family in the land changing minds

Declaration of Intent

1. We, the Council, Fellows and Members of the Royal College of Psychiatrists, are seriously concerned at the stigma encountered by people suffering from mental disorders, their relatives and those who care for them.

2. The experience of our patients is that discriminatory attitudes are widespread within the general public of all ages, the media, the medical profession, employers, banks, insurance companies, building societies, educational bodies, housing authorities, and many other organisations.

3. The Royal College has launched a new Campaign - **Changing Minds: Every Family in the Land** which will:

   - increase public and professional understanding of
     - anxiety
     - depression
     - schizophrenia
     - alcohol and drug misuse
     - dementia
     - eating disorders;

   - emphasise how all of us may be affected directly or through those close to us;

   - reduce the stigma attached to those disorders and discrimination arising from it;

   - narrow the gap between the beliefs of health care professionals and the public about the nature and effectiveness of treatment.

4. The Campaign will challenge inaccurate representation, in the media and elsewhere, based on stigmatising attitudes and stereotypes ("nutter", "psycho", "schizo"), myths ("all people with schizophrenia are violent"), misunderstandings ("mental illness cannot be cured") and discriminatory attitudes ("I don't want nutters living in my backyard").

5. The Campaign will stress the importance of mental health promotion as an issue for all of us. It will re-affirm the role of diagnosis and treatment - psychological, social and physical - in the effective management of mental disorders.

6. Within the Campaign, the College will work collaboratively with other organisations to seek changes, not only in attitudes and behaviour, but also in legislation. We aim for the same success as that achieved against discrimination based on race, gender and sexuality. There should be no room for stigma in the third millennium.

Appendix B

Deaths of Detained Patients in England and Wales

a Report by the Mental Health Act Commission on information collected from 1 February 1997 to 31 January 2001

EXECUTIVE SUMMARY

Introduction

1. Since 1996, it has been the policy of the Mental Health Act Commission (MHAC) to maintain a record of every patient who has died while subject to detention under a section of the Mental Health Act 1983 and to enquire into any such death when this has been considered to fall within the terms of the Commission's remit. The purpose of the MHAC Report on their findings from 1 February 1997 to 31 January 2000 is to contribute both to the ongoing debate about the care of patients subject to the 1983 Act and to the NHS priority of making a substantial reduction in the number of suicides among patients and in the population as a whole.

2. The work recorded in the main report was done by the Commission's Vice-Chairman, Professor Richard Williams, with the assistance of Professor Gethin Morgan. They have taken great care to stress the methodological limitations of the study. These concern:-

    - Uncertainty about the comprehensiveness of the basic information, which is provided on request and not as a statutory requirement;
    - Incomplete data insofar as the number of deaths reported during the period is still awaiting the outcome of inquests;
    - The inability of the Commission to compare the data in detail with relevant figures relating either to the general population or the population of those who may be mentally disordered but not subject to the 1983 Act;
    - The absence of any directly comparable earlier or contemporary data. (But broad comparisons are made with the outcome of an earlier MHAC Review in 1995 (footnote) and with the National Confidential Inquiry (footnote)).

3. In spite of these reservations, it is considered that the conclusions drawn are robust enough to confirm conclusions drawn in the earlier reviews of similar material and to suggest that more still needs to be done to ensure that the messages drawn from analytical material are effectively translated into practice. The full report contains a wealth of detail which should be of interest to all practitioners and includes a summary of main findings and recommendations. The purpose of this extended summary is to provide ready access to some of the key information.

4. The report considers the deaths of 1,4471 people subject to detention under the Mental Health Act during the chosen three year period. Hospital staff reported 1,218 of them to the MHAC has having died from natural causes.

Deaths from Natural Causes

5. Not unexpectedly, there is a preponderance of elderly patients in this group - 76% over 65 years and 56% over 75 years. 53% were men and 94% were white. The estimated rate of death from natural causes is 822/100,000 sections per annum for 1997-2000.

6. The most significant finding in relation to these patients is that 47% of them died within one month of admission and 18% between one month and ten weeks. This reflects findings in the earlier review. It suggests that close monitoring and analysis of deaths within a short period of admission might throw light on the types of illness or experience which led to them and could have significant implications for

the treatment of mentally disordered patients before they reach the stage at which compulsion becomes necessary.

Unnatural Deaths

All Unnatural Deaths

7. Two hundred and fifty-three (17%) of the 1,471 cases under review resulted in an inquest. 168 verdicts were recorded as suicide or open, 31 as accident or misadventure, 4 as due to drug abuse and 5 as natural causes. The outcome of 45 of these inquests is not yet known.

8. Only 2% of the unnatural deaths were over the age of 75 and 78% were less than 45 years. 72% were men and 83% were white. The most common causes of death were:-

- Hanging 34%
- Jumping from a height 14.2%
- Being hit by a train 11.5%
- Drowning 8.3%
- Overdose 5.1%

9. Forty-nine per cent of those who died unnaturally were diagnosed as suffering from schizophrenia and 20% from depression. The diagnostic categories of all psychoses and depression, with associated disorders, accounted for 78% of all unnatural deaths. Personality disorders were included in 11% of cases.

10. Only 32% (82) of unnatural deaths occurred within a psychiatric unit. Nineteen per cent (48) were patients on agreed leave and 33% (83) were absent without leave. This reflects the findings of the previous reviews and emphasises the importance of risk assessment, security, and the need for clear policies on leave under Section 17 of the 1983 Act, particularly when a patient fails to return at the expected time. Absence without leave implies that the patient has deliberately broken the rules and that staff have been caught unawares. Suicide while the patient is on agreed leave suggests that the suicide risk was not anticipated. Post death audit may help to clarify problems of assessment and management.

Deaths by Accident or Misadventure

11. Thirty-one (12.5%) of the unnatural deaths were categorised as by accident or misadventure. 58% (18) were men and 42% (13) women. 68% (21) were less than 45 years of age. 12 deaths were in a psychiatric ward, 8 in general hospital units, 5 in a public place, 4 in hospital grounds and 2 at home. 4 were on leave and 7 absent without leave.

12. Because of the small number of deaths by accident or misadventure, they were not compared in detail with the deaths that were found at inquest to be due to suicide. There is imprecision in the categorisation of deaths at inquest that makes valid analysis difficult without detailed case-by-case examination. Nevertheless, the information provided suggests that the inquest verdicts of accidental death encompassed many deaths which might, on clinical grounds, have been regarded as suicides. (14 of them had been regarded as at risk of self-harm and were under special observation for that reason).

Suicide

13. For the purpose of the MHAC report, open verdicts at inquest have been included as suicides to avoid under-estimation of death by suicide on clinical grounds. This is similar to the practice of the Confidential Inquiry. This approach gives 168 cases of suicide, excluding the 45 where the inquest verdict has not yet been returned.

14. Seventy-six per cent (128) of the detained patients identified as suicides were men and 24% (4) women. 80% of all the suicides in the present study were aged 45 years or less at the time of death; the median

age was 34, with a range from 18-73. This suggests that younger people who are detained because of a mental disorder are certainly more at risk of suicide than older people. (Middleton and Gunnell have presented recent data supporting their view that there has been a continuing increase in the rate of suicide among males aged 25-34 years.)

15. The most common methods of suicide were:-

- Hanging 40%
- Jumping from a height 17%
- Jumping before a train etc 15%
- Drowning 10%
- Drug overdose 4%

16. The most common categories of mental disorder among the suicides were schizophrenia and related disorders (49%), affective disorders (24%) and psychotic episodes (10%) – a total of 83% (cf 89% in the 1995 Review).

17. Only 29% (48) of the suicides occurred in a psychiatric ward and 4% (6) in hospital grounds. The majority, 41% (69) took place in a public place while the patient was on approved leave or absent without leave. This underlines the importance of risk assessment and careful Section 17 procedures, as mentioned in paragraph 10 above.

18. Twenty-five per cent (41) of suicides occurred while the patient was being observed every 15 minutes or less. This finding emphasises the need to review observation procedures. Post-death audit should focus on this.

Hanging

19. The work by Middleton and Gunnell suggests that hanging as a general method of suicide has increased threefold in 15-24 year old men and twofold in young women since 1979. Hanging was reported to the MHAC as the cause of death in 34% (86 – 66 men and 20 women) of the 253 cases reported to the coroner as unnatural. 40% of suicides and 16% of deaths by accident or misadventure were due to hanging. Hanging is therefore a key factor in the prevention of suicide.

20. Death by hanging implies a fracture of the second cervical vertebra. The current review's closer analysis of ligatures and load-bearing supports used in cases reported as hanging suggests that many of these hangings could be due to strangulation. For example, a ligature less robust than one likely to cause a fracture may cause:

- Compression and/or trauma to the larynx or trachea in the neck causing asphyxiation;
- Reflex cardiac inhibition leading to cardiac arrest;
- Failure of blood supply to the brain

21. If this hypothesis is correct, it is highly relevant to the care of suicidal patients, whether detained or not. Since 58% of the hangings occurred in a psychiatric unit, the possibility of strangulation suggests that attention needs to be paid to the removal of a wider range of ligatures than may be necessary to avoid cervical fracture, greater attention given to the load-bearing capacity of some integral components of a normal ward environment and fundamental changes in design considered to achieve long-term improvement. It also has implications for the immediate management of episodes of hanging and for the application of appropriate resuscitation techniques.

Observation Procedures

22. Perhaps more importantly, the hypothesis has implications for the nature of observation, since it is much easier to see whether someone is hanging from a height than whether a supine figure is attached to a fixture at the same height that may be causing strangulation. This is particularly relevant because 25% of all hangings occurred despite observation every 15 minutes or more frequently.

23. The 1999 Report of the Confidential Inquiry comments on the variations in how observation procedures concerning suicide risk are implemented. It questions the rationale and value of intermediate levels of supervision. Without knowing the number of patients who undergo special observation at all levels and

the rate of suicide exhibited by them, the MHAC review suggests that it is premature to dismiss the value of these long-established procedures. The figures on suicide by hanging, in particular, suggest that there needs to be a judicious balance between the level of ward security, one-to-one contact between patients and staff, and a gradual reduction in the intensity of supervision during the period of recovery so that each patient may eventually acquire the freedom and responsibilities inherent in a normal ward routine.

Restraint

24. Among the deaths reported to a coroner, the MHAC information showed 22 instances in which restraint had been used in the week before death. Three of the 22 people who died after or during an instance of restraint were from African or Caribbean ethnic cultural groups. Such small numbers render any kind of statistical analysis hazardous. At the time of writing (July), inquests had been completed in only 17 of these cases, in two of which death had occurred while the person concerned was being restrained and in four restraint had been used during the preceding four hours. It is clearly very important to be able to establish how far, in any individual case, the use of restraint may have contributed to a simultaneous or subsequent death. Knowledge of whether and how it did so should contribute to the development of safer methods of restraint.

Incidence and Trends

25. The data available are not at present sufficiently consistent or reliable to enable any assumptions to be made with confidence about either incidence or trends in any of the factors examined. It is likely that the 1995 review under-estimated the number of suicides whereas this review may have slightly over-estimated, partly because of the combination of open verdicts with suicides and partly because of assumptions made in those cases where the inquest verdict is not yet known. There are also several different ways in which the number of detentions under the 1983 Act (i.e. sections) can be calculated.

26. The deaths reported to the MHAC during the 1990s occurred over periods of time in which the sectioning rate was rising. There were also fluctuations over short periods in the numbers of informal in-patients who became subject to detention after admission. (This was particularly true in 1998-1999, probably as a result of the Bournewood case). In order to provide a basis for comparison, the authors of the report considered the number of sections for one year in each period of the two MHAC reviews, i.e. 1993-94 and 1998-1999. In each selected year, the number of initial admissions under section was added to the number of informal in-patients subsequently made subject to detention. The resulting figures for comparison were 39,582 in 1993-94 and 49,648 in 1998-1999, an increase of 25.4%.

27. Bearing in mind all these uncertainties, the report estimates that the number of deaths by natural causes is approximately 408 a year, giving an estimated rate of 822 per 100,000 sections. A comparable rate for 1993-94 cannot be calculated because of the different reporting system then in place.

28. On the same tentative basis, the *number* of suicides among detained patients may have increased by 42% - from a total of 95 “probable suicides” in the two years from 1992-1994 to an estimated projected total of 204 in the three years from 1997-2000 and the *rate* of suicide among detained patients during the same period may have increased by 14%. The rate of suicide among detained patients now is estimated at about 137 per 100,000 sections, compared with an estimated 120 per 100,000 at the time of the 1995 review. This compares with a rate of 11 per 100,000 in the general population in 1992. This is hardly unexpected, given that suicidal tendency or an expression of intent are often the cause for an application for detention under the 1983 Act, but underlines the importance of reducing suicides among detained patients.

29. However tentative these figures may be, it seems probable that there has been a true increase in the number of suicides and a possible increase in the rate of suicide among detained patients in the period under review. This attempt to provide comparative data, however cautious, highlights the need to create a credible and consistent database against which to measure progress and to identify the factors most likely to lead to prevention.

Gender, Age and Ethnicity

30. There is no clear indication of any changes in incidence or trends in age, gender or ethnicity as compared with the 1995 review. Partly because of the very small numbers involved, it is virtually impossible to assess whether ethnicity has any bearing on the likelihood of unnatural death.

31. The major ethnic groupings in this study, with the 1995 figures in brackets, were 83% white (76%) and 5% Black Caribbean (7%). This proportionality cannot be compared with national figures because the information in the last census of population in England and Wales is almost certainly inaccurate now. It appears likely that the number of young people from black and ethnic communities has risen rapidly – the CRE factsheet for 1995 shows that ethnic minority populations now have proportionately more young people than the white population. This situation poses challenges in analysis of any data on ethnicity.

32. Whatever the position may be, the need to recognise diversity and concern about the disproportionate number of people from black and ethnic minorities who are detained under the 1983 Act make it essential to improve the ability to analyse and compare relevant data in order to assess whether ethnicity has any bearing on deaths among detained patients. It also underlines the need for comprehensive post-death audits.

Monitoring and Data Collection

33. The authors of the report stress the need for clinical skills to be informed by attention to the evidence from systematic research as well as by awareness of the individuality of each patient. Qualitative as well as quantitative information is necessary to produce good clinical practice. The interpretation of quantitative data often requires return to the narrative gained from good reflective clinical practice. In this way, the two broad approaches to inquiry can reverberate and mutually interact.

34. This approach is illustrated by the methodology adopted by the MHAC to inquire into the deaths of detained patients. Although the data presented in the report provides a good basis for ongoing monitoring and comparative work, attempts at analysis have revealed gaps and suggested ways in which the data could be improved and refined to enable the material it produces to be even more informative. The MHAC is amending its database and adjusting its methodology to close the gaps identified, thus increasing the value of future analysis.

Summary of Recommendations

35. The MHAC report makes the following recommendations. Those which reflect this Extended Summary are as follows (paragraph numbers refer to this Summary):

- Closer monitoring and analysis of the deaths of patients who die within a short period after being detained should be undertaken, possibly as part of a wider research project (paragraph 6);

- In revising guidance on and training in risk assessment, particular attention should be paid to the findings on unnatural death while patients are on approved leave or absent without leave (paragraphs 10 and 17);

- Ways of improving the categorisation of inquest data for research purposes should be explored further, possibly in conjunction with the Confidential Inquiry (paragraph 12);

- Deaths by hanging should be more closely analysed to establish how far they include strangulation and the implications of such an analysis for preventative measures (paragraphs 19-21);

- The use of restraint should continue to be recorded and carefully monitored in all cases and where there is an unnatural death the post-death audit should pay careful attention to the use of restraint during and prior to the death (paragraph 24);

- The figures on incidence and trends should be treated with extreme caution. There are difficulties inherent in comparing the two MHAC reports and uncertainties about calculating the appropriate numbers of detentions. Nevertheless, it is likely that the absolute number of suicides has risen and possible that the incidence of suicide among detained patients has risen between 1992 and 2000. Continuing and possibly increased vigilance is undoubtedly necessary. (Paragraphs 25-29).

- The need for careful monitoring of differences in gender, age and ethnicity is emphasised and any post-death audit of death from unnatural causes should pay particular attention to ethnicity and its possible effect on the cause of death. (30-32).

36. The main findings and recommendations summarised above lead to a number of more generalised recommendations. These are that:

    - Efforts to identify and remove any aids to suicide should be continued as well as intensified in certain areas identified in this report;

    - Risk assessment should continue to be developed and refined, with particular attention to the need for well trained and highly skilled and motivated staff;

    - The resource implications of more sophisticated environmental safety and greater vigilance in observation should not be under-estimated;

    - There should be a detailed post-death audit after every unexplained or unnatural death;

    - The Department of Health, the National Assembly for Wales, the Mental Health Act Commission and other bodies with responsibility for the care of detained patients should co-operate to create a consistent but dynamic database. This should enable incidence and trends to be more accurately assessed and provide an ongoing means of developing better practice; and

    - The Mental Health Act Commission (or its successor body) should continue to develop its own processes for reviewing deaths of detained patients and produce regular published reports on its findings.

Conclusion

37. The MHAC recognises that the figures for unnatural deaths show only the failures. The prevention of suicide generates no data. The Commission has no doubt that the dedication and care of hospital staff prevent more suicides than are not prevented. Nevertheless, if any additional life can be saved by greater awareness of the factors involved in previous suicides, emphasis on them must be worthwhile.

Mental Health Act Commission
February 2001

Appendix C

The National Visit 2: Key Findings

1 The National Visit 2 continued the focus on the key areas from the Commission's Equal Opportunities Policy that Commissioners had been trained in and felt were crucial to the care of Black and minority ethnic detained patients, i.e. ethnic monitoring, dealing with racial harassment of patients, staff training in race equality and anti-discriminatory practice, and the provision of, access to, and use of interpreters. Only a brief summary is provided here as the full report is now published and available.[117]

2 104 mental health and learning disability units were visited. These included acute and medium secure units, and high secure hospitals in the NHS, and acute and medium secure facilities in the independent sector. Information was collected from 119 wards, and from the case notes of 534 Black and minority ethnic detained patients.

3 The largest minority ethnic group among the patients was Black Caribbean, comprising 42% of the total. More than two thirds of the patients were men, and the majority were aged between 25 and 44 years. The most commonly recorded religion was Christianity, with Muslims comprising the next largest group.

4 116 patients did not have English as their first language; between them they spoke 26 different languages. Fluency in English varied between nearly all of the Black Caribbean patients to only half of the Bangladeshi patients.

Conclusions from the National Visit 2

5 One immediate effect of the Visit, and of the many pilot visits which preceded it, has been to raise the awareness of many units to the specific issues in caring for this group of patients, which is a necessary precursor to any change in practice.

6 The Visit has shown that there is still a considerable development agenda. People from Black and minority ethnic communities are often not receiving care that is sensitive to their cultural backgrounds. This is reflected in the Visit's findings on recording and monitoring of ethnicity, harassment, training of staff and use of interpreters.

7 The aim of the Visit was not simply to highlight bad practice but rather to raise awareness of these key issues amongst managers and practitioners, and identify and share areas of good practice thus improving the care for detained patients from Black and minority ethnic groups. In-depth analysis of the data, as well as a thorough examination of all the written policies and procedures collected from

[117] Sainsbury Centre for Mental Health

the units and wards visited, will identify further examples of good practice which can be disseminated, to help those services which have been slower to develop in these areas.

Key findings of the National Visit 2

Recording and monitoring ethnicity

- Half the units had written policies, procedures or guidelines on recording ethnicity of patients. All units routinely recorded patients' ethnicity, but not all used the ONS categories. With a few exceptions, this data is not being put to great use.

Without knowing the language and dialect spoken by their patients, ward staff will be unable to obtain an appropriate interpreter. The interrelationship between language, dialect and religion demonstrates the importance of recording full information on all of these.

Dealing with racial harassment of Black and minority ethnic patients by other patients, or by staff

- Three quarters of the units had no policy on dealing with racial harassment of Black and minority ethnic patients by other patients, or by staff. Fifty nine patients (11%) whose notes were examined had reported incidents of racial harassment.

Race equality and anti-discriminatory practice

- Two thirds of the units had no policy on race equality and anti-discriminatory practice for staff, and a similar number did not provide training on this for their staff. However, several examples of good practice were provided, demonstrating a wide range of training and other activities aimed at raising staff's awareness and understanding of the religious and cultural needs of Black and minority ethnic patients. Many units had devised resource packs containing useful information.

Provision of, access to and use of interpreters

- Half the units had a policy on the provision and use of interpreters, but only three quarters used interpreters who were trained in interpreting.
- Two thirds of the wards had used patients' relatives or friends to interpret for them; this is of concern, as widespread use of family members as interpreters can compromise objective decision-making by staff.

Although people from Black and minority ethnic groups may be fluent in English, at times of stress, including periods of mental illness, some may prefer to use their mother tongue and would therefore require an interpreter.

Appendix D

The Commission's Regional Consultation Exercises

Background to the Regional Consultation Exercises

1 In order to meet Goal 5 of the Commission's equality statement (*To increase the number of under-represented groups amongst staff, Commission members and appointees* - see Chapter 6.14 above), we have, since our inception, been keen to appoint a breadth of Commissioners with a wide variety of skills, knowledge and experience, and like most agencies in the health and welfare field, have tried to attract those from Black and minority ethnic communities. We aimed to achieve 20% of all Commission appointments from Black and minority ethnic groups. This would be slightly higher than the Black and minority ethnic in-patient population, which is approximately 18%.

2 A number of measures were undertaken to achieve this:

- **Targeted advertisements** in the mainstream and the Black press with a clear message encouraging Black and minority ethnic applicants;
- **Flyers** distributed to over 1000 key Black and minority ethnic organisations, to ensure that:
  - the adverts received wide exposure within Black and minority ethnic communities;
  - organisations where suitable candidates were likely to be were targeted;
  - the process gave a clear message of the Commission's commitment to the implementation of equal opportunities; and
  - the recruitment process was not delayed and the cost was minimal.
- **Existing Commissioners** were asked to identify potential applicants. Our internal bulletins and ongoing training ensured that all Commissioners were aware of the Equality Programme and asked for their support in its implementation.

3 These short-term initiatives, coupled with the measures that we had taken over the years, produced some initial successes. However, the processes also clearly identified the constraints to achieving the targets set. These were broadly based around three areas:

- **The low profile of the Commission** within the targeted and wider community. Few people were aware of the existence of the Commission and fewer still understood its role and remit.
- **The selection and recruitment process** needed to be reviewed and the sift criteria, panel make-up and process of interview reexamined to ensure that applicants were not being discriminated against and that all applicants' views on equality were ascertained.
- **The geographical and professional balance of Commission Visiting Teams** was constrained by the lack of significant Black and minority ethnic communities within certain geographical areas and the requirement to have a representation of Commissioners with the different professional backgrounds.

4 It was apparent that the low profile of the Commission, the need to review the recruitment process and the requirement for geographical and professional balance would have to be addressed on an integrated basis and that more direct means of engaging local Black and minority ethnic communities would be required.

5 In order to develop an integrated response, we undertook the innovative and creative step of initiating a series of regional consultation exercises which not only identified a wide range of inequalities with respect to mental health services and Black and minority ethnic communities but also helped to:

- considerably raise the profile of the Commission;
- enable effective and meaningful consultation with community and user groups as well as service providers;
- provide a vehicle for people to access accurate information on the role and remit of the Commission; and
- encourage suitable people to apply to become members of the Commission.

The Regional Consultation Exercises

6 A summary of the methods and findings from the three regional consultation exercises follows, highlighting the five key areas which formed the focus of the survey: mental health services for Black and minority ethnic communities; detention under the Mental Health Act; race equality initiatives, including ethnic monitoring; interpreting services: and services for women. It combines the views of all those consulted and interviewed during the course of the survey along with the findings from the seminars.

7 This summary cannot cover the full range of the issues raised by participants. Greater detail can be found in the regional reports[118].

8 Three regions were selected for the consultations. Greater Manchester and the West Midlands were selected because of their substantial Black and minority ethnic populations. The North East was selected as a balance to the other two regions because of its smaller and more dispersed Black and minority ethnic populations. The Commission was under-represented by people from Black and minority ethnic groups in all three regions at the beginning of these consultations.

9 The 1991 census identified the proportion of the population as being of minority ethnic origin as 8.2% in the West Midlands, 5.9% in Greater Manchester, and 1.4% in the North East. In all three regions, the Black and minority ethnic population is concentrated in inner city areas, with the associated problems of unemployment and social deprivation. Since the 1991 census, the growth of the

[118] University of Central Lancashire / Mental Health Act Commission (2000) **Mental Health Act Commission National Consultation on Mental Health Issues and Black and Minority Ethnic Communities – Greater Manchester Report**
University of Central Lancashire / Mental Health Act Commission (2000) **Mental Health Act Commission National Consultation on Mental Health Issues and Black and Minority Ethnic Communities. – West Midlands Report**
University of Central Lancashire / Mental Health Act Commission (2001) **Mental Health Act Commission National Consultation on Mental Health Issues and Black and Minority Ethnic Communities – North East Report**

indigenous white population aged sixteen or under has remained stable or decreased, whilst the Black and minority ethnic population has, and continues to, increase three to fourfold.

10 The ethnic diversity within this section of the population must be stressed. The term 'Black and minority ethnic' encompasses a wide range of communities with different language groups, cultures, religions and geographical regions of origin and includes refugees and asylum seekers. This changing and diverse demographic profile presents many challenges to statutory providers of mental health services.

The Process

11 The methods employed to undertake the consultation exercise combined action research and community development techniques. The project was not intended as 'research', but rather the methods were designed to provide a 'snapshot' about a number of key aspects of mental health issues, from the perceptions of Black and minority ethnic communities and from those involved in providing and commissioning these services.

12 A key aim of the exercise was to listen to community groups and service providers and to raise salient issues in relation to mental health, service provision and Black and minority ethnic communities through feeding back the views of participants as part of a community event or seminar.

13 This innovative approach to community and service engagement had the further advantage of enabling the Commission to maintain its focus on the priority areas already identified i.e. ethnic monitoring, racial harassment, women, access to interpretation services and recruitment of Black and minority ethnic Commissioners.

14 This ensured that the comprehensive approach taken in the our Equality strategy involving training, guidance notes and the National Visit 2 was further developed with the introduction of the local area consultation exercises or 'roadshows', as they came to be known.

15 Interviews and focus groups involving more than approximately 50 organisations in each region took place involving Black and minority ethnic community members, mental health service professionals, local authority social services, GPs, police and probation officers, and members of relevant voluntary organisations. This part of the exercise was followed by a local seminar where the Commission had the opportunity to discuss its remit and Equal Opportunities programme and statutory and voluntary organisations could explore mental health services through workshops facilitated by local Black and minority ethnic community groups.

16 The process enabled:

- the Commission to act as a catalyst in promoting greater contact and involvement between Black and minority ethnic communities and local service providers and commissioners of services;

- the identification of individuals from local Black and minority ethnic communities who could contribute directly to the seminars;
- an increase in the pool of potential of Black and minority ethnic applicants to the Commission; and
- an increase in awareness and knowledge about the Commission and particularly our work in the area of promoting race equality

17 The model was piloted and tested in Greater Manchester and the West Midlands by the Ethnicity & Health Unit of the Univesity of Central Lancashire, with the Unit acting as a facilitator and trainer in the North East where Commissioners themselves undertook the fieldwork activities. This ensured capacity building within the Commission: developing direct contact between the Mental Health Act Commissioners, local service providers and commissioners of those services and local Black and minority ethnic groups and individuals.

18 Additional outcomes from the process included further local area developments as a direct consequence of the seminars and increased contact with Black and minority ethnic organisations and groups. For example, in Manchester the local authority and mental health service commissioners organised a follow-up seminar which was attended by eighty local people and led to the creation of a number of specific goals for improved partnership working in that area.

The Findings

Mental Health Service Provision for Black and Minority Ethnic Communities

19 Mental health services for Black and minority ethnic communities were found to vary greatly, both within and between the three regions. Arguably the demographic profile and the dispersal of Black and minority ethnic communities within the regions, in many instances influenced the quality and equity of service provision. For instance, within the larger conurbations of the three regions innovative and creative services that aimed to respond to the needs of Black and minority ethnic mental health service users were to be found: day care provision in the courtyard of a West Midlands Mosque; day and lunch clubs for Chinese people and Asian women in the North East; funding and facilities for voluntary organisations in Greater Manchester. However, very often, away from the inner cities, and sometimes within them, where Black and minority ethnic populations are smaller but not necessarily insignificant, services were only provided on an ad hoc and piecemeal basis. This phenomenon was most noticeable in the North East where, outside the larger cities, there had been little attempt to address the needs of Black and minority ethnic communities; it was also noticeable in many areas of Greater Manchester and in the rural areas of the West Midlands.

20 Whilst there was little demand for completely separate services targeting Black and minority ethnic communities from any of the community groups surveyed, there was a strong consensus amongst them that mainstream services should develop and deliver appropriate services to meet the multidimensional needs of communities.

21 There was a powerful perception amongst the Black and minority ethnic community groups interviewed across the three regions that the level of poor mental health is unacceptably high within many Black and minority ethnic communities. This perception was expressed alongside an acknowledgement of the difficulties faced by the statutory sector in recognising the challenges of diversity. For instance, the Greater Manchester community groups highlighted the fact that the concept of mental health differs not only from community to community, but also for some communities between generations within the communities. Many community representatives and statutory providers noted that people from Black and minority ethnic communities often only access mental health services at times of acute crisis and fundamental breakdown.

22 A complex set of factors was highlighted as influencing deteriorating mental health and lack of uptake of services, many of which were interdependent. For instance:

- the stigma associated with mental ill health amongst some communities,
- the shortage of people from Black and minority ethnic communities working in mental health services,
- lack of cultural awareness by service providers,
- poverty, alienation, racism, drug and alcohol misuse.

Suggested responses from all three areas included more preventive mental health work targeted at Black and minority ethnic communities, cultural awareness training for service providers and mainstream assistance to strengthen the community mental health voice and an acceptance and provision of alternative therapies to treat mental illness.

Detention under the Mental Health Act 1983

23 There was a perception amongst Black and minority ethnic communities that the Mental Health Act is being used disproportionately in relation to their communities and that detention is on the increase. Although this view was not unanimously agreed by the statutory sector, some providers did share the view. In the Greater Manchester region women from the South Asian and Chinese communities, young African-Caribbean men, older Irish men and refugee groups were seen as particularly vulnerable. Refugee groups were also identified as being vulnerable by the voluntary sector in the West Midlands, although the statutory sector respondents in that region held a widespread view that African-Caribbean men were the group detained in numbers disproportionate to their number in the wider community.

24 In the North East the voluntary sector was more concerned with the inappropriate way the Act is initiated, particularly in relation to refugee communities, than with its disproportionate use. This view was echoed in part by the statutory sector who expressed the opinion that the small size of the Black and minority ethnic population did not make the numbers of detentions an issue, but that when detention is initiated it is sometimes done so by staff who have a lack of understanding and knowledge of the needs of the Black and minority ethnic population thereby impeding compliance with the Code of Practice.

25 In both the Greater Manchester and West Midlands regions the opinion was expressed in different ways that a reduction in the use of the Act would be an important barometer of the success of mental health services in effectively meeting need.

Race equality initiatives including ethnic monitoring

26 In all three regions a variety of issues were identified by both the statutory and voluntary sectors as crucial to providing equitable mental health services. These included increasing numbers of staff from Black and minority ethnic communities, raising awareness and understanding of the differences between white/western and other conceptions of mental health, respecting cultural differences, increasing language skills.

27 In the West Midlands and Greater Manchester regions staff recruitment and training was the most common way in which statutory services had attempted to address these issues. Targets, staff support groups, mentoring schemes, development programmes and race equality training had all been introduced. In both regions the emphasis on staffing had been supplemented by consultation with Black and minority ethnic user groups (although this consultation varied greatly within the regions) and also by the introduction of specific services (again varying greatly) to meet the linguistic, cultural and religious needs of Black and minority ethnic patients.

28 In contrast the North East with its smaller Black and minority ethnic population had few strategic initiatives in place. Although amongst many of the service providers in the North East there was a genuine will to provide equitable services, particularly amongst those who were detecting a shift in the pattern of demand on services caused by the arrival of relatively large numbers of asylum seekers in the area, the view of the voluntary sector was that there had been developments in thinking but this had not necessarily led to improvements in practice.

29 It was clear from comparing the three regions that where services were most responsive and most equitable there existed strong partnerships between the statutory and voluntary sectors. Within all three regions the surveys revealed a genuine desire from many of those who participated to forge real partnerships between the statutory and voluntary sectors. Partnership was defined in the North East consultation as having shared values, shared goals and most importantly a shared vision based on sound principles of equality. In Greater Manchester the regional consultation was followed up with a conference organised by Manchester Social Services to explore partnership working further.

Ethnic monitoring

30 Within all three regions there were major inconsistencies in the monitoring of service uptake and ethnic monitoring of workforces. Concerns were raised by respondents from both the statutory and voluntary sectors about the effectiveness of ethnic monitoring initiatives and the use made of the resultant data.

Interpreting services

31 Across all three regions, there is clearly room for improvement in interpreting services. The lack of competent, qualified interpreters trained in mental health issues was seen as a major shortfall in service provision. Many respondents from the statutory sector acknowledged this deficiency in their service and admitted using family members, telephone based language services and Black and minority ethnic staff members all of which they saw as inappropriate but sometimes necessary. A very small minority of statutory respondents claimed to offer a comprehensive interpreting service.

Services for women

32 Specific services for women in general were found to be lacking throughout the consultation with specific services for women from Black and minority ethnic communities being almost unheard of. Statutory respondents in all regions did report of a number of ad hoc initiatives which had been introduced to support women from different communities. Many in patient service providers spoke of treating all patients holistically in terms of gender, race, culture and religion. However, particular concern was expressed by community groups in the North East for the plight of women from asylum seeking and refugee groups whose linguistic, cultural and geographical isolation would make them particularly vulnerable to stress and depression. These same factors were also reported by other regions as being an issue for many women from the Chinese and South Asian communities and in the Greater Manchester area the emergence of a number of voluntary groups with a particular focus on women's mental health is seen as evidence of a particular need which is currently not being met by statutory services.

Conclusions and future developments

33 The methods outlined above provide a model of the engagement of Black and minority ethnic communities, mental health service users, service providers and commissioners. This model can be adapted and developed for other health services and for other minority groups.

34 The high level of consultation resulted in capacity building around mental health issues and has given ownership of the project to all those who participated.

35 An indication of the success of the project is the increase in the number of people from Black and minority ethnic communities applying to become members of the Commission: the current proportion is 22%, 2% higher than our original aim.

36 The findings from this project will contribute to forging true partnerships between people from Black and minority ethnic communities and the providers of mental health services and other relevant organisations, on both local and national levels. In this way, the challenge of delivering mental health services that consistently and effectively meet the needs of diverse communities can be addressed. Developing these partnerships will require strategic thinking; commitment from all parties especially statutory authorities and other providers; and the development and cherishing of local networks.

ANNEX E

Summary of the Mental Health Act Commission's Response to the Green Paper Proposals on the Reform of the Mental Health Act 1983

The following is the summary of the Commission's full response to the Green Paper[119]. The full document is available upon request from the Commission Office. Paragraph references in parentheses refer to the text of the Green Paper itself

GUIDING PRINCIPLES

(Consultation Point A)

1. The Commission supports the inclusion of principles in new mental health legislation. There should be a wider set of principles than those proposed in the Green Paper, which place as much emphasis on risk to health as safety as grounds for compulsion and which more strongly assert that alternatives to the use of compulsory powers should be sought. (paragraphs 49-51)

2. The obligation to ensure that good quality care for detained patients is consistently achieved should be reinforced by the inclusion of reciprocity as one of the underlying principles. (paragraph 53)

3. Legislation should address, as far as possible, the issue of non-discrimination in relation to areas such as employment, travel, insurance, housing, education and the public representation of mental disorder. (paragraphs 56, 126)

DEFINITION OF MENTAL DISORDER

(Consultation Point B)

4. The Commission supports the use of a single, generic category of mental disorder to describe persons falling within the scope of a new Mental Health Act. However, there should be greater clarity about the threshold of the disorder which would justify the use of compulsion and the terms 'nature' and 'degree' should be retained in the wording of the criteria for a compulsory order. (paragraph 57)

THE ENTRY INTO FORMAL ASSESSMENT

(Consultation Point C)

5. The Commission recommends that the applicant for admission should be an approved social worker in order to ensure that there is professional distance between the applicant and recommending clinician and that full account is taken of the patient's social circumstances as well as healthcare needs. There are also benefits in securing the early involvement of social services so that consideration can be given to ensuring the continuity of care following an episode of compulsion. (paragraph 63)

6. The Commission would be most concerned if admission procedures resulted in a diminution of safeguards. However, if the application and recommendation are provided by mental health professionals who are specially trained with one or both having previous knowledge of the patient, a second recommendation might become superfluous. (paragraphs 65 - 66)

7. Regulations should be introduced as part of the new legislation to improve the process of approval of clinicians to make medical recommendations, thereby increasing their availability. (paragraph 67)

8. The development of large integrated health and social care trusts makes it difficult to ensure the independence of the applicant from the hospital that will be responsible for care and treatment. Furthermore, it is not helpful to retain the concept of hospital as the centre for the provision of care and treatment. (paragraph 68)

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[119] **Reform of the Mental Health Act 1983** ***Proposals for Consultation***. *Cm.4480 Nov 1999. www.doh.gov.uk/mentalhealth.htm*

EMERGENCY DETENTION

(Consultation Point D)

9. The Commission submits that the maximum period for emergency detention for the purpose of an assessment to be completed should be reduced to 24 hours. (paragraph 69)

10. The Commission would be most concerned if two professionals were not involved in an emergency admission from outside the hospital. In the case of in-patients, the 24 holding power could be initiated by a duly trained and authorised mental health practitioner, including a registered mental health or learning disability nurse who has undertaken specific training. (paragraphs 69-70)

THE NEED FOR AN INDEPENDENT REVIEW WITHIN 7 DAYS

(Consultation point E)

11. The mechanism of a 7 day independent review could not achieve the three functions of ensuring that statutory documentation is in order, that prompt assessment and care planning has taken place and that continued compulsion is justified.

12. The primary responsibility for the scrutiny of statutory documentation must rest with the mental health unit responsible for managing the provision of compulsory care and treatment.
    - Agreed inter-disciplinary report of assessment and care planning should be completed within a time-scale of 28 days, but patients' representatives should be able to check that such a report is available and question any part of it on behalf of patients.
    - In order to avoid a disincentive for the patient to apply for an earlier hearing if the outcome might be an extension of their detention, an expedited tribunal should only have to consider whether the patient should be released from detention under the Act at that point and not make any decisions about future compulsion. (paragraphs 71 - 76)

THE TRIBUNAL

(Consultation Point F)

13. There needs to be a clearer distinction between the judicial function of deciding whether the criteria for compulsion have been met and the clinical function of determining the optimum treatment. (paragraph 77)

14. Tribunals should consist of a legal chair and two other members, not necessarily with direct experience of mental health services. The Commission is opposed to a single-person tribunal whether or not the case is contested. (paragraphs 78 - 79)

THE CRITERIA FOR COMPULSORY CARE AND TREATMENT

(Consultation Point G)

15. The Commission prefers the model without a capacity test, but strongly recommends that the criteria are more narrowly defined to ensure that patients are only made subject to compulsion when it is in their best interests. (paragraphs 81 - 83)

16. The Commission would have major concerns about the introduction of an incapacity test as a key component among the criteria for compulsion. It doubts whether the presumption in favour of capacity and the requirement that the tribunal would have to be satisfied that capacity has been lost would be sufficient safeguards against improper application. (paragraph 82)

COMPULSORY POWERS IN THE COMMUNITY

(Consultation Point H)

17. It is accepted that community orders might prove of practical use for some individuals with severe mental illness who regularly default on medication on discharge from hospital and then abruptly relapse. They would also allow for a smoother transition between hospital and community care, possibly reducing the length of stay. But the Commission would only support the introduction of community orders if the additional criteria recommended by the Expert Committee were adopted. (paragraph 87)

18. There are concerns about how a patient subject to a community order might demonstrate that treatment is no longer required. Consideration should be given to the patient having the right to apply to a tribunal to have a period of time without psychotropic medication being compulsorily administered while still remaining subject to formal assessment. (paragraphs 88, 90)

TRIBUNAL POWERS OF DISCHARGE

(Consultation Point I)

19. The Commission is strongly of the view that clinical supervisors should be left the power to discharge the patient when the criteria for imposing compulsory care and treatment are no longer met. (paragraphs 91 - 92)

CRIMINAL JUSTICE SYSTEM

(Consultation Points J, K, L)

20. The Commission supports the proposal for the Court to have a single power to order assessment and treatment to inform its decision whether to make a mental health disposal. (paragraph 93)

21. The Commission supports the proposal for either the Court of the clinical supervisor to grant leave of absence. (paragraph 94)

22. The Commission supports the Expert Committee's recommendation that the tribunal's power be extended to include decisions concerning leave of absence and transfer between hospitals for patients under restriction orders. (paragraph 95)

23. Although not highlighted as a consultation point, the Commission agrees with the suggestion that a compulsory order made by a court should authorise that care and treatment can be given in hospital or the community on a similar basis to non-offenders. (paragraph 96)

24. The Commission recommends that the remit of its successor body should be extended to cover both prisoners referred for and awaiting transfer to hospital and that there should be a duty to record all administration of medication said to be justified under common law. (paragraph 97)

POLICE POWERS

(Consultation Points M, N)

25. The Commission supports the proposal that police powers to remove people from public places to a place of safety be extended to cover private premises which they have legitimately entered. (paragraph 98)

26. The Commission supports the suggestion that arrested persons who appear to be suffering from mental disorder should, where necessary, get early access to a gate keeping assessment. (paragraph 99)

ECT

(Consultation Point O)

27. The Commission is not convinced that a refusal of consent to ECT by a mentally capable patient necessarily should prevent that treatment being imposed. Although many patients who might be considered for ECT as a potentially life-saving treatment will not have mental capacity due to their illness, some may retain capacity. The Commission cannot see the benefit of creating a system whereby clinicians would find advantage in diagnosing their patients as lacking mental capacity. (paragraph 103)

28. Given that ECT can be a life-saving treatment, the Commission's view is that the treatment should be available under provisions covering urgent treatment. (paragraph 105)

SAFEGUARDS FOR SPECIFIED TREATMENTS

(Consultation Point P)

29. The Commission recommends that naso-gastric feeding for anorexia nervosa should be identified as a specific treatment that is subject to special safeguards. (paragraph 103)

30. The Commission doubts whether it is practical to adopt criteria by which the Secretary of State can decide which treatments should be covered by special safeguards. Each treatment could be dealt with on its own merits, but if criteria are needed at all, the concept of 'invasiveness' would be relevant. (paragraph 106)

31. The Commission agrees with the Government that depot medication should not be subject to special safeguards. It is also doubtful that it is realistic to legislate about polypharmacy or the administration of medication above BNF recommended dosages, partly because this relies on a legislative interpretation of the British National Formulary (in effect, giving it a use for which it is not designed). Good practice in the use of medication could be maintained by other means, such as guidance issued in the Code of Practice, by NICE and through clinical governance. (paragraphs 107 -108)

SHOULD THE THREE-MONTH PERIOD BE CHANGED?

(Consultation Point Q)

32. The Commission recommends that protection of a second opinion should be offered either from the beginning of the imposition of treatment or after a shorter period than 3 months, even if such treatments are exploratory. (paragraph 109)

EMERGENCY TREATMENT

(Consultation Point R)

33. The Commission is strongly opposed to the proposal that patients might be detained without effective treatment that would be within their best interests for any period other than whilst being held for formal admission procedures to be completed, believing it to be unethical. (paragraph 111)

THE NOMINATED PERSON

(Consultation Point S)

34. The criteria for appointing a nominated person for a person who does not nominate anyone and who lacks capacity to do so should be based upon what the person concerned can do for the patient, rather than his or her relationship with the patient. (paragraph 112)

INFORMATION SHARING

(Consultation Points T, U)

35. The Commission believes that the further development of guidance and protocols on the sharing of information in respect of patients subject to compulsory powers is essential. (paragraph 114)

36. There should be a system of review available to the patient who thinks that information has been or is about to be improperly shared, including when information is to be given to victims of a restricted offender. (paragraph 115)

MATTERS NOT INCLUDED IN THE GREEN PAPER

37. There is no mention in the Green Paper of the need to provide more statutory guidance on control and discipline issues (seclusion; restraint; powers to search patients, withhold property, refuse leave or access to hospital activities, interfere with freedom of communication and association). The Commission urges the Government to include the regulation of the powers to exercise control and discipline, in some form, in legislation. (paragraphs 118 -119)

38. The Green Paper makes no reference to the Expert Committee's recommendation of a user's right to an assessment of his or her own mental health needs. The Commission urges the government to reconsider

this recommendation, which would potentially reduce the risk of some individuals engaging in behaviour harmful to themselves or others before they received attention for their mental health needs. (paragraph 121)

39. The Commission also urges the Government to reconsider the Expert Committee recommendation concerning the introduction of a number of specific rights with corresponding duties which would apply to patients under compulsion. The Commission particularly wishes to emphasise that there should be a duty to provide information, which should extend not only to information on the legal position of patients and their rights but also on the care and treatments offered.(paragraphs 55, 122 - 123)

40. The gap in the provision of safeguards for compliant but incapacitated patients remains. The Commission considers that the Expert Committee recommendation that the extension of second opinion provisions to all patients without capacity to consent, whether or not they are subject to formal compulsory powers, would be a step in the right direction in ensuring that the care and treatment provided is in the best interests of such patients. (paragraphs 124 - 125)

41. The Commission recommends that additional safeguards should be introduced to prevent patients from disadvantages that may be consequential to their having been made subject to compulsion. (paragraph 126)

Appendix F

MANAGING DANGEROUS PEOPLE WITH SEVERE PERSONALITY DISORDERS

Response of the Mental Health Act Commission to the proposals for policy development

1. INTRODUCTION

1. The Mental Health Act Commission (MHAC) acts as a watchdog, on behalf of the Secretary of State and the National Assembly for Wales, on the operation of the Mental Health Act 1983 (the 1983 Act) in England and Wales. During the period of the MHAC's Eighth Biennial Report, from April 1997 to March 1999, Mental Health Act Commissioners made over 1500 visits to facilities holding detained patients, had private meetings with over 15000 detained patients and made informal contact with 8000 others. Although relatively few of these patients will have been diagnosed as having a personality disorder, these visits and meetings put the Commission in a unique position to comment on the Government's proposals.

2. The 150 Commissioners are psychiatrists, psychologists, doctors, nurses, lawyers, social workers and other specialists or "lay" people with a special interest in mental disorder and many of them also have experience of either the criminal courts or the prison service or both. They therefore cover a very wide range of expertise and a correspondingly wide range of views. All Commissioners have been invited to comment individually on the Government's proposals, which have been considered in depth by the Commission's Legal and Ethical Special Interest Group. This response reflects views expressed by the Group and has been approved by the MHAC Board but cannot be regarded as reflecting a consensus of all Commissioners.

Summary of the Commission's views.

3. The Commission welcomes the consultation document as a valuable trigger for discussion of the difficult issues raised by the need to balance the safety of the public against rights of individuals who are believed likely to be dangerous. It is also a useful starting point for the development of an integrated policy for handling those who pose a real threat to the safety of the general public or of individual members within it.

4. The Commission's views are ser out in some detail in the following paper but may be summarised as follows:

i. there is not sufficient clarity about what constitutes either "dangerousness" or "sever personality disorder" to justify detention on any basis other than actual criminal behaviour or the likelihood of hospital treatment alleviating or preventing a deterioration in a mental disorder.

ii. There is not sufficient evidence to show that the risk to the public from people with a personality disorder who might be regarded as dangerous is great enough to justify significant changes to current mental health legislation.

iii. If a Government believes that new indeterminate custodial disposals are needed for people who have committed criminal offences, this is a question of preventative detention under the criminal law and the issue of personality disorder only becomes relevant if a hospital disposal would provide a better chance of reducing dangerousness by alleviating or preventing a deterioration in mental disoder. In this context, we believe that "treatability" shopuld be interpreted broadly to include care and treatment which "is likely to enable the patient to cope more satisfactorily with his disorder or its symptoms, or…stops his condition becoming worse"[120].

iv. The work described in Part 3, paragraph 35 onwards; Part 4; and annexes D and E in the consultation document goes a long way towards addressing problems in managing individuals who can reliably be regarded as dangerous. Disposals already available to the Courts but apparently underused would also meet some of the concerns expressed. It would be premature to make significant changes to

[120] Mental Health Act Memorandum - paragraph 16

mental health legislation before all these initiatives have had a chance to work and to be properly assessed.

v. There would be advantage in having a multi-disciplinary specialist service for the assessment of dangerousness but this should be a second stage to, rather than a replacement for. Existing arrangements for assessment under mental health legislation and should be closely linked to funding for special provision.

vi. Considerable additional benefits could be gained from changes in funding, increased and improved inter-agency training and greater multi-disciplinary co-operation in relation to people thought likely to be dangerous, regardless of whether they are diagnosed as having a sever personality disorder.

vii. There are also additional preventative measures which could reduce the likelihood of danger to the public.

viii. Finally, each of the three preceding points could enhance research and development which could lead, in due course, to a more empirical assessment of the need for and propriety of a new categorisation of "dangerous people with severe personality disorder".

5. All of the Commission's views are based on adherence to two fundamental principles of the **centrality of the concept of justice** and the need for **reciprocity** where people are compulsorily detained other than as a result of criminal proceedings. In our view, the concept of justice requires that the liberty of the individual should be restricted only in accordance with clearly defined legislative provisions and only when it is proved to be essential for their own protection or for that of the public. Detention o0n grounds other than criminal behaviour, e.g. for reasons of public health or safety whether based upon actual illness or behaviour or, even more crucially, on the likelihood of such illness or behaviour, must adhere to the principle of reciprocity, i.e. that the individaul concerned must be provided with whatever services are most likely to alleviate or prevent a deterioration in the condition which determines detention.

Dangerous people with severe personality disorder

6. The Commission found great difficulty in commenting on the analysis in the consultation document because, although it accepts the need for a generic term to describe the people to whom the Government proposals refer, we believe that to categorise "dangerous people with severe personality disorder" is wrong and unnecessarily distorts the whole approach to the problems that the document sets out to address. Annex A to the Government document itself highlights the lack of any consensus as to what is meant by "severe personality disorder" and the summary of research in Annex C prompts the following comments:

   - There are no measures to define what is meant by "severe" personality disorder, nor is there any definition of "dangerousness" which relates uniquely those with personality disorders (whether severe or not) as compared with other dangerous individuals who may show no sign of mental disorder.

   - Although it is possible to identify many common developmental and behavioural indicators which may lead to behaviour attributed to personality disorder , risk assessment has to be based upon knowledge of individuals rather than on a group label because of the lack of group homogeneity or predictability.

   - There is little evidence to show that particular approaches to treatment are successful except in relation to particular individuals.

7. **The Commission believes that this term should be rejected because it gives the wrong impression that this is a clearly recognisable group rather than a wide spectrum of very different individuals requiring an equally wide spectrum of management.**

8. The Commission has concerns about this term which are more particular to its function of monitoring the implementation of the Mental Health Act. The constant juxtaposition of the words "dangerous" and "sever" with "personality disorder" is very likely to give rise to a general belief that people with personality disorders are likely to be a danger to the public. There is no empirical basis for such an assumption. Moreover, media inaccuracy and the linkage with mental health services which is emphasised in the consultation document are likely to fual the perception that because personality disorder is a mental disorder (and "mental disorder" and "mental illness" are not commonly distinguished from each other), the

implication is that mentally ill people are more likely to be dangerous than anyone else. **However unjustifiable these linkages are, we are concerned that they:**

- **will perpetuate the stigmatism attached to mental illness by implying that mentally ill people are more likely to be dangerous and that dangerous people who are mentally ill are inevitably more dangerous than those who are not;**

- **may increase racial prejudice because of the diproportionately high number of Black people who are detained under the Mental Health Act (even if for reasons other than personality disorder);**

- **will act as a disincentive to the very people who are most in need of mental health treatment but will not seek it for fear of being labelled as dangerous.**

These likely outcomes are directly contrary to the Government's strongly stated support of the principle of non-discrimination and the very positive action which is already being taken to ensure that help is made available to mentally ill people as early as possible.[121]

The extent of the problem

9. Although the consultation document (Part 2,pargraphs 3 and 4) provides estimates of the number of people who might be regarded as falling within the DSPD group, there is little empirical basis for this estimate, nor for the assumption that greater availability of indeterminate disposals for the group referred to would lead to a reduction of 200 serious crimes a year. In 1998/99 there were only 50 court and prison disposals and 38 civil detentions for reasons of psychopathic disorder in England[122]. The consultation document records that less than 2% of those liable for indeterminate sentences under criminal legilation received such sentences. **Both these figures suggest that, before assuming that new disposals are necessary, greater attention needs to be paid to the reasons for not using existing ones.**

10. No information is available about how many of the 680 patients detained in hospital facilities (on 31 March 1999) with a diagnosis of psychopathic disorder might be considered to be dangerous in the sense envisaged by the proposals. There may be some whose personality disorder might not be labelled "severe" but who could be dangerous, and vice-versa. The assumption that people with a psychopathic disorders are likely to be a risk to the public seems to be based upon media hyperbole about the very small number of such people who have committed serious offences. Where there has been a public inquiry into such cases, the failure has often been in the non-use of existing services than in the absence of legislative provision. The assessment of risk which might justify compulsory detention for someone who has not already proved to be dangerous should surely be comparable with the kind of epidemiological study which supports other health initiatives.

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[121] see **Psychiatric Bulletin**, **23**:12 Dec 1999 for support of these views.

[122] Department of Health (October 1999) **Statistical Bulletin: In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation: 1988 -89 to 1998-99**.

APPENDIX G

MENTAL HEALTH ACT COMMISSION

Summary Financial Statements 1999/2000 & 2000/01

1998/99 £'000s	Revenue Account	1999/00 £'000s	2000/01 £'000s
	Fees and Expenses		
70	- Chairman & Non Executive Board Members	38	73
1,330	- Commissioners	1,242	1,238
1,051	- SOADs	978	1,055
	Management & Support Staff costs		
91	- Senior Management Costs	90	87
443	- Support Staff Costs	447	465
	Other Operating Costs and Expenses		
168	- Administration Expenses	194	200
146	- Accommodation & Office Equipment	226	262
0	- Cost of Capital Employed	14	22
3,299	**Gross Operating Costs**	**3,229**	**3,402**
	Funding Sources		
3,230	- Department of Health	3,115	3,066
?	- National Assembly of Wales	?	?
41	- Misc Fees and Recharges	73	91
3,271	**Total Resources Available**	**3,188**	**3,157**
	Analysis of Deficit(Surplus)		
0	- Cost of Capital Employed	14	22
24	- Unfunded SOAD Fees & Expenses	9	283
0	- Unfunded Costs Re Judicial Reviews	0	52
4	- Over(Under)Spend On All Other Activities	18	-112
28	**Net Deficit(Surplus)Per Accounts**	**41**	**245**
211	**Accumulated Deficit C/Fwd**	**252**	**497**
	Balance Sheet		
	Current Assets		
61	- Debtors	36	50
4	- Cash In Hand	2	2
	Current Liabilities		
-276	- Creditors due within 1 Year	-290	-549
-211	**Net Current Assets(Liabilities)**	-252	-497
	Funded by		
-211	**General Fund at Department of Health**	-252	-497

Extract From Notes to the Accounts

33	1 Average Staff Employed	32	31
160	2 Average Number of Commissioners	169	175
165	3 Average Number of SOADs	161	185
£55,000	4 Chief Executives' Remuneration (Part year costs only 2000/01)	£51,000	£44,519

£14,204	5 Chairman's Remuneration	£12,590	18,540
	6 Remuneration of Other Non Executive Directors		
2	- £0 to £5,000 pa	5	3
1	- £5,000 to £10,000pa	1	2
1	- £10,000 to £15,000pa	0	1

Summary Directors Statement on Internal Financial Accounts

The Chief Executive, together with the other Directors, has a responsibility for reviewing the effectiveness of the organisation's system of internal financial control. In carrying out such reviews in accordance with EL97(55) directors are required to confirm that the 'minimum standards' laid down by the NHS Executive have been in existence within the organisation throughout the financial years now reported.

The directors confirm thast they have undertaken such review and that the above requirements have been met with the exception that

a) there was no audit or remuneration committee. Instead, a Finance and Audit sub-committee of the Board operated throughout both years now reported.

b) the Fraud and Corruption Policy and Standing Orders were not adopted by the Board until 21 March 2001

By Order of the Board at its' meeting on 16 August 2001

Dated 31 August 2001 Signed

Paul Hampshire, Chief Executive

Statutory Auditor's Report and Opinion

We have examined the summary financial statements set out on pages ??? to ??? Of this report and the summary director's statements on internal financial control.

Respective Responsibilities of Directors and Auditors

The directors are responsible for preparing the Bi-ennial Report. Our responsibility is to report our opinion on the consistency of the summary financial statements and the summary director's statements on internal financial control with the statutory financial statements. We also read the other information contained within the Bi-ennial Report and consider the implications for our report if we become aware of any mis-statements or material inconsistencies with the summary financial statements.

Basis of Opinion

We conducted our work in accordance with Bulletin 1999/6 'The Auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In our opinion the summary financial statements and the summary director's statement on internal financial control are consistent with the statutory financial statements of the organisation for the years ended 31 March 2000 and 2001 respectively and we have issued an unqualified statement for both years.

Signed

Chris Wilson
Statutory Auditor

District Audit
1st Floor
Bridge Business Park
Bridge Park Road
Thurmaston
Leicester LE4 8BL

Appendix H

Mental Health Act Commission Members 1999 - 2001

Ms M Agar

Mr C Aggett

Mr V Alexander ~

Dr H Allen

Dr T Ananthanarayanan[W]

Ms A Anderson*

Mr A Backer-Holst

Ms C Bamber[+]

Mr R Bamlett

Dr S Banerjee

Mr M Beebe

Dr C Berry[W]

Ms K Berry

Mr A Best

Dr D Black

Mr J Blavo

Ms L Bolter

Dr D Brandford

Mr R Brown

Mr B Burke

Ms H Burke*

Ms J Burton

Ms F Cassells*

Ms M Casewell

Mr H Chapman

Ms Noelle Chesworth

Miss M A Clayton[+]

Mr F Cofie ~

Mrs A Cooney

Ms S Cragg

Mr C Curran*

Dr O Daniels

Dr C Davies

Mr H Davis[W]

Mr A Deery

Mr B Delaney ~

Mrs S Desai

Dr D Dick*

Mr M Dodds[W]

Mrs Margot DosAnjos[+W]

Mr R Dosoo

Mrs P Douglas-Hall

Mrs G Downham

Mr A Drew

Mr R Earle[TM]

Mr T Eaton

Ms P Edwards

Dr A El Khomy ~

Mr H Field

Mr P Fisher ~

Mr M Follows

Mr M Foolchand[W ~]

Miss D Frempong ~

Ms E Frost

Mr S Gannon

Ms M Garner

Ms E Gilham

Mr M Golightly

Ms J Gossage

Mr H Griffiths

Ms C Grimshaw

Mr G Halliday

Miss C Harvey

Mrs S Harvey[W~]

Miss S Hayles

Mrs J Healey

Mr S HedgesW

Miss A Henry

Ms P Heslop

Mrs C Hewitt

Mr D Hewitt

Mr D Hill+

Mr M Hill

Mr B Hoare

Dr J Holliday

Mr W Horder ~

Mr J Horne

Ms B Howard

Mr P Howes

Ms L Ingham*

Mr C Inyama

Mr M Jamil

Dr T Jerram

Ms L Jones*

Dr O Junaid

Dr A Kelly

Nr N Khan

Mr S Klein[TM]

Dr S Knights ~

Mr G Lakes CB MC[+]

Ms A Lawrence

Mrs S Ledwith

Mr P Lee

Mr N Lees OBE [TM]

Ms P Letts

Ms H Lewis

Mrs J Lewis[W]

Mrs M Lloyd[W]

Canon F LongbottomTM

Ms E MacMin ~

Ms M Madden

Dr S Manjubhashini

Mr J Marlow[W]

Miss L Marriot

Mr Y Marsen-Luther [TM]

Dr R Mather

Miss M McCann

Mr C McCarthy

Mr D McCarthy[TM]

Ms S McKeever

Ms A McKenna

Dr J McKenna

Ms J McKenzie*

Mrs S McMillan

Miss N Mehta ~

Mrs J Meredith

Mr A Milligan ~

Mr J Moran

Mr B MorganTM

Mr A Morley

Mr P Moxley

Ms M Napier

Mrs A Navarro

Mr M Naylor

Ms M Nettle

Mr I Newton

Mr R Nichol

Mr L Nicholas

Inspector N North

Ms P Oglivie[W]

Mr B O'Hare

Ms J Olsen*

Mrs J Oraka ~

Ms C Parker*

Mrs E Parker

Mrs J Patel

Mr K Patel OBE [+]

Mrs J Patterson

Ms L Pavincich

Mr A Persaud

Mr R Peters

Mr S Pierre*

Mr R Plumb[TMWMs]

Mr E Prtak [cc]

Ms M Purcell*

Mrs S Ramprogus

Mr S Ramrecha

Ms E Rassaby[TM*]

Ms E Reid ~

Ms Marion Rickman

Dr G Roberts

Ms H Roberts

Mr N Robinson MBE JP

Mr R Robinson

Ms J Rogers [TM*]

Ms H Ross*

Dr R Ryall[TM]

Ms N Sadique ~

Dr A Sayal-Bennett

Mr J Sedgeman

Ms B Sensky

Mrs D Shaw

Mrs K Sheldon

Dr M Smith ~

Mr R Southern[W]

Mrs R Spafford

Ms J Spenser[W]

Ms S Squires[W]

?Ms P Stott ~

Dr M Swann

Mr M Taylor

Mr P Taylor

Mrs H Thoma[W]

Mr P Thompson ~

Ms J Turnbull

Ms J Tweedie

Mr J Walker

Mr R Webster*

Ms M Wenham ~

Mr M Wilce

Prof R Williams+

Ms R Wiliams-Flew

Mr A Williamson[TM]

Mr B Windle

Mr T Wishart

Mr J Withington*

Mr T Wrigglesworth

Mr A Wright

Mr T Wright

KEY to symbols

+	Board Member
TM	Team Manager
W	member undertaking visits in Wales
cc	Complaints co-ordinator
*	member whose appointment ended during the period described
~	member appointed during the period

Appendix I

Second Opinion Appointed Doctors 1999 – 2001

Dr M Abdurahman
Dr R Abed
Dr P Abraham
Dr D S Addala
Dr S W Ahmad
Dr M Al-Bachari
Dr M Alexander
Dr S Ananthakopan
Dr T Ananthanarayanan
Dr R P Arya
Dr D Atapattu
Dr G Bagley
Dr S Benbow
Dr J Besson
Dr R Bloor
Dr J Bolton
Dr C Boyd
Dr A Briggs
Dr C Brook
Dr C Brown
Dr N Brown
Dr M Browne
Dr A Burke
Dr A Cade
Dr C Calvert
Dr W Charles
Dr A Chaudhary
Dr R Chitty
Dr M Cleary
Dr J Cockburn
Dr J Colgan
Dr J Conway
Dr M Conway
Dr M Courtney
Dr C Cruikshank
Dr R Davenport
Dr J Davies
Dr M Davies
Dr N Davies
Dr K Davison
Dr G Dawson
Dr V Deacon
Dr N Desai
Dr M Devakumar
Dr D Dick
Dr G Dubourg
Dr K Dudleston
Dr J Dunlop
Dr B Easby
Dr A Easton
Dr C Edwards
Dr A El-Komy
Dr V Evans
Dr G Feggetter
Dr T Fenton
Dr S Fernando
Dr E Gallagher
Dr G Gallimore
Dr N Gittleson
Dr S Goh
Dr M Goonatilleke
Dr H Gordon
Dr E Gregg
Dr G Grewal
Dr J Grimshaw
Dr K Gupta
Dr D Hambridge
Dr M Harper
Dr T Harrison
Dr F Harrop
Dr B Harwin
Dr G Hayes
Dr M Hession
Dr S Hettiaratchy
Dr O Hill
Dr R Hill
Dr G Hughes
Dr R Hughes
Dr K Hussain
Dr M Hussain
Dr J Hutchinson
Dr G Ibrahimi
Dr S Iles
Dr J Jain
Dr H James
Dr S James
Dr P Jeffreys

Dr J Jenkins

Dr B John

Dr D Jones

Dr R Jones

Dr S Joseph

Dr F Judelson

Dr A Kaeser

Dr S H Kamlana

Dr G Kanakaratnam

Dr A Kellam

Dr J Kellett

Dr K Khan

Dr L Kremer

Dr G Langley

Dr N Lockhart

Dr M Loizou

Dr R Londhe

Dr B Lowe

Dr M Lowe

Dr G Luyombya

Dr J Lyon

Dr P Madely

Dr B Mann

Dr H Markar

Dr H Matthew

Dr F McKenzie

Dr D McVitie

Dr P Meats

Dr G Mehta

Dr I Mian

Dr G Milner

Dr A Minto

Dr N Minton

Dr B Moore

Dr K Mosleh-Uddin

Dr N Murugananthan

Dr D Myers

Dr G Nanyakkara

Dr T Nelson

Dr J Noble

Dr M O'Brien

Dr A Okoko

Dr R Oliver

Dr D Pariente

Dr J Parker

Dr G Patel

Dr I Pennell

Dr A Perini

Dr R Philpott

Dr W Prothero

Dr I Pryce

Dr E Quraishy

Dr D Rajapakse

Dr T Rajmanickam

Dr D Ramster

Dr S Rastogi

Dr N Renton

Dr E Richards

Dr J Rucinski

Dr R Sagovsky

Dr G S Sama

Dr G Sampson

Dr P Sarkar

Dr G Shetty

Dr A Silverman

Dr N Silvester

Dr I Singh

Dr S B Singhal

Dr M Smith

Dr A Soliman

Dr C Staley

Dr S Stephens

Dr N Suleman

Dr M Swan

Dr R Symonds

Dr L Tarlo

Dr T Tennent

Dr R Thavasothy

Dr R Thaya-Paran

Dr I Thompson

Dr P Urwin

Dr N Verma

Dr G Vincenti

Dr J Waite

Dr C Wallbridge

Dr A Walsh

Dr D Ward

Dr B Weerakoon

Dr M Weller

Dr A Whitehouse

Dr A Wilson

Dr S Wood

Dr A Yonance

Appendix J

Background Documents to this Report

KEY DOCUMENTS

Deaths of Detained Patients in England and Wales, Mental Health Act Commission, 2001
Safe enough? Inspection of Health Authority Registration and Inspection Units 2000 Social Services Inspectorate, Department of Health 2001
Mental Health National Service Framework (and the NHS Plan): Workforce Planning, Education and Training, Underpinning Programme: Adult Mental Health Services: Workforce Action Team Final Report Department of Health 2001
Detained: SSI Inspection of Compulsory Mental Health Admissions Department of Health 2001
An Audit Pack for Monitoring the Care Programme Approach, Department of Health, 2001
Mental Health Policy Implementation Guide, Department of Health, 2001
National Service Framework for Older People, Department of Health, 2001
The Vital Connection: An equalities framework for the NHS, NHSE, 2001
Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001
Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, National Confidential Inquiry 2000
Reform of the Mental Health Act - White Paper, Department of Health, 2000
Reform of the Mental Health Act - Summary of consultation responses, Department of Health, 2000
The NHS Plan, Department of Health, 2000
Improving Working Lives, Department of Health 2000
Finding and Keeping, Sainsbury Centre for Mental Health 2000
National Visit 2 – Improving Care for Detained Patients in Black and Minority Ethnic Communities, Sainsbury Centre for Mental Health, 2000
Women and Mental Health, Edited by Dora Kohen, 2000
A Health Service of all the talents, Department of Health, 2000
The Race Equality Agenda of the Department of Health, 2000
Provision of NHS Mental Health Services, Fourth Report, Health Select Committee, 2000. Volume I - *Report and Proceedings*; Volume II - *Minutes of Evidence and Appendices*
No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse Department of Health 2000
National Service Framework for Mental Health
Safer Services - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 1999
A systematic review of research relating to the Mental Health Act (1983), Department of Health, 1999
Effective care co-ordination in mental health services, Modernising the care programme approach, 1999
Making a Difference, Department of Health, 1999
Managing Dangerous People with Severe Personality Disorder: Proposals for Policy Development, Home Office, 1999
Addressing black and ethnic minority mental health in London – a review and recommendations, London NHSE, 1999
The Mental Health Act 1983 - Explanatory Memorandum on Parts I to VI, VIII and X
The Mental Health Act 1983 - Code of Practice 1999

STATISTICS

In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1999-2000 Department of Health, February 2001
Guardianship under the Mental Health Act 1983, England, 2000, Department of Health, February 2001
Statistics of Mentally Disordered Offenders in England and Wales, 1999, Home Office, Issue 21/00, issued 30th November 2000
Admission of Patients to Mental Health Facilities in Wales, 1999-00 SDB 116/2000. Available free from Viv Trew, Health Statistics and Analysis Unit, National Assembly for Wales, Cathays Park, Cardiff, CF10 3NQ (Tel: 029-2082-5016; Fax: 029-2082-5350; Email: vivien.trew@wales.gsi.gov.uk
In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1989-1990 to 1999-2000 Department of Health, October 2000
Mental health review tribunals for England and Wales - annual report 1997 - 1998, Department of Health, May 2000
Electro Convulsive Therapy: Survey covering the period January 1999 to March 1999, England, September 1999

GOVERNMENT CIRCULARS

HSC 2001/015: LAC (2001)18 - Continuing Care: NHS and Local Councils' responsibilities
HSC 2001/011 Care Standards Act 2000: transition arrangements for the creation of the National Care Standards Commission
CRIMINAL JUSTICE AND COURT SERVICES ACT 2000: AMENDMENTS TO THE SEX OFFENDERS ACT 1997. Home Office Circular 20/2001
Data Protection Act 1998: protection and use of patient information. HSC 2000/009
THE HUMAN RIGHTS ACT 1998 Health Service Circular 2000/025 & Local Authority Circular LAC (2000)17
Modernising mental health services: mental health grant 2000/2001 MISC (2000)18
After-care under the Mental Health Act 1983: section 117 after-care services LAC (2000)3
After-care under the Mental Health Act 1983: section 117 after-care services HSC 2000/003
Mental health grant (MHG): use of slippage 1999/2000 MISC (2000)1
Effective care co-ordination in mental health services Modernising the care programme approach - A policy booklet
National framework for mental health : Modern standards and service models for mental health HSC 1999/223
HSC 1999/180: LAC (99)30 - Ex parte Coughlan: Follow up Action
Commissioning in the new NHS specialised commissioning high and medium security psychiatric services HSC 1999/141
NHS modernisation fund and mental health grant for child and adolescent mental health services 1999/2002 HSC 1999/126
Mental Health Supplementary Credit Aprrovals 1999/2000 for Developing Social Care Services For People With Mental Illness HSC 1999/058
Mental Health Act 1983 revised code of practice HSC 1999/050
Modernising mental health services NHS modernisation fund for mental health services & mental health grant 1999/2002 HSC 1999/038
NHS beacon services HSC 1999/034
Mental Health Act 1983 code of practice : guidance on the visiting of psychiatric patients by children LAC (99)32
Guidance to local authority social services departments on visits by children to special hospitals LAC (99)23
NHS modernisation fund and mental health grant for child and adolescent mental health services 1999/2002 LAC (99)22
Modernising mental health services NHS modernisation fund for mental health services & mental health grant 1999/2002 LAC (99)8
Still building bridges : inspection of arrangements for the integration of care programme approach with care management CI (99)3
L v Bournewood Community and Mental Health NHS Trust decision by the House of Lords in the appeal HSC 1998/122
Joint finance and mental health HSC 1998/037
Modernising Mental Health Services: safe, sound and supportive LAC (98)25
Training support programme "Letting through light: a training pack on black people and mental health" CI (98)13
Court of Appeal judgement L v Bournewood Community and Mental Health Trust MISC (98)7 MISC (98)7
Moving into the mainstream SSI report on inspection of services for adults with learning disabilities CI (98)6

Appendix K

Mental Health Act Commission Publications

Patient Information Leaflets

Leaflets are available in the following languages from the Commission :- Urdu, Bengali, Gujerati, Punjabi, French, German, Somali, Vietnamese, Cantonese, Mandarin, Tamil, Spanish, English, Welsh. Copies in English and Welsh can be downloaded from the Commission website (www.mhac.trent.nhs.uk). Bulk orders of any leaflet are £12 per 50 copies +£1.50 p&p from chiefexec@mhac.trent.nhs.uk or the Commission office.

Leaflet Number 1 - *Information for Detained Patients about the Mental Health Act Commission*

Leaflet number 2 - *Information for Detained Patients about Consent to Treatment (Medication)*

Leaflet Number 3 - *Information for Detained Patients about Consent to Treatment Electroconvulsive Therapy (ECT)*

Leaflet Number 4 - *Information for Detained Patients about How to Make a Complaint*

Leaflet Number 5 - *Information for Patients about Neurosurgery for Mental Disorder (Psychosurgery) and The Mental Health Act Commission*

Practice and Guidance Notes

Available on the MHAC website www.mhac.trent.nhs.uk, or individual copies can be requested free of charge from the Commission office.

Practice Note 1	*Guidance on the administration of Clozapine and other treatments requiring blood tests* (issued June 1993, updated March 1999)
Practice Note 2	*Nurses, the administration of medicine for mental disorder and the Mental Health Act 1983* (reissued March 2001)
Guidance Note 1	*Guidance to health authorities: the Mental Health Act 1983* (issued December 1996, updated March 1999)
Guidance Note 3	*Guidance on the treatment of anorexia nervosa under the Mental Health Act 1983* (issued August 1997, updated March 1999)
Guidance Note 2/98	*Scrutinising and rectifying statutory forms under the Mental Health Act 1983* (issued November 1998, updated March 1999)
Guidance Note 1/99	*Issues surrounding Sections 17, 18 and 19 of the Mental Health Act 1983* (issued August 1999)
Guidance Note 2/99	*Issues relating to the administration of the Mental Health Act in Registered Mental Nursing Homes* (reissued December 1999)
Guidance Note 1/2000	*General Practitioners and the Mental Health Act 1983.* (reissued May 2000)
Guidance Note 1/2001	*Use of the Mental Health Act 1983 in general hospitals without a psychiatric unit* (issued August 2001)

Other publications

Deaths of Detained Patients in England and Wales; a Report by the Mental Health Act Commission on Information Collected from 1 February 1997 to January 2000.

Mental Health Act Commission publication. 44pp February 2001 £7.95 pbk

The executive summary of this Report is at appendix X above. Copies of the full report are available from the Commission Office for £7.95 + £1 p&p (postage free for orders of more than 5 copies). Cheques should be made payable to the Department of Health.

Mental Health Act Commission Eighth Biennial Report (1997 – 1999).

Stationery Office publication ISBN 0 11 322280 7 309pp August 1999 £14 pbk

Report available from the Stationery Office and bookshops

Appendix L

Contacting the Mental Health Act Commission

You can contact the Mental Health Act Commission at the following address:

Mental Health Act Commission

Maid Marion House

56 Hounds Gate

Nottingham

NG1 6BG

Tel: 0115 9437100

Fax:0115 9437101

E-mail: Chief.executive@mhac.trent.nhs.uk

Website: www.mhac.trent.nhs.uk