Parliamentary News

(October 1985–March 1986: Part II)

Special Hospitals (patient abuse)

On 5 March Mrs Renée Short asked the Secretary of State for Social Services how many allegations of cruelty or abuse to patients in Special Hospitals had been made during the last seven years and what disciplinary procedures had been taken as a result. Mr Whitney replied that at Rampton Hospital a special police inquiry team was set up in May 1979 following allegations of widespread ill-treatment of patients. The police team which completed its work in May 1983 investigated more than 1,000 allegations, some of which related to incidents alleged to have occurred several years previously. As a consequence of that investigation 24 members of the staff of the hospital were charged with one or more offences. Of those 10 were convicted of one or more offences, three subsequently had their convictions quashed by the Appeal Court and a further five are at present awaiting the hearing of appeals to the House of Lords. Disciplinary procedures have been initiated in all cases of staff still employed at the hospital who were convicted, but that action is in suspense in those cases where the outcome of the appeal is still awaited. Between May 1983 and December 1985 51 allegations of physical cruelty or abuse were made to the Hospital managers. None of those resulted in disciplinary procedures. It is understood that the police were also continuing to receive allegations during that period, some of which repeated earlier allegations, but none of them resulted in prosecutions.

The position in the other three Special Hospitals in the seven years since 1979 to 1985 was as follows: Broadmoor Hospital—78 allegations of various kinds were made. Following preliminary investigation either to clarify the nature of the allegation or to establish whether there was any supporting evidence or corroboration 18 of these allegations were investigated more fully. In three of these cases the patients concerned referred the matter to the police. In 11 other cases the Hospital Managers asked the police to investigate and in one of these cases a member of the staff was prosecuted and sentenced to a term of imprisonment. Disciplinary procedures were taken in that case (resulting in dismissal) and in one other case. In addition, two members of staff were formally counselled by their professional superiors. Moss Side Hospital—there were 55 allegations. Twenty-three of these were referred to the police but there were no prosecutions. Disciplinary procedures were followed in three cases and in addition five members of the staff were formally counselled by their professional superiors. Park Lane Hospital—there were 10 allegations of which six were referred to the police for investigation. No prosecutions or disciplinary procedures resulted.

Scottish mental illness hospitals

The Scottish Secretary gave figures for the numbers of in patient beds in mental illness hospitals for each of the last seven years (6 March 1986). This indicated a decrease in the total number of beds from 17,577 in 1978 to 16,444 in 1984. Psychogeriatric beds had increased in number from 1,995 in 1978 to 3,208 in 1984. Adolescent beds remained approximately the same (79 in 1984), as did child psychiatry beds (102 in 1984), but mental illness beds had decreased from 15,379 in 1978 to 13,055 in 1984.

Drugs misuse and AIDS

Sir Bernard Braine, Chairman of the All Party Committee on Drug Misuse, on a Motion on the Adjournment of the House on 6 March raised the question of the transmission of AIDS virus through contaminated shared needles and syringes among drug users. The pros and cons of providing freely available clean syringes and needles was discussed and the Minister for Health gave the Government view on this matter, referring to the doubtful legality of supplying equipment when it might be used for illegal purposes and other issues.

Emergency psychiatric services

On 7 March in reply to a question Mr Whitney (DHSS) was asked to state which local authority social services departments do not provide a 24-hour emergency psychiatric service. He said that at present Bexley, Gateshead, Barnsley and Kent do not have such a service but the last two are known to be in the process of introducing one.

National Health Service (Management)

On 14 March Mr Steven Norris, (Oxford East) initiated a Debate on the National Health Service Management Inquiry of 6 October 1983 and the implementation of the major recommendations of the (Griffiths) Report.

Mental Health (Northern Ireland) Order 1986

On 17 March 1986 the House of Lords approved the Mental Health (Northern Ireland) Order 1986 which was laid before the House on the 28 January. It replaces and amends the existing mental health legislation which is contained mainly in the Mental Health (Northern Ireland) Act 1961. The Order gives effect to the proposals of

an interdepartmental working group which were largely derived from the recommendations of an independent committee set up under the chairmanship of a member of the Northern Ireland judiciary, Mr Justice McDermot.

Among the main provisions, Part I of the Order gives a definition of mental illness, the first time that mental illness has been defined in the United Kingdom legislation. A second change is the replacement of the term 'arrested or incomplete development of mind' by the term 'mental handicap'. There is also a category of severe mental handicap and a sub-category of mental handicap, 'severe mental impairment', (including an additional element of abnormally aggressive or seriously irresponsible conduct). The criterion for compulsory admission is rather more restrictive than in the 1961 Act and includes the concept of the substantial likelihood of serious physical harm as one of the two criteria for compulsory admission and detention. Part II dealing with compulsory admission to hospital and reception into guardianship introduces a new system of admission by Article 4, central to which is a period of assessment. All patients who are compulsorily admitted to hospital will be held initially for an assessment period of up to 14 days before a further decision is taken. This can be followed (Article 12) by a period of up to six months for detention for treatment. This is renewable for a further six months and then annually. Powers similar to Section 5 involving nurses in the English Act are also introduced. Similar guardianship powers to the English Act are also included. Part III deals with offender patients and follows very closely Part III of the 1961 Act but introduces a number of changes which reflect amendments to the law in England. There will thus be powers to remand for examination or treatment, but courts will continue to have the power to make a hospital order regardless of the availability of a hospital place although health and social services boards responsible for the administration of the admitting hospital will be given an opportunity to make representations to the court before an order is made. Restriction orders will only be imposed to protect the public from serious harm. Part IV is about consent to treatment and is very similar to the corresponding provisions in the English and Scottish legislation. Part V of the Order brings together the provisions relating to the Mental Health Review Tribunal and introduces a number of new measures designed to strengthen it and to increase the opportunities for patients to have their cases considered. Part VI provides for the establishment of a Mental Health Commission to protect the interests of the mentally disordered. The Commission will be an independent multi-disciplinary body of not more than 12 part-time members including the chairman and vice-chairman. Unlike its counterpart in England and Wales, the Mental Health Act Commission, the new body's role will not be restricted to detained patients. It will cover voluntary patients, people in guardianship, people in residential accommodation and indeed anyone suffering from mental disorder. The Commission will monitor the working of the Order, investigate complaints, visit patients, make reports to the appropriate authorities and it will have a discretionary power to require these authorities to provide it with information about the action they have taken as a result of any reports. Other functions of the Commission include the appointment of independent doctors and other persons to verify consent and provide second opinions, the appointment of doctors for detention procedures and a review of decisions to withhold patients' mail. Part VII deals with the registration of private hospitals and Part VIII is concerned with the management of the property and affairs of mentally disordered patients and replaces the existing law on this subject mostly contained in the Lunacy Regulations (Ireland) Act 1871. Part IX contains a Code of Practice and places a number of miscellaneous duties on the Department of Health and Social Services Boards. A duty is placed on the Department (Article 111) to produce, publish and keep up to date a Code of Practice for the guidance of professional staff concerned in the treatment of mentally disordered patients. The second is the duty placed on Health and Social Service Boards (Article 115) to appoint approved social workers. Part X deals with offences under the Act and Part XI miscellaneous matters.

Lord Prys-Davies commented that the National Schizophrenia Fellowship preferred the formal admission procedures in the England and Wales and Scottish Acts and the mental handicap bodies were disappointed that mental handicap should be included in the Order. There was concern that the Northern Ireland Order should contain different definitions from those in the other Acts. Lord Prys-Davies also considered that the new Commission should be given more powers and more resources. Lord Donaldson of Kingsbridge was concerned that differences in the Northern Ireland Order were being slipped through with very little opportunity to debate them.

In his reply to the debate Lord Lyell said that £200,000 has been made available by the DHSS in 1986–87 to cover the new Commission's costs. He said in reply to a point that had been made, that financial constraints had prevented an allocation of resources for a medium secure unit in Northern Ireland but, in addition, the Review Committee on the Services for the Mentally Ill (DHSS April, 1980) expressed doubts as to whether this is the best and most efficacious way of treating and rehabilitating severely disturbed patients. The Committee favoured the different course of providing appropriate care in high intensive nursing care units. On another point, the extension of legal aid to cover representation before tribunals was made in 1983 under the Assistance by Way of Representation Scheme.

Mental Health (Northern Ireland Consequential Amendment) Order 1986

A number of Acts of Parliament confined solely to Great Britain or to the United Kingdom as a whole required to be amended as a result of the changes introduced by the Mental Health Order. These amendments are included in this Order and were approved on 17 March 1986.

Welfare provisions for the multi-handicapped

On 26 March 1986 the House of Lords debated the above subject which had particular reference to problems addressed by the Disabled Persons (Services, Consultation and Representation) Bill which was recently introduced in the House of Commons by Mr Tom Clarke, MP. The full details may be studied in *House of Lords Weekly Hansard* No. 1320.

Adjournment

The House of Commons adjourned for the Easter Recess on 27 March until 8 April 1986.

The House of Lords adjourned for the Easter Recess on 26 March until 7 April 1986.

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Interim Guidelines on Consent to Medical and Surgical Treatment, Contraception, Sterilisation and Abortion in the Mentally Handicapped

Section for the Psychiatry of Mental Handicap

Questions about the ability of mentally handicapped people to give valid consent to medical and surgical treatment and the procedures to be adopted in obtaining such consent have been highlighted by the new Mental Health Act and recent court cases. As yet there are no definitive guidelines and the advice which follows is based on good and reasonable practice. In these difficult areas the principles of acting in good faith and duty of care in Common Law and, when in doubt seeking a second opinion, act to protect the individual consultant.

It should be noted that a consultant psychiatrist can only signify his agreement to treatment proposed for a patient in his care and cannot give legally valid consent. He/she should make this clear on any form signed and to the doctor who is to carry out the treatment.

The advice which follows primarily relates to mentally handicapped people resident in mental handicap hospitals or other NHS units.

Medical and surgical treatment

Many mentally handicapped people are able themselves to give valid consent to medical and surgical treatment if an explanation is given in simple terms. The legal requirements are that sufficient information has been given to the patient concerning the nature and possible complications of the treatment, having regard to the mental and physicial state of the individual. In doubtful cases it is the consultant psychiatrist's duty to make a clinical judgement as to whether or not an individual is able to give valid consent.

Where a mentally handicapped person is deemed unable to give valid consent although relatives cannot give legally valid consent for another adult, longstanding good practice has been to seek the agreement of the next of kin. If such agreement is withheld the consultant in charge of the patient should seek a second opinion from another medical colleague and then act in what he/she considers to be in the best interest of the patient. Where there is no next of kin the consultant psychiatrist in charge of the patient after consulting with other professionals involved in care and treatment should act in what he/she considers to be in the best interest of the patient.

Relatives should never be asked to sign a form of consent or agreement to emergency treatment on a 'blanket' basis. When emergency treatment is required and the patient is unable to give valid consent every effort should be made to obtain the agreement of the next of kin. If they cannot be contacted after reasonable effort the consultant in charge of the case should act in what he/she considers to be in the best interest of the patient and ensure that the relatives are informed of any treatment carried out as soon as possible.

Contraception

Contraceptive measures are only indicated in patients who are engaging in an active sex life or are deemed to run a high risk of sexual exploitation. The majority of mentally handicapped people to whom this applies are able to give valid consent to such measures. Nevertheless this is an