

THE
FIRST BIENNIAL REPORT
OF THE
MENTAL HEALTH ACT
COMMISSION
1983-85

*Laid before Parliament by the
Secretary of State for Social Services
pursuant to Section 121(10) of the
Mental Health Act 1983*

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CONTENTS

<i>Sections</i>	<i>Page</i>
1 Introduction	5
2 The Commission—structure and organisation	5
3 The context of Mental Health legislation	7
4 The main changes made in 1983	7
4.1 Changes to improve rights of patients	7
4.2 Other changes	8
5 The Commission's functions	9
6 Features of the Commission's role	9
6.1 Mentally handicapped people	9
6.2 Other limits of the Commission's role	11
Informal patients—the incapable	11
the <i>de facto</i> detained	11
Children	12
Prisoners	12
6.3 The Hospital and the Community	12
6.4 Legal advice	13
7 Visits to hospitals and nursing homes	14
7.1 The purpose and ambit of visits	14
7.2 The pattern of a visit to a hospital or home	15
8 Subjects arising on visits	16
8.1 The nature of the Unit	16
8.2 Social Services and Community Services	17
8.3 Admissions	18
8.4 Assessment	20
8.5 Guardianship	20
8.6 The Patients, their wards and care	21
8.7 Documentation	22
8.8 Information for patients	22
8.9 Consent and second opinions	23
8.10 <i>De facto</i> detention	24
8.11 The granting of leave to detained patients	25
8.12 Treatment outside a hospital—the “long leash”	25
8.13 A patient's “appeal” to the Managers	27
8.14 Mental Health Review Tribunals	28
8.15 Patients' monies and property	29
8.16 Rehabilitation and discharge	30
8.17 Education and training	31
8.18 Transfers within the British Isles	31
9 Visits to Social Services Departments	32
10 Complaints	33
11 Second opinions	36
11.1 Appointed doctors, and second opinion statistics	36
11.2 Acceptance of the second opinion procedure	37
11.3 The system adopted	37
11.4 Concordance of doctors	38
11.5 Problems encountered	39
11.6 Reviews of treatment	41
11.7 Psychosurgery and hormone implants	41
11.8 Conclusion	42
Table 1	42
Tables 2–3	43
Table 4	44

<i>Sections</i>		<i>Page</i>
12	The Special Hospitals	44
	12.1 Background	44
	12.2 Management and management philosophies	45
	12.3 Visiting	46
	12.4 Complaints	47
	12.5 Home Office	48
	12.6 Mental Health Review Tribunals	49
	12.7 Summary	50
13	The draft Code of Practice	50
14	Postal packets	52
15	Black and ethnic minorities	53
16	The present and the future	55
	16.1 Present important problems	55
	16.2 Special future issues	56
17	Conclusion	56
Appendices		
	Appendix 1 Financial Arrangements	57
	Appendix 2 Complaints Cases	58
	Appendix 3 Addresses of Commission Offices	63

REPORT

1. INTRODUCTION

This Report summarises the activities of the Mental Health Act Commission during the first two years since it was established. It is sent to the Secretary of State under Section 121(10) of the Mental Health Act 1983. The experience of those two years has enabled the Commission to collate much information and to identify many areas in the mental health services for detained patients (and, by implication in certain respects, for informal patients as well) in which particular difficulties arise both in practice and in law. This Report and the draft Code of Practice which the Commission has been formulating seek to resolve some of those difficulties, and to place others on record so that solutions may be found for them.

At the outset it should be said that the Commission found that it had been inserted into a complex structure of responsibilities for, and inspection of, the fields of mental health services. Commissioners, with their own professional and practical backgrounds, have insisted that contact be made with other organisations directly concerned in those responsibilities. The Commission's functions constitute a new and different overview, of provision for the detained patient. It would be right to pay tribute to the welcome afforded to the new arrival by other bodies in both the public and voluntary sector. Commissioners have reciprocated by participation at numerous conferences, seminars and training exercises held by others, and have had the benefit of contributions from outside their own ranks at their plenary conferences. This widespread and generous co-operation from other organisations should be recognised with gratitude.

Commissioners would also like to acknowledge with gratitude the hard work and patience of the Commission's staff, who like us had urgently from the outset to learn a new job and to develop patterns of work which were at that time undeveloped and untried. The same appreciation and gratitude must also be extended to all in the NHS who with rare exceptions have shown unfailing co-operation and courtesy in the course of our dealings with them.

2. THE COMMISSION: STRUCTURE AND ORGANISATION

The Commission was set up on the 1 September 1983. It started on its statutory duties a month later, on the 30 September 1983 when the new Mental Health Act came into force.

It is a Special Health Authority, and consists of a Chairman and 91 other members. The services of all Commissioners are part-time, amounting in practice during the past two years to an average of more than two days a week for each Commissioner, (after allowing for usual holidays and illness). The design was for one day a week. It has not been possible for the tasks given to the Commission to be properly carried out within that design.

The Commissioners are drawn from different professional backgrounds:

doctors, nurses, lawyers, social workers, academics, psychologists, specialists of various kinds, and lay members.

All have particular knowledge and interest in one or more fields of the mental health service. We live and work in different places all over England and Wales. This geographical spread enables the duties laid on the Commission to be carried out more easily in all parts of the country. Commissioners were initially appointed by the Secretary of State (DHSS and Wales) for a period of two or more years. While all Commissioners are eligible for reappointment, a regular annual intake of some new members and an outflow of old members is proposed.

The Commission has been divided into three geographical Regions: the North Western, with 26 members; the North Eastern with 23 members; and the Southern with 42 members. Each Region has elected its own Chairman and Vice Chairman, and has its own regional offices and secretariat, at (respectively) Liverpool, Nottingham and London.

At the centre is the Commission's Central Policy Committee (CPC), which meets at least monthly in London, with secretarial facilities which it shares with the Southern Region at the London office. The CPC consists of the Commission's Chairman and nine Commissioners appointed by the Secretary of State, and six co-opted members who are usually the Chairmen and Vice Chairmen of the three regions.

It has been inevitable that, with a large membership drawn from many different fields and spread over a wide area, the first years of the Commission's work should have included a period of trial and formative investigation. The Commission, like Athena, sprang fully-formed into being; but with no existing pattern or framework for performing those tasks which it had to undertake one month after being set up. That framework has been developed empirically as the Commission has gathered collective experience.

It was decided initially that, within certain principles to be established by the CPC or by the Commission as a whole, each Region should retain a degree of autonomy. This was to ensure that if practices in hospitals, mental nursing homes and the community were found to vary regionally, they could be assessed and attended to in the first instance by the appropriate Region of the Commission, and that local knowledge would be employed. It has also enabled variation in fulfilling functions to be experimented with and assessed. Each region adopts its own organisation of labour for its field-work. For example, the Southern Region for visiting purposes is organised into small teams drawn from different disciplines.

Each Region has held regular meetings of its own, with in effect three essential objectives:

- (a) to decide on regional procedures and aims, within the common patterns and guidance provided by the CPC;
- (b) to share information and experience gained by Commissioners during their various activities on behalf of the Commission; and

(c) to formulate ideas and recommendations for transmission to the CPC.

In addition, the full Commission has met half-yearly. Four such Commission meetings have been held. At them, Commissioners' differing experiences in hospital-visiting and other activities throughout the country have been shared, and decisions affecting general policies for the Commission's work have been taken. In effect the Commission is a large multi-disciplinary team, operating through progressively smaller teams of similar multi-disciplinary origin.

In the early days of the Commission, the office equipment and the limited staffing provided for it hardly inspired confidence. But conditions have improved. Since May 1984 three micro-computers have been supplied, and although relations between them and the staff have not always been cordial, a *modus vivendi* has been established for about the last 12 months. However even now the Commission has not been able to obtain linkages between the three computers.

The finances of the Commission are dealt with in Appendix 1, on page 58.

3. THE CONTEXT OF MENTAL HEALTH LEGISLATION

The work of the Commission has to be seen in the context of the regimes set up for the mental health services.

More than 25 years ago, the Mental Health Act 1959 had inaugurated a new deal for mentally ill and mentally handicapped patients. But experience showed that the new deal had its own defects, and the Mental Health (Amendment) Bill in 1981 sought to remedy some of these. As a result of the considerable attention which the new Bill then received, the Bill was substantially changed before it was passed. The 30 September 1983 was the date set for its coming into force. But earlier in 1983 a further Act was quickly passed, to consolidate and replace both the relics of the 1959 Act and the Amendment Act. It is the terms of that 1983 Act which now form the context for the Commission's functions, and in particular the protection of the interests of detained patients.

While the 1983 Act has retained the essential structure provided in 1959 for compulsory detention, it has also made important changes. Since another of the Commission's functions has been to keep under review the exercise of the powers and the discharge of the duties laid down by the Act, it is useful to bear in mind the principal changes superimposed by the 1983 Act on to the practices in mental health which had grown up since 1959.

4. THE MAIN CHANGES MADE IN 1983

4.1 Changes designed to safeguard or improve the rights of patients or potential patients:

- (a) the introduction of the concept of "mental impairment" associated with "abnormally aggressive or seriously irresponsible conduct"; and the elimination of "sexual deviancy and dependence on alcohol or drugs" as sole factors warranting detention for mental disorder.

While the introduction of “mental impairment” was designed for the above purpose, the results have been mixed. Patients suffering from a mental handicap are referred to separately in Section 6.1 of this Report on page 9;

- (b) the shorter period of detention (6 months) for the main form of admission for treatment;
- (c) added support by Social Services, under express duties to provide sufficient social workers approved as having “appropriate competence” in dealing with mentally disordered patients; to interview a patient before applying for his admission; to provide social workers’ reports; and to provide after-care services after the discharge of certain patients (in co-operation with District Health Authorities, on whom a similar express duty is placed);
- (d) tightening up of some of the formal requirements for compulsory admission, and of the supporting documents;
- (e) the better defined, but more limited, powers given to guardians;
- (f) additional or improved rights of application to a Mental Health Review Tribunal for discharge, and the automatic reference of a patient’s case to a Tribunal in certain circumstances;
- (g) the power of a Tribunal to discharge an offender patient who is subject to a restriction order;
- (h) improved rights on the part of detained patients to receive information about their legal status and other rights under the Act;
- (i) the requirement that a restriction order can only be made by the court when it is necessary to protect the public from “serious” harm;
- (j) the changes described in (a) and (b) in the next paragraph (which perform the dual function of both facilitating proper treatment and improving the rights of detained patients);
- (k) the setting-up of the Commission, to perform the tasks described below in Section 5 of this Report on page 9.

4.2 Changes designed to facilitate proper treatment of patients and to clarify issues of importance:

- (a) the concept of a Code of Practice for the guidance of doctors and other professionals in relation to the admission of patients under the Act and the proper treatment of both detained and informal patients;
- (b) making clear (by express words) the power of the “responsible medical officer” (“rmo”) to give compulsory treatment to patients admitted for up to six months or 28 days, subject to the rmo’s duty (in the case of ECT, or medicine already given for three months) to obtain a certificate, from another doctor appointed by the Commission, to the effect that the treatment should be given;
- (c) the requirement that before giving ECT, or medicine where medicine has already been given for three months, to a consenting detained

patient, the rmo must himself certify in writing that the patient has in fact consented;

- (d) a statutory power given to rmos to give compulsory treatment to detained patients in an emergency, without having to obtain a certificate;
- (e) the added power given to rmos to give compulsory treatment to patients admitted for up to 28 days for assessment of their condition;
- (f) the power given for a rmos nominated deputy to detain an existing informal in-patient for 72 hours;
- (g) the "holding power" given to a nurse to detain an existing informal in-patient in emergency for up to six hours.

5. THE COMMISSION'S FUNCTIONS

The tasks assigned to the Commission under the Act can be collected under four heads:

- (A) protecting the interests of detained patients by:
 - (i) visiting and interviewing them in hospitals and mental nursing homes;
 - (ii) investigating complaints by and about detained patients;
 - (iii) keeping under review the way in which the powers and duties under the Act are carried out (so far as they relate to detention or detained patients);
- (B) arranging for:
 - (i) the provision of "second opinions" by appointed doctors (and in special cases, also by lay people), where the Act requires such opinions to be obtained before treatment is given to detained patients (or, in the special cases, to informal patients as well);
 - (ii) the carrying out of "reviews" of such treatments at later stages, when second opinions have been given;
- (C) drafting the Code of Practice already referred to;
- (D) reviewing any decision made at a special hospital to withhold a postal packet or its contents, if a review is applied for.

Reports upon all these functions of the Commission are made in Sections 7-14 of this Report, beginning on page 14. In Section 6 we draw attention to certain other features of the Commission's role, and in particular those areas where the Commission has a limited or no function.

6. FEATURES OF THE COMMISSION'S ROLE

6.1 Mentally handicapped people

- (a) The majority of detained patients whose interests the Commission protects are those who suffer from mental illness. But another, much smaller, group of detained patients within the Commission's overview

are those who suffer from a mental handicap and fall within the Act.

- (b) Parliament gave the Commission a comparatively limited brief in respect of people with a mental handicap. The majority of the powers and duties under the Act relate only to those mentally handicapped people who are "mentally impaired" or "severely mentally impaired", (a condition which includes adverse behavioural conduct). Thus the greater proportion of people with a mental handicap are now not within the ambit of the Act or overview by the Commission.
- (c) In visiting mental handicap hospitals and latterly Social Services departments during the first two years we have become concerned that these limitations may entail possibly adverse consequences for people with a mental handicap. It is true that the stigma of formal categorisation is avoided, but it may be doubted how much room there still is in the lives of some severely handicapped people for further vulnerability to stigmatisation. More significantly there is no automatic access to the benign statutory effects such as the Manager's duty to explain to the patient his rights, overview by the Commission, second opinion on treatment, appeal and automatic reference to the Mental Health Review Tribunal, and entitlement to jointly organised after-care.
- (d) The Commission's responsibility under the Act to mentally impaired patients empowers it to visit all hospitals and mental nursing homes having detained mentally handicapped patients, or entitled to receive them. It has almost invariably been warmly welcomed and encouraged to view facilities throughout such hospitals and homes, not just those impinging on the formal patients. Commissioners have been consequently struck by the dramatically wide variation in quality of provision, sometimes even within the same hospital, and in attitudes and planning towards the policy of dispersal to small-scale services in home neighbourhoods.
- (e) Not surprisingly, in the early days of the new Act's operation there has been some confusion at hospitals about the definition of "mental impairment", especially in relation to the previous concepts under the 1959 Act, and about the correct implementation of the procedures in those hospitals which have little opportunity to practise them. Guidance on the definitions, as frequently requested and given, should also be available in the Code of Practice; as will be assistance for those who have to deal with the question of "consent" in different contexts, including that of incapacity as a result of mental handicap.
- (f) Many interesting developments have been noted such as the willingness of some hospitals and Social Services departments to encourage types of "advocacy", to provide a voice independent of authority for those whose voice or thought is insufficient for rational self-assertion. In the field of the special hospitals it is notable that many fresh efforts are being made to rehabilitate and transfer patients who are mentally impaired to less restrictive surroundings, although the lack of longer-term secure facilities has resulted in some transfer delays.

- (g) All Commissioners have taken part in visiting mental handicap hospitals and Social Services departments. A group of about 20 Commissioners, representing all the constituent disciplines, have expressed a special interest in developing a response to some of the difficult issues in mental handicap. This group has also received various requests for consultation from bodies and people outside the Commission, and invitations to disseminate examples of good practice. It is hoped that work will continue to clarify the rights of those handicapped patients who are protected and those who are not protected by the Act, and the legal responsibilities in this connection of staff and authorities; and that there will be more time in the next two years to study the opportunities of the mentally impaired offender to receive therapeutic rather than penal disposal, and to examine how far suitable treatment is available generally for that tiny minority most likely to be detained—the violently disturbed.

6.2 *Other limits of the Commission's role*

It should be pointed out that the Commission's direct brief relates to a very small part only of the resident population in mental hospitals and nursing homes. The figures speak for themselves. There are about 110,000 "resident" informal patients at any one time, and only 6,500 patients detained under the Mental Health Act. It is true that some of the work done by Commissioners will indirectly have helped informal patients and that it should, in due course, help them more directly through the Code of Practice.

The Secretary of State has power (under Section 121(4) of the Act) to direct the Commission to keep under review any aspects of the care and treatment of informal patients. Clearly a direction in relation to the total care and treatment of all informal patients would have considerable implications for resources, involving not only questions of cost, but also the availability of qualified personnel sufficient for such a task. But it is for others to assess such factors relating to resources.

During these two formative years, we have been increasingly concerned about the position of informal patients, particularly those long-stay patients who may be incapable but are not detained. This concern is particularly reflected in the paper on "Consent to Treatment", prepared by the Commission for the purposes of the draft Code of Practice, as referred to in Section 13 of this Report on page 52. That paper has now been published, and is therefore publicly available.

In another respect the Commission's attention has focussed on a special group, namely those informal patients who for one reason or another are subject to "*de facto* detention" in a locked ward or room, a physical form of detention (whether long or short) which is outside the Act. This feature is specially referred to in Section 8.10 of this Report on page 24.

The Commission will decide at its next full meeting in October 1985 whether to request the Secretary of State to direct, as a beginning, that the Commission should keep under review the care and treatment of informal

patients who are physically detained against their expressed wishes. This is not intended as a criticism of the use of such a form of physical detention, which may (or may not) be justified by the circumstances of a particular case, but as a means of holding the balance between care and other rights.

The Commission also proposes to ask the Secretary of State to consider the implications of the proposals made in Section 10 of the Commission's paper on "Consent to Treatment", relating to informal incapable patients; in particular, the proposal to afford to such patients in certain cases a protection analogous to the second opinion procedure of the Act.

A third group of patients (numbering about 3,000) who fall into a special category are the children and young people resident in mental handicap and illness hospitals. It is rare for anyone under the age of 16 to be sent to hospital under the compulsory powers of the Mental Health Act. Where compulsion is thought necessary, it is usually provided under a Child Care Order, with the juvenile court making a hospital order (or guardianship order) similar to that under Section 37 of the Mental Health Act. Such patients, however, have none of the protections afforded by the Mental Health Act. Particular dangers for them are that they tend to get lost in the system; having been "volunteered" by parents or guardians for treatment at an early age, they remain as "voluntary" patients for the rest of their lives; and in some places their care and treatment tends to receive a low priority.

A further group of mentally disordered people who deserve special attention are those who are already in a different place of detention, but not under the Mental Health Act: namely those in prison. The group includes both those for whom no place in a hospital could be found or who were not recognised as mentally disordered at the time of their conviction, and those who have become mentally disordered while in prison. The number of people in this group is not known, but one estimate at least has assessed the number at a significant percentage of the total prison population. The fact that they are in prison instead of in hospital entails inevitably some loss of adequate care or treatment for them, and creates great difficulties for those charged with their control and care, particularly over the issue of their consent for treatment when they are acutely disordered. In one sense, such prisoners can be said to have a right to be detained under the Mental Health Act and to be admitted to a hospital, (whether a special or an ordinary hospital). Thereby, they would both receive the good effects of such detention (namely the opportunity for proper treatment and care, and the statutory protections against abuse) and, being already detained, would not suffer so much stigma as a result of being detained under the Mental Health Act.

The House of Commons Committee on Social Services is shortly to consider the Prison Medical Service, and will no doubt be looking at the special position of those prisoners who are mentally disordered.

6.3 The Hospital and the Community

There are many issues on which the Commission's task leads and will increasingly lead to its involvement with services in the community. Some of the areas identified are:

- (a) the availability, outside the limits of the hospitals, of qualified personnel to assess people who may have to be compulsorily admitted to hospital;
- (b) the difficulties experienced by the relatives of people who may have to be so admitted, in so far as these difficulties may affect the interests of those detained;
- (c) the care and treatment of detained patients who are on leave from a hospital. This entails consideration of the scale and calibre of the services provided by the Community Psychiatric Nursing Services in particular areas, as well as the services within hostels or group-homes where such patients may be on leave;
- (d) the issue of a community care order, which is discussed in Section 8.12 of this Report on page 25;
- (e) the availability, at all points within the community, of those care facilities, which are so essential for the consideration of the proper discharge and rehabilitation of detained patients and also of their after-care.

We have become conscious of the fact that because our limited time has had initially to be concentrated on hospitals as a main focal point where the majority of detained patients are placed, our involvement with the issues affecting the community services has not yet been adequate to do justice to the importance of those services.

Many serious criticisms have been made by organisations and individuals about an insufficiency of services in the community, and about the dangers of a policy of closing hospitals before community services have been built up. The Commission believes, as a result of the evidence which it has seen, that this is another focal area upon which (within the limits of its brief) it should now concentrate more precisely.

The lesson, perhaps, of the experience which Commissioners have had during the last two years is that the problem of improving community services is one which has to be tackled empirically and locally. Wide variation in the extent and calibre of such services has been observed. This is a problem which the Commission, with its localised commitment, can seek to help to resolve or at least to reveal. The wider question of policies to develop community services, which will lead to the closure of some hospitals, is clearly outside the Commission's brief, except insofar as we may draw attention to the effect of such policies upon issues such as those listed above.

6.4 Legal advice

One small but important issue is the Commission's role in relation to giving legal advice. On very frequent occasions, Commissioners and their staff in the offices have been and continue to be asked questions of law. The questions vary from the easy to the very difficult. The Commission has almost invariably sought to give such help as it can (with warnings that formal legal advice should be obtained from the inquirer's legal adviser). But it is not the

Commission's function to act as a legal advice service; and the scale of such inquiries often exceeds the extent of the time and care which Commissioners and staff can devote to giving such assistance. On matters of practice, a duty to provide answers is recognised. But while the Commission will continue to give at least practical help where possible on questions of law, staff of health authorities ought to become used to consulting their own available legal adviser. And the Commission may have to cry Halt, whenever the habit exceeds the bounds of the limited time available.

7. VISITS TO HOSPITALS AND NURSING HOMES

7.1 The purpose and ambit of visits

Visiting hospitals and mental nursing homes throughout England and Wales has been and will remain one of the continuous activities of Commissioners. The visits have a two-fold purpose: to interview detained patients and observe the conditions in which they are placed; and to see how the provisions of the Act are in practice being observed and to offer advice and guidance to staff about their practices.

In a period of 20 months, 937 such visits in total have been made, covering 523 hospitals and homes.

Commissioners have operated in teams (sometimes large, sometimes small) on a geographical basis. Broad principles for the pattern of visits and the matters to be observed and dealt with were agreed upon, but the teams have a wide discretion as to the approach and emphasis which they wish to adopt. In this way they can adapt to the differing circumstances between one hospital and the next.

There are 728 hospitals and mental illness/handicap units, and 60 nursing homes in England and Wales, and of these, 515 hospitals and 24 homes have or may have detained patients. Visits have been made to the latter category, but (in the main) not to those which neither have nor will have such patients. The aim has been to visit each hospital or home initially at least once a year, and to increase that frequency, where necessary.

Experience has shown the need to vary the frequency of visits, to match the size or the need of the hospital concerned. Visits generally last one day; but in some cases where there are many detained patients or special problems, it has proved necessary for a team to visit the same hospital on two or more days in one session.

Each visit is usually arranged in advance with the hospital or home, and current information obtained from it so that the Commissioners are aware of the up-to-date position before arriving. The Commission is entitled to make unannounced visits, and in some places has begun to do so.

The time constraints of a visit are considerable. Much has to be dealt with in a short space of time. A cross section of typical matters arising are described in Section 8 of this Report at page 16. Visits however do not, and are not meant to, constitute detailed investigations. Our role has essentially to be a

empirical one, both in dealing with issues raised by detained patients and in reviewing how the Act is working and how the interests of patients are being looked after.

The Commission has aimed to be a catalyst of good practice; to observe and detect both the good and the bad policies and practices, and to disseminate the good. In this task we have ourselves been able to learn much, and we acknowledge a debt to those hospitals and their staffs who have intelligently studied the new Act and initiated procedures to carry out and monitor the changes. Commissioners do not seek to claim credit for all improvements in practice which have arisen during the past two years, but they have all had direct experience of improvements following upon their visits. It is hoped that the climate of learning and discussion, which visits have sought to create, has helped to favour self-reform, which should be accelerated when the Code of Practice is approved.

The wide scope of the Commission's visits throughout the country provides an opportunity to collect information ranging over almost all hospitals and homes. That opportunity has already been of great assistance for the purpose of drafting the proposals for the Code of Practice. But the scale of the activities of Commissioners and the secretarial staff has been such during these initial years that it has not yet been possible systematically to collect and organise all the obtainable information. With the proposals for the Code of Practice now completed, the systematic collection of data should now become a practical project for the future.

In its relationships, the Commission has aimed to report always to the Managers (eg the District Health Authorities, for NHS hospitals) and to expect responses from them, with regard to the results of any visit. But face-to-face discussion and guidance takes place at the Unit in question, and with the Unit's staff. Members of the managing Authority are invited to and often do attend the meetings at the Unit, where they perform a welcome and useful part.

Commissioners would like to pay tribute to the warmth and tolerance which they have almost invariably encountered in their visits. It is right also to mention their admiration for the unsparing dedication shown by so many members of staff whom they meet. But these factors cannot deter Commissioners from making critical comment where it is justified.

7.2 The pattern of a visit to a hospital

The pattern usually adopted for a day's visit has been (and continues to be) that Commissioners on arrival have held a meeting with senior representatives of the disciplines in the hospital, lasting up to an hour or more. Problems arising at the hospital are discussed, and the Commissioners can inform themselves about hospital plans, policies and practices.

After the initial meeting, Commissioners have visited wards, and in particular those where detained patients are currently placed; have interviewed those patients who wish to see them; have introduced themselves

to those patients who have not asked to see them; and have discussed with ward-staff questions arising on the ward and (where appropriate) issues emerging from the interviews.

Commissioners are free at any time to change the form of their visit, according to the needs of the occasion. They may choose to visit any part of a hospital or home for the purpose of investigating matters affecting the interests of the detained patients. They have adapted their programmes to fit particular circumstances by, for example, investigating also the occupational therapy facilities or industrial workshops (where they exist) in a hospital, in order to see the conditions under which the detained patients are occupied and trained.

Another duty undertaken on such visits has been to sample (within the available time) the documentation held by the Managers as justification for the detention and treatment of the detained patients, including those resident not only at the time of the visit, but also in the interval since the hospital was previously visited. In appropriate cases, this will also include examination of some of the patients' case notes and the hospital's ECT records.

At the conclusion of each visit, a final meeting with staff representatives has been held, to mention and discuss any matters arising during the visit. A record of all these matters is then made, by a letter reporting on the visit to the Managers of the hospital or home. The Commission expects to receive an answer to that report, with the Managers' responses on each of the matters raised. On the next visit by Commissioners, such matters are followed up, if they have not been further dealt with in correspondence in the intervening period.

8. SUBJECTS ARISING ON VISITS TO HOSPITALS AND HOMES

The categories of issues dealt with on hospital visits are never closed. Apart from the more usual problems referred to below, unexpected issues of all kinds often arise, and have to be dealt with either at once or by subsequent letter. But the following subjects form a cross-section of typical matters raised and taken up on such visits. All the relevant ones are of course dealt with in the draft Code of Practice.

8.1 The nature of the Unit

- (a) The pattern of the services provided by the Unit has been the initial subject of enquiry. The enquiry covers also the extent and nature of the catchment area, and staffing issues. This is the background material, to familiarise Commissioners with the work of the Unit and to give them an understanding of any problem which may affect the interests of detained patients.
- (b) Information about plans for changes or development of services at the hospital, which may affect the conditions in which detained patients find themselves, has to be sought. It has been seen that the run-down of services at one Unit in favour of another often creates a vacuum affecting conditions of care.

- (c) Some experiences have shown that a Unit's ability or inability to present a clear picture of its own role often reflects the standards maintained in the Unit. Some hospitals have such profiles of themselves ready at call, whereas others have found it difficult to project any clear picture.
- (d) Attitudes in a Unit, both at management and ward level, as to the importance of multi-disciplinary team-work require to be examined. Being itself a multi-disciplinary body, the Commission is very concerned to encourage such team-work. We have observed that Units still vary greatly in their attitude to and use of the valuable contributions to patient care which the different professions may make, and that, in some, little weight appears to be attached to the views of some members of the team.
- (e) Apart from the main professions, the Unit's other services in the form of, eg, psychologists' assessments and advice or occupational therapy facilities will be significant factors affecting the care and rehabilitation of patients. Accordingly Commissioners have had to inform themselves about these, and to pursue questions arising from such information. A significant resource problem is often involved in the provision of such services, and it is clear that this problem can only be grasped at management level. For social services provision, see Section 8.2 below.
- (f) The Unit's policies with regard to seclusion and complaints have to be examined and assessed.

We have been able to advise considerable improvements in such policies, and also to cross-fertilise relevant ideas, by using satisfactory features at some Units as good examples for others less efficient or enlightened to follow. The policies have then to be followed up so that the degree of correspondence between the policies and the practices, which often has significant bearing on patient care, can be assessed.

8.2 Social Services and Community Services

- (a) The nature and extent of social services for mental health and handicap purposes both in hospital and in the catchment area are explored by Commissioners with the help of social services representatives. Problems of the non-alignment of health boundaries and local authority boundaries, resulting in the presence of more than one social services authority, have arisen.
- (b) The provision and training of sufficient Approved Social Workers (ASWs) have been particular difficulties during the period in question, mainly due to industrial action. This matter has been consistently pursued by Commissioners, in view of its significance for the admission of detained patients. Fewer than 1,000 social workers passed the necessary examinations for ASW, and at least some English counties have no fully qualified ASWs at all. The transitional approval authorised by the DHSS resulted in about 4,000 social workers being so approved. But however conscientiously individual social workers

apply themselves, it is clear that the standards aimed at by the Act have still not been met and will not be met in the near future.

- (c) The “out-of-hours” social services provided have been a focus of attention, for the same reason. There is no express legal requirement on authorities to provide a 24-hour service, and although good practice and commonsense clearly point to the need for such a service, four authorities at present provide none. Inevitably such a practice results in increased use of applications by nearest relatives, or detention arising from the powers given to the police by Section 136.
- (d) The need for strategic planning and active co-operation between Health and Local Social Services Authorities has required particular advocacy by the Commission, with the object that those Authorities should
 - (i) establish common objectives in assessing situations where compulsory admission is possible;
 - (ii) provide effective out-of-hours services and emergency services, for admission purposes, in the form of an available and experienced medical and social work team at the point of assessment;
 - (iii) employ the powers of guardianship where appropriate;
 - (iv) establish (with the police) acceptable procedures for dealing with persons detained under Section 136, see page 19;
 - (v) develop the services necessary for performing properly the express duty now laid on such authorities (in co-operation with voluntary agencies) to provide after-care after a patient’s discharge; and for that purpose should overcome any difficulty arising because of the different funding arrangements for hospitals and local authorities;
 - (vi) enable the transfer of services from a traditional hospital to the community (where such transfer has been decided upon) to be carried out effectively and with the least damage to patients’ interests and staff morale.
- (e) In general, since the Commission attaches great importance to plans for rehabilitation of detained patients (as part of a wider “plan of treatment”) their future in the community after discharge necessitates examination of the psychiatric and care services there provided.

Because of the involvement of Social Services Authorities with admissions under the Act and related matters, it was decided that Commissioners should also visit such Authorities; and these visits are dealt within Section 9 of this Report at page 32.

8.3 Admissions

- (a) The incidence of applications made by nearest relatives for the admission of patients has been the subject of Commissioners’ attention on their visits. The Commission’s view is that the absence of any independent social work assessment before admission is a serious loss

for the patient. Among other things, it means that less restrictive alternatives are not considered. An important protection available for a patient is an interview by a properly qualified and experienced social worker before any application is made. In the absence of sufficient ASWs, present standards cannot universally be those intended by society.

- (b) Attention has also been directed towards the incidence and varying use of Section 4 (emergency admissions) and the outcome for patients admitted under that Section. While in some places emergency admissions have been frequent, in others there has been a marked drop in their rate. In some regions patients are admitted under Section 4 simply because an Approved Doctor is not available.
- (c) Accordingly enquiries have been directed to establishing whether locally there are sufficient Approved doctors. A current review by the DHSS, the Royal College of Psychiatrists and other bodies is awaited.
- (d) The Commission has extensively advocated procedures for ensuring that the powers to detain existing in-patients under Section 5 are properly used. The evidence suggests that the nurse's power is being comparatively little used, but that the doctor's power is in some places extensively used, particularly by nominated deputies, and sometimes repetitively, which is not good practice. The Commission has advised that as senior a doctor as possible should be nominated as the deputy, and that the nomination be made explicit, so that ward staff know for certain who the deputy is. In some instances, it may perhaps be impossible to use senior doctors as deputies; but in that event safeguards should be employed, such as a telephone consultation with the rmo or otherwise with a consultant; and the Unit's use of the power and also the outcome for the patients so detained should be monitored.
- (e) Very wide variations both in the use made by local police of the power under Section 136 to remove persons to a place of safety and also in the outcome for persons so removed have been observed. This is in line with research findings which point to differing results between London and other areas. But, even within the metropolitan areas, divergences have been observed by Commissioners. The proper use of the power requires active co-operation between local police, the health authority and the local authority in establishing procedures and limits and in monitoring the results. The police have the power to choose the place of safety, and their practice varies again as between London and other areas. A current detailed research study is being carried out by MIND, with the support of the Metropolitan Police, into police practices in relation to mentally disordered people. Its findings will be significant for the purposes of establishing guidelines for good practice (which may in the result prove to be dictated by local considerations). It will be important to know how far police practices are influenced by attitudes and co-operation from health and social services authorities. At present good practice suggests that the hospital or a community treatment centre is to be preferred as the usual place of safety, alternatively that a team (of a doctor and social worker) should be ready and available to go quickly to another place of safety

(such as the police station) to assess the person detained.

- (f) The conflict between the interests of a patient who asks that his nearest relative should not be informed of his admission for assessment, and the requirement under Section 11(3) of the Act that the nearest relative should be informed, has been the focus of some attention. A conflict of interests always arises in such a case, but it seems that by law the social worker is bound finally to override the request of the patient, however reasonable and justified it may be. Instances have arisen where, for arguably good reason, social workers have bent, if not broken, the law.

8.4 *Assessment*

One of the advantages of Commissioners' hospital visits, complaints visits and second opinion visits has been the opportunity to evaluate practice in relation to making applications and recommendations for detention or overriding dissent. Many of the Sections of the Act make personal interview and assessment an essential step in these processes. In practice we have found a high level of competence by professionals in undertaking these responsibilities, but three aspects are worth drawing attention to:

- (a) Sometimes the competence is disguised by the standard of recording the interview. The standard has varied from the excellent to the chaotic. In the more difficult instances Commissioners have had to resort to detective work in order to piece together the assessment, and this difficulty must also affect other professionals who have to rely on the assessment. We would suggest that good assessment deserves good reporting.
- (b) The description supporting the grounds for detention has sometimes been expressed solely as a diagnosis, rather than as an observation of facts. To say: "This person believes he is Satan, has attacked his wife with an axe and set fire to the local church," is more informative to other persons than to say: "This person is a dangerous paranoid schizophrenic." Commissioners believe that observations are to be preferred to inferences; although the inferences may of course also be given if thought fit.
- (c) It may seem unnecessary to point out that when a patient is admitted for assessment under Section 2, an assessment needs to be made and properly recorded. But this is not always done. A multi-disciplinary assessment is a necessary step in all cases, whether the patient is thereafter discharged or remains as an informal patient or is put on Section for treatment.

8.5 *Guardianship*

- (a) Under both the 1959 and 1983 Act, the use of guardianship has been far from extensive (fewer than 200 cases a year). The new Act has more clearly defined the powers of a guardian, but limitations on the use of guardianship are as follows:
 - (i) the definition of "mental impairment" has had the effect that fewer mentally-handicapped persons are seen as able to be placed

under guardianship. The change in the definition and its association with behavioural features have frequently not been understood and have led to avoidance of the issue of guardianship by those responsible for admitting patients.

- (ii) while a guardian has the power to insist on the patient's attendance for medical treatment, he cannot insist that the treatment be taken. This means that some patients who could live in the community if medication were obligatory cannot do so. The associated question of treatment for hospital patients who are on extended leave is referred to in Section 8.12 on page 25.
 - (iii) some social services departments are reluctant to consider guardianship in view of the demands which they anticipate could be made on their resources in terms of manpower and residential services.
- (b) Some Commissioners have sought to encourage the greater use of guardianship, but only on the basis of careful individual selection. Although it is a less restrictive measure than detention, it is seldom regarded as a serious option. The control of a patient's medication is often seen as a prerequisite, but this is not always so, and a general change of attitude would, in the Commission's view, result in the identification of people who could benefit from guardianship instead of detention.

8.6 The patients, their wards and their care

- (a) Commissioners have attached particular importance to interviewing any detained patients who wish to see them. Such interviews are almost always held in private, and patients are free to speak of anything they choose. Sometimes matters of general or individual significance arise in this way, and (with the patient's permission) are then taken up by Commissioners with ward staff or with more senior representatives of the hospital staff at the final meeting of the visit. Even where nothing of great significance has emerged from such an interview, the importance of this opportunity for the patient to talk with Commissioners cannot in our view be exaggerated.
- (b) Particular attention is paid to the conditions of the wards where detained patients are placed, and to the facilities available for the preservation of individual dignity and personal choice, when living is necessarily restricted within a close community such as a hospital ward. Many suggestions for improvement made by Commissioners have quickly been taken up by Units, and a more homely and creative atmosphere created for the patients.
- (c) Facilities of course vary considerably, from the admirable to the abysmal. It is generally not the age of the buildings which is the dominant feature, but the ingenuity and adaptation, or the lack of it, which has been brought to bear in the wards. Some old buildings have been imaginatively adapted, while some new buildings have rapidly been made to look like old-time institutions. Simple partitioning and

curtaining and the strategic positioning of furniture have often made easily accessible bedroom cubicles out of an unprepossessing dormitory, or have created quiet areas where patients can come to terms with their current problems.

- (d) Some hospitals have used former staff houses located on the hospital site to increase the provision of domestic-scale accommodation, so giving small groups of patients the opportunity to live in a family setting.
- (e) There are still hospitals and units where basic facilities such as bathrooms and showers are inaccessible to patients because doors are kept locked. The need for a ruling on keeping such doors locked when there is no risk to patients should be reviewed periodically. Units have also been observed where recreation facilities are available only after work programmes have been completed: the reasons for this again need to be reviewed from time to time.
- (f) Questions arise in relation to patients who belong to black or ethnic minority groups. A special Section, No 15, of this Report at page 53 refers to the needs of such patients.

8.7 Documentation

- (a) Since the Act has introduced further formalities as regards the written requirements for admission, Commissioners have paid attention to the Units' various records and methods of record-keeping in relation to detained patients. Hospitals have been introduced to improved methods of monitoring their admissions in this respect and of ensuring that the legal requirements are properly carried out. The Act introduced new obligations, which sometimes have been imperfectly understood. Where necessary, Commissioners have sometimes held special seminars for hospital staff.
- (b) Where it has appeared that issues of the legality of an admission have arisen, such issues have been referred to the Managers. Doctors have been guided as to the most satisfactory ways in which to observe the proper formalities of medical recommendations, and of reports under Section 5(2) (doctors' holding power).
- (c) We have also drawn attention to the need for administrative arrangements to monitor the stages of a patient's history in the Unit, and to keep track of requirements such as the need for renewal of detention, the conversion of his section, or his discharge; the entitlement (or, in the long-term, entitlements) of the patient to seek a Tribunal hearing, so that he may be informed at the appropriate time or times; the need arising for any statutory certificate in relation to the patient's treatment; and the giving of information under Section 132 to the patient about his relevant rights.

8.8 Information for patients

- (a) The extensive obligations laid upon the Managers of Units to ensure that patients are adequately informed about their rights under the Act

have been the subject of much emphasis and advice from Commissioners. It has been recommended that the proper carrying out of these obligations entails a multi-disciplinary approach. The extent of the information, and the timing of the provision of the information, are seen as factors requiring contributions from different quarters (including social workers), with organisation of the procedures being provided by the Managers, on whom the duties rest. It seems clear also that it is the Managers who must deal with the problems of translation and interpretation of information for their patients. This concerns not only those whose understanding of English (or Welsh) is limited, but also those afflicted by blindness or deafness.

- (b) Units have varied greatly in the practices initially adopted by them to perform their obligations as regards giving information to patients. These ranged from a practice whereby administrators alone have tried to perform those obligations on behalf of Managers, to a practice whereby nurses alone have carried out the functions. Even where a multi-disciplinary input is used, training in the skills of explaining complicated legal rights is essential, particularly for nurses on whom the burden of giving oral information usually falls in practice.
- (c) It has been pointed out that some of the information given in written form in the printed leaflets (relating in particular to the special treatments under Section 57, or to ECT) may be irrelevant in particular cases and may have to be adapted by Units in order to avoid causing unnecessary fears or distress to patients. Another feature which merits attention is the probably unintended implication in some of the leaflets that a patient's request to the Managers to discharge him should take priority over an appeal to a Mental Health Review Tribunal. This may have the effect that some patients admitted under Section 2 may lose the right to appeal to a Tribunal, by reason of time running out, if they are not made aware that an "appeal" to the Managers is not a substitute for, or a preliminary step before, pursuing their right to appeal to a Tribunal. This is referred to in more detail in Section 8.13 of this Report at page 27.

8.9 Consent and Second Opinions

The issues which have arisen most commonly in relation to consent and second opinions have been:

- (a) the questions involved in obtaining of consent at common law—which has not been superseded, as some suppose, by the 1983 Act;
- (b) the position in particular of the long-term patient (whether detained or informal) who is incapable of giving consent;
- (c) the problem of giving treatment for a purely physical condition to a mentally disordered patient who is incapable of giving consent;
- (d) the need (which the Commission has always advised) for a plan of treatment for each detained patient, save those on short Section;
- (e) many issues relating to the circumstances in which certificates under Section 58 of the Act (Certificates, by both rmos and doctors appointed by the Commission, for ECT and medication) become necessary;

- (f) the need to seek to obtain common-law consent initially for any treatment which may (if the consent cannot be obtained) have to be given under the compulsory powers;
- (g) the matters which should be incorporated in the Certificates under Section 58;
- (h) the identity of the rmo for treatment and reporting purposes, when a patient is transferred to another hospital temporarily or on trial;
- (i) practical questions involved in an Appointed doctor's visit, including in particular the availability of two "other professionals" for him to consult and the recording of their views;
- (j) the need to monitor both treatments given under a consent certificate by the rmo (Form 38) and treatments given in an emergency under Section 62;
- (k) the circumstances in which "reviews" under Section 61 arise, and the procedures involved.

As well as dealing with these kinds of issues on their visits, Commissioners have produced and published the paper on Consent to Treatment, which is referred to in Section 13 of this Report at page 52. Second opinions by Appointed doctors are dealt with separately in Section 11 of this Report at page 36.

8.10 De facto detention

- (a) The physical detention of some informal patients in locked wards or side rooms, without the protections afforded to detained patients, has sometimes been drawn to Commissioners' attention. The justification for such a practice would have to be found under common law. The practice reflects the conflict between a progressive approach (with a resulting reluctance to employ formal detention under the Act even in respect of difficult patients) and the use of an authoritarian style of management or an excessive reluctance to give positive treatment to unco-operative patients. A balance clearly has to be maintained between two extremes.
- (b) Such patients who are detained "de facto" are not within the jurisdiction of the Commission. An extension of the Commission's role in relation to such patients is canvassed in Section 6 of this Report, at page 11.
- (c) The experience of the Commission in its visits points to the following proposals:
 - (i) On every ward which is or may be locked, a clear written policy should be available indicating to all staff the appropriate action to take when an informal patient, (whether he is safe or unsafe on his own) asks to leave.
 - (ii) When an informal patient is acutely disturbed and needs to be confined in a ward or room against his expressed wishes, this should be only for a brief period either for the duration of the

emergency or, if appropriate, until the patient can be formally detained.

- (iii) Wherever practicable, patients should be grouped in wards in such a way as to separate those who do not require constraint from those who do.
- (iv) Where common law necessity can be invoked, informal patients found wandering at large may be persuaded to return to the ward for their own safety or returned with minimum force.
- (v) Compulsory admission should be seriously considered for patients who persistently abscond or attempt so to do, or who protest against, or otherwise resist, a return to hospital.

8.11 The granting of leave to detained patients

In the past, Health Authorities and staff have found themselves in difficulties as a result of detained patients being granted leave by members of staff not authorised to do so, particularly when the detained patient has subsequently committed an offence. Under Section 17 of the Act, the only person able to grant leave of absence outside the hospital to detained patients is the rmo. However, in a well run system of patient care, this decision will be taken in conjunction with the other members of the multi-disciplinary team. It is important that this aspect of patient care be thoroughly understood by all those concerned and that a definite policy be established by the Authority. Furthermore it would be beneficial that this policy should concern itself not only with the granting of leave outside the hospital, but that such a policy should concern itself with the freedom of movements of the patients within the hospital from ward to ward or between departments, so that both patients and staff alike are well aware of what is expected of them. The Commission's advice is that only the rmo may grant such leave; but that a plan of treatment enables him to authorise in advance various aspects of leave as may be suitable.

8.12 Treatment outside a hospital — the "long leash"

- (a) No subject has given rise to more dispute than the question, which is frequently raised with Commissioners, whether a detained patient can be treated "compulsorily" (ie under threat of recall to hospital) while on conditional leave, under Section 17, in the community. Various legal issues arise; and indeed at least one of them is at present before the Court of Appeal.

The questions arising under Section 17 are bound up with the wider debate whether there should be a power to give long-term compulsory treatment in the community. That debate became active when BASW, in 1976, made a proposal for such a power in the form of a Community Care Order. But the concept of any form of compulsory treatment outside hospital has hitherto been rejected, save for the power given by Section 17 to grant conditional leave. The use which in practice has been made of Section 17 is in effect a substitute for a compulsory

power to treat people in the community.

- (b) Our experience in visiting hospitals and homes has shown that in some places considerable use of the power to grant conditional leave to patients detained under Section 3 is made by doctors as a means of ensuring that the patients can live outside hospital while continuing to have “compulsory” treatment. In some cases, the patient’s detention has been renewed under Section 20, with the patient returning nominally to the hospital for that purpose, or sometimes not even returning at all: and in such an event, the “long leash” treatment continues beyond the six months of a detention under Section 3.

It seems likely that, with the reduction in hospital beds, the greater use of hostel and group home accommodation and the expansion of community psychiatric nursing services, the practice of using Section 17 as a substitute for a community care order could become more widespread.

- (c) The Commission has formed certain views about the limits of law and practice under Section 17, which can only be briefly stated in such a Report as this. But the Commission is, however, concerned that the wider issue of treatment in the community should be re-opened, in the light of present circumstances. It seems to the Commission that there is at present no conclusive argument either way in that debate. Both good and ill may come of either solution. The question for society, in its role of seeking the best interests of patients, is, which solution will produce the better balance of good and ill? In that debate, it is essential that some more effective measurement of the risks on both sides be obtained. The Commission, which has itself debated various alternative views as to how more of the good can be achieved, with less of the ill, proposes to seek ways of assessing more accurately the countervailing risks.
- (d) Meanwhile as regards Section 17, the views which Commissioners would wish to advocate as regards good practice (related, of course, to the law) are:
 - (i) any use of the power to detain under Section 3 for the purpose of immediately sending the patient on conditional leave in order to have “compulsory” treatment in the community is wrong in law and certainly in practice;
 - (ii) any use of the power under Section 20 to renew an authority to detain a patient who is on such leave, by nominally recalling him to hospital or not recalling him at all, is wrong in law and certainly in practice;
 - (iii) if at any time during a detained patient’s leave (whether it is conditional or not), his condition becomes such that he is eligible for discharge, he should as a matter of principle be discharged at that time, and there is no ground for keeping him “detained but on leave” until the authority to detain runs out. But the difficulty in practice for doctors is to recognise whether and when his condition reaches that point, and his need to continue to have

- treatment may be an important factor in assessing that eligibility;
- (iv) while detention legally continues, the power under Section 17 to send a detained patient on conditional (and, of course, unconditional) leave is an essential means of assessing a patient's eligibility for discharge. The imposing of a condition that the patient should have treatment while on leave, with the sanction of recall, appears not to infringe any principle.

Some of these issues may receive judicial consideration by the Court of Appeal in its decision due in October 1985, in *Reg. v Halstrom, ex p. Waldron*.

8.13 A patient's "appeal" to the Managers

A detained patient's so-called "appeal to the Managers" for his discharge has often caused misunderstanding in hospitals which we have visited. The leaflets which were published officially, as samples of the written information required to be given by Managers to detained patients, inform patients that they can request Managers to discharge them. This has often become called "an appeal to the Managers", but it is a non-statutory "appeal" or request, not a set procedure laid down by the Act.

The Managers are primarily the people who "detain" and therefore at common law are legally liable for any deprivation of liberty which is not justified by the Act. It follows that they have the right and the duty to end a deprivation of liberty as soon as it appears not, or no longer, to be justified by the Act. The Act therefore confirms their right to make an "order" of discharge, but says nothing about the grounds for so doing, and nothing about an "appeal" by a patient for them to do so.

A patient is entitled at any time to ask the Managers to discharge him, and in so doing, he is exercising any citizen's right to demand his liberty from someone who (he claims) is infringing it. This is the "appeal" referred to. But it is not limited to any particular stage or time, in the way in which a statutory appeal to a Tribunal is limited. A cry for liberty may be made at any time. Both the patient's interests and the Managers' interests then coincide in requiring the Managers to decide whether to accede to the patient's request.

Two issues then arise for the Managers. What is the relationship of such an 'appeal' to the patient's statutory right of appeal (in defined cases) to a Tribunal? And how formal and detailed should their enquiry be, before determining whether or not to discharge the patient?

The Commission has been suggesting that as a matter of practice it is very important that a patient should not be diverted from exercising his right of appeal to a Tribunal, if he so wishes. If therefore he is informed, eg on admission, or at a time when a renewal of authority to detain him is proposed, that he has a right of "appeal" to the Managers, he should also be told (maybe on successive occasions) of the statutory right of appeal to a Tribunal and helped to make such an appeal, if he so wishes, within the time allowed. The "appeal" to the Managers should not be seen as a substitute for, but as

additional to, the formal right of appeal which Parliament has provided. The time factor may be of particular importance in the case of a patient admitted, under Section 2, for 28 days.

The enquiry itself is one which a committee or sub-committee of Managers should carry out, and should not be delegated to an officer. With regard to its nature the choice lies between the extremes of a full formal enquiry, like a Tribunal's, and an investigation limited to the documentary legality of the detention. The Commission is concerned that the patient's "appeal" is properly dealt with, but in a manner consistent with the need to avoid too much formality, with its demands on professional time and risks to hospital relationships.

The particular circumstances of the "appeal" may suggest the degree of detail required. For example, an "appeal" made just after the Managers have already for their own purposes assured themselves that the patient has properly been detained, or a repetitious "appeal" by the patient, may not need the same degree of investigation as one made in different circumstances.

In general it seems necessary to avoid excessive formality, such as any form of court-like or Tribunal hearing, with two sides "lined up". But equally the Managers will need to inform themselves of the patient's reasons for his appeal, and this may best be done by interview, unless an interview is inappropriate in the particular circumstances. So too, where the appeal requires it, the Managers will wish to inform themselves of the rmos and other professionals' views, either in a written form or by interview. Since discharge is in issue, the nearest or most concerned relative will need to be informed, and his observations sought. If the legality of the admission process itself is in question, the documentation will probably be the main focus of attention, but even then evidence from participants may have to be collected in a manner designed to cause the least disruption. In general, a mean has to be struck between rigidity and ineffectiveness.

8.14 Mental Health Review Tribunals

- (a) One of the purposes of the Mental Health Act 1983, to provide more opportunities for detained patients to have their detention reviewed, appears to have had substantial success, judging from the increase in numbers of applications to Mental Health Review Tribunals. In 1982 the total number of applications was 1,329 while in 1984 the total (including restricted and unrestricted patients) came to 3,445. The figure for the first six months of 1985 was 1944 and assuming a similar rate for the rest of 1985 the total for the year would be 3,888, thus indicating a continuation of the rise in applications. The introduction of automatic Tribunals (under Sections 68, 71 and 75) accounts for part, but only a part, of the increase: in 1984 this amounted to about one seventh of the total figure.
- (b) In some hospitals the explanations and assistance given to patients about eligibility and procedures for making application for a Tribunal are very thorough. In others it is still considered enough to hand out

the relevant forms, and to offer a list of the Law Society's Mental Health Review Tribunal Panel, and only if a patient requests it. We should like to see an overall improvement in helping patients to understand the way in which Tribunals function, and how to obtain representation and legal aid for that purpose.

- (c) There has been a disappointingly high incidence of delays in Tribunal hearings. This is due to a variety of causes. Some are due to Authorities or doctors failing to file their statements or reports within the three weeks required by Tribunal rules; and social workers at times are slow to provide reports when requested to do so. Delays in arranging the hearings are not uncommon, and one explanation offered is shortage of Tribunal staff. The consequence, whatever the cause, is to erode the rights of detained patients.
- (d) As regards the powers of Tribunals, one area of doubt relates to the extent, if any, of a power to make recommendations regarding patients on restriction order and to recall cases when their recommendations on such patients are not acted on. The Secretary of State has publicly accepted that the Tribunals may make such recommendations as they think appropriate. But statements by the Secretary of State do not constitute the law (which binds the Tribunals); nor do his statements resolve the more important issue of sanction, namely the power of recall. It would be helpful to have clarification as to whether Section 72(3) does in fact extend to all patients, including restricted patients. Another criticism which has been made arises from the fact that at present only a patient's own authorised doctor has a right of access to his medical records for the purpose of advising him about an application to the Tribunal. There is a case to consider as to whether similar access should be afforded to the patient's "authorised" representative and to an independent social worker for the purpose of advice or preparation for a Tribunal.
- (e) Other aspects of Tribunals in relation to restricted patients are referred to in Section 12 of this Report on the Special Hospitals, at page 49.

8.15 Patients' monies and property

- (a) A number of complaints and questions have been addressed to Commissioners regarding a patient's monies and property. One recurring problem is the extent of a patient's rights to benefits, and the practical job of securing those benefits. Research has shown that it is a major task to assess what is due and to advise patients and their relatives. In some hospitals, efficient patients' affairs officers can and do perform these functions. In others however, there is no patients' affairs officer, and the matter is left to nurses, social workers or a general administrator to cope with. In a few psychiatric hospitals, a Citizens Advice Bureau has been sited, and in at least one hospital, a legal advice centre. None, so far as has been gathered, has been set up in a mental handicap or special hospital.
- (b) On the issue of expenditure by patients in NHS hospitals, one vexed question raised with the Commission is the spending, on communal

items, of money belonging to patients who do not have full capacity to understand financial questions. No official general guidance has been received on this kind of issue since 1971, but the DHSS are currently preparing detailed advice, which is being circulated for consultation. If this is published, the problem may be remedied. In special hospitals, patients are not allowed to handle money: the proposed advice from the DHSS does not appear to deal with the position in the special hospitals.

- (c) Another recurring problem is the case of detained patients' property outside the confines of a hospital. The Court of Protection exists to manage the property and affairs of a patient who because of mental disorder is incapable of managing his property and affairs. But often the property is small and could be managed more easily than through the formal processes of the Court and a receiver officially appointed. Many practical problems can often be dealt with by social workers and nurses: but see Complaint Case No 6 in Appendix 2 at page 61. A method more formal than that, but less formal than the Court process, is often needed. A power to manage limited property or money should perhaps be given to a local authority guardian (as under the 1959 Act) for this purpose.

8.16 Rehabilitation and discharge

- (a) Great variation has been observed by Commissioners in the steps taken by different hospitals for the purpose of the discharge of detained patients. This applies both in relation to long-stay and short-stay patients.
- (b) We have sought to advocate the view that the discharge of a patient should be regarded as a process, rather than an event — a process of stages leading up to the event of physical discharge. Sudden discharges from the hospital should be a thing of the past: but in practice it seems that they are not. Even the new statutory duty to give the nearest relative at least seven days notice of an impending discharge seems to imply that seven days is sufficient; but the plan should generally be much longer than that. Indeed the concept of "giving notice" to the person on whom the patient may have to be dependent is foreign to the principle of timely preparation for a discharge, which should include a full involvement of that person in the preparation.
- (c) Some hospitals have raised the question whether treatment plans should include the rehabilitative preparation which is necessary before discharge. We regard rehabilitation as an essential part of a patient's treatment plan, and have suggested that from the early stages of a patient's stay in a hospital, the team should be looking to the later stages of rehabilitation and ultimate time of discharge. This is not to suggest that the door must be made to revolve too rapidly: for some patients discharge may be remote and rehabilitation may be a long process, but even within a longer time-scale the future for the patient should be in mind.
- (d) It has sometimes seemed that the distinction between discharge from a Section and physical discharge from the hospital is not always kept

in mind. The stage at which a patient, on discharge from a section, is prepared to remain voluntarily and submit willingly to the continued treatment proposed for him may be an essential stage in the rehabilitative process. Equally the discharge from section should not be delayed because the patient is not ready for discharge from the hospital, if he is willing to remain and to receive treatment.

- (e) As noted elsewhere, plans for the provision of after-care under Section 117 of the Act are in general not far advanced, even after two years. This is highly detrimental to the formulation of rehabilitative and discharge plans, to which a knowledge of after-care facilities to be provided under that Section is essential.

8.17 Education and Training

In general, hospitals and health authorities have been careful to set up education and training schemes for staff who have to be familiar with principles and good practice arising from the new legislation.

With the passage of time, however, and even with a passage of only two years since the inception of the Act, memories can fade. Moreover experience of operating some parts of the Act may not create familiarity with other parts of the legislation and regulations which are equally important.

Many "study days" and seminars on relevant principles and procedures have been instituted by various authorities and agencies, although there appears to have been no overall national scheme. Such one-off events are thoroughly laudable, but they have the disadvantage of lacking continuity. A build-up and continuity of staff understanding of the law and good practice are now a necessary part of the treatment and care of all patients, and especially of those who are detained or liable to be detained.

What is more, staff do not necessarily stay in same post or unit. This may produce a lack of continuing shared experience of practice, and an increasing lack of familiarity with the legislation on the part of those who come to operate a unit.

In view of the need for staff to be familiar with and to understand the law and practice, and in view in particular of the demanding duty to provide proper information to patients about various provisions of the Act, it is suggested that a broadly based (possibly nationally based) scheme of education and training represents an advisable step in the operation of the Act and the spread of good practice.

In the light of two years experience in the operation of the Act and practices growing up around it the Commission may be able to advise on the formulation of such a training scheme.

8.18 Transfers within the British Isles

One fairly obscure issue concerns transfers of detained patients within the larger area of the British Isles. Since the 1983 Act makes provision for transfers of detained patients to hospitals in England and Wales from other

parts of the British Isles, the Commission needs to consider the rights of those patients who, if so transferred, fall within their purview. There are three questions:

- (a) if a patient is so transferred, should a reassessment take place to ensure that continued detention under the 1983 Act is proper?
- (b) when should a Mental Health Review Tribunal consider the case of a patient so transferred?
- (c) should different enactments passed by Parliament at Westminster for various jurisdictions defining medical criteria for patients' compulsory detention be consistent with one another?

(a) Reassessment

Patients, including those convicted of an offence, are sometimes transferred from Scotland, Northern Ireland, Isle of Man, and the Channel Islands to hospitals in England and Wales. It would not be appropriate to give here all the differing complicated provisions of law in those jurisdictions as to the grounds for detention. But, given the variety of definitions and the exclusion of most mentally handicapped patients from compulsory detention in England and Wales after 30 September 1983, the Commission considers that a statutory reassessment of any incoming patient should be introduced. The present draft Northern Irish Order provides that a patient, on arrival there, has to be reassessed to ensure that his condition warrants detention under Northern Irish law. There is no such requirement in the English 1983 Act.

(b) Tribunals

Under the 1983 Act regular entitlement to a hearing by a Mental Health Review Tribunal is available to all detained patients. The availability is triggered by the date of compulsory admission (or renewal of detention). For patients transferred from other jurisdictions, however, the 1983 Act appears to provide for their detention to start again, on the date of their admission to an English or Welsh hospital as if they had been initially admitted under the 1983 Act on that date. This must put them at a disadvantage in postponing their access to a Mental Health Review Tribunal. The fair solution could be to grant them a right to apply to a Tribunal on the date which would have been allocated if their original detention, or its renewal, had taken place in England or Wales.

(c) Consistency of legislation

In view of the confusions caused by the differing concepts used in the various jurisdictions, the Commission suggests that consideration should be given to achieving some consistency.

9. Visits to Social Services Departments

From the terms of the Act itself and the evidence obtained in our visits to hospitals and homes, it is clear that the provision of adequate social services is a key factor in the protection of detained patients' interests. The Commission decided, therefore, to begin visiting the Social Services Departments of local authorities, in order better to review the carrying out of the duties and powers conferred on ASWs and local authorities by the Act, and also to enable

Commissioners to relate the preparation of the Code of Practice to current issues of social services practice. Some of the issues involving the social services have already been referred to in Section 8.2 of this Report at page 17.

The time available for this additional visiting, within the part-time limits of Commissioners' commitment, has been hard-won; but nevertheless it has been found.

Not all Social Services Departments have yet been visited, but 24 selective visits have been made, to provide a good cross-section. In due course, all will be visited.

As with visits to hospitals, multi-disciplinary teams of Commissioners have been involved.

The meetings between Commissioners and Social Services personnel have been a two-way process of learning. Commissioners have learnt much of the organisational, staffing and training problems in the social services, insofar as they affect the mental health powers and duties laid on local authorities and ASWs. Equally Senior Managers in Social Services Departments have been enabled to test out, with Commissioners, questions arising from the Mental Health Act in relation to their policy-making and service development. Field workers also have provided information and received guidance on practical issues arising in connection with their duties and powers.

The problems identified, upon which the Commission will continue to concentrate, relate principally to the adequacy of communication and collaborative work between Health and Social Service Authorities. The areas for such collaboration are those mentioned above at page 18, which are worth summarising again:

- (a) objectives in relation to the compulsory admission of patients
- (b) the provision of out-of-hours and emergency services for admission purposes
- (c) the use of guardianship
- (d) procedures for use of Section 136 powers
- (e) the provision of after-care (in collaboration with voluntary bodies), after discharge of a patient
- (f) the transfer of services from a hospital to the community.

It will also be of concern to the Commission clearly to establish the need to ensure that ASWs, in carrying out the duties laid on them, enjoy all necessary legal and service support. Issues relating to the training and appointment of ASWs have already been mentioned in Section 8.2 of this Report at page 17.

10. COMPLAINTS

Although the Commission's function in investigating complaints has many similarities to that of the Health Service Commissioner, there are also

differences. Contact has been made and maintained with him and his office, both in order to gain an insight into his techniques and also to ensure that the respective roles are complementary and not overlapping. The Commission is itself subject to investigation by him, and this is likely to concern principally the propriety and efficiency of procedures rather than the merits of cases inquired into by the Commission.

Complaints come in all shapes and sizes. After some experience of them had been obtained, it became possible to categorise them under headings; these are set out below. On first presentation a complaint may appear trivial or extremely serious. This impression can mislead. The first task, therefore, is to establish the true nature of the complaint. Where the complainant or patient has, on our invitation, so requested, two Commissioners have paid a visit to identify the ambit of the complaint. Trivial presentations have sometimes veiled a far more serious matter, whilst some serious allegations have on preliminary inquiry turned out to be without foundation. The complaints, once identified, have needed investigation in a variety of ways (which are referred to later). At an appropriate stage a response has been sent to the complainant. Even where this has not been a complete explanation, justification or refutation of what was alleged, it has sometimes been appropriate to indicate that some more general feature has been revealed in the inquiry which does not appear satisfactory.

At this stage the Commission's function can change. By contrast with other statutory complaint procedures, the end does not necessarily come when a complaint is upheld or dismissed (whether or not subsidiary recommendations or comments or suggestions for suitable acknowledgement of a defect are attached to the decision). The Commission can then pursue another role, of overseeing the exercise of powers and duties under the Act. From the particular complaint the process can move on to look at broader issues which may affect staff and patients at a hospital or group of hospitals.

The advent of the Commission undoubtedly led to expectations by patients, their relatives and advisers that it would be possible at last to cut through obstacles to a clear outcome. The Commission was thought to be endowed with "teeth". In fact it does not bite very much, but it can exert pressure, and exert it in increasing degrees in the right quarters. The results may be slower and less dramatic, but there are signs that they may be effective. The mishandling of an individual situation may be irretrievable, but intervention may prevent it happening again to that or any other patient. In this the Commission can reinforce what staff and managers are continually seeking to achieve.

The precise nature of the Commission's functions under Section 120 has caused a little perplexity. It has been interpreted as providing a second stage where a complainant is not satisfied after taking an issue through the hospital's own complaints procedure. Although this is the normal route which the Commission initially recommends, a primary investigative function is not ruled out in some cases; it must be said that such an exercise can be very demanding in terms of time spent, on both Commissioners and staff, and has not been lightly undertaken.

The categories of complaint have been identified, but will continue to be adapted as experience develops. Each heading is in itself a label covering a variety of problems. In the period between 30 September 1983 and 30 June 1985 the Commission received 1,549 oral or written communications which can broadly be called complaints. Of these 533 were judged as needing pursuit to the necessary extent by a team of two Commissioners. In the following table the total exceeds this number because some complaints have been concerned with more than one matter.

Category	Number	Percentage
Offences against the person	67	8.31
Medical care and services	72	8.93
Medical treatment	108	13.39
Nursing care and services	69	8.56
Other professional care and services	59	7.32
Domestic care, living arrangements and privacy	43	5.33
Finance, benefits and property	38	4.71
Deprivation of liberty	65	8.06
Leave, parole, transfer, other absences from hospital	95	11.78
Mental Health Review Tribunal matters	64	7.94
Family matters	4	0.49
Administration	41	5.08
Local authority services/functions	12	1.48
Social, recreational, educational matters	28	3.47
Ethnic, cultural, religious matters	5	0.62
DHSS, Home Office, other Government Departments	30	3.72
Complaints about Mental Health Act Commission	6	0.74
	806	

In order to investigate "complaints" the Commission has used a wide range of procedures. A simple point may be elucidated on the spot, during a visit, by a question to the ward staff. A few matters have needed detailed and lengthy inquiry. Between these extremes every variation has occurred. Unlike the Health Service Commissioner, the Parliamentary Commissioner for Administration or the Scottish Mental Welfare Commission, the MHAC has no judicial powers, for example to compel attendance of witnesses or to deal with a failure to co-operate by way of contempt of court. Although the above two bodies use such powers only rarely, no doubt the availability of those sanctions in itself makes them unnecessary in most cases. The provisional view of this Commission is that it would not wish to be endowed with such powers. They would be attended by the need for strict procedures and formality, and considerable time-commitment for which the Commission is unequipped. Even without such powers, the obligations of natural justice are still paramount, but complaints can be dealt with less formally. Moreover, the emphasis often shifts from the actual complaint to a review of the way in which a hospital or unit is observing the spirit of the Act.

For such activity a formalised procedure would be out of place. The Commission does, however, have in mind that the Parliamentary Commissioner or the Health Service Commissioner could be invited to intervene on matters within his jurisdiction, if formalities seem to have become imperative.

Appendix 2 to this Report at page 59 sets out the record of investigation of a number of complaints. These are examples of the variety of complaints received, and of action taken to resolve the problems. As is now usual the cases have been rendered anonymous. They are drawn from all three of the Commission's regions, and include some from the special hospitals. The Commission was aware that its appearance on the scene could activate certain patients, not least people detained over long periods, to complain about matters large and small. The Commission is an additional channel to that employed in writing to HM The Queen, the Prime Minister and other persons in authority. It was also anticipated that some would seek to test the new Commission by making a complaint. It is foolish to reject complaints, or indeed communications, as being thus tainted. If they are, the reality quickly emerges. Otherwise, as the Appendix demonstrates, even an amorphous or vague complaint can contain substance. Institutional and procedural frustrations, as well as real abuse, are of vivid concern to patients; they need a sympathetic hearing and a realistic resolution.

11. SECOND OPINIONS

11.1 Appointed doctors, and second opinion statistics

Part IV of the 1983 Act represents an innovation in Mental Health legislation, in prohibiting the giving of certain treatments, to detained patients principally, unless a favourable second opinion (from a doctor) and other opinions (from laymen, in special cases) is or are obtained. It is potentially contentious, because it gives the power to a person or persons other than the patient's own consultant to decide whether the statutory prohibition should be lifted.

These new requirements were phased-in over the months following the coming into force of the Act on the 30 September 1983. Similarly the Commission phased-in the appointment of the second doctors and laymen who are needed for the giving of the opinions required by the Act. Initially only 20 consultant psychiatrists, all members of the Commission, undertook the assessments under Part IV. They also prepared a set of guidelines for themselves and other newly Appointed doctors, and these were subsequently circulated by the DHSS to all rmos. An extended panel of 70 experienced psychiatrists practising throughout England and Wales was appointed in January 1984, and they attended training seminars before beginning to serve. Such doctors are appointed by the Commission on an annual basis, and are expected to attend the seminars and refresher courses. Small changes in the personnel have been and will be made, primarily to improve the geographical spread and to offer opportunity to other rmos to participate in the work.

Each of the three Regional groups of the Commission has its own system for monitoring the operation of the second opinion procedures, and these in turn are overseen by the Central Policy Committee.

Some of the statistical results are shown in the Tables at the end of this Section, as follows:-

Table 1(a)	Male and female patients who received second opinion visits under Section 58
Table 1(b)	The types of treatment considered under Section 58
Table 1(c)	The Section under which patients were detained, where second opinions were given under Section 58
Table 1(d)	Cases for opinion under Section 57
Table 2	Second Opinions given under Section 58, totalled by Health Authority Regions and by Commission Regions
Table 3	Differences in demand for second opinions under Section 58 from various units (based on a six month pilot study in one Region of the Commission)
Table 4	Statistics for psychosurgery

11.2 Acceptance of the second opinion procedure

In general, acceptance of the requirements of Part IV of the Act by doctors and others has been good. By some, the obtaining of a second opinion has been seen as a positive support and welcomed accordingly. The great majority of practitioners have adopted the system without complaint, and with increasing ease. Some problems have been encountered, and these are referred to below.

But one important issue raised by the experiences of Commissioners and by some of the figures given in the Tables is why there has been a differential rate of second opinions sought and given, both in respect of particular Health Authorities and particular hospitals and units. There are various candidates for an answer to that question. One of the candidates must be the possibility of an attitude on the part of some rmos who may have chosen not to persist with treatment in the face of a refusal of consent by a detained patient and the need to obtain a second opinion. It is clear that there is an area here for research to test the various possible explanations.

11.3 The system adopted

When a second opinion is needed, the rmo is considered by the Commission to be the person responsible for ensuring that a request, generally by telephone, is made to the Commission's appropriate Regional Office. An Appointed doctor is nominated, and visits the hospital.

Appointed doctors, when assessing patients, are advised to check the validity of the documents by which the patient is detained and then to interview in private the patient, the nurse and a second person professionally involved. The Appointed doctor is expected to consider the evidence presented by the rmo in support of the treatment which he is proposing, and to do so in the light of a broader treatment plan involving current and immediately foreseeable proposed treatments. It is advisable that the full treatment plan

is recorded in the cases notes in advance of the visit, but, where feasible, the rmo should also discuss the plan with the Appointed doctor. During this discussion the Appointed doctor attempts, if necessary, to reach agreement with the rmo on a plan which they can both support. The exercise differs from an academic second opinion in at least two respects. Firstly, it is to judge the validity of the reasons presented by the rmo for his choice of treatment. It is not to impose a personal opinion as to how the Appointed doctor would himself proceed in the same circumstances. Secondly, as an issue of civil rights, it is to consider whether the case for that treatment is strong enough for the consent of the patient to be dispensed with or overridden, where ECT or medication is concerned.

The Commission decided that no formal appeal mechanism for rmos would be established at this stage of the Commission's life, although the Chairman would personally review problem cases. He has not needed to do so. If a repeat request for a second opinion were made within a short time of a previous assessment, the same Appointed doctor would normally be asked to return.

The target of the Appointed doctor attending within 2 working days of a request for a second opinion for a course of ECT, and within 5 working days for medication, has been met with very few exceptions.

In addition to consulting with the rmo, the Appointed doctor also consults with two other persons who have been "professionally concerned with the patient's medical treatment", as required by the Act. One of these has to be a nurse; problems in finding a suitably qualified nurse for this purpose have been rare. The second person for consultation is referred to below in Section 11.5(c) on page 40.

11.4 Concordance of doctors

It is clear that there has been a high measure of agreement between Appointed doctors and rmos as regards treatments to be given under Section 58. However to assess the exact extent of that agreement, and to assign reasons for it, are matters of some difficulty which would require further time and research.

The procedure advised by the Commission for second opinion visits has encouraged a process of discussion between the doctors, so that even where the Appointed doctor is not prepared to approve the treatment initially proposed by the rmo, an agreed plan and treatment may emerge from the joint discussions. There seems little doubt that cases where there is downright disagreement, without any form of treatment acceptable to both doctors, have been very rare. At the other end of the scale, the acceptance by Appointed doctors of the treatment proposed by the rmo has been very frequent, probably of the order of 90 per cent (plus). In between, there are those cases in which the Appointed doctor has felt himself unable to approve the original proposal, but as a result of discussion there has emerged an agreement as to a modified or substituted treatment (for which a certificate in Form 39 may or may not have been necessary).

For a number of reasons, the Commission is not satisfied with the evidence so far collected on these questions, and has been making arrangements to refine the methods for data collection, on issues which are difficult to record fully or accurately because of the variety of some of the events which arise on second opinion visits. However it seems quite clear that there has been a high rate of acceptance by Appointed doctors of treatments proposed by rmos.

Research may be thought necessary to assess the impact of the second opinion process and its value to detained patients. No doubt a substantial part of the concordance can be explained by the facts that second opinions are generally to be requested in respect of well-established and widely agreed treatment procedures, and that the role of the Appointed doctor is not to impose his own views as to which treatment can properly be supported as an acceptable form of treatment. But it remains to be determined whether, for example, the very existence of the second opinion requirements is having the effect that some proposals which might otherwise have been made are being dropped, so that patients are in general being referred under Section 58 only for well tried treatments; or whether there are other possible explanations.

The Commission has neither the facilities nor the funds to carry out research of such a nature, although it should be able to assist with some data.

11.5 Problems encountered

A number of problems have been encountered in the working out of the requirements of Part IV of the Act (all of them capable of solution, in the Commission's view, by suitable action by those concerned):—

- (a) Coherently written treatment plans supporting the proposal for treatment are sometimes lacking when Appointed doctors visit. The difficulties of understanding created by this are sometimes compounded by the absence of the rmo, who in about one-third of the cases (in one study) where Appointed doctors have visited has been unavailable in person or on the telephone. Too often the Appointed doctor has to deal with a junior doctor with little knowledge of the case; and there is sometimes an issue as to who has in fact initiated the request for a second opinion.
- (b) Both the definition of the proposals being made by the rmo and the proper content of the Appointed doctors' certificates have given rise to difficulty. The Commission believes that at least an upper limit for an ECT course should be set, and that BNF dose ranges provide a useful point of reference for medication. It is recognised that at times the maximum BNF dosages may need to be exceeded, but where this is necessary, the reasons for exceeding them should be recorded in the case notes and the dosage agreed and certified by the Appointed doctor. In other cases, named drugs and exact dosages need not be specified, where a recognised class of drugs can be given. Non-specific proposals such as "a course of treatment" do no more than evade the purpose of the Act and have not been found acceptable.

- (c) Occasional difficulty has arisen over the availability of the “second professional” whom the Appointed doctor has to consult before issuing any certificate. When this occurs, it is often due to the fact that there is no or little multi-disciplinary involvement; and in some cases it has been necessary to defer issuing a second opinion until genuine involvement of other disciplines has been initiated. In one sample of 213 visits, the second professionals consulted were:—

Social Workers	82%
Occupational Therapists	11%
Psychologists	5%
Others	2%

Social workers, therefore, are heavily used for this purpose. But a proportion of chronically ill long-stay patients are nursed in continuing care wards without social workers or occupational therapists being involved, and without the benefits of a coherent rehabilitation programme. For them deferment of a second opinion has been or may become necessary. It has also been observed that consultation with (eg) a less-qualified occupational therapy aid who knows the patient closely is often more helpful than with a more qualified but less familiar professional, even if the latter is more easily available.

- (d) “Flagging” systems, to ensure that the more-than-three-month medication rule and the requirement of a certificate in Form 38 where the patient has consented are implemented, are not always in force in some hospitals. While the primary responsibility for ensuring that the requirements of Part IV of the Act are observed lies on the rmo, it is clear that administrators have a part to play in employing flagging systems.
- (e) In some cases it has been found that a request for a second opinion has been made, when the patient was not in fact detained under an appropriate section. Appointed doctors have found it necessary to check this before visiting.
- (f) In some cases it has not been recognised by practitioners that if a second opinion is not requested and given, treatment (within Section 58) cannot be given legally unless either the patient consents and Form 38 is signed, or treatment is justified as urgent under Section 62.
- (g) In some instances, excessive use of Section 62 seems to have been made; eg, in one case 12 ECT applications were made under that Section. When the Section is invoked, a request for a second opinion ought generally to be made, so that repeated use does not arise. It is suggested that each hospital ought to have a recording and monitoring system in relation to the use of Section 62.
- (h) When an Appointed doctor has visited, he has sometimes found that the patient has changed or changes his mind and gives his consent so that Form 38 (signed by that doctor under Section 58(3)(a)) is appropriate. It is advisable for the Appointed doctor in all cases to

remember that he has a function to certify consent if the facts warrant it, as well as the function to give a second opinion if there is still no consent.

11.6 Reviews of Treatment

The Commission has made arrangements for the making of the reports which are required under Section 61 to be sent to the Commission (acting for the Secretary of State) and which enable reviews of treatments, for which a second opinion has been given, to be made by the Commission. These arrangements were made in a letter, and its enclosures, addressed in September 1984 to Health Authorities. In general, these reports by rmos have to be made when any renewal of authority to detain a (non-restricted) patient is sought. A specimen form for the report to the Commission has been provided.

In order to ensure that, when a treatment comes up for review under Section 61, there is a proper and independent assessment of the case, the Commission decided to adopt the practice of sending, on a first review, a different Appointed doctor to interview the patient and to determine whether the treatment ought to continue in the light of the facts at that time; and on any subsequent review, of again sending an Appointed doctor, unless it appears to a multi-disciplinary group of Commissioners in the Region concerned that there are good reasons for waiving the requirement on that occasion. This practice will continue until experience determines whether the level of monitoring is satisfactory.

The Commission has been advising hospitals to institute a flagging system to remind rmos of their duties in providing a report under Section 61 to the Commission at the appropriate time, relating to the treatment, the patient's condition and his present state of willingness to consent.

Other reviews of treatments which were the subject of second opinions may also be required, where the Appointed doctor has qualified or limited his certificate in a manner which makes a review (or a further certificate) necessary. But this sanction by Appointed doctors appears to have been rarely used, in view of the fact that statutory reviews under Section 61 have to be held.

11.7 Psychosurgery and hormone implants

Public anxiety about the special treatments is reflected in Section 57 of the Act. As regards psychosurgery, the Commission has tried to implement the requirements of that Section with the sensitivity which the legitimate intrusion into clinical matters demands: not always, it seems, with a recognition of great success in achieving that sensitivity. However, apprehension and misunderstandings on both sides have subsided. The Commission has evolved procedures in consultation with psychiatrists and neurosurgeons for fitting the requirements of the Section to the practices involved in psychosurgery. The detail of these is too complex to be included in this Report, but is dealt with in the draft Code of Practice. Problems remain, but a reasonably workable system has, it is believed, been built in principle. The Commission has established a special group of Commissioners to look at the procedures

under Section 57 and to continue the discussions with the relevant people and bodies. Vital as these cases are of course to the patients and practitioners involved, they are numerically few: Table 4 indicates the results of the procedures undertaken by the Commission under Section 57.

As regards surgical implants of hormones to reduce male sexual drive, there has been minimal experience to report. One request was made for a certificate, but it was deferred and not pursued. Two others, each a provisional enquiry, were made, but again were not taken further.

11.8 Conclusion

The Commission's work has been made easier by the acceptance of the interest in the statutory second opinion process shown by most psychiatrists. In many respects the Act codifies good clinical practices which have been followed by psychiatrists. The Commission would like to thank the Appointed doctors who have undertaken their duties seriously and sensitively, and who have also had to spend considerable time in giving explanations in order to dispel misinterpretation and misunderstanding.

The various major difficulties have now been identified and the Commission sees as part of its task the proper resolution of those problems which are within its powers.

TABLE 1

Second opinions to 30.6.85, (by sex of patient, treatment and section)

Table 1a: Totals by Sex (under section 58)	
Male	1,781 (44.17%)
Female	2,251 (55.82%)
	4,032
Table 1b: Totals by Type of Treatment	
Medicines	1,886 (46.77%)
ECT	2,146 (53.24%)
	4,032
Table 1c: Totals by Section	
Section 2 (assessment)	747
Section 3 (treatment)	2,567
Section 37 (treatment via courts)	537
Others	181
	4,032
Table 1d: Section 57 Opinions	
Psychosurgery	38
Hormone Implant	0

TABLE 2

Second opinions under Section 58 (by Regions)

Totals by health regions	Mentally impaired	Others	Total
Mersey	5	118	123
North West	29	194	223
West Midlands	10	334	344
Wales	4	105	109
Northern	5	188	193
Yorkshire	9	289	298
Trent	22	324	346
East Anglia	10	136	146
N E Thames	2	252	254
N W Thames	19	260	279
S E Thames	5	268	273
S W Thames	6	147	153
Oxford	—	117	117
Wessex	4	160	164
South Western	8	183	191
Broadmoor Special Hospital	—	89	89
Rampton Special Hospital	177	236	413
Park Lane Special Hospital	—	138	138
Moss Side Special Hospital	50	74	124
Private Establishments	—	55	55
Total	365	3,667	4,032
Totals by Commission Regions			
Southern	1,779		
North East	1,256		
North West	997		
Total	4,032		

TABLE 3

Demand for second opinions (six months in Commission's N W Region)

(a) Large Mental Illness Hospitals		
Hospital	No. of Detained Patients	Requests
A	69	12
B	81	9
C	28	5
D	33	1
(b) D.G.H. Units		
	No. of Detained Patients	Requests
M	26	10
N	35	7
O	13	1
P	16	1
Q	4	1

TABLE 4

Statistics for Psychosurgery

(1)	Total number of requests for psychosurgery second opinions received up to 23 August 1985 (in any form — ie from doctor, hospital staff, patient, in writing or by telephone) — 57
(2)	Consent agreed — 34
(3)	Consent refused — 4
(4)	Request deferred or withdrawn, usually following consultation with Appointed doctor — 17
(5)	Visits currently being arranged — 2

12. THE SPECIAL HOSPITALS

12.1 Background

There are four “Special Hospitals”, that is to say hospitals provided “for persons subject to detention under the Mental Health Act 1983 who in the opinion of the Secretary of State require treatment under conditions of special security . . .”. Three of the hospitals, Broadmoor, Park Lane and Moss Side are managed directly by the Secretary of State acting through a DHSS Office Committee and local hospital management teams. Rampton is managed by a Review Board, a special health authority created following the Boynton Inquiry. The Review Board’s present term is due to expire in 1986, and Commissioners understand that its continuation and the general principles of managing the special hospitals are at present being considered by the Secretary of State.

The number of patients at each of the special hospitals at any one time is about:

Broadmoor	..	..	..	494	(Broadmoor is currently being rebuilt, and some patients have been transferred to the other special hospitals.)
Rampton	..	..	..	590	
Park Lane	..	..	..	304	
Moss Side	..	..	..	258	
Total				<u>1,646</u>	

The Commission has a special responsibility for detained patients. Thus a substantial proportion of its work has been concentrated upon the special hospitals. Although the three Regions have organised their visiting and complaints arrangements differently, the attendance of Commissioners has placed a heavy, frequent and continuous burden on the staff. In total there have been 197 Commission visits to the special hospitals during which 1,535 interviews were conducted with patients.

The special hospitals have, in recent years, been the subject of considerable public scrutiny, much of it severely critical. The Commission was seen by many staff as yet another body whose principal task would be to find fault. The Commission certainly has the duty to find out what is wrong, and to endeavour to right it, but it sees co-operation with management and staff as one very important way of achieving this. It must be said however that the initial suspicion has not been easily or totally overcome, and that, as subsequent paragraphs will show, much is still left to do. The Commission wishes, however, to record its recognition of the personal commitment and service of the majority of staff in the special hospitals. We should also record that physical conditions for patients and staff are often poor and impede proper care.

Another, and perhaps equally serious, misperception of the Commission's role is that many patients (and their relatives or legal representatives) have had, and may continue to have, an exaggerated belief in what the Commission can do. The most important fallacy was that they felt that the Commission could interfere directly in management decisions: whether these were major, such as in respect of discharge, or transfer to local hospitals nearer home; or in relation to local matters, such as ward transfers, ward and hospital routines or the resolution of difficulties with staff or with other patients.

12.2 Management and Management Philosophies

The DHSS "Office Committee" sees itself as a quasi health authority, delegating the management decisions to the local hospital management teams. On the other hand, the local managements defer to the DHSS Office Committee differently, apparently according to their own traditions. Nowhere, so far as the Commission is aware, is the division of function clearly enunciated: if it has been, local staff are unaware of it. One notable example of the confusion is in the "parole" practice—is this, or is it not, a proper responsibility of the special hospitals? If so, where is the policy governing it? If not, what is the rehabilitative function of the special hospitals?

Another example is in the duties of the managers. The Commission is able to assess the efficiency and efficacy of the performance of managerial functions in NHS hospitals. But in three of the special hospitals there is no health authority, and therefore no visible members and no distinction, as in the NHS, between members of the authority and the paid members of staff. More important, the patients do not recognise any distinction between the managerial tiers, even where they are aware of their existence.

An important example of confusion is in the reconciliation of "therapy" and "security". Those who are confined in special hospitals are hospital patients suffering from some form of mental disorder. There can be no hard and fast rules, but the Commission has seen marked variations in the balance of these two criteria not only between institutions; but also within institutions; between inter-disciplinary staff groups; and within groups of the same profession. This last is sometimes manifested between different shifts on the same ward. There is a need for these disparities to be addressed and for staff to be given guidance.

Obviously the Commission's major concern is that these differences directly affect the patient. The Commission has been encouraged to see the worst of them mitigated by the growth of Patient Care Teams and Care Programmes. But these are sometimes intermittent or non-effective, dependent particularly on the practice and availability of the rmo: where such practice and availability differ markedly within an institution, these factors are prone to cause patients to become disaffected and staff to become demoralised.

The practices in the four hospitals are often different, and this is a source of grievance to patients who are transferred from one to another, and find very different practices affecting their daily living. Another matter of disaffection is that decisions are applied with a broad brush, whereas the incidents giving rise to the decisions may have been solely confined to, or affected by, the actions or conduct of one individual.

The Commission hopes that the publication in due course by the Secretary of State of the Code of Practice will help to reduce these differences. Commissioners are pleased to know that at present a "Seclusion Policy" for all the special hospitals is being prepared, and the local management teams have been asked to consider it and to formulate, subject to the DHSS Office Committee's approval, a procedure for their own hospital.

12.3 Visiting

The pattern of visiting is different in each of the Commissioner's three regions. In the North West, all the members (apart from those professionally concerned in the work of the particular hospital) visit Park Lane and Moss Side twice a year as a group. In between, groups of members make visits to wards and units which have been "allocated" to them.

At Broadmoor and Rampton, the hospitals have been sectorised for visiting purposes, and a small team regularly visits its own allocated sector. A special group of Commissioners has maintained liaison with the management, in meetings and by other contacts.

In each Region one or more members of each of the other regions may be attached to a main visiting group, to facilitate comparison and co-ordination of the practices, especially the good ones, in the different special hospitals.

As the groups, like the Commission, are multi-disciplinary, these visiting arrangements have enabled Commissioners to get to know both patients and staff on particular wards and to see where the management problems of the ward lie. The danger, of course, is that the Commissioners might be seen by patients as part of the "establishment" rather than distinct from it. This is a risk which the Commission has to take, but considers justifiable.

The Regions have had the following objectives in their visits to the hospitals:

- (a) The achievement of an understanding of the nature and functions of the hospital.

- (b) The monitoring of the Mental Health Act 1983.
- (c) The safeguarding of patients' rights.
- (d) The investigation of patients' complaints.
- (e) The encouragement of good practice.

It is right to conclude that in each of the Regions some progress has been made, but that in some quarters it has been slow.

12.4 Complaints

NHS hospitals have clearly defined complaints procedures. It does not always follow that complaints are competently dealt with or that the complainant is satisfied with the outcome. However there are various appeal mechanisms both inside and outside the Authority concerned. Ultimately the complainant can ask the Health Service Commissioner (HSC) to investigate his complaints, and it is for the HSC to decide whether such a complaint is outside his jurisdiction. It is a duty of all health authorities to see that complainants are properly advised of their right to complain and of the channels open to them if they are dissatisfied with the local inquiry. It is also their duty to educate and train staff about the importance of the complaints system.

Patients in three of the four special hospitals (ie, other than Rampton) do not appear to be well informed about their rights of complaint. The special hospital managers do not appear to have considered how the complaints procedures, which the Department correctly enforces in NHS hospitals, might be translated into the special hospitals, albeit in an adapted form. This is not to say that some complaints are not examined carefully and remedies provided, but the Commission's perception is that they are not regarded in principle as a positive right of the patient and an important aspect of management's monitoring. If management does not stress these positive benefits, but rather takes a negative and defensive stance, it is difficult for staff to take a different view.

Many of the complaints investigated by the Commission have not been found to be justified; some have proved impossible to resolve; but others have been well founded, and on occasion the hospitals have recognised a failure. But it is rare in these cases for an apology to be offered. It is also unusual for the staff involved to be told the outcome.

There is one class of complaint, alleged assaults by staff on patients, which is automatically referred to the police. It is rare for the police to find evidence which would satisfy a court of law. In such cases it has not appeared to be the practice for the hospitals to deal with any non-criminal, but nevertheless professionally improper, aspect of the complaint internally. Guidance to NHS hospitals issued by the DHSS differentiates between police action and that which the health authority can take without interfering with the proper prerogatives of the police. We recommend that the management at the special hospitals should pay closer attention to these responsibilities.

Many of the complaints raised seem trivial. But these may represent important irritations; they may be masks for more serious dissatisfactions; or they may be matters about which the complainant feels it "safe" to complain.

Some patients are incapable by means of their mental impairment or other disability from complaining. Managers have a duty to ensure that their rights are safeguarded and their vulnerability is not exploited. Rightly, they vest considerable confidence in the calibre and integrity of the staff. But there is a narrow line between that and complacency. Even more delicate is the balance between patient care and staff loyalty. There should be a clearly established channel for complaints by staff about patient care, which is accepted at all levels of management and by staff organisations. There is currently a study being undertaken by the National Association of Health Authorities in relation to complaints by staff about patient care.

12.5 Home Office

Most of the patients are on restriction orders or directions, and therefore require Home Office approval for leave and the implementation of recommendations by Mental Health Review Tribunals for transfers to other hospitals. The Commission has had many complaints, from patients and staff, about the time taken in considering these. Mr David Mellor, MP, Minister of State at the Home Office, accepted an invitation to talk to the Central Policy Committee on these issues. He explained the constraints upon him and the careful personal study that he gave to each application. The Commission appreciates the important responsibilities of the Home Secretary but is concerned to seek to ensure that such delays as occur are the inevitable consequence of proper consideration, rather than of avoidable bureaucracy.

The Commission recognises that responsibilities in the effecting of a transfer from a special hospital to another hospital will be divided between a Health Authority or rmo (at the receiving hospital), the DHSS or Rampton Review Board (as managers of the special hospital), and the Home Office; and that the passing of time may be legitimate in the necessary processes. But it must not be forgotten that the person who is at the "receiving end" of those processes is the patient. Commissioners have met cases (where complaints have been made by patients) in which any reasonable man would say that the delay in effecting and completing a transfer was quite unacceptable, unless a very satisfactory explanation not only can, but actually is, given by the above authorities. It is recognised that the precise facts in each instance have to be looked at on their merits. But the Commission is concerned to enquire whether the methods used in the nexus of divided responsibilities are as rationalised as they can be, and whether a sufficient sense of responsibility and urgency exists at all stages. We attach a high priority to this enquiry.

Another issue which has arisen (mainly on visits to NHS hospitals) in relation to restricted patients is the identity of the rmo in those cases where a patient is allowed by the Home Office to go on trial leave or temporary transfer from a special hospital to a NHS hospital. It is the Home Office view

that the various responsibilities of the rmo can properly be divided between the patient's "rmo" at a special hospital and his new "rmo" at the NHS hospital. Questions have been addressed to the Commission as to whether this can be so. The Commission believes that there are considerable difficulties in the way of the Home Office view, both in law and in the practice problems which arise for the rmo at the receiving hospital.

The Commission has also been asked for its views about good practice involving Home Office practice in relation to restricted patients, albeit patients who have already been transferred from a special hospital to a NHS hospital. If such a patient after transfer is conditionally discharged from the NHS hospital and it becomes necessary to have him back in hospital in order to assess his condition, is it better for the NHS rmo to place him under another section (Section 2) for that purpose, or for him to be recalled by the Home Office under a recall warrant? Home Office practice favours the first course, on the grounds that it is less restrictive than a recall. (It is probable that there is no legal bar to a patient being subject to two sections in this way.) But one consequence is that the patient loses the chance of an automatic Tribunal hearing under Section 75(1). Although as a Section 2 patient, he would have the right to a quick Tribunal hearing and might win an order for discharge from that Tribunal, the Home Office would still be entitled to recall him on the restriction order or direction. And this consideration may deter him from seeking to exercise his right, as a Section 2 patient, to a Tribunal hearing.

12.6 Mental Health Review Tribunals

Patients' rights of appeal to Tribunals were considerably enhanced by the 1983 Act, as were the powers of the Tribunals. The Commission does not see its duty to review the working of the 1983 Act as extending to the detailed activities of the Tribunals. That responsibility lies with the Lord Chancellor's Department and the Council on Tribunals. It may not, however, generally be realised what change was made as a result of the decision of the European Court of Human Rights in *X v. United Kingdom* in 1981. Where a patient has been convicted of an offence and made the subject of a hospital order and a restriction order, a Tribunal (in practice chaired by a circuit judge) can now with complete authority decide on an absolute or conditional discharge. However a lesser decision, such as transfer to a less secure hospital, or leave of absence, remains subject to the Home Office's total discretion. Transfer and leave are commonly the first stage in the rehabilitative programme for a special hospital patient, since discharge may be too abrupt a move. Some patients, who were originally convicted of a criminal offence and given a prison sentence, have subsequently because of mental disorder been transferred to hospital, usually one of the special hospitals. The effort made by the Home Office and Prison Medical Service to effect such transfers is laudable. However so long as the prison sentence continues, and this in the case of a life sentence means life, the Mental Health Review Tribunals' recommendations, of all kinds, remain subject to the Home Office's overriding decision. The Tribunals continue to have in these respects "advisory functions only" (as the European Court described, in *X v. United Kingdom*, the recommendations of the Mental Health Review Tribunals).

The requirement that a judge should chair a Tribunal for a restricted patient has caused delay, of which the Lord Chancellor's Department is aware. The Commission has co-operated with Tribunals in facilitating consideration of parole leave where such was thought necessary before the Tribunal could consider a discharge. The Commission has also helped in facilitating the finding of less secure accommodation, the provision of which has proved most difficult for the mentally impaired patient.

12.7 Summary

The Commission believes that much progress has been made in the first two years in building up constructive relationships with the patients, staff and management of the special hospitals. It knew that the process would be difficult, but benefits could not come unless there was understanding by the Commission of the difficult work in the special hospitals; and by the special hospitals of the Commission's statutory duties and its genuine concern to maintain a balanced view about the realities in special hospitals. Commissioners have found much to commend, and the majority of staff are seen to be caring and committed. With co-operation, the Commission hopes that the special hospitals will be enabled to avoid the public criticisms to which they have been subject.

The Commission's concerns are with:

- (a) the management philosophy, its formulation and communication to patients and staff;
- (b) the lack of clear lines of responsibility in management arrangements;
- (c) the practical and realistic implementation of patients' rights;
- (d) the co-ordination of the various statutory agencies affecting patients' rights welfare—eg Secretary of State for Social Services, the Home Secretary, Mental Health Review Tribunals, and local authority Social Service Departments;
- (e) the way in which complaints are regarded, investigated, and acted upon; and
- (f) the reduction of the delays in the transfers of patients from special hospitals.

13. THE DRAFT CODE OF PRACTICE

The preparation of proposals for a Code of Practice has been central to the work of the Commission in its first two years. A very great deal of time and effort has had to be directed to that end.

It became clear, in the early stages of the Commission's existence, that in order to supplement the experience of the individual Commissioners in various fields of mental health work, it would be necessary collectively to observe and to digest existing practices throughout the country and to test empirically those points in which particular issues of good or bad practice arose. This was accordingly done. It coincided with the formative months during which the visiting and complaints procedures of the Commission were evolving.

Under the Act, the Code of Practice has to be designed to cover two separate fields:

- (a) the guidance of doctors, managers and all staff in relation to the compulsory admission of patients under the Act, and
- (b) the guidance of doctors and other professionals in relation to the “medical treatment” of mentally disordered patients.

The first of these two requirements relates only to detained patients, or (to be more exact) those who are about to be, or are in the process of becoming, detained. The second requirement, however, relates to all mentally disordered patients, ie including all informal patients in a hospital or mental nursing home and indeed, it seems, in the community.

Moreover since “medical treatment” is defined widely in the Act to include “nursing and also care, habilitation and rehabilitation under medical supervision”, it is clear that the Code has to be designed to cover all aspects of care and treatment of any mentally disordered patient. In this respect alone the Commission’s warrant embraces the whole field of practice, relating to all kinds of mentally disordered patients.

With this in mind, the Commission divided itself up into small teams, ranging from three to ten members in number. Each team was composed of various disciplines and was allotted a particular field of practice to consider and to cover in a draft Chapter of the Code. The teams met and corresponded before producing a draft. Teams which covered subjects with common boundaries liaised in order to achieve (it is hoped) consistency. Each draft chapter was then considered collectively by the Commission as a whole, and by other individual Commissioners. Matters of contention were debated at Commission meetings and Regional meetings. After editing, the final completed draft “proposal” for the Code is shortly to be delivered to the Secretary of State.

The Commission does not at present recommend that any additional form of medical treatment should be made subject to the procedures laid down in Section 57 of the Act. It has to be remembered that those procedures apply both to detained patients and to informal patients. They represent society’s restrictions on the administration of very special treatments, going beyond even the control required by the common law. It seems right that before any form of treatment is added to the list of very special treatments, a very broad measure of agreement has to be obtained. No such measure of agreement has been obtained, even among Commissioners. Accordingly no extension of Section 57 is recommended.

The Chapters of the draft Code are entitled respectively:

- Admission to Hospital
- Admission through the Courts
- Guardianship
- Consent to Treatment

Compulsory Powers and Second Opinions
Psychological Treatment
Rehabilitation
Patients presenting particular management problems
Social Aspects
Information
Discharge
The Role of Relatives
Duties of Managers
Informal Patients
Mentally Handicapped Patients
Special Needs of Black and Ethnic Minority Groups.

It is of course impossible in this Report to deal with the detail of the draft Code: this will, however, be made available as part of the statutory consultation process.

One of the most difficult areas has been the issue of Consent to Treatment. That issue is a very wide subject, covering all the problems of the consent of mentally disordered patients to purely physical treatments, as well as to treatments for their mental disorder, including treatments other than medical treatments. It is, moreover, a subject in which the questions of practice have to be related closely to the existing rules of common law, and to go beyond them in those areas where the law is uncertain.

Because questions of consent have continually arisen on our visits to hospitals and elsewhere, the Commission decided to publish the paper on Consent to Treatment which had been prepared by one of the teams for the purposes of the draft Code of Practice. This is probably the first time that an attempt has been made to deal comprehensively with all the questions of consent which arise in relation to the treatment of mentally disordered people.

The paper is also, in effect, a consultation paper, which contains in one passage (relating to the treatment of incapable informal patients) proposals as to how the law could be shaped to give such patients a degree of protection analogous to that available to detained patients, without involving them in the complexity and stigma of formal detention. In other respects the paper seeks to deal pragmatically with issues which arise, on the basis of the law as it is and good practice as the Commission thinks it should be.

14. POSTAL PACKETS

The Commission's statutory duty to review decisions at special hospitals as to the withholding of postal packets or anything contained in them has not had to be exercised very frequently.

In the Southern Region, there have been two formal requests for review.

On one of them, the withholding was upheld. On the other, arrangements were made which removed the grounds for withholding.

In the North Eastern Region, there have been two formal requests for review. One of them was then withdrawn. On the other, the withholding was upheld.

In the North Western Region, there have been eight formal requests (all from Park Lane and none from Moss Side). Three of them were cases where senders complained that money sent by them to the patients had been "withheld", whereas the money in each case had been placed straight into the patient's account. The hospital's standard letter to senders has been modified as a result. Three other requests were from patients, and one from another sender: on all of these, the withholding was upheld. One further request for a review came from both a sender and a patient: while the withholding in that case was upheld, the Commission's inquiry led to a practical compromise which appeared to satisfy both sides.

In three other cases in the North West Region complaints about correspondence were made to the Commission, but not as requests for review under Section 121(7) of the Act. Two of these were from Park Lane and one from Moss Side. They were each made on the grounds that a packet sent by a patient to one of the privileged persons described in Section 134(3) had been wrongly withheld. On one of these, the complaint was upheld and the hospital acknowledged its mistake. The other two complaints were rejected by the Commission.

A complaint was made to the Commission by MIND that the Broadmoor Management were opening and inspecting all correspondence addressed to MIND by patients at that hospital. Advice was given by the Commission about the complex legal issues and powers arising from Section 134 of the 1983 Act; and the Southern Region's Broadmoor Group of Commissioners took up the matter with the Broadmoor Hospital Management Team. The HMT refused to accept the interpretation of the law put forward by the Commission, but agreed to respect the privilege afforded by Section 134(3) to legally qualified persons instructed by a patient as his legal adviser, if MIND identified the qualified solicitors on their staff and informed the hospital when one was instructed as a legal adviser. The same offer was made by the HMT in response to a similar complaint made to the Commission by the National Council of Civil Liberties, after the Commission's Broadmoor Group had again taken the matter up with the HMT.

15. THE INTERESTS OF BLACK AND ETHNIC MINORITY GROUPS

The Commission has been aware of criticisms from black and ethnic minority communities that their mental health interests are not at present sufficiently taken into account, either in the provision of services or in the safeguarding of their rights.

Three matters of particular concern have been drawn to our attention:

- (a) Members of these communities seek recognition of the fact that some of their needs are different from those of the indigenous population. They feel that this is often overlooked when health and social services are being planned, and that they suffer disadvantages additional to those commonly experienced by mentally ill or handicapped people.
- (b) There are suspicions about the way in which the mental health laws are operated, at times—they feel—against their best interests, and there is a feeling that cultural features are not always sufficiently considered when diagnoses of mental illness are made. Research studies appear to support such anxieties in some districts.
- (c) These fears were not allayed by the fact that originally no Commissioners had been appointed from the black and ethnic minority communities themselves.

The Commission would like to see more consideration given to concerns of race and culture. Fears of these kinds cause considerable distress, worry and tension, both when they are justified and even when they are not justified. On such sensitive issues, it is as important to remove the grounds for such fears in the latter case as in the former case.

During their visits to hospitals Commissioners have paid attention to the different needs of detained patients from black and ethnic minority groups. Outside the hospitals, meetings with relevant organisations and individuals have been attended, with a view to increasing the Commission's knowledge and understanding of the issues.

The Commission believes that certain practical measures could be generally introduced now which would help to allay some of the present concerns:

- (a) Instead of individual health authorities having to translate information leaflets, the leaflets should be translated centrally, and tape-recordings made for those who have difficulty in reading and writing any language; deaf people also need facilities.
- (b) Adequate arrangements should be made in all health authorities for interpretation of information to patients and relatives, both before admission and during a patient's stay in hospital. It is not appropriate to rely on family members (and especially not children), or even on bilingual members of staff. Commissioners would like to see health and social services authorities combining to provide a pool of interpreters, perhaps on a regional basis, with appropriate training in the concepts and terms used, their accurate transcription as well in English as in the other language concerned, and in the sensitivities involved.
- (c) Steps should be taken to ensure that when such patients need to be represented on appeals, they should have the choice of seeking such representation from a member of their own community. The local Community Relations Officer would be of help on this.
- (d) The living arrangements for such patients should be caringly studied. Appropriate food ought to be readily provided, particularly conform-

ing to religious practices. The importance of special clothing should be appreciated.

- (e) Access to religious leaders and appropriate places of prayer may be needed, and patients who may be inhibited should be encouraged to make their needs known.

We have accepted a responsibility for maintaining a close interest in these questions and being alert to new ones. We recommend that all health and social service authorities should do likewise and designate a senior member of their staff to have a specific responsibility in this area, to liaise with local organisations and to monitor the special services needed.

16. THE PRESENT AND THE FUTURE

16.1 Many problems have been identified in the pages of this Report. There are inevitably others. For some of the problems pragmatic solutions have been found. Others remain at present unresolved. Without attempting an exclusive list, we can perhaps usefully point to the following as being important issues (not necessarily in an order of priority) which clearly should engage the attention of all those concerned:

- (a) The “long-leash” problems: see page 25;
- (b) Care services in the community: see page 12;
- (c) Co-operation in relation to “after-care”: see pages 18 and 33;
- (d) Management of special hospitals: see page 45;
- (e) Delays in transfers from special hospitals: see page 48;
- (f) The provision and training of Approved Social Workers: see page 17;
- (g) The Managers’ duty in relation to giving information: see page 22;
- (h) Issues under Section 136: see page 19;
- (i) The patient’s “appeal” to the Managers: see page 27;
- (j) Informal patients who are *de facto* detained: see page 24;
- (k) Factors affecting black and ethnic minority groups: see page 54;
- (l) Junior doctors as nominated deputies under Section 5(3): see page 19;
- (m) The Act and mentally-handicapped people: see page 9;
- (n) The further development of multi-disciplinary teamwork: see page 17;
- (o) Rehabilitation of patients: see page 30;
- (p) A patient’s request that his nearest relative is not informed: see page 20;
- (q) Assessment under Section 2: see page 20;
- (r) “Flagging” arrangements by administrators: see pages 22 and 40;
- (s) Plans of treatment: see pages 23 and 39;
- (t) Consent and informal incapable patients: see pages 11, 12 and 52;

- (u) The contents of certificates under Part IV: see page 39;
- (v) Delays in Tribunal hearings: see page 29;
- (w) Education and training: see page 31;
- (x) The extent to which guardianship can and should be used: see page 20;
- (y) The need for research on issues raised: see page 39;
- (z) Mentally disordered people in prisons: see page 12.

16.2 For special attention in the future the Commission proposes to give a high degree of priority to issues arising in relation to:

- (a) Care services in the community which affect detained patients: see page 13;
- (b) Seeking ways of preventing delays in transfers from special hospitals: see page 48;
- (c) Mentally disordered people in prisons: see page 12;
- (d) Management of special hospitals: see page 45;
- (e) More effective collection of data for reviewing the working of the Act.

17. CONCLUSION

The Commission's activities described above indicate that it has found much to engage its attention. Duties under the Act have been supplemented by points referred to the Commission by Ministers and members of both Houses during the Parliamentary debates. Pressures of time plunged Commissioners into a multitude of activities from the outset. Their multi-disciplinary background has proved a source of strength, and also a rich seed-bed for discussion and indeed disagreement. Our policies have had to be formed quickly; these are always open to refinement, or indeed change.

It is not to be expected that everything in this Report will attract agreement. Something would be wrong if that were the outcome. Mental health services will remain a controversial area, open to constant debate and revision. The Commission hopes, however, that its first Report may elicit reactions, and that these will be made known to it.

In the next two years there should be time for some consolidation. It will be possible to assess what has been done and what remains to be done, both on issues which have already presented themselves and on new issues which stand in front of us. The Code of Practice will be under scrutiny. Research needs to be done, either by others, or if by the Commission, then only with an additional resource. The computer will increasingly allow the retrieval of facts which will show society the way in which the 1983 Act is working. The Commission sees ahead of it a programme of useful and creative work. If the same future can be held out for the patients under mental health care, the work of all who contribute to that care will be rewarded.

APPENDIX 1

FINANCIAL ARRANGEMENTS

In the last full year the Commission cost the tax payer some £911,000.

The Commission is financed directly by the DHSS. The only items in respect of which the Commission holds its own budget are fees and expenses of members and of doctors appointed to give second opinions. This expenditure is cash limited in the same way as the expenditure of other health authorities. The provision of second opinions is required by the Mental Health Act 1983 and is therefore not susceptible of limitation by the Commission. An unexpectedly large number of second opinion visits could consequently distort the Commission's budget.

Secretariat costs, including accommodation, salaries, stationery and telephones, are met by the DHSS from its general administration vote, and is not, at present, cash limited.

For the first full financial year of the Commission's existence (1984/85), the cash limit for fees and expenses was set at £704,000. Actual expenditure was £623,000.

The principal expenditure met directly from the DHSS general administration vote was estimated as follows:

Staff salaries, including NI contributions and superannuation	£190,000
Stationery, postage, telephone, accommodation	£98,000

A Finance Committee has been set up and is attempting to provide costings of individual items of expenditure, such as routine hospital visits by Commissioners, complaint investigation and meetings. It is also concerning itself with those items of expenditure for which the Commission holds its own budget. The Commission acknowledges that, as a Special Health Authority, it must be fully responsible for expenditure within its control. Provision has been made to do this, and a system instituted to gain the approval of the Commission as a whole to its budget and accounts.

APPENDIX 2

COMPLAINTS CASES

Case 1

A mentally impaired patient detained on a restriction order was granted a conditional discharge by a Mental Health Review Tribunal. The four conditions laid down had been carefully and adequately investigated, the Tribunal having held, in all, three hearings over nine months including receipt of evidence from an independent social worker and psychiatrist.

Almost a month later, when at the hospital on other business the patient's solicitor was surprised to see the patient still detained there. On the patient's behalf he promptly complained to the Commission late on Friday afternoon indicating his intention to apply for an order of *Habeas Corpus* the following week.

This complaint raised numerous interesting issues, the most immediate and important being the apparent denial of the patient's liberty contrary to the Tribunal's decisions.

This main substance of the complaint was quickly resolved by one Commissioner making many telephone calls to all the parties involved, including the rmo, the Home Office, the Tribunal clerk, the Unit Administrator and his deputy and the Director of Social Services, with the result that the patient (who had spent the intervening weekend at home on leave anyway) was actually discharged from hospital pursuant to the Tribunal decision on the 7th day after receipt of the complaint.

Two Commissioners then investigated the issues more deeply. They found that the very experienced charge nurse had been alarmed by the failure to discharge the patient.

Their investigation revealed a breakdown in relationships and communication between the rmo and others, particularly the unit administrator. It brought about a keen critical self-appraisal by all disciplines in the hospital about many aspects of the 1983 Act, especially the changes relating to Tribunals and their powers relating to patients subject to a restriction order.

This complaint also brought into focus the respective roles of the Mental Health Review Tribunal and the Commission, and a useful dialogue took place. It seems clear that once a Tribunal has granted a patient conditional discharge, whether deferred or not, it reasonably assumes that it can rely on the relevant hospital staff concerned with the patient to see that its decision is implemented. In this case this reliance was not borne out until the Commission's help was sought.

Case 2

Four patients interviewed by Commissioners on a routine hospital visit complained about differing attitudes by nursing shifts, some undue strictness and verbal and physical abuse.

At the end of the visit the complaints were promptly communicated to the Unit Management Team. A full internal investigation was carried out by the hospital whose report revealed that some nursing care and attitudes on the ward in question required re-examination, and that staff required further training and guidance especially in handling behavioural problems. The allegations of physical abuse were held to be unfounded. This was accepted by the patients who then stated that they were satisfied with the hospital's enquiry and response.

Case 3

In October 1984 a special hospital patient wrote to the Commission complaining that he was still waiting to hear from the Home Office about the result of a Mental Health Review Tribunal held in February 1982, under the 1959 Act.

This complaint was referred by the Commission to the Home Office along with a number of other complaints from patients in all three Regions concerning alleged Home Office delays in dealing with various kinds of recommendations (especially transfers by rmos and Tribunals).

It transpired that the patient's file had been lost in March 1982. The Home Office had forwarded it to the DHSS for consideration and comment on the Tribunal recommendation, but although recorded as having been returned by the DHSS it had not apparently been received back in the Home Office.

The patient's complaint had brought this unfortunate situation to light. The file relating to the February 1982 Tribunal has been rebuilt and the patient was sent a response by the Home Office. It was pointed out to the patient that he is eligible for another Tribunal under the new legislation.

Case 4

The patient has suffered from schizophrenia for about 10 years and has had several periods in hospitals. Her father made several complaints to the Commission, namely:

- (a) he had difficulty in communicating with his daughter's consultant;
- (b) he felt the current level of dosage of her depot injections was too high (being higher than on previous occasions in a different hospital);
- (c) he had doubts about the plan for his daughter to reside with her mother (from whom he was divorced) on discharge.

The Commissioners visited the complainant and had access to the patient's medical records and talked to the staff involved.

The complainant was advised that his daughter was now an informal patient and was free to choose where she lives. The dosage of medication would vary from time to time according to her clinical state but this must remain a clinical decision by her consultant. Commissioners did ask whether the consultant could increase contact with the father and whether he could be given increased community support in an effort to keep him involved with

his daughter's care. A reply was received that every effort to do so would be made if the father made an approach.

Examination of the documents in this case also led the Commissioners to suggest that case records should be annotated when the status of a patient changes. It also appeared that both the parents on occasions in the past had been deemed the nearest relative, and the hospital was advised to consider this in case the need to detain arises again in the future.

Case 5

The patient made several complaints claiming as follows: that his detention was unlawful, he was not ill, he was subject to tight restrictions on his movements, staff were biased and unhelpful towards him, he was an informal patient under duress and had to remain in hospital for physical and financial reasons.

Commissioners interviewed the patient and inspected the documents. The documentation relating to the detention was in order; a subsequent Mental Health Review Tribunal did not recommend discharge. It was apparent to the Commission that the patient had a lack of confidence in his social worker which was affecting his progression back to the community. It also transpired that the patient either had not received or had not understood an explanation why he had been detained.

The Commissioners asked the hospital to examine the possibility of changing the patient's social worker and raised the question of making sure patients are aware of their rights. The Administrator agreed to take up the question of a change of social worker and to reconsider procedures to ensure that a patient's rights are fully explained.

Case 6

A person made several complaints to the Commission on behalf of his ex-wife, a patient who had been detained:

- (a) that mail addressed to her had been opened by hospital staff;
- (b) that on discharge the patient was given house keys which were not hers, and that there had been indications that her own keys had been "borrowed", implying that some unauthorised person had entered her home;
- (c) that pressure had been brought to persuade the patient to sell her home;
- (d) that adequate records should be maintained, recording the searching for and removal of property from patients' homes.

The Commission referred these complaints to the Hospital Administrator for investigation and in due course received a reply.

Points 1-3 were found to be unsustainable. Mail had been placed unopened into another envelope and forwarded to the patient who had left the hospital.

The locks to her house had been changed after her discharge from hospital. The Health Authority had no influence over the sale of the patient's house which had correctly been handled by the patient's solicitor.

The Commission was informed that, if taken home by social workers, patients are allowed to collect property items. Authorisation for such visits is kept in the medical notes. If any other person goes to a patient's home he has to be escorted and a record made of the list of items brought back to the hospital. This had been done in this case but the record of items brought back could not be found. The Commission asked the Health Authority to ensure that all visits by patients to their homes and all property removed on such visits be accurately and permanently recorded by the Authority.

It was also suggested that a detailed procedure be prepared for the guidance of all staff involved in such activity. These recommendations were accepted and procedures are being revised.

Case 7

The patient was detained under the powers which enable a convicted offender to be transferred from prison to a hospital.

He complained to Commissioners that he had lost from his locker some valuable books and some clothing. He was advised to take it up with the Unit Management Team and if still not satisfied to contact the Commission again. The Unit Management Team advised him they would not pay any compensation: the patient was not satisfied and contacted the Commission again. The patient appeared not to know that he had further recourse to the hospital managers. With his permission the Commission wrote to the managers asking for a review of the decision. In due course the patient was granted an *ex gratia* payment in respect of his claim.

Case 8

A patient complained that for a period of two weeks he had been kept in pyjamas. The Commissioners were concerned about the hospital's policy, the lack of explanation and discussion with the patient, and the possibility that he was not receiving sufficient fresh air and exercise.

The hospital explained that initially the patient, who had a tendency to abscond, had agreed to stay in his pyjamas. They said that the position had been reviewed weekly but that no notes of these reviews had been kept.

They agreed that the case showed many shortcomings in their review and recording procedures and told the Commission how they intended to remedy these.

Case 9

Commissioners investigating a complaint about the lack of action following the decisions of a Mental Health Review Tribunal were gravely disturbed to find that an important contributory factor had been the failure of professional staff caring for the patients to communicate properly with each other.

The Commission took up many of the issues with the District Health

Authority, but were so concerned about the intra-professional difficulties that they drew them to the personal attention of the Chairman of the Regional Health Authority.

Case 10

The patient was concerned about the level of social services support to be given to her at discharge; in particular, the arrangements to help with the care of her adolescent handicapped children.

The Commission consulted the local social services department, which then provided the appropriate services and explained their policies.

Case 11

A patient had complained of an assault. He considered that the hospital managers had not investigated it properly and complained to the Commission.

The Commissioners' investigation showed that the health authority had not followed DHSS procedures, nor conducted a reasonable inquiry into the allegation.

The health authority:

- (a) reopened the inquiry and instigated a members' investigation, and
- (b) they reviewed and improved both their complaints procedure and the monitoring of its implementation.

Case 12

A patient and her co-habitee complained that:

- (a) the patient had not given valid consent to ECT;
- (b) the co-habitee had been improperly excluded from the hospital;
- (c) the co-habitee had not been recognised as the patient's "nearest relative";
- (d) another person, treated as being the nearest relative, had been coerced to agree to the patient's compulsory admission.

On investigation the Commission did not uphold complaint (a). As to (b) they recognised the hospital's right, in the interests of the patient and other patients, to exclude the co-habitee, but were critical of the way in which the decision had been implemented. The hospital has instituted a new procedure. Complaint (c) was well founded: the co-habitee was the nearest relative as defined in the Act, and the hospital is formulating a new policy accurately to identify the nearest relative. In relation to (d) the Commissioners considered that the way in which the admission was handled probably led to misunderstandings. In particular no social worker had been allocated to the patient; such a person could have reduced or eliminated misunderstandings. The hospital and local authority have taken action to increase the social worker establishment and to allocate one to every detained patient.

APPENDIX 3

Address of Mental Health Act Commission Offices

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LIVERPOOL L19 0NF
Tel: 051 427 2061*/6213

(Northern, Yorkshire and Trent RHAs):

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