THE MENTAL HEALTH COMMISSION (February 2005)

Introduction

The Review of the Mental Health Commission Working Group (hereafter referred as to the Group) has met monthly since December, 2003. In keeping with the Mission Statement of the Review of Mental Health and Learning Disability (Northern Ireland) the Working Group is multi-disciplinary with user and carer representation and from the outset has adopted an inclusive and transparent approach. The Group fully recognised the fundamental values and guiding principles on which the overall Review is based in particular:

- the need for high quality effective services (treatment, care and support) for people with mental ill health and/or a learning disability;
- reducing stigma;
- promoting social inclusion;
- the need for collaborative working among all relevant stake holders.

Terms of Reference

1. To carry out an independent review of the work/role and effectiveness of the Mental Health Commission.

2. To take into account

   (a) the overarching need to recognise, preserve, promote and enhance the personal dignity of all people with mental health needs and/or with a learning disability;
   (b) service user/carer views;
   (c) the views of relevant stakeholders;
   (d) the views of the Mental Health Commission itself;
   (e) the role and working arrangements of similar watchdog bodies in other jurisdictions; and
   (f) the outcome of other reviews of the Mental Health Commission.

3. To make recommendations as to the future role/status of the Mental Health Commission.

THE MENTAL HEALTH COMMISSION

Overview

The MacDermott Report (Mr Justice MacDermott was appointed to review the Northern Ireland Mental Health Legislation and reported in October 1981) recommended the creation of a Commission to safeguard the rights of people with a mental disorder. Subsequently the Commission was established under the provisions of Part VI of the Mental Health (Northern Ireland) Order 1986 and is a non-departmental public body of the DHSSPS charged with the duty "to keep under

review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by this Order" (Article 86(1) of the Order).

Article 86(2) of the Order provides that in the exercise of its functions under Article 86(1) it shall be the duty of the Commission:

(a) to make inquiry into any case where it appears to the Commission that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage;
(b) as often as the Commission thinks appropriate to visit and interview in private patients who are liable to be detained in hospital under this Order;
(c) to bring to the attention of the Department, the Secretary of State, Board, HSS Trust or a person carrying on a private hospital, residential care home, voluntary home or nursing home the facts of any case in which in the opinion of the Commission it is desirable for the Department, the Secretary of State, the Board, the HSS Trust or that person to exercise any of their functions to secure the welfare of any patient by:

    (i) preventing his ill-treatment;
    (ii) remedying any deficiency in his care or treatment;
    (iii) terminating his improper detention in hospital or reception into guardianship; or
    (iv) preventing or redressing loss or damage to his property.

(d) to advise the Department, the Secretary of State, Board, HSS Trust, or any body established under a statutory provision on any matter arising out of this Order, which has been referred to the Commission by the Department, the Secretary of State, the Board, the HSS Trust, or the body, as the case may be; and
(e) to bring to the attention of the Department, the Secretary of State, Board, HSS Trust, or any other body or person any matter concerning the welfare of patients which the Commission considers ought to be brought to their attention.

In the exercise of its functions Article 86(3) provides that the Commission may:

(a) where it thinks fit, refer to the Mental Health Review Tribunal the case of any patient who is liable to be detailed in hospital or subject to guardianship under this Order;
(b) at any reasonable time visit, interview and medically examine in private any patient in a hospital, private hospital, residential care home, voluntary home or nursing home or any person subject to guardianship under this Order;
(c) require the production of and inspect any records relating to the detention or treatment of any person who Is or has been a patient in a hospital, private hospital, residential care home, voluntary home or nursing home or relating to any person who is or has been subject to guardianship under this Order.

The Commission comprises a part-time Chairman and 14 part-time Commissioners (from psychiatry, social work, nursing, allied health professions and lay members)

supported by 8 WTE administrative staff and a personal secretary. The main non-financial objectives of the Commission are:
(a) monitoring of prescribed forms;
(b) monitoring of treatment plans and care plans;
(c) appointment of psychiatrists to Part II and Part IV status of the Order;
(d) hospital visiting;
(e) community visiting;
(f) reviewing untoward events.

These objectives are described in detail in the Mental Health Commission's 7th Annual Report along with activity data relating to each objective.

Views of Service Users/Carers

In addition to views of the user/carer representatives on the Working Group views were sought from LAMP (Life After Mental Health Problems), The Northern Ireland Association for Mental Health (NIAMH) and the four Health and Social Care Councils. Comments from the NIAMH, LAMP and Alzheimer's Disease Society in the Summary of Main Points from Initial Submissions document were also noted.

Overall, user/carer views were many and varied but common themes did emerge:

(a) the fact that the Commission includes service users and lay members was welcomed but it was very strongly felt that a much larger proportion of Commissioners should be users/carers;
(b) any lay members should not be former health and social care professionals.
(c) the Commission lacks "teeth". It is ineffective, does not have a high profile and provides insufficient information; its reports are not made public;
(d) the Commission should be a watchdog body for community services and those who lack mental capacity;
(e) the Commission is not talking to patients, users, carers and advocates as it should;
(f) links between the Mental Health Commission and the Mental Health Review Tribunal and between the Commission and the Health and Social Care Councils are virtually non existent. There are no links with the Equality Commission.

Views of the Working Group

The Working Group's views on the perceived strengths and weaknesses of the Commission are listed at Appendix 2 as are specific comments from a user representative on the Working Group.

Other Stakeholder Views

Health and Social Services Boards

The views of Boards are included in the Mental Health Review – Summary of Main Points from Initial Submissions document. The fact that the review included an examination of the role and function of the Mental Health Commission was generally welcomed. In addition one Board specifically wished to underscore the importance of

continuing to maintain the necessary checks and balances currently offered by the Mental Health Commission.

Health and Social Care Trusts

Many of the Trusts are represented on the Working Group and a few Trusts made comment in the Initial Submissions document. Again a review of the role and functioning of the Mental Health Commission as part of the overall Review was welcomed. Specific comments were as follows:

> "consideration needs to be given to the establishment of an appropriate external inspection body for mental health services in Northern Ireland. The Mental Health Commission plays a limited role in addressing specific issues relating to individual patients".
>
> "the Mental Health Commission has not functioned effectively as a watchdog. It has been more concerned with administrative errors/issues".
>
> "the Trust supports the retention of the Mental Health Commission but would like to see its role enhanced".

Views of Parallel Bodies

The Group believed that any review of the role and function of the Mental Health Commission should take account of the opinions of other public bodies that are charged with protecting the rights and freedoms of the individual. Accordingly other public bodies in Northern Ireland that have a direct concern for the rights of the individuals including those with a disability were contacted (a) to inform them about the review (b) to give them an opportunity to express their views.

1. Northern Ireland Human Rights Commission

The Following comments were made in its publication Connecting Mental Health and Human Rights (December, 2003).

(a) the remit of the Mental Health Commission should be reviewed against international standards;

(b) the Commission should receive adequate funding;

(c) it should be considered whether the Commission might be more effective and independent if a number of full-time commissioners were appointed on a one or two yearly basis;

(d) there should be more service users and /or carers appointed as commissioners and involved in the running of the Commission;

(e) Non-medical commissioners should have access to whatever records they need to investigate any concerns.

2. Equality Commission for Northern Ireland

The Equality Commission has powers under legislation to require public sector bodies to demonstrate equality of treatment and opportunity across the nine areas of potential discrimination outlined in the Northern Ireland Act (1998). This is a strong tool for the Equality Commission to use in promoting the rights and interests of people with mental ill health and Learning disabilities. However, the Equality Commission regards the Disability Discrimination Act as particularly weak in supporting the rights of individuals who have experienced mental ill health.

The Equality Commission is not aware of any recent or past contact with the Mental Health Commission.

3. Health and Social Care Councils

Their views are included in Views of Service Users/Carers listed earlier in this report. At a meeting with members of the four Councils it was noteworthy that apart from the senior officers few Council members knew anything about the Mental Health Commission and links between the Councils and the Mental Health Commission were viewed as virtually non-existent.

4. Ombudsman

The relationship with the Mental Health Commission was described as reasonable although there were some minor concerns around conflicts of interest. The Ombudsman has the power to consider clinical decisions but principally is concerned in ensuring that due process is followed.

5. Mental Health Review Tribunal

The Mental Health Commission may refer a patient's case to the Mental Health Review Tribunal for review. The Mental Health Review Tribunal may refer a patient's situation to the Commission if an irregularity in the terms or conditions of detention is noted or suspected. In practice referrals between the two bodies are very rare.

6. Registration and Inspection Units (R & I Units)

The R & I Units feel that they have liaised successfully with the Mental Health Commission over the past 11 years. They also feel that they have established a good working relationship with the Commission and value its advice and guidance on issues relating to people with a mental disorder.

The R & I Units would like to see the powers of the Commission strengthened; in particular they feel that it is vital that all commissioners have the right to examine all records (with the usual rules applying to medical notes) pertaining to facilities they are required to visit.

The R & I Units believe that the appointment of full-time commissioners should be seriously considered. They further believe that the Mental Health Commission should

become an arm of the HPSS Regulation and Improvement Authority with conditions which would preserve and enhance its unique role and remit in relation to persons with a mental disorder.

Parallel bodies were generally receptive to future improved and transparent working arrangements.

Reviews of the Mental Health Commission

As indicated earlier the Mental Health Commission is a non-departmental public body and Cabinet Office guidance requires a review of such bodies once every five years (quinquennial review); this guidance, part of the "Modernising Government" initiative makes clear that examinations such as quinquennial reviews "provide an opportunity to make a step change in the delivery of central government services to the public".

The first quinquennial review of the Mental Health Commission reported in 1995.

The second quinquennial review was carried out by KPMG Consulting in two parts. Stage I examined the continuing need for the functions carried out by the Mental Health Commission and whether those functions are best carried out by a non-departmental public body; in doing so it examined the appropriateness of possible alternative organisational options. Stage II reviewed the effectiveness and efficiency of the way the Commission delivers its service with a view to producing recommendations for the future role and operation of the Commission. The KPMG Report was produced in May 2001 but because of the advent of Best Practice – Best Care the completion of the quinquennial review was delayed. Deloitte and Touche were commissioned in July 2003, as part of the final stage of the quinquennial review, to consider the KPMG review in the light of Best Practice - Best Care; the review was expanded to also cover the staffing needs of the Commission.

1. **KPMG Report**

KPMG noted "…. an overwhelming consensus among key stakeholders of the continuing need for a body to keep under review the care and treatment of patients suffering from mental disorder and safeguard the rights of detained patients". It is only possible here to summarise some of the key recommendations made in relation to the Mental Health Commission.

(a) Role of the Commission

(i) rather than a legalistic interpretation of its role and duties the Commission "should embrace the broader onus of care that the legislation places to develop a more formative, proactive and developmental role, encompassing spreading best practice, identifying and highlighting key strategic issues and acting as advocates for patients…";

(ii) "the Commission's role should relate to care and treatment in the broadest sense, focusing on people primarily but also on issues such as physical environment that impact upon the quality of life that is central to their recovery and well-being";

(b) Best Practice

"the Commission should act as a vehicle for fostering continuous improvement and spreading best practice in the care and treatment of patients with mental disorders…";

(c) Care in the Community

"to some degree the Commission remains more associated with the hospital sector and has less of a presence in the community sector the Commission should strive to further develop its role in this area ….. one key area for development …. is a perceived gap in oversight of those in supportive living".

(d) Monitoring of trends and patterns

"the Commission should monitor trends, patterns and issues in, and impacting upon, mental health care";

(e) Patients and relatives/carers

the Commission must tackle perceptions of it "as somewhat remote from and unresponsive to patients and their relatives/carers….";

(f) Patient advocacy

"the Commission should liaise with and work through independent advocates who could act as eyes and ears of the Commission and channels of information to and from it, helping it to engage with users and learn about issues affecting care and treatment from their perspective";

(g) Voluntary sector and user groups

- (i) "the Commission should consider setting up some sort of Consultative Forum involving key voluntary sector bodies to discuss issues pertinent to the provision of care and treatment of mental disorder, particularly from the user perspective";
- (ii) "users and carers groups are attached to hospitals and Trusts and should be consulted by the Commission ….";
- (iii) "the Commission should consult with ex-patients who have gone through "the system";

(h) Overlaps with other agencies

- (i) "the Commission should develop closer working relationships with Registration and Inspection Units";
- (ii) "the Commission should develop a much closer working relationship with the Mental Health Review Tribunal, in particular this would relate to the exchange of information in relation to trends and patterns relative to detention";

(i) Membership of the Commission

(i) "Users should be represented on the Commission, probably in the form of ex-patients …. there should be at least two user representatives on the Commission";
(ii) one member should be appointed to represent the perspectives and interests of relatives and carers;
(iii) lay members of the Commission should be genuinely lay members of the public;
(iv) every effort should be made to try and ensure that professional members of the Commission are practising;
(v) the Chair of the Commission should have a medical background with mental health expertise and personal attributes of enthusiasm and a strategic approach to developing the Commission's activities.

(j) Visits

"the Commission should work towards a more systematic approach and clarity of focus to visits to improve the objectivity, consistency and impact of this activity and to allow it to form a more in-depth picture of the quality of care and treatment provided …. unannounced visits should be increased";

(k) Reports

(i) "reports from the Commission should contain clear recommendations for action to enhance care and treatment and a mechanism devised for a follow-up 'audit' of these";

(ii) "reports or a summary of the issues arising from them should be provided to the Department";

(l) Resources

"the recommendations we have made for changes to the focus and conduct of the role and activities of the Commission are wide ranging. It would not be expected that the Commission could become operational in all of these respects and transform its activities overnight. Rather what is set out is a strategic view towards which the Commission should work and develop over the medium term and which would require a strategic plan to advance towards. To some extent the recommendations outlined seek to address a situation in which the role and activities of the Commission have been relatively under-developed over the years, partly as a result of relatively limited resources …… resources would need to be examined on a basis of a detailed strategic plan".

2. **Deloitte Report** (Finalised in April 2004)

This study was required to review (a) the organisational structure and staffing of the Commission including the impact of the proposals of Best Practice - Best Care and (b) to determine the best value for money organisational structure and staffing to fulfil the Commission's functions and the accepted recommendations of the KPMG Report. The study was not an evaluation of the work or effectiveness of the Commission; the

primary focus was on the effectiveness of the internal organisation of the secretariat of the Commission.

Deloitte noted that the Mental Health and Learning Disability Review and the establishment of the Regulation and Improvement Authority are directly relevant to shaping the future strategic context for the Commission's work. Whilst recognising that the full implications of these developments for the Commission are not yet clear Deloitte felt that all decisions regarding the Commission's longer term direction should be taken in the context of these developments.

In its conclusions Deloitte again noted a need for considerable discussion and debate regarding the future of the Commission particularly in terms of its overarching strategy, priorities and how it relates to the new Regulation and Improvement Authority. In the longer term Deloitte felt that there are three main ways in which this relationship could be defined:

(a) all responsibilities that currently pertained to the Commission could transfer to the Regulation and Improvement Authority;

(b) the Regulation and Improvement Authority could "sub-contract" to the Mental Health Commission, which would retain its legal functions and have lead responsibility for Regulation and Inspection in the Mental Health sector;

(c) both organisations retain separate identities and responsibilities but operate within an agreed framework of co-operation with clearly defined heads of agreement.

Recommendations presented for consideration by the Mental Health Commission and the Department included:

(i) the Commission, the new Regulation and Improvement Authority and the sponsor branch within the Department should engage in discussion regarding the options presented above as soon as is practicable following the consideration of this issue by the Review of Mental Health Policy and Legislations Legal Affairs Sub-Committee;

(ii) the current overall structure and staffing complement should be retained but careful consideration should be given to recommendations (which follow) regarding the allocation of roles and responsibilities; and to

(iii) process design; these latter recommendations are very detailed and not repeated here as they are not relevant to the Terms of Reference of the Working Group.

The Mental Health Commission's Response to the Review

The Acting Chief Executive and four members of the Commission presented a paper at the June 2004 meeting of the Working Group and tabled the Mental Health Commission Strategic Plan 2004–2009. The main points of the presentation were:

(a) the Commission considers that its role and capacity to help vulnerable people in all situations could be strengthened with additional statutory powers. These powers should include :-

   (i) a wider legislative scope to allow the review of treatment and care in all statutory, voluntary and private organisations including criminal justice (police detention, prison facilities) housing, employment and education;
   (ii) all Commission members having rights of access to medical and other records where appropriate;
   (iii) rights of access to all people with a learning disability or mental health needs wherever they may be;
   (iv) unfettered access to all statutory and professional bodies that provide service to people with a learning disability or mental health need (for example the General Medical Council);
   (v) the ability to enforce decisions of the Commission;
   (vi) the removal of the requirement for the Chairperson to have a legal background.

(b) the Commission also considers that it should remain as a separate independent body and the main reasons for this are as follows:

   (i) people with a learning disability or mental health needs are vulnerable and need their own independent watchdog body;
   (ii) mental health and learning disability would become marginalised if the Commission were part of another HSS body;
   (iii) the Commission's focus is on people and not solely on measurable standards and services. HSS bodies that focus on measurable standards and services overlook the real issues of concern that can't be measured such as quality of life;
   (iv) the Commission is independent of Health and Social Services and is seen by its users as an independent arbitor. This independence will be diluted or lost if the Commission were a part of another HSS body.

Additional comments from the Commissioners present included:

> "nobody to champion needs of mentally ill and those with a learning disability if Commission wound up";
>
> "the new strategic plan will raise the profile of the Mental Health Commission and it will be more assertive";
>
> "one of the great strengths of the Commission is its multi-disciplinary membership";
>
> "need for independent body to review care and treatment of patients with mental disorder";
>
> "the Commission could be effective if it continued the best of the present and adopted the approach of the former Northern Ireland Hospital Advisory Service".

Mental Health Commission Strategic Plan 2004–2009

Commissioners, senior staff and representative carers/users attended a Strategic Planning Workshop on the 8–9 March 2004. The purpose of the Workshop was to:

(a) consider the Commission's external environment;
(b) evaluate the Commission's own resources;
(c) review the Commission's vision and mission statement;
(d) identify key issues that need to be addressed;
(e) establish the key priorities.

The outcome was as follows:

Mental Health Commission Vision - "to be the leading independent watchdog and advocate of people with a learning disability or mental health needs".

Mental Health Commission Mission - "to safeguard the interests and promote the well-being of people with a learning disability or mental health needs by keeping under review their treatment and care including the use of the Mental Health (Northern Ireland) Order 1986".

Mental Health Commission Values - "independence, objectivity, accessibility, confidentiality, integrity, accountability, empathy, person focused, outcome focused, quality focused".

Based on the new vision/mission statements, and values an environmental SWOT (strengths, weaknesses, opportunities and threats) analysis was carried out. The following were identified:

Strengths - strong multi-disciplinary organisation, well trained commissioners and staff. Good relationship with DHSSPS. Commissioner and staff interest in their work area, increasing involvement of users/carers.

Weaknesses - a low public awareness and community profile, low involvement of users and carers, lack of resources resulting in areas not being reviewed or being inadequately reviewed, poor data analysis, lack of clarity regarding role in complaints, low contact/engagement with areas outside mental health or learning disability services (e.g. primary care, education and criminal justice).

Opportunities - review of the Mental Health legislation, devolved government, voluntary advocacy, user and carer networks, build on second quinquennial review.

Threats - resource limitations, inability to review full spectrum of mental health care (e.g. primary care, unregistered homes, supported housing), inability to access patient records by all commission members. The HPSS Regulation and Improvement Authority (if roles/remits aren't clarified).

Nine key strategic priority areas are identified:

(i) review all hospitals;
(ii) review treatment and care in the community;
(iii) review complaints and untoward events;
(iv) review children's treatment and care;
(v) develop partnerships;
(vi) appointment of Part II / Part IV doctors;
(vii) information and communication;
(viii) reviewing prescribed forms/treatment plans;
(ix) maintain a corporate governance system that meets all statutory and accounting requirements.

Priority areas for review within mental health and learning disability were identified. These are listed in their entirety at Appendix 3. The Commission feels that due to lack of resources it can only review areas with priority 1, priorities 2–5 will not be addressed without additional resources.

WATCHDOG BODIES IN OTHER JURISDICTIONS

Considerable information was obtained about (i) the Mental Health Commission in the Republic of Ireland (ii) the Mental Health Act Commission in England and Wales and (iii) the Mental Welfare Commission in Scotland. All three are very different in relation to their stage of development. It is only possible here to present some key facts for each one.

Mental Health Commission in the Republic of Ireland

This body was established in April 2002 under the Mental Health Act 2001 and is just becoming fully operational in mid 2004. The Mental Health Act 2001 is largely focused on ensuring the rights of individuals who require compulsory admission and detention and does not specify entitlements to specific standards of care, this latter function being given to the Mental Health Commission. The Commission is responsible for protecting the rights of those detained under the Act but also for fostering and encouraging the establishment of high standards in the delivery of mental health care generally. The responsibility of the Commission with regard to quality of services is enabled through the appointment by the Commission of an Inspectorate of Mental Health Services and this Inspectorate is a substantive and well resourced body. The Commission has power to close down units which it feels are, for whatever reason, not delivering high quality care.

Thus the Mental Health Commission is independent, with investigative powers, the ability to enforce change, multi-professional, includes users/carers and is appropriately resourced.

The Mental Health Act Commission (England and Wales)

This body was originally established under Section 120 of the Mental Health Act 1983 to monitor the operation of the Act in respect of detained patients and to visit and interview detained patients in private. It therefore relates only to detained

patients and sees its mission as "safeguarding the interests of all people detained under the Mental Health Act".

The Mental Health Act Commission is one of four Commissions which merged to form the Health Care Commission (formally CHAI) in April 2004. At least initially the Mental Health Act Commission will continue to function much as before in relation to its statutory duties until the 1983 Act is repealed. The Mental Health Act Commission (formally at least) welcomes the streamlining of inspection of Health Care and recognises "the significant opportunities presented by the merger …… to improve the inspection, regulation and monitoring of services and in particular protections afforded to detained patients". The Commission is however concerned that the importance of visiting detained patients is recognised and welcomes the statement that the new body will "promote equal citizenship by ensuring that the wellbeing and healthcare of vulnerable groups including children, older people, people with learning disabilities and people with mental illnesses (particularly those detained under the Mental Health Act 1983) are fully reflected in our assessments and that their rights are safeguarded".

The Commission is optimistic that the integration of functions will provide an opportunity to enhance the protection of the rights of detained patients and sees the challenge of the next two years as making that opportunity real.

Mental Welfare Commission (Scotland)

The functions and duties of the Mental Welfare Commission are laid out in the Mental Health (Scotland) Act 1984 and the Adults with Incapacity (Scotland) Act 2000 and include:

- to protect persons who may by reason of mental disorder be incapable of properly protecting themselves or their interests and where appropriate to discharge persons from detention and to revoke community care orders;
- to enquire into any case where it appears there may be ill treatment, deficiency in care or treatment, or improper detention of any person who may be suffering from a mental disorder;
- to visit regularly anyone who is liable to be detained in a hospital and those subject to community care orders;
- to monitor people on intervention orders and visit appropriately.

These duties must be fulfilled until April 2005 when the new Mental Health (Care and Treatment) (Scotland) Act 2003 comes into force. Under the new Act the Commission shall continue as a body corporate known as the Mental Welfare Commission for Scotland but as well as retaining its broad protective function in respect of people with mental illness and/or a learning disability it will have greatly expanded duties and powers e.g.

- to promote best practice in relation to the operation of the Act and in particular in relation to observance of its principles, to monitor the Act's effect on the individual patients and carers across Scotland;

- to visit people subject to compulsory Orders including those subject to compulsory measures in the community; Commission doctors will have the power to carry out medical assessments if necessary on these and other visits.
- visit other people with mental disorder in a variety of settings at home and in hospitals, care homes, day centres and other health and social care settings across Scotland. The Commission will also have duties to visit mentally disordered people in prison and other criminal justice settings.

The membership of the Scottish Commission would indicate that there is a significant investment of resource in full and part-time commissioners and also in the professional and administrative staff available to support the work of the Commission.

MONITORING AND REGULATION IN NORTHERN IRELAND

Best Practice – Best Care (Consultation Paper August 2001) set out proposals for new arrangements aimed at providing high quality services in the HPSS including:

(a) a proposal to introduce a system of Clinical and Social Care Governance backed by a statutory duty of quality and supported by continuing professional development;
(b) a proposal to monitor the delivery of services through the introduction of a new independent body – a Health and Social Services Improvement Authority;
(c) A proposal to extend and improve the regulation of services;

Following the consultation period these proposals were accepted and enshrined in law by the **Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003.** Among other provisions the Order:

(a) establishes a new independent body, the **Northern Ireland Health and Personal Social Services Regulation and Improvement Authority** with overall responsibility for monitoring and regulating the quality of health and social care services delivered in Northern Ireland;
(b) introduces a statutory duty of quality to be placed on Health and Social Services Boards, Trusts and some special Agencies with regard to services they provide;
(c) gives the Regulation and Improvement Authority powers to review and inspect quality of services provided by the HPSS including evaluating clinical and social care governance arrangements designed to underpin the statutory duty of quality placed on HPSS Boards and Trusts etc.

The Regulation and Improvement Authority will replace the four existing Health and Social Services Boards Registration and Inspection units. A Chairman and Chief Executive have recently been appointed and Care Standards are currently being developed for regulated services consequent upon the establishment of a Standards Development Task Group. As yet there are no standards being developed for hospitals apart from independent hospitals and no specific mention of mental health services but the Order allows for the Department by regulation to confer additional functions on the Regulation and Improvement Authority as deemed necessary.

RECOMMENDATIONS OF THE WORKING GROUP

The Working Group has discussed, debated and deliberated upon the information and views outlined in this report and agreed the following:

- There is a very clear need for an independent watchdog body to monitor and regulate the services provided to people with mental ill health and/or a learning disability.
- This body should continue to be enshrined in legislation and any proposed review of the Mental Health Order should take cognisance of this.
- Whether such a body stands alone or is part of the Regulation and Improvement Authority the core requirements are as follows:

  - a clear remit which includes all patients/clients with mental disorder and/or a wherever they are and which is communicated and widely known
  - investigative powers
  - the ability to enforce change
  - strong leadership with executive authority
  - removal of the requirement for the Chairman to be from a legal background
  - incorporation of a range of professionals who are still practising (i.e. up to date) and a core team of permanent staff (for consistency); this would represent a mix of career and seconded staff
  - adequate representation of users/carers
  - any lay members should not be former health and social care professionals
  - development of advocacy role
  - fostering of good communication with patients, users and carers
  - fostering of continuous improvement
  - dissemination of best practice
  - open access to records subject to the recognised principles of confidentiality and data protection
  - proper funding and adequate resources
  - an appropriately skilled workforce
  - addressing priority areas already identified in the Mental Health Commission's Strategic Plan (2004 – 2009).

- The future watchdog body should become an integral arm of the Regulation and Improvement Authority known as the Mental Health Commission as long as :

  - the core requirements outlined above are honoured
  - strong service user and carer input is incorporated; a reference group of service users/carers representing the various sub-specialities should be set up
  - the remit is not limited to people detained under the Mental Health Order
  - the special needs of people with mental disorder and/or a learning disability (irrespective of where they receive their care) are included in the remit e.g. the community, supported housing, general hospitals, prison hospitals
  - the Commission should have its own budget
  - the executive head of the Commission must have a position on the Senior Management Team/Board of the Regulation and Improvement Authority
  - members should not only be multi-professional but should represent the different patient/client groupings (i.e. what is needed to do the task in hand)

- the Commission can approve a centre as being suitable for the care of detained patients
- the new/revised legislation should provide powers to the Commission to issue an improvement notice, powers of enforcement including closure where necessary.

Appendix 1

PERCEIVED STRENGTHS OF THE MENTAL HEALTH COMMISSION

1. Independence.

2. Commissioners are part-time and work in a Health and Social Care setting thus increasing credibility (part-time also a weakness however).

3. Inspectorial role (needs to be strengthened).

4. Regional overview of service provision (but do not exploit this sufficiently).

5. Hospital and Community visits (but need to be more focused and thematic, bringing in experts if necessary).

6. Lay membership (want real lay membership however).

7. Service user membership.

8. Committed secretariat.

9. Review of serious incidents (potentially good but needs to be developed).

10. Review of guardianship.

11. Scrutiny of prescribed forms (but needs to do this beyond the assessment process and also need more information about circumstances of detention).

12. Ability to refer cases to DHSSPS for remedy (needs to be strengthened).

PERCEIVED WEAKNESSES OF THE MENTAL HEALTH COMMISSION

Remit of Mental Health Commission

(a) Brief as described in the Mental Health Order is too broad to be meaningful. Need a specific remit which has authority within the new Legislation.

(b) Does not extend to community based services.

(c) Commission has "no teeth", just makes endless recommendations. The Trust reports are too "broad brush" and lack specific action points; in practice the reports do not make a difference.

(d) Inconsistent approach to reporting of e.g. suicides; Trusts have to report but GPs under no onus to do so.

(e) Some tables in annual reports are partial and misleading e.g. Suicide by Trust area related to (d) above.

(f) Boundaries with other bodies not always clear (e.g. Arms Length Inspection Units, former NIHAS).

(g) Lack of standards to inspect against; leads to inconsistency of approach.

RESOURCING OF MENTAL HEALTH COMMISSION

(a) The Mental Health Commission is not properly resourced to undertake necessary activities.

(b) It is not resourced to research best practice and disseminate same.

WORKFORCE/TRAINING

(a) There are no full-time Commissioners.

(b) Training for Commissioners is insufficient.

(c) CEO is in practice the Chief Administrator rather than a functioning Chief Executive. Policy is disseminated by the Chairman.

(d) Chairman is not full-time or even 50% part-time.

(e) Staffing structure in need of review.

CULTURE

Administrative structure is far too bureaucratic. The Commission has not been allowed to develop its own culture (secondments from DHSS).

DISSEMINATION OF INFORMATION

(a) Commission gets copious information about incidents but patterns/key learning points are not disseminated to the Trusts.

(b) Until recently only negative feedback given: good practice not disseminated.

SERIOUS INCIDENT REVIEWS AT TRUST LEVEL

(a) Commission takes these at face value although 95% of reviews recommend no further action. Commission should review records or at least do spot checks.

(b) General Practitioners are not involved in these reviews.

COMPLAINTS

There is a lack of clarity about how the Mental Health Commission deals with complaints and about overlap with Trusts.

RECORDS

(a) Review of Treatment Plans. Only Consultant Medical members can look at treatment plans.

(b) Non medical members do not have access to patient records (non clinical as well as clinical).

USER INVOLVEMENT/ADVOCACY

(a) There is a lack of user representation and a need to consider how best to involve users and carers.

(b) The Commission does not ensure that advocates (for all age groups) are available in each hospital and that their role is known.

(c) The Commission does not link sufficiently with advocates that are in place.

DETENTION

The Commission does not get background report about detained admissions (only the forms). The situation with guardianship is different.

VIEWS OF USER REPRESENTATIVE ON WORKING GROUP

- **Recruitment and selection of Commission**

There should be a service user on interview panels.

- **Training**

The Commission should have a training programme/strategy to train appropriate health staff about its role and function.

It should also use this opportunity to promote advocacy.

- **Independence**

Service users feel that independence of the Commission is essential. Service users are more likely to trust a totally independent body.

- **Monitoring of medication**

There should be a system in place for the monitoring of medication. There are examples when over prescription takes place (particularly in acute wards). This can be administered at dangerous levels.

- **Advocacy services**

The Commission should monitor the availability of local advocacy services, particularly in acute wards. They should also ensure they have clear lines of communication with advocates.

- **Legislation**

Legislation should be in place ensuring psychiatric patients are informed of the existence and availability of the Commission and local advocacy services. Monitoring of patients awareness of these services should take place.

Appendix 2

MHC STRATEGIC PLAN 2004 – 2009

Commissioners and staff identified all of the potential strategic areas that the MHC could deliver its Vision and Mission responsibilities. It was considered important that mental health and learning disability should be examined separately because of the different needs of these groups. Commissioners and staff prioritised each of the strategic areas of mental health and learning disability, from the highest (1) to the lowest (5).

Mental Health

The following priorities were agreed for mental health:

Priority 1

- Psychiatric Hospitals
- Community Facilities
- Supported Housing
- Community Mental Health Teams
- Assertive Outreach Teams
- Crisis Response Teams
- Detention
- Review of Treatment Plans
- Appointment of Part II and IV Doctors
- Second Opinions
- Guardianship
- Complaints and Untoward Events
- Child and Adolescent Mental Health Services
- Elderly Functionally Mentally Ill and Dementia

Priority 2

- General Hospitals
- Primary Care
- Brain Injury Services
- Autistic Spectrum Disorders
- Patient Advocacy Services
- Addiction Services
- Groups likely to lose contact with services (e.g. homeless, refugees etc.)
- People with communication problems (e.g. deaf people etc.)

Priority 3

- Prisons
- Juvenile Justice

Priority 4

- Day Care Services
- Forensic Services

Priority 5

- Respite

Learning Disability

2.1 The following priorities were agreed for learning disability:

Priority 1

- Learning Disability Hospitals
- General Hospitals
- Community Facilities
- Supported Housing
- Community Learning Disability Teams
- Detention
- Review of Treatment Plans
- Appointment of Part II and IV Doctors
- Second Opinions
- Guardianship
- Complaints and Untoward Events
- Day Care Services

Priority 2

- Primary Care
- Respite
- Autistic Spectrum Disorders
- Forensic Services
- Elderly Dementia
- Ethnic Groups e.g. Chinese and Travellers

Priority 3

- Patient Advocacy Services

Appendix 3

LIST OF BODIES CONSULTED

(other than those represented on the Group)

Northern Ireland Association for Mental Health

L.A.M.P (Life After Mental Health Problems)

Mental Health Review Tribunal

Health and Social Care Councils
(Noeleen Devaney attended a meeting of the four Councils)

Ombudsman

Equality Commission for Northern Ireland

Mental Health Commission in the Republic of Ireland

Mental Health Act Commission in England and Wales

Mental Welfare Commission in Scotland
(Mary O'Boyle visited this body in Scotland)

Appendix 4

PRESENTATIONS TO THE GROUP

Stephen Jackson, Acting Chief Executive of the Mental Health Commission - Mental Health achievements to date and vision of the future (14 January, 2004)

Jennifer Holmes, Project Leader, Standards Development Group, DHSSPS (15 April, 2004)

Stephen Jackson, Acting Chief Executive of the Mental Health Commission, plus four commissioners - Review of the Mental Health Commission – views of the Commission (17 June, 2004).

Appendix 5

DOCUMENTS REVIEWED

The Mental Health (Northern Ireland) Order 1986

KPMG Report – Quinquennial Review of the Mental Health Commission *DHSS May, 2001*

Mental Health Commission 7th Annual Report (2002/2003)

Mental Health Review – Summary of Main Points from Initial Submissions (January 2003)

Connecting Mental Health and Human Rights – Chapter 4, The Mental Health Commission *Northern Ireland Human Rights Commission December, 2003*

Best Practice – Best Care *DHSSPS May 2002*

Deloitte Report - Review of the Mental Health Commission's Organisation, Structure and Staffing *DHSSPS April 2004*

Mental Health Commission's Strategic Plan 2004 – 2009 (*Mental Health Commission March 2004)*

Letter from Stephen Jackson, Acting Chief Executive of the Mental Health Commission regarding the Review of the Mental Health Commission (June 2004)