King's Fund

2 November 2004

Clerk to the Scrutiny Committee, Draft Mental Health Bill 2004

House of Commons

London SW1A 0AA

Dear Sir

DRAFT MENTAL HEALTH BILL

We are grateful for the opportunity to submit comments to the Scrutiny Committee. The King's Fund is an independent charitable foundation working for better health and health care, with a special focus on London . We carry out research, policy analysis and development activities, working on our own, in partnership and through development grants.

The Fund is a member of the Mental Health Alliance, the grouping established in 1999 to comment on the Government's proposals to reform the Mental Health Act 1983. We support the views set out in the Alliance's submission to the Scrutiny Committee.

Without repeating the Alliance's views, there are some issues we believe are particularly important, and we comment on these below. Our comments are informed in particular by the findings of our major Inquiry into London's mental health services, published in 2003, *London's State of Mind.* These demonstrated that although good mental health services exist, there are still serious problems facing many people with serious mental health needs who are being failed by the present system, including those who are subject to mental health legislation.

What should a new Mental Health Act do?

The Government is clear that "The purpose of mental health law is to protect patients and others from harm that can arise from mental disorder" (*Improving Mental Health Law: Towards a new Mental Health Act, Summary*, September 2004). New legislation is certainly needed to update the Mental Health Act 1983, partly to reflect changes in practice and partly to address breaches of human rights legislation. Unfortunately the Government has followed traditional thinking about mental health law. It should have started from the premise that patient and public protection is best served not just by measures taken in certain limited circumstances when a patient becomes seriously ill, but by setting out duties to provide good care from an early stage of illness. This it fails to do.

The Bill therefore starts from the wrong perspective. Rather than tackle issues of patient care and support, it focuses on risk and dangerousness. At a time when the Government is

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promoting the cause of patient choice, the Bill introduces new powers to restrict choice for some patients living in the community, even when they have the capacity to make decisions for themselves.

Similarly, the Bill does little to support the Secretary of State's assertion that he wishes to ensure the NHS is genuinely a health not an illness service, and that everything should be "geared towards preventing illness".

In adopting this approach, the Government is missing a real opportunity to introduce powers and duties that would tackle the wider issue of public health mental health. For example, it fails to introduce a right to an assessment of mental health needs - not just an assessment for compulsion at a point of crisis - and to have assessed needs met. At the same time, the Bill removes the specific Mental Health Act 1983 duty on authorities to provide aftercare services following discharge from compulsion until they are no longer needed.

We know that earlier intervention and consensual aftercare would mean that fewer people would reach a stage where they could become a danger to themselves or others, and that, as a result, compulsory powers would be required less often.

Community-based treatment Orders

One of the most controversial aspects of the Bill is the introduction of community-based treatment Orders. The Committee will be aware that powers already exist under the Mental Health Act 1983 for extended leave and guardianship, together with supervised discharge powers that were introduced in 1995. All of these allow for a patient to be in the community under some form of restriction or obligation. We believe it would be a useful for the Committee to explore with the Department of Health and mental health professionals why these current provisions are not widely used and why the Government does not consider them adequate to deal with the problems of patient and public safety.

In addition, the Committee may be aware of the considerable literature that has been published over the last 20 years or so on the introduction of community-based Orders around the world (primarily from Australia, New Zealand and the United States). The findings from studies in this area suggest that there is still considerable uncertainty on whether community-based orders are effective and in what circumstances. Again this may be a fruitful area to pursue.

Our analysis suggests such Orders may work for a small number of people when they are backed by well developed community support services. But the research also suggests that if there are good community support services then introducing community-based Orders makes little or no difference to outcomes. In other words, it appears that it is the services that are crucial rather than the Orders.

One area that does concern us is the impact these Orders may have on the overall levels of compulsion with the system. This is a topic that does not appear to have been researched in any depth and at present we do not know how many more people might be subject to compulsion under a community-based Order system, compared to the number subject to compulsion at present. The Government has said that it is not its intention to increase the number of people under compulsion. But along with other critics of the Bill we have real worries that patients who are not now subject to compulsion may find themselves drawn into

the system. We are currently undertaking a small study into this area based on similar systems in other countries and hope we may have some findings to submit to the Committee before it reports next March.

Workforce

There are significant resource issues linked to the Bill, the most evident being the apparent shortage of staff to ensure the new procedures are properly implemented. The main groups involved are consultant psychiatrists to participate in Tribunals; community psychiatric nurses and other community staff to monitor people living in the community under a compulsory Order; and the new statutory advocates.

The Committee will be aware that similar (though not identical) new legislation has already been passed in Scotland and will come into effect in 2005. A Scottish National Mental Health Services Assessment of March 2004 concluded that "There are not enough staff to make the Act work, especially psychiatrists, mental health officers and advocacy workers..... The Review Team found that..... there will be difficulties in implementing [the Act] and significant changes and developments will be needed".

Such problems are also very likely to be met in England and Wales. According to the Department of Health's own figures (NHS Workforce Vacancy Survey, March 2004), there are significant vacancy rates in England among consultant psychiatrists (9.6%, that is 334 whole time equivalents, the largest percentage shortfall among any group of medical staff), yet it estimates that the new legislation will need an additional 130 psychiatrists (page 134 of the Explanatory Notes to the Bill). The Tribunal arrangements set out in the Bill would be impractical without this significant increase.

There are also shortages of psychiatric nurses, with the Department of Health figures showing community psychiatric nurses with 1.9% vacancies (235 wtes) and "other psychiatry" nursing staff with 4.7% vacancies (1,282 wtes) in England. The Department of Health estimated need for the Bill is for an extra 110 nurses. Should the Bill become law then community psychiatric nurses would have a major role in monitoring whether people subject to compulsion in the community were adhering to their care plans.

On top of this, there is the introduction of a right to statutory advocacy. While welcome, this will involve the recruitment and training of a whole new category of staff. The Department of Health estimates 140 will be required for England and Wales. Even assuming that the number of people under compulsion remains broadly the same after new legislation is passed as today (there were 46,900 detentions under the 1983 Act in 2002-03 in England alone according to the Office of National Statistics Bulletin 2003/22), this would seem to give each advocate an impractical workload.

While we are aware of the Government's plans to meet the workforce implications of the Bill, we are not convinced this has been properly thought through.

Positive aspects of the Bill

However let us conclude on a positive note - the Bill does contain some welcome provisions, including the right to statutory advocacy, the change from the nearest relative to a nominated person and a more regular Tribunal system. We hope that the Committee will be able to build

on these aspects and recommend amendments to the Bill to produce something that will help create a modern mental health system that encourages early intervention and supports those with mental health problems, thereby creating a service that protects patients and the public alike.

I hope these comments are helpful - if you require anything further from us please do not hesitate to get in touch.

We are happy for this submission to be in the public domain.

Yours sincerely,

Niall Dickson

Chief Executive