SUMMARY

This article discusses the findings of an exploratory study involving semi-structured interviews with a sample of Mental Health Act (MHA) Commissioners. MHA Commissioners are employed by the Care Quality Commission (CQC) in England to monitor patients who are deprived of their liberty under the Mental Health Act 1983 (as amended by the Mental Health Act 2007). The study was designed to examine the impact of the transfer of responsibility of mental health detention monitoring in April 2009 from the Mental Health Act Commission to the CQC. The interviews were devised around the United Nations Optional Protocol to the Convention Against Torture (OPCAT) framework, which provides a useful benchmark for effective monitoring of deprivations of liberty to national inspection bodies (known as National Preventive Mechanisms), such as the CQC. Article 18 of the OPCAT advises a regular system of preventive visits by independent expert monitors, as well focusing on the promotion and protection of human rights. There is paucity of data on the work of MHA Commissioners in England to date and the author was unable to locate any previous studies on the subject. This study is timely and important as the CQC has been heavily criticized following the abuses uncovered at Winterbourne View care home and in the wake of the Mid Staffordshire Inquiry. Consequently, in 2012, the CQC undertook a major strategic review. The findings of this study suggest that, whilst there is some evidence of compliance, the CQC still has some way to go to effectively fulfill its monitoring duties in line with the provisions of the OPCAT.

I. INTRODUCTION
The CQC is the independent regulator of health and adult social care services in England. All providers must be registered by the CQC and before the CQC will grant a licence to operate, the providers must show that their services meet the national essential standards for quality and safety. The CQC attempts to discharge this function by employing generic inspectors to visit providers at least once every two years, talk to the people who use it and the staff, observe how the care is provided and check the provider’s records. It can take enforcement action when providers are failing to meet the essential standards.

Protecting the rights of people who are detained under the Mental Health Act 1983 (MHA) is also a vital and distinct part of the CQC’s work. It has statutory responsibility to monitor deprivations of liberty under the MHA. The MHA permits compulsory detention in hospital and, in some circumstances compulsion in the community, provided certain criteria are met. This function was previously carried out by the Mental Health Act Commission (MHAC), which had been established in England and Wales to monitor, on behalf of the Secretary of State, the operation of the MHA in respect of patients detained in hospital. The MHAC’s work involved the deployment of independent Commissioners to carry out regular visits to all National Health Service (NHS) and independent hospitals and care homes in England and Wales where patients may be detained; check the legality of detention and interview patients in private to ascertain whether they are being treated appropriately and within the law. Commissioners would be allocated to a particular region and would be required to visit a range of facilities where patients are detained every 12-18 months. The MHAC adopted a proactive visiting regime involving routine announced and unannounced visits. In general, Commissioners would meet with staff, visit wards, chat to patients, inspect relevant paperwork to check the legality of detention and meet with individual patients in private to find out about the conditions of detention. Indeed, the patient interview was at the

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1 Introduced by the Health and Social Care Act 2008.

2 The essential standards are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

3 As amended by the Mental Health Act 2007. In Wales, the Healthcare Inspectorate has now taken over this monitoring role, as well as regulating standards of health and adult social care in Wales.

4 Scotland is governed by its own mental health legislation and has a similar specialist monitoring body - the Mental Welfare Commission. In Ireland, the presence of the Mental Health Commission is designed to ‘promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under [the 2001 Mental Health] Act’. S. 33(1) Mental Health Act 2001 (Ireland).
heart of its inspection work, as required by section 120 of the MHA. Commissioners were employed on a part-time basis and came from a variety of backgrounds, spanning psychiatry, psychology, social work and law as well as former service users. Having completed the inspection, Commissioners completed a report, provide feedback and make recommendations to the relevant unit/facility. Section 120 also gave the MHAC the power to investigate complaints, and assist with the production and revision of the Mental Health Act Code of Practice and Biennial report.

The MHAC did not have a broader function to regulate care standards in the same way as the CQC. Its key focus was on the protection of individual patients whose rights are restricted under mental health legislation, however it did comment more generally in its biennial reports on the conditions of care for patients detained in psychiatric settings in an attempt to drive improvements in standards. The reports also demonstrated a deep concern for human rights principles, which became an important feature of the MHAC’s safeguarding work. The Parliamentary Joint Committee on Human Rights praised the MHAC in 2007 for its ‘systematic approach’ to human rights. However, the MHAC’s remedial powers were limited as it could only investigate complaints when hospital managers had not been able to satisfactorily resolve the issue and it was unable to award any remedies to complainants. Furthermore, its role was hampered by its lack of enforcement powers. It could not compel providers to make specific changes and relied heavily on persuasion and the co-operation of mental health care providers to implement its recommendations.

The functions of the CQC remain the same following the transfer of responsibilities and Commissioners continue to perform their monitoring function in a similar vein. However, the CQC’s remit is much broader than that of the MHAC, as it can look at mental health patients who are admitted informally in hospital and in care homes, as well as patients who are formally detained. In addition, the CQC, unlike the MHAC, can take enforcement action if standards are not being met. The government’s rationale for the change was to enhance professional regulation, improve patient safeguards, create an integrated regulator and harmonise standards across health and adult social care. But critics were concerned that the move could impact negatively on the rights of service users and create an even greater

5 ‘The regulatory authority must make arrangements for persons authorised by it to visit and interview relevant patients in private’ (S. 120(3)).

6 ‘The Human Rights of Older People in Healthcare’, HL 156, HC 378, 2006-7 para. 188.
squeezed on limited resources. Some of these concerns have, to an extent, already been borne out, as the work of the CQC has been subject to considerable scrutiny and critique, both in the media and by politicians, government departments, public inquiries and parliamentary committees. For example, the National Audit Office commented that ‘against a background of considerable upheaval, the CQC has had an uphill struggle to carry out its work effectively and has experienced serious difficulties’. The organization was further criticized in February 2013 for its failure to protect patients from substandard care by the Mid Staffordshire NHS Foundation Trust Public Inquiry. Specifically, in the context of the CQC’s mental health monitoring function, there have been concerns about its capacity to fulfill its statutory functions under the MHA, particularly given the increasing numbers of detained patients in hospital and the community. And following the neglect and abuses uncovered by the BBC at Winterbourne View care home in Bristol in 2011, the CQC was censured for its failure to identify and target such mistreatment of patients with learning disabilities. These failings led to the resignation of the CQC’s Chief Executive, Cynthia Bower, in September 2012, a public consultation and major internal review of the CQC’s approach, which brought about recent changes to the CQC’s practices and guidance.


9 Amyas Morse, Head of the National Audit Office, 2 December 2011 located at www.nao.org.uk/publications/1012/care_quality_commission.aspx. See further NAO, Department of Health The Care Quality Commission: Regulating the quality and safety of health and adult social care, Report by the Comptroller and Auditor General, Session 2010–2012 HC 1665, published on 2.12.2011. The Parliamentary Health Select Committee has also been highly critical of the CQC’s overly tight timescales and resources, bureaucratic process and distorted priorities – see Session 2010-12, HC 1430 Ninth Report: Annual Accountability Hearing with the Care Quality Commission.

10 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry HC 947 (The Stationery Office February 2013). Located at www.midstaffs.org.uk. Additional criticisms of the organization were made in the Grant Thornton report into the CQCs regulatory oversight of the standards of care of maternity services at University Hospitals Morecambe Bay in June 2013 – see The Care Quality Commission re: Project Ambrose (Grant Thornton June 2013) located at www.cqc.org.uk/sites/default/files/media/documents/grant_thornton_uk_llp_morecambe_bay.pdf.


12 See for example ‘Reform the Regulators: What happened at Winterbourne view was a scandal against decency’, The Telegraph, 7.8.2012
The CQC has clearly faced considerable challenges and been subject to widespread condemnation. The evidence in the political and public domain to date suggests that the extent to which the CQC is able to provide a more effective monitoring safeguard is open to question. Drawing on the results of interviews conducted with a sample of MHA Commissioners, this paper explores the work of Commissioners and evaluates how their monitoring role has changed since the CQC took over. The research attempted to find out the extent to which the external perceptions of the CQC are evinced on the ground by some of those who carry out the monitoring work within the organisation. And, in particular, whether the CQC is meeting its obligations as a National Preventive Mechanism (NPM) under the OPCAT to patients who are deprived of their liberty. The UK government ratified the OPCAT in December 2003 and designated 18 institutions for the NPM in 2009, including inter alia, the CQC for England, the Mental Welfare Commission for Scotland, and in Wales, the Healthcare Inspectorate. NPMs are independent national bodies that have the mandate to conduct regular visits to places of detention, as well as to make recommendations and observations to the government and relevant authorities to improve the situation of persons deprived of their liberty. They have a key role in the prevention of torture by conducting regular visits to places of detention, and they also have a broader preventive function, which involves raising awareness and highlighting the issues of torture and OPCAT within the State.13

There is considerable variability within States about the choice of body as NPM. The UK is unique in that it has designated numerous organisations as the NPM, in contrast to other countries who have only one designated NPM, such as an ombudsman or national human rights institution. As some commentators have noted, ‘one size does not fit all’14 but the divergence of approaches has meant that NPMs have attracted considerable attention and challenge. For organisations, such as the CQC, which have a broader regulatory mandate in addition to their NPM mandate, it can be difficult to prioritize the NPM work and align the two functions. Nevertheless, it is clear that the unique NPM aspect of the OPCAT has ‘been seen as raising the most potential for improved implementation by the State’15 and research conducted by Rachel Murray et al into the implementation of the OPCAT suggests that


15 ibid. p. 115.
‘considerable expectations’ have been placed on NPMs to monitor and enforce it.\textsuperscript{16}

The focus to date has been very much on the NPMs visiting mandate, and the OPCAT’s Subcommittee on the Prevention of Torture (SPT) has produced guidance to NPMs on how this mandate should be discharged.\textsuperscript{17} The OPCAT expressly requires that such NPMs be designated by the State parties, and details some of the basic powers and protections necessary for a NPM to be effective. The key elements of that effectiveness are: a blend of appropriate experience and expertise of visiting teams; a regular system of preventive and unannounced visits and operational and financial independence from the State.\textsuperscript{18} The involvement of service users in inspection arrangements coupled with a focus on protecting human rights are also highly desirable in this context. Accordingly, the study design was aimed at exploring these aspects of the CQC’s mental health monitoring function.

**II. THE RESEARCH STUDY**

The project focused primarily on the work of Mental Health Act Commissioners (MHACs) and involved semi-structured interviews with a self-selecting sample of Commissioners and other employees working in the mental health division of the CQC. A self-selecting sample is quicker to recruit and it is generally easier to gain access to the participants. However, the study is relatively small in scale and there are obvious limitations to this approach.\textsuperscript{19} It will not necessarily be a representative sample and may be subject to bias, and is not therefore reflective of the experiences of all MHA Commissioners. However, the aim of the research was not to produce generalizable results, but rather explore the work of some Commissioners in depth. And given the paucity of data to date, the qualitative data presented here does provide some useful and interesting insights into the work of Commissioners and the impact the CQC take-over has had on their s. 120 monitoring role.

\textsuperscript{16} ibid.

\textsuperscript{17} SPT, *Guidelines on National Preventive Mechanisms*, CAT/OP/12/5, 9 December 2010. This is discussed in more detail later in the article.

\textsuperscript{18} Several concepts appear in Article 19 which are fundamental to the NPM – preventive visits; undertaken on a regular basis that form part of an overall system of visits; experts of the NPM should have the required capabilities and professional knowledge and the NPM should have functional independence from the State. Article 20 provides that NPMs should also have the opportunity to have private interviews with persons deprived of their liberty without witness and the liberty to choose the places they want to visit and the persons they want to interview. For further discussion of these key elements see E Steinerte, R Murray & J Laing, Monitoring those deprived of their liberty in psychiatric and social care institutions and national practice in the UK (2012) 16(6) *The International Journal of Human Rights* 865-882.

\textsuperscript{19} M Denscombe, *The Good Research Guide*, 4\textsuperscript{th} Edn (Open UP 2010) Chapter 10.
particular, the data sheds further light on the visiting methodology and extent of the integration with the compliance arm of the CQC. The data is further limited as the study did not include interviews with service users. This was not possible due to the timescale and difficulties in accessing patients who may have spoken to Commissioners, particularly those admitted on acute short-stay wards. In that sense, the data collected from the Commissioners relating to their perceived effectiveness in terms of impact on service users may be distorted. It should also be borne in mind that the comments are anecdotal, as it has not always been possible to verify their accuracy by independent/supporting evidence. However, some attempts at triangulation were made through observations, by checking interview content against other interviews for consistency and consulting supporting documents, where possible.

The interviews took place between January and October 2012. The interviews were voluntary and conducted on the basis that the identity of the participants would not be disclosed. Volunteers were sought via an email circulated to Commissioners and information about the study was also included in the Commissioner’s quarterly newsletter. The sample of 18 respondents represents 15% of all active Commissioners (there are currently approx. 100 visiting commissioners). They were drawn from a number of professional backgrounds, including social work and mental health nursing as well as CQC and mental health services/management/administration, and they were based across different geographical locations – ranging from cities to rural countryside across England, predominantly across the South West, South East and the Midlands. The sample did include a couple of Commissioners who were former service users. The respondents had varying levels of Commissioner experience – some were recent appointments (within the last 12-18 months or so) and others had performed the role for several years. After the initial email contact, arrangements were made to conduct the interview at a convenient neutral location. All participants were informed in advance about the purpose and scope of the research study and informed consent was sought from each participant before the interview took place. Participants were given an opportunity to withdraw from the study for a short period after the interview.

Each interview lasted between 60-120 minutes, depending on the time available to the interviewee and how much each interviewee wanted to say. All interviews were conducted on a face-to-face basis between the interviewer and participant. All participants agreed to be

20 It was apparent from the literature review that there is currently no data available about the direct experiences of patients/service users with MHA Commissioners/inspectors and there is clearly a need for further research in this area.

21 M Denscombe op cit. p. 189.
recorded. The data was coded using a numbering system and stored securely in accordance with Data Protection legislation. The recording was transcribed and a copy of the transcript was sent to each participant and checked for accuracy prior to the data being used in the study. It is important to establish trust and rapport between the interviewer and interviewee. Accordingly, each participant was asked in a general way at the start of the interview about themselves and their role. Each respondent was prompted to explain his/her own background, professional expertise, how long they had worked as a MHA Commissioner/CQC employee and how / why they had chosen to take on the role. They were then asked the following broad trigger questions as a guide to the discussion, bearing in mind the key aspects of the s. 120 duty and the OPCAT monitoring framework:

- Explain your role as a Commissioner in terms of visiting methodology, contact with patients, staff & relatives/carers, reporting structure etc. Please clarify the proportion of announced/unannounced visits that you carry out and whether you have carried out any joint visits with service users and/or compliance inspectors.
- Are you aware of any relevant international/national human rights issues/standards, particularly the requirements of OPCAT for NPMs, and/or HR guidance from the CQC and to what extent does it inform your day-to-day monitoring & inspection work?
- Describe your relationship with the CQC compliance team – co-ordination and protocols; joint visits /reporting; communication and information exchange; has there been any formalization of the roles/responsibilities?
- What initial training did you receive to help you to perform the role? Do you receive any on-going support and training? If so, what form does it take – frequency, content etc and from whom?
- Can you provide specific examples of how you affect change/’make a difference’ to patients? Do you think that patients value your monitoring work and the opportunity to talk to you? What about the staff perception of your role?
- Have there been any recent/are there any potential changes to the role, such as to visiting methodology? How do you feel about them and the future of your monitoring role?

The interviewer modified the questions for other CQC mental health division employees and asked the participants supplementary questions as required, to clarify and expand on their answers during the course of the interview.

The transcripts were analysed and the main findings are summarized below. It was apparent that, at the time of the study, there were a number of internal organizational changes.
taking place within the CQC, and many of the Commissioners in the study were uneasy with this and concerned about the future of their role. During transitional periods a degree of uncertainty is to be expected and this may have impacted on the nature of the responses during the interview. The CQC was also facing trenchant criticism from certain official bodies, the public and the media during the course of the study, which may also have impacted on staff morale and the perceptions of the interview sample. Nevertheless, a number of recurring themes have emerged from the narrative accounts of the respondents, indicating that the issues are shared among the wider group. These themes are outlined below, and some tentative conclusions may be drawn from them about the CQC’s approach to monitoring mental health under s. 120 and its compliance with the OPCAT.

III. THEMES EMERGING FROM THE STUDY

A. The ‘Make-Up’ of MHA Commissioners

The MHAC prided itself on the breadth and depth of expertise of the Commissioner body. They were recruited from a diverse and broad range of professional backgrounds and brought with them a corresponding standard and quality of expertise. As one participant in the study commented: ‘Commissioners…. have a whole range of backgrounds and skills’ (Interviewee 3) and commentators have described the MHACs workforce as comprising ‘a notable array of specialist expertise’. 22 Significantly, the distinctive role of MHA Commissioners has been retained within the CQC and they continue to monitor the care of people detained under the MHA. The mental health monitoring function would appear to be distinct from the CQC’s broader regulatory work, as recommended by the UN Subcommittee on Prevention of Torture (SPT) 23 in its Guidelines for National Preventive Mechanisms. 24 The Commissioners’ specialist role has thus far been preserved, however, the findings of this study suggest that there has been a dilution in the breadth of expertise of the Commissioners in recent years. Previously, it was a truly multi-disciplinary approach, involving significant social work, clinical – psychiatry, psychology and pharmacy input, - as well as those with a


23 The SPT is established under OPCAT to promote and monitor its implementation as well as having a preventive mandate to conduct its own visits to monitor all deprivations of liberty in States parties and provide advice and assistance to NPMs.

24 ‘Where the body designated as the NPM performs other functions in addition to those under the Optional Protocol, its NPM functions should be located within a separate unit or department, with its own staff and budget’ CAT/OP/12/5, 9 December 2010, para. 32, available on http://www2.ohchr.org/english/bodies/cat/opcat/mechanisms.htm.
legal background. The workforce now is less diverse and predominantly comprised of social work/mental health nursing, with much less clinical and legal involvement. As one participant in the study surmised: ‘I would suggest now the Commissioners are more likely to be social workers or nurses or Mental Health Act Managers. You will find very few lawyers, there is a handful these days’ (Interviewee 16).

Appropriately qualified nurses and social workers do have important skills and knowledge about mental health and the application of the legislation. Nevertheless, this contraction is unfortunate, as it is essential to bring diversity of knowledge and a breadth of expertise and experience to the visiting role, particularly from an OPCAT perspective. The requirements of Articles 18 (1) and (2) of the OPCAT state that the NPM should ensure that its staff has between them the diversity of background, capabilities and professional knowledge necessary to enable it to properly fulfil its NPM mandate. In the context of monitoring mental health deprivations, this should include, inter alia, relevant legal and health-care expertise (emphasis supplied). As one interviewee remarked, it is important to preserve the blend of expertise as it ‘brings credibility to the role’ (Interviewee 3), which helps to promote respect and co-operation from patients and staff.

Some respondents felt that this change to the complexion of the workforce had already started before the CQC took over, and may be explained by the fact that lawyers/doctors would be less likely to take on the role now due to changes in pay/working conditions. Also, employers may be less willing to release them from their regular job to perform the role:

‘Back [in the mid-1990s] you would have had much more latitude in employers releasing people for two days a month and seeing it as part of their sort of career development… There’s less of that happens these days and people find that if they want to be a Commissioner they have to do it in their annual leave or they have to work part-time and do it in the other half of their week when they are not working, so I think those were fundamental differences’ (Interviewee 16)

This interviewee also felt that ‘the role lost a lot as a result of the loss of those other professions’. Some respondents commented on how much they valued the advice and support from other Commissioner colleagues, particularly those from a different professional background/discipline. It was clear for some that peer-support assisted them to perform their

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25 The SPT has suggested that the NPM approach should be ‘multi-disciplinary’ and the involvement of psychiatric/medical expertise is crucial in helping to identify the practical signs of abuse – R Murray et al op cit p. 135
monitoring role and deal with certain issues which may fall outside their professional knowledge and competence: ‘… I do think that’s really important, you learn so much from each other’ (Interviewee 15). Indeed, the shift in Commissioner expertise and dilution of legal input in particular may well have had an adverse impact from a human rights/OPCAT perspective, as those with a trained legal eye may be able to focus more critically on potential human rights breaches and legal deficiencies.

The benefits of this shared expertise and knowledge exchange is exemplified in the following quote:

‘it was enormously helpful to have a psychiatrist on hand where you could say – “is this right?” You know, “this amount of medication?” Or a lawyer there… there are nuances in how something works statutorily and they would give a different perspective all the time, social workers similarly giving a different – “well, what about the carers?” you know… you shared one another’s expertise, you gained strength from that’. (Interviewee 16)

In fact, this was perceived to be the greatest and most valuable source of support and advice: ‘I used to learn a lot from that, from peer work’ (Interviewee 15) and ‘there was some induction and training but the main support was from your team members…. I was very open about my service user experience and they were very supportive’ (Interviewee 13). It was also felt by many in the study that there was a lot of ‘on the job’ (Interviewee 4) learning: ‘I think the most learning took place when you were actually doing the visit’ (Interviewee 15). Given the part-time, challenging and potentially ‘isolating’ nature of the Commissioner role, these findings reinforce the need to provide robust support to Commissioners from the centre as well as by the area/regional team managers - Mental Health Operational Managers (MHOMs). It was felt by a few Commissioners in the study that the quality of support provided by the CQC to Commissioners was variable and some relationships with MHOMs were poor: ‘I don’t think the management of the Commissioners has been terribly consistent and some Commissioners need more management than others’ (Interviewee 16). For one particular respondent- ‘my main gripe is lack of support’ (Interviewee 8). There is arguably a need for the CQC to focus on providing quality and consistency in this regard, as well as promoting recruitment from a broader range of relevant professions, especially those with a legal and clinical background, in order to ensure that the CQC’s obligations as a designated NPM are adequately fulfilled and the organisation commands sufficient respect and authority among the sector.

B. Visiting methodology
By and large, the focus on the patient interview and visits to detained patients would appear to have been preserved by the CQC. This is important from an OPCAT perspective, as provided in Article 20(d): NPM’s should be given ‘the opportunity to have private interviews with the persons deprived of their liberty’. Commissioners are still carrying out regular visits to units and meeting directly with detained patients: ‘We continue to see patients on a regular basis’ (Interviewee 2). Indeed, this was felt by the respondents to be an integral aspect of the s. 120 role: ‘Patient perspectives and interviews with patients is the priority’ (Interviewee 3); ‘I think the focus on visiting is the really important aspect and the nature of how we fulfil the remit, I think that is the most important thing’ (Interviewee 2) and ‘it is really important because you’ve got to have some idea of what life is like for people on the ward’ (Interviewee 8). Yet many respondents in the study were still concerned about the future of the mental health inspection/monitoring role. They were worried that the s. 120 focus on individual patient experiences could, in time, become lost within the broader CQC regulatory framework/objectives. This concern has been voiced by other researchers who have commented that NPMs who also have non-NPM remits (such as the CQC) have got to balance their NPM commitments with their broader mandate, which can pose significant challenges.26 In the words of one respondent in this study:

‘it is certainly not a tick box approach to interpreting section 120 but very much thinking about people’s experience, thinking about what it is actually like to be on a ward…. there is potentially a tension in the role between talking to people and looking at documents…. as we moved into CQC and linking with compliance inspectors in terms of creating and understanding the boundary between the [two]…I think we are still working that one out really’ (Interviewee 3).

Another echoed these sentiments: ‘The patient interview is important. It is at the heart of our work and we must never lose that… My personal view is if you are spending more time watching a computer screen than talking to a patient the balance is wrong and at the moment I think we spend too much time searching records ’ (interviewee 5). Others felt that there was a difference in the approaches taken by the commissioners and compliance inspectors to their respective functions: ‘The focus for Commissioners is very much for individual patients and their experiences and how you can help them and to me it seems that compliance take a broader view of what conditions are like generally and don’t want to go down to that level’ (Interviewee 6). This is further demonstrated by these quotes: ‘the thing about the Mental Health Act functions it’s a different piece of legislation, it’s fundamentally different, it’s about individual rights so it’s about monitoring the implementation of the [MHA], It is

actually different from the role of regulation’ (Interviewee 17) and ‘I could see how it should work in theory, and for me there was a clash of approaches that, in terms of focusing on individual patient experiences, as opposed to what you call box ticking in a way and the different style of intervention’ (Interviewee 10).

This ‘clash of approaches’ may have been exacerbated during the period of the study, as the CQC was, at the time, in the process of devising and introducing new visiting methodology and documentation for MHA inspections. As described by one interviewee: it is ‘an attempt to map out the Mental Health Act and say in our monitoring role what should we be looking at’ (Interviewee 3). As a consequence, several respondents were concerned that the essence of the s. 120 duty i.e. focus on interviews (i.e. qualitative monitoring) would be replaced by a less preventive and quantitative (i.e. tick box) approach:

‘I think we did a lot of qualitative monitoring and not enough quantitative monitoring and so, of course… the balance needs to be shifted but I would be sad if that was lost completely because it tells you an awful lot about the participation of patient and the respect for patients and whether people are listened to and whether they are given a platform to speak’ (Interviewee 1).

Some expressed the view that recent changes to their working conditions and visiting methodology had already impacted negatively on the amount of time they felt they could spend meeting/talking to patients and staff during a visit: ‘We visit less than under the old regime’ (Interviewee 1) and there was a perception now that ‘it is process driven and paperwork driven, I think we have become too paper orientated, too bureaucratic… at the expense of clients’ contact,’ (Interviewee 15) and ‘Probably ticking more boxes now. …I don’t see as many patients’ (Interviewee 5).

This shift is also reflected to an extent in the CQC’s Annual Mental Health Act Monitoring reports.\(^27\) Four have been published so far and they all contain far less detail and depth of analysis, in comparison with the MHAC’s biennial reports. As one interviewee observed ‘there is no richness in the story of [the CQC] reports’ (Interviewee 4) as the focus now is more on key issues, rather than providing a comprehensive and detailed examination of the operation of the mental health legislation. This may be due to the fact that the reports are required on a more regular annual basis. But it could be indicative of the fact that the time spent with patients collecting such data has diminished or that the information is no longer assimilated centrally within the CQC. There is also an indication in the monitoring reports

\(^{27}\) Available on the CQC’s website: www.cqc.org.uk.
that the total number of annual visits by Commissioners has declined since the CQC took over,\(^{28}\) which echoes the views of some of the respondents in the study.

In light of the CQC’s obligations as NPM it is crucial for the organisation to preserve the focus on qualitative monitoring and ensure frequent direct visits/contact with patients and service users. As provided in the UN SPT Guidelines for National Preventive Mechanisms: ‘The State should ensure that the NPM is able to carry out visits in the manner and with the frequency that the NPM itself decides. This includes the ability to conduct private interviews with those deprived of liberty and the right to carry out unannounced visits at all times to all places of deprivation of liberty, in accordance with the provisions of the Optional Protocol’.\(^{29}\)

Another aspect of the visiting methodology emerged from the responses in the study, in that it was apparent that there was some variability in approach to the monitoring/visiting role among the participants. As Interviewee 16 noted: ‘I know that there has been huge variability even within teams never mind different parts of the country there has not been consistency’. Whilst this does reflect individual styles and approaches, and provides flexibility and the ability to tailor visits to particular units/institutions and types of detained patients, it also creates inconsistency and uncertainty. This ‘hit and miss’ approach (as described by Interviewee 1) was recognised by other respondents in the study:

‘I was given an enormous amount of autonomy in terms of how I manage my time, when I’d visit and to some extent how I did the visits and in some ways that was valuable, but I think what it also allowed the development of very many different ways of doing the job and also inconsistencies’ (Interviewee 3).

The CQC should therefore strive to harmonize the monitoring role, whilst at the same time respecting the particular demands of the s.120 duty and the professional skill and judgement of Commissioners. It is vital to achieve the right balance to the monitoring function, as another interviewee suggested: ‘To me it’s having a framework, a clear framework but some flexibility’ (Interviewee 17).

\(^{28}\) In 2012/13, the CQC carried out 1,502 specific Mental Health Act inspections and met with 4,478 detained patients (CQC, Monitoring the Mental Health Act in 2012/13 (CQC 2014) p. 7). During 2011/12, the Commissioners carried out 1,546 visits and met with 4,569 patients in private (CQC, Monitoring the Mental Health Act in 2010/11 (CQC 2011). In 2009/10, the Commissioners met with 5,078 patients, made 1,711 visits to wards, around 1 in 3 of those visits were unannounced and 9% took place at the weekend (CQC, Monitoring the Mental Health Act in 2009/10 (CQC 2010) p. 16).

\(^{29}\) CAT/OP/12/5, 9 December 2010, para. 25. (Emphasis supplied).
Indeed, the value of adopting a more homogenous approach to visiting was recognised by some of the respondents in the study: ‘…some of the more structured responses to gathering data and doing something with it were clearly needed for more consistency’ and ‘…there is a lot of proposed new methodology and papers..... A more consistent approach. That is very welcome… which has been a bit hit and miss in the past’ (Interviewee 10). This could tie in with the SPT guidelines on good practice and visiting methodology for NPMs, which has been mentioned above.\textsuperscript{30} Greater uniformity of approach to visiting could also be achieved by providing more effective and consistent management of Commissioners, as highlighted in the previous section: ‘[managers] should be supervising and monitoring….I don’t think the management of the Commissioners has been terribly consistent and some Commissioners need more management than others and that’s the same anywhere’ (Interviewee 16).

The CQC appears to be focusing on a combination of announced and unannounced visits, which is important from an OPCAT perspective – to ensure that there is a balanced approach of pro-active and reactive visits. However, some respondents were concerned that the balance may now have shifted too far in favour of unannounced visits, which can be counter-productive in some mental health settings, such as rehabilitative or disability units, for example. As one Commissioner commented:

‘I think there are specialist areas where [unannounced] doesn’t always work like disabilities because if you turn up on the day when the speech and language therapist isn’t there or the patients aren’t prepared for you, you get less out of the visit’. (Interviewee 4)

Others felt that it was important to preserve announced visits so that patients are given an opportunity to prepare and meet with inspectors: ‘the drive will be towards most being unannounced but that is problematic if you are going to certain places where people want to see you and they have already planned to go out’ (Interviewee 7); ‘If people don’t know you are coming, the visit can’t be managed’ (Interviewee 3) and ‘I think it can create a feeling that somehow you are trying to catch people out and the other big disadvantage for me with very few detained patients is you can roll up and discover they don’t have any detained patients on that day so you’ve made a completely wasted visit’ (Interviewee 8). One respondent also observed that ‘things get cancelled for patients because we have turned up unannounced’ (Interviewee 4). Respondents stressed that there is a need to maintain some announced visits in a mental health context, perhaps to arrange professional support such as an interpreter or

\textsuperscript{30} Ibid. para. 5 and pp. 5-6.
speech/language therapist: ‘if you are visiting a specialist deaf unit where you might need
interpreter support’ (Interviewee 3); in a rehabilitative unit where patients may be out during
the day, or a forensic/high secure setting where short term notice is required. As encapsulated
in the following quote:

‘I must just say that I have had complaints made about doing unannounced visits by
the patients in forensic because they like to know when you are coming because if
they have got a full work programme or they are on leave, if they are out for the day,
we come and we have gone… And it is not the best way of getting material from staff
as well, because if you want to speak to senior staff then they are not necessarily
there’ (Interviewee 1).

The CQC’s ability to impose sanctions, take enforcement action and require providers to
make improvements was welcomed by some: ‘I mean that is one good thing about the CQC if
we’re allowed to do our jobs properly that we have got teeth now and we can make providers
behave and … that is long overdue’ (Interviewee 8) and ‘Now the sanctions that are available
and the pressure that is available to seek the wider aspect of the CQC are indeed much more
likely to have beneficial results’ (Interviewee 2). Yet, several respondents were concerned
that the CQC’s enforcement approach is a double-edged sword, which could prove counter-
productive and have a detrimental impact on their relationship with providers/units. As one
participant remarked: ‘if you use teeth it is punitive. I’m aware that enforcement action
around the [MHA] there has been some but not a lot, it’s been sort of piecemeal, but… is that
the best way to achieve change?’ (Interviewee 17). Several respondents valued the strong
relationships, respect and trust that they had nurtured with providers and felt that it enhanced
their credibility and boosted the likelihood of co-operation from unit staff. Experience
documented here suggests that the MHAC was able to effect change at a local level for
patients in a more persuasive and informal way, based on the respect and trust which had
developed over time between visiting Commissioners and patients/staff. As one respondent
observed: ‘I actually think that throughout the tenure I served informal, gentle encouraging
persistent persuasion from a base of knowledge and expertise probably had as much influence
as the regulator with the enforcement power’ (Interviewee 16). Staff too could benefit from
the Commissioner’s involvement in this way, perhaps by drawing the management’s attention
to staffing levels, training needs or conditions in the ward:

‘… [ward staff] would say that because they felt that in certain circumstances they
would talk about issues in a management meeting and they would not get that much
progress… but if they say to the Commissioner they will get more weight to pursue
the argument with the management… a range of all sorts of issues about bed
occupancy will be one, staffing levels will be another one, staff training another one… [and] annual leave allocation’ (Interviewee 15)

Some of the evidence in this study would suggest that, whilst the MHAC was often criticised for not being able to enforce change, the reality may have been rather different in terms of Commissioners being able to nurture trust, respect and relationships with staff and providers to implement their recommendations in a more subtle and less ‘punitive’ way. As one interviewee explained:

‘[the MHAC] were certainly able to demonstrate that something positive happened as a result of a lot of the action points… It was getting user feedback so even if it was just having better information about rights or the food so I think there were lots of examples where day-to-day experience of people who used services was improved by a Mental Health Act Commissioner visiting... The Mental Health Act Commission had a big thing, some issues that you shouldn’t be deprived of their daytime clothing so that doesn’t happen now. It seems a small thing but I think it’s just one that had contributed to a change that considers more the rights of a person or the experiences of a person… Just thinking of that example, the impact of that is quite significant’ (Interviewee 17)

So it would appear that the MHAC may have commanded some respect from staff and patients on the basis of ‘expertise and knowledge’ rather than ‘power’. Of course, whilst developing strong relationships and trust is important, there is a corresponding risk of developing too cosy a relationship with providers, which could impact on the quality of monitoring. This was explicitly recognised by one Commissioner in the study: ‘I felt that there was a considerable danger of (to use a better word) colour blindness that if you are going to the same place year in and year out… what am I not seeing here?... has it got too cosy?’ (Interviewee 14). This can distort priorities, resulting in the promotion of the interests of the providers/staff above those of the patients/public and also lead to complacency and ‘colour blindness’ during visits. Some respondents acknowledged that they were aware of these dangers: ‘I was very alert to it and I think most Commissioners are… But I mean having had a social work profession it’s, that’s one of the things that is beaten into you’ (Interviewee 16); ‘I managed to recognise the danger before it became a danger, a potential for an increased familiarity which might have taken the edge off objectivity’ (Interviewee 2) and were mindful of the need to minimize it: ‘I... should move and cover a different patch because after four or five years there is a danger you get too close to people you are working with and I thought it would be an idea to move’ (Interviewee 10).
One final point relating to the visiting methodology emerged from the interviews, in terms of following up recommendations and measuring the ‘impact’ of visits. The UN SPT Guidance to NPMs states that there should be clear and effective systems in place for making recommendations and following up implementation post-visit.31 There seemed to be a degree of uncertainty and lack of clarity among some respondents about the existing process for submitting visit reports, how that is fed back to the unit/providers (as well as to generic compliance inspectors) and subsequently monitored: ‘The annual statements, we wrote them last year but we were asked not to write them this year, we are told that the relationship with the provider is through compliance so we are meeting less and less with the senior managers and doctors’ (Interviewee 1). There are also concerns that some issues are not picked up by either compliance or commissioners and may fall within the gaps: ‘there does seem to be a gap in the middle between the monitoring standards overall and the detail of individual patients and individual wards’ (Interviewee 1). This points to the need for the CQC to promote greater clarity and consistency in this regard to ensure effective follow-up, in line with the SPT guidance. This could be facilitated by more systematic data collection and central co-ordination.

C. Human Rights Focus and Service User Involvement

The CQC has stated that it has a strong commitment to equality and human rights,32 which is obviously especially important where there are deprivations of liberty. It should be the bread and butter of the inspection work of Commissioners and was recognised as such by some of the interviewees: ‘Equality and human rights is the core business, that is what we do’ (Interviewee 1) and ‘a potential breach of the Human Rights Act is something that [the providers] would take notice of’ (Interviewee 8). This was undoubtedly one of the strengths of its predecessor, the MHAC.

The CQC’s ‘rights based’ approach is certainly evident in the rhetoric of the regulator, although the findings of this study would suggest that it is not so apparent in the reality of the day-to-day work of the Commissioners. As other researchers have noted:

‘Even if one is lucky enough to have an institution which on paper complies with OPCAT requirements, in reality, as research on the performance of [National Human

31 Op cit Para 38.
Rights Institutions] has shown, many other factors come into play in determining whether it has any impact on the ground.”

For example, there was limited awareness among many participants of any CQC human rights guidance for inspectors and/or relevant international human rights standards/obligations, such as the OPCAT or the UN Convention of the Rights of Persons with Disabilities (CRPD): ‘... certainly it doesn’t feel like to me like there has been any specific human rights training for commissioners’ (Interviewee 4). Several interviewees opined: ‘I haven’t been given any training [on a human right scheme]’ (Interviewee 1); ‘I don’t know what the scheme is’ (Interviewee 1) and ‘I think that as an organisation, we haven’t given much profile to be honest to our OPCAT responsibilities to date’ (Interviewee 3). This is disappointing, as the SPT Guidelines to NPMs suggest that: ‘The Recommendations of the NPM should take account of the relevant norms of the United Nations in the field of the prevention of torture and other ill-treatment’. Other researchers have identified the difficulties faced by NPMs who may have to balance their NPM commitments with broader mandates, particularly where that broader mandate, for example, an ombudsman, ‘is premised on receiving complaints or maladministration’. However, it should be easier to assimilate the two when the wider mandate and ethos is focused on human rights, as should be the case with the CQCs broader regulation and inspection work.

Indeed, the majority of participants in the study indicated that they were firmly committed to human rights issues and were aware of the need to focus on basic human rights and protections whilst carrying out their visits. However, this seemed to be dependent on the individual Commissioner and their professional knowledge and personal commitment to human rights, rather than any central guidance/direction from within the CQC. As one participant remarked when questioned about this: ‘that’s been diluted and dwindled and remains with individual Commissioners but that isn’t where it should be, it should be with the organisation’ (Interviewee 16) and another stated: ‘I do know about human rights but I haven’t had any training from the CQC about it. I just know about it because of my teaching so I am aware of it and I am aware that the CQC is a public authority and the obligations are.

33 R Murray et al op cit. p. 137


35 Op cit para. 36 (Emphasis supplied).

36 R Murray et al op cit p. 123
I am curious about whether it should be a little bit more explicit’ (Interviewee 7). There was also a lack of awareness among participants of the CQCs specific NPM monitoring role under the OPCAT and/or how it links to the MHA monitoring function.

The MHAC was not designated as a NPM under the OPCAT, and so the transition to the CQC and added NPM responsibility may have been unclear or confusing for the Commissioners, especially if it was not made apparent to them at the time. The evidence presented here suggests that Commissioners have been told very little, if anything, about the CQCs role under the OPCAT or the need to focus on international human rights standards as well as domestic law/policy. It is equally unclear whether the organisation itself is aware of the need to focus on the OPCAT responsibilities as distinct from the MHA monitoring role, or whether the OPCAT simply provides a mandate for a function which was already being carried out under s. 120. Consequently, there is a need for awareness of the NPM function to permeate more deeply throughout the monitoring work and for the CQC to make this more explicit to its front-line inspectors. The results of this study also suggest that awareness of the internal CQC human rights guidance is poor among those discharging the monitoring function. Moreover, the current guidance makes passing reference only to the CQCs obligations under the OPCAT (and other UN human right instruments, such as the CRPD). It is heavily predicated on the European Convention on Human Rights, which is a useful benchmark, but is not a panacea.\(^\text{37}\) It would be helpful for the CQC to provide greater focus and clarity to Commissioners on other international human rights standards and the OPCAT guidelines, to assist them to discharge their inspection role in line with those provisions. There is clearly a need for more human rights training here. This would also achieve a degree of consistency and uniformity of approach to the monitoring function and promote a greater level of engagement with substantive international human rights standards on the ground.\(^\text{38}\)

As one interviewee remarked: ‘in terms of equality and human rights I think there’s a real commitment to it… but it is still early days’ (Interviewee 17). These findings echo those of other researchers. For example, a study into the Dutch Healthcare Inspectorate found that the NPM tends to use national standards, but awareness should be raised about the international ill-treatment standards and the organisation’s designation as a NPM should be made more explicit to all stakeholders.\(^\text{39}\)

\(^{37}\) Ibid. p. 39

\(^{38}\) As recommended in the NPM Guidelines by the UN SPT, op cit para. 36.

\(^{39}\) V L Derckx, *Implementing the Torture Convention: protecting human dignity and integrity in healthcare: The functioning of the NPMs in the Netherlands with respect to persons deprived of their liberty residing in healthcare settings* (University of Groningen 2013).
An important aspect of the SPT guidance relates to the composition of NPMs, promoting human rights and ensuring a sufficient blend of expertise and experience. In that respect, it is essential to promote service user involvement in monitoring and inspections. Services users bring the benefits of their personal experience to the inspection and could pick up on issues, which may be invisible to inspectors without first-hand experience of detention. Patients may also find it easier to open up and share their experiences with former services users. Increased integration of patients and service users in regulatory and inspection work was also strongly recommended by the Mid Staffordshire Inquiry report.40

Participants in the study seemed to value the input of service users enormously and welcomed their involvement in the inspection process. A small number of the Commissioners in the sample were themselves former service users, and other Commissioners had carried out joint inspections with service users: ‘...[it] was terribly useful.... she’s had so much experience of being in hospital and although I can empathize and I know what to ask and I have learned a lot over the years talking to patients, it’s not the same as being locked up yourself (Interviewee 8) and ‘I have done three visits with [a service user] …[it was] very very worthwhile, it was such a learning experience. It made me see things that no matter how passionate I am and how critical I am....I am still a provider and so I tend to identify with staff. So going with the person has made me realize, just think about what it is like to live here, you know. So that was enormously helpful’ (Interviewee 6). It was also perceived by participants to be important for the patients to have an opportunity to talk to service users/former service users during the inspection: ‘What was also useful was service users joining us in visits... They have a different, unique perspective which comes out of their own experience of being detained... It was quite reassuring for the clients that they had someone who was actually speaking for them as far as possible’ (Interviewee 15). There was also evidence among some of the participants in the study of a strong commitment to promote greater service user involvement:

‘it is very much my desire to... find stronger ways of representing the user voice through everything that we do around the Mental Health Act and thinking about our OPCAT responsibilities... I think we have to root our reporting of our activity and indeed how we subsequently design our activity in that user experience’ (Interviewee 3).

The CQC does appear, in principle, to be committed to this objective, as promoting service user involvement forms an integral part of its Equality and Human Rights Scheme.\textsuperscript{41} This has been reinforced in the CQCs most recent Mental Health Act Annual Report, which states that there is an expectation that service users will have ‘a central voice in the planning and delivery of care and treatment’.\textsuperscript{42} This will be achieved in a number of ways, including continuing to consult with service users on the Service User Reference Panel (SURP)\textsuperscript{43} about their experiences and including former service users on the Experts by Experience inspection programme. The programme includes approximately 300 former service users who are trained to help the CQC carry out its inspections. This commitment is echoed by some of the study findings: ‘I think the really fundamental part of the CQC that has been there from the outset, which is still there, is about making sure that the voices and experience of people using services actually influence the regulatory judgements. We’ve got lots of examples of that being done well…. The CQC findings are very much informed by the experience of the person using or receiving the service and I think there’s a sort of general principle that works very well’ (Interviewee 17). This is certainly a positive sign and goes some way towards promoting OPCAT compliance and awareness of patient perspectives in discharging the monitoring role.

\textit{D. Collaboration with compliance}

Crucial to the CQCs success as an effective monitor is the extent to which the joint arms (compliance and mental health) are working together effectively. As noted by one respondent:

‘… it is clearly a policy direction that the two will work more closely together, not least to share knowledge and share information… It is really important to link in to the regulatory function and equally that the Mental Health Act Commissioners understand how the regulatory function works so that where there are intractable issues that have been rehearsed over and over again with a particular provider, or particularly worrying issues that we use the enforcement powers of the Health and Social Care Act to demand change’ (Interviewee 3).

\textsuperscript{41} CQC, \textit{Equality and Human Rights Scheme Review of our progress in 2010/11: Priority 1 (July 2011)} located at \url{www.cqc.org.uk}.

\textsuperscript{42} CQC, \textit{Monitoring the Mental Health Act in 2012-13} (CQC January 2014) pp. 8 & 80.

\textsuperscript{43} The SURP is a panel of 20-30 members who have experience of being detained. The CQC seeks the panel’s views on a number of different issues, including strategy, methodology and information for the public.
It was encouraging to hear that the benefits of joint working with the compliance arm of the CQC were recognized by several respondents in the study: ‘...there is the other work force, the compliance work force working under the Health and Social Care Act which must demand that we rethink our role because it would be crazy to be going out there and all looking at the same thing... it is beholden on us to think about how best we use the resources and skills that we have in a way that doesn’t duplicate what one is doing’ (Interviewee 3) and ‘I am happy to work with them and surprisingly they are very much like us’ (Interviewee 5). But there are indications that it has worked better in some areas than others, which is summed up in the following quotes: ‘... experience of working together has varied enormously...[and] the awareness of [the joint working] protocol amongst the compliance inspectors will also be variable’ (Interviewee 3), and ‘if you interviewed Commissioners from different parts of the country you would get different responses... and I think that is down to CQC structures in that particular region... it was haphazard would be the best way to describe it but not through lack of will’. (Interviewee 16)

Indeed, there was a wide range of responses on this issue ranging from: ‘My experience is actually probably pretty positive, because I have a number of joint visits. ..I think I have built up a really good working relationship with [the compliance inspector]. ...we compare reports before we send them to the provider so that has worked really well’ (Interviewee 4) and ‘I think it is really useful if compliance inspectors and Mental Health Act Commissioners can do joint visits because I think it brings the two functions together. At our regional teams people from the compliance unit will come and that has been incredibly helpful’ (Interviewee 1); to more negative reactions: ‘...theoretically we are working together with compliance but they are doing their own thing and we are told to tell them what we’re doing’ (Interviewee 13); ‘... it is a bit of one way traffic’ (Interviewee 5); ‘I understand and appreciate and welcome the potential for integration but as far as I am concerned, which may be entirely to do with me, well largely, it hasn’t happened yet. ...My personal experience is extremely limited’ (Interviewee 2) and ‘I don’t know why the compliance relationship is so poor in this neck of the woods’ (Interviewee 14). These findings echo those of other researchers who have highlighted the challenges of joint working and collaboration in the public sector, due to cultural and professional differences and overlapping boundaries.44

One respondent felt that ‘the link with [the compliance arm of] the CQC is still being worked out, it’s still very nebulous’ (Interviewee 13). But it is essential to align visits,

promote joint working and ‘pool our findings’ (Interviewee 1) to avoid duplication and ensure that issues do not fall in the gaps. It is also crucial to provide mutual support, as many respondents reported feeling ‘lonely’ and isolated (Interviewee 4) and uncertain about the future of their role within the CQC and would welcome joint working: ‘it is a very lonely role and it can be very difficult and very stressful and very isolating so I certainly would have welcomed doing joint visits and would indeed try to organize joint visits’ (Interviewee 3). This clearly signals a missed opportunity (thus far) to align and strengthen the monitoring and regulatory functions of the CQC and bridge some of the gaps mentioned here.

E. Staff and Patient Perceptions: Making an ‘impact’?

Although Commissioners’ powers are limited in that they are unable to discharge patients, having the opportunity to talk to an independent visitor was perceived by the Commissioners in the study to be appreciated by some patients: ‘Most people seem to want to like the opportunity to talk to somebody’ (Interviewee 13) and ‘it is almost like a therapeutic informal form of counselling if you like and a rehash of their rights’ (Interviewee 15). Of course, it must be remembered that the study did not include service users’ direct experiences, so this evidence is purely anecdotal and unverified.

The CQC publishes very little evidence of its ‘impact’ for patients. Other research studies have pointed to the paucity of data and difficulties of evaluating impact in this context. This was recognised by one of the respondents in the study: ‘I do not think we are very good at collecting examples of where we have made a change or where we have made a difference… the outcome for the individual, the impact of our visits for the individuals’ (Interviewee 3). In fact, it was felt by some respondents that assessing the ‘impact’ of an inspection, or outcome of a visit for patients, is easier in some settings than others:

‘I think in particular like the high secure and maybe the medium secure where a relationship was built up because the patients stayed there a long time whereas in acute units or community units patients move on more and more quickly’ (Interviewee 17).

Moreover, it was felt to be easier to cite examples of ‘impact’ at a local or individual level, as opposed to responses to systemic failures, which are more difficult to measure/quantify, as one of the Commissioners explained: ‘more systemic failures are more

45 See for example J Laing & R Murray, An international comparative review of monitoring mechanisms for mental health legislation (Care Quality Commission 2013).
difficult for the patients to see the results of aren’t they, when we take those up and possibly have some success’ (Interviewee 14). In the words of one Commissioner in the study:

‘I think the times when they have felt helped ……obviously we are seeing them, as you know, privately and if they raise issues in relation to their immediate care on the ward which are mainly personal to them, then I invariably say shall we call in the Ward Manager and talk about this, the three of us. And I facilitate that sort of discussion.’ (Interviewee 14)

In this way, Commissioners felt that they were able to effect change for patients (and staff too) and make an impact at a local or individual level, as well as discharge their visiting function under s.120. The SPT Guidance to NPMs stresses the importance of following up on the implementation of recommendations to assess the impact of visits, and this would seem to be occurring with some MHA Commissioner visits, albeit on a more informal or ad hoc basis. The responses provided by the Commissioners in the study suggests that the CQC did not appear to be collecting or collating this data on a regular or systematic basis, but it would be an important and useful exercise to undertake to ensure a degree of follow up, in line with the SPT guidance. Some participants in the study did provide examples where informal discussions with hospital staff had led to changes/improvements in relation to the day-to-day life of patients on the wards, particularly about food/mealtimes and privacy. For example, one participant described how his involvement led to the discontinuation of offices being used as bedrooms for patients in one unit, due to concerns about privacy and patient safety – there was inadequate heating and a lack of privacy due to internal glass panelled doors. And another said: ‘And so I’ve sort of been able to sort it out to make sure somehow they get cosmetics or whatever they need so that’s an example where I’ve made a difference and they said so and a patient somehow wrote a letter saying, thanking me and then saying, and bringing up some other issues as well’ (Interviewee 11). Another specific example included asking staff to put ‘privacy film’ on exterior windows for patients: ‘that was one issue that I got resolved, in fact they put a privacy film on all exterior windows because patients in the garden from another ward were able to look into the bedrooms’ (Interviewee 8).

And the following provide further examples from participants of the issues that seem to matter to individual patients:

‘The issues that I pick up on, and it’s a bit of a sort of dialogue between me and the patients… prescriptions in particular, I go to quite a few low secure units and things like use of mobile phones, they can’t use mobile phones, but sometimes patients

46 Op cit para. 38.
complain about it, sometimes they don’t. Searching, routine and random searching wherever they go, even if they’ve been escorted. They can’t get out in the garden area without an escort, even though it’s fenced in and very safe. You never know, they might have an escorted leave out in the community, and they’re not allowed to go out into the garden, its issues like that’ (Interviewee 11).

Another opined:

‘that conversation with a patient, that finding out what goes on on your ward today, what happens every day…. Those conversations were just hugely valuable because you’d really find out what happened on that ward some patients would just say “well actually just having the nurse knock on the door would be kinda nice…” if you’re detained on a ward you can’t leave it, you’ve got no opportunity to control how your life is conducted, the one thing you could have control over is privacy then I think that its part of the monitoring role’. (Interviewee 16)

One Commissioner suggested that: ‘we were certainly able to demonstrate that something positive happened as a results of a lot of the action points.. It was getting user feedback so even if it was just having better information about rights or the food so I think there were lots of examples where the day-to-day experiences of people who used services was improved by the MHAC visiting’ (Interviewee 17). These matters may not appear particularly significant, yet they are of extreme consequence to patients: they affect their basic human rights, such as privacy and dignity as well as the environment and tolerability of day-to-day life on the wards. The issues are also relevant to the s. 120 monitoring role, as they relate to the care and treatment that is provided under the MHA. As one participant remarked:

‘if somebody comes into the hospital under the detention of the Mental Health Act they are coming in for this notion of availability of treatment, so treatment means environment, staffing, diet, place of safety, activities, psychotherapy, talking therapy and then the definition of treatment in the Mental [Health Act] as you know is very, very broad…. having a safe environment…. meaning having enough staff, ligature proof rooms, safe environment meaning having activities to do, having proper diet, having proper rest, safety, dignity, privacy - all these are about treatment’ (Interviewee 15).

47 ‘Medical treatment’ is broadly defined under s. 145 of the MHA as including nursing, psychological intervention, specialist mental health habilitation, rehabilitation and care in order to alleviate, or prevent a worsening of the patient’s disorder, its symptoms or manifestations.
There are indications however that some of these matters are perceived by the CQC to be more appropriately dealt with and monitored by the generic compliance inspectors, according to the published quality and safety standards. This points to potential tension and ‘overlap’ in the roles and highlights the need for effective and clear integration (‘we need to be clear about who does what, where there is discretion and where there isn’t’ (Interviewee 1)) to ensure that there is no duplication or that issues do not ‘fall between the gaps’ (Interviewee 4). As one participant observed: ‘I feel sometimes a little bit embarrassed because compliance have been in and actually covered the same ground, might have covered the same ground as I’ve covered’ (Interviewee 11).

Commissioners do tend to visit more frequently than generic compliance inspectors, they have specialist and expert knowledge of mental health services and legislation (unlike the generic inspectors), and they try to spend longer talking directly to patients. In which case they are well placed to gather evidence about care and treatment standards on the wards to feed into the CQC’s overall regulatory function. This approach is also incredibly helpful in terms of delineating and fulfilling the CQCs mandate as NPM, where the focus is intended to be on the conditions of detention and prevention of torture and inhuman treatment. As some interviewees said: ‘We can pick up on what [the patients] are telling us and feed that back to change things in the ward’ (Interviewee 11); ‘We have a much more detailed approach to the Mental Health Act but a lot of it is transferrable from the standards, especially the stuff around care planning and [patient] involvement and so on’ (Interviewee 1) and Commissioners regularly encountered ‘real privacy and dignity issues or engagement issues’ (Interviewee 4) on the wards. Establishing and communicating clear joint working protocols to staff is imperative – so information can be shared effectively among the different inspectors to ensure that issues do not fall within the gaps and that there is a joined up approach to both functions. There was some evidence that the CQC has already published a joint working protocol in an attempt to promote collaboration and delineate boundaries, but awareness of the protocol among participants was variable: ‘I have seen the protocol but I think there is some feeling that a lot of people hadn’t, so I don’t know whether that just depended on what area you are in’ (Interviewee 4), and in some cases, non-existent: ‘Well I

48 For example, Standard 2 relates to patients receiving care and treatment which is appropriate to their needs; Standard 3 relates to patients feeling safe and Standard 1 requires patients to be treated with respect and be involved in their care and support.

49 ‘They don’t visit as frequently as we do.... We are told that the relationship with the provider is through compliance.... yet certainly the providers I visit say compliance are too remote.’ (Interviewee 1)
am aware that there ought to be …I have to say it hasn’t reached us as far as I am concerned’ (Interviewee 2).

There would appear to be concerns among some Commissioners in the sample that the unit staff perception of them (and the CQC) is different now and is ‘less of a kind of co-operative relationship… I mean a regulator is there to regulate and it does shift when you’ve got power, it will shift… it’s a different respect [now], it’s a respect of power not of expertise and knowledge’ (Interviewee 16). This may impact negatively on the ability of Commissioners to command respect/trust and effect change in the subtle way described above. As one interviewee remarked:

‘I also think that the Mental Health Act Commission certainly had a status with providers whether they be NHS or private providers….your conversations with senior managers started to change and certainly the back end of that second year and third year [after the CQC took over] I would say relationships changed a lot between the Commissioner and, not necessarily the ward staff but the managers above that, they were much more challenging’ (Interviewee 16).

Conversely, another participant felt that the CQC now had a more potent effect as it ‘tends to install a sense of doom more than the Mental Health Act Commission did, so I think people recognise, staff recognise that the CQC is a force to be reckoned with rather more than the Mental Health Act Commission was’ (Interviewee 2). Some Commissioners however reported that ward/unit staff may be ‘confused’ (Interviewee 16) about the relationship between MHA Commissioners and generic inspectors: ‘they confuse us with [compliance] inspectors’ (Interviewee 4). Again, there is obviously a need for greater clarity to be provided to the sector and the CQC’s own inspectors on the relationship between the two arms of the CQC and their respective functions, especially the significance of the NPM role.

IV. CONCLUSION

Dame Brenda Hale opined that the MHAC would be a very ‘hard act to follow’ and the findings from this study would suggest that she was not far off the mark in her prediction. The findings presented here suggest that the CQC does still have some way to go to discharge its monitoring functions in an effective manner in line with the OPCAT.

From an OPCAT compliance perspective, there are some positive signs, such as a continued commitment to involve service users in visits/inspections; the maintenance of a regular and preventive visiting regime and the preservation of expertise in discharging MHA

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inspections. There is also evidence of some integration and joint working with compliance (although it is somewhat ‘haphazard’) and some anecdotal evidence, which suggests that a subtler, more collaborative approach to monitoring can be perceived as effective in bringing about change. It is often key in establishing trust and good working relationships with providers, which can be productive and beneficial for both patients and staff. In the wake of the Mid Staffordshire Public Inquiry, it is crucial to promote trust and openness within the NHS. And the CQC should endeavour to convey how it is building trust and making this type of ‘impact’ more clearly to its staff, patients and the wider public.

However, there are indications from this study that the transition has not been without difficulty. Commissioners have reported feelings of isolation and doubt about the future of the role, as well as a lack of support. Significantly, there is great uncertainty among Commissioners about the CQC’s role as a NPM. It is clear from this study that some CQC inspectors are unaware of the organisation’s specific functions in this regard or how that responsibility differs, if at all, from the s. 120 monitoring role. The results of this study suggest that Commissioners have been discharging most aspects of the NPM role, though perhaps more by accident than design, through the system of regular visits and detained patient interviews under s. 120. And by looking at broader issues of care and treatment during inspections, they are able to monitor conditions of detention and focus on inhuman treatment. Other researchers have alluded to the fact that for many NPMs, it is often perceived to be ‘business as usual’, but the NPM mandate requires additional resources and OPCAT ‘adds a different strand to the visiting mandate’. In that sense, the OPCAT NPM responsibilities and how they link in with the s. 120 duty, should be made more explicit to frontline staff.

It is also significant that concerns were expressed by several Commissioners in the study about some of the changes to the visiting methodology – in particular the apparent shift towards a more tick-box approach and the perceived diminution in direct contact with patients. This is regrettable, as the patient interview is at the core of the s. 120 duty and is crucial to maintain from an OPCAT (Article 20) point of view. The responses of the sample suggest that there are also currently inadequate systems in place for following up recommendations and assessing the impact of visits, and this is another area of concern, as it is recommended by the SPT in its Guidance to NPMs.

In response to some of the external criticisms of the organisations, the CQC embarked on a strategic review towards the end of 2012, part of which involved a public consultation. This engagement with the public, patients and providers is significant and

51 R Murray et al op cit p. 119.
suggests that the organisation is willing to promote service user/patient involvement and an inclusive approach to its work. The new strategy was launched in April 2013 and the overall focus has been placed on increased service user involvement and promoting patient rights. The regulator is taking positive steps to publish better information for the public, introduce national teams with specialist expertise and develop new standards of care. Specifically, with respect to mental health monitoring, there is a commitment (on paper at least) to strengthening patient rights in line with the OPCAT requirements and to align more closely the mental health and mental capacity oversight. Some of the findings from this study have demonstrated that awareness of the OPCAT and/or the CQC’s specific NPM role among some front-line inspection staff is patchy and/or inconsistent. To date, there has been limited engagement on the ground with substantive human rights standards or the OPCAT requirements and little practical guidance offered by the CQC. The CQC’s new strategy also pledges to continue to involve people with direct experience of mental health care more extensively in the inspection and monitoring work, through the Experts by Experience programme. There is also a commitment to improve the training and guidance to front line staff. This emphasis on training is crucial and is also recommended by the SPT in its guidance to NPMs, as there is some anecdotal evidence from this study with regards to confusion about boundaries, roles and responsibilities as well as some lack of central support and guidance. The strategy has been bolstered in a mental health context by further commitment to expand Commissioner expertise and integrate the compliance/mental health monitoring functions. Moving towards a more collaborative approach is clearly necessary and desirable. So too is the CQC’s fresh commitment in the strategy to including ‘professional experts’ from ‘the range of disciplines’ to carry out mental health inspections, including doctors, psychologists, pharmacists, and ‘other therapists’, although legal experts (as recommended by the SPT) are not included on the list.

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52 See further [www.cqc.org.uk](http://www.cqc.org.uk)


54 Ibid. p. 22. See also CQC, *A fresh start for the regulation and inspection of mental health services* (TSO 2013) p. 11.

55 Ibid. p. 21.

56 Op cit. para. 31.


58 Ibid. p. 11.
The new strategy is promising. There are signs that the CQC is committed in principle to clarifying and improving the monitoring system and OPCAT compliance and is already taking steps to remedy some of the deficiencies. It is also important to clarify public/staff expectations of the organization and try to eradicate confusion about roles/functions as well as support front-line staff. Plans to increase integration and merge findings in a single report for providers\(^\text{59}\) will certainly assist with this process. However, the strategy is suspiciously silent on the precise details of the new approach. There is very little indication of how many extra visits will be carried out for detained patients and what inspectors will be focusing on during the visits. In that respect, it is unclear to what extent the new strategy will remedy the concerns expressed here about the diminution in visits and apparent shift towards a more quantitative approach. There is also very little detail in the strategy about how the CQC will be assessing the impact of its monitoring role and following up recommendations. As highlighted in this article, these are key areas where further development is required for the CQC to strengthen its protection for detained patients in line with the OPCAT. The CQC should also send out stronger signals about the value of the MHA inspection team (both internally and externally) and create a positive working environment to benefit all stakeholders. Most importantly, as the OPCAT suggests, the organisation must ensure that qualified and experienced mental health inspectors/visitors continue to provide adequate protection for an extremely vulnerable group of patients. Commissioners do seem willing to embrace the changes and work together with the compliance arm of the CQC to better protect patients: ‘I think it could be very positive if we were given the resources and the support to do all this new stuff’ (Interviewee 7).

The need for an effective monitoring body is even more germane following the recent Health Committee’s post-legislative scrutiny of the Mental Health Act 2007.\(^\text{60}\) The Committee’s report suggests that there has been a sharp increase in the number of formal admissions under mental health legislation and inappropriate use of the legislation as a route to obtaining in-patient treatment: it would appear that ‘being detained is the ticket to getting a bed’. So the presence of effective, independent expert monitors in line with the OPCAT to check the legality of detention and visit patients on a regular basis is imperative.

\(^{59}\) Ibid. p. 10.

\(^{60}\) *First Report: Post Legislative Scrutiny of the Mental Health Act 2007*, Session 2012-13, HC 584 at p. 3, para. 27.