The Mental Health (Amendment) Bill

Bill 8 of 1997/98

Research Paper 97/138

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Dr. Julian Lewis MP's Private Member's Bill, the *Mental Health Amendment Bill*, is due to be debated on Second Reading on 12 December 1997. Its aim is to improve access to in-patient psychiatric facilities for people who do not meet the criteria for compulsory admission but who are still in need of "sanctuary". This Paper discusses the background to the Bill, including the changes in mental health legislation over the past hundred years, the shift from providing care in institutions to a policy of "care in the community", the current pressure on in-patient psychiatric beds, and conditions in psychiatric units. It then describes the Bill clause by clause and summarises the responses that have been made to it by interested organisations.

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I Summary

Julian Lewis MP's Private Member's Bill, the *Mental Heath Amendment Bill* (Bill 8 of 1997-98) is prompted by the concern that the way the policy of "care in the community" has been implemented in practice has led to patients who need in-patient care in a safe environment being unable to access such care. This Paper attempts to summarise some of the background to the community care debate, before summarising the contents of the Bill and the responses that have been made to it by groups representing patients and healthcare professionals.

Part II of the Paper gives a brief summary of how mental health legislation has changed over the past hundred years, from the *Lunacy Act 1890* to the *Mental Health Act 1983*. It comments on the extent to which this legislation has been concerned with the powers of the state to intervene when a person is suffering from mental disorder, rather than with the kind of services which should be provided.

Part III of the Paper describes the shift to the idea of "care in the community": the principle that mentally ill people should, wherever possible, be cared for in their own homes or in community based hostels and homes, rather than in large institutions. It discusses how the implementation of this policy has been accompanied by increasing pressure on acute (that is, short-term) psychiatric beds, especially in the inner cities and discusses the possible reasons for this. These include the argument that community facilities have not developed quickly enough to replace the facilities once provided in large institutions: patients may need to be admitted to acute beds because the community services available are not sufficient to cope with a relapse or acute episode of their illness; alternatively, patients may remain in acute beds, even though they do not need acute care, because of a shortage of other facilities to which they could be discharged, such as longer-term nursing care or supported housing in the community. This Part of the Paper also looks at the conditions in psychiatric units and at the policy announcements on care in the community and its relationship to in-patient care by both the current and previous Governments.

Part IV summarises the *Mental Health (Amendment) Bill*. Clause 1 of the Bill would require each Health Authority in England and Wales to prepare a strategy for the provision of in-patient care for those in need of it, monitor progress towards implementing the strategy and make an annual report to the Secretary of State on that progress. Clause 2 would require Health Authorities to ensure that all in-patient beds in existing psychiatric units are provided in single-sex ward areas and that all room and ward doors are provided with adequate locks. Clause 3 makes the same provision for future psychiatric units.

Part V describes the responses to the Bill by organisations representing people suffering from mental disorders and from the healthcare professions. The move to legislate on single-sex

wards is generally welcomed, but the response to the requirement to prepare a strategy on in-patient provision is more mixed: some organisations have welcomed it as a way of making Health Authorities give higher priority to in-patient psychiatric provision, while others believe it will not achieve this aim and will simply create added bureaucracy.

II A history of psychiatric provision

Most of the legislation affecting the provision of psychiatric care in England and Wales focuses not on the kind of care patients should receive, but on the powers of the state to intervene when an individual is suffering from mental disorder and is deemed in need of treatment. The current legal framework is found in the *Mental Health Act 1983*, which is a consolidation of the *Mental Health Act 1959* and the *Mental Health (Amendment) Act 1982.* Amendments to the 1983 Act have since been made by the *Mental Heath (Patients in the Community) Act 1995* to allow for patients to be "supervised" in the community once they have been discharged from hospital. Whilst significant changes were made by the 1982 and 1995 Acts, it was the 1959 Act which signalled a fundamental shift in approach to the care and control of people suffering from mental illness.

Before the 1959 Act, the relevant legislation for mentally ill people was found in the *Lunacy Act 1890* and the *Mental Treatment Act 1930.* The former provided for poor law officials or relatives to apply for a judicial order to "certify" a "lunatic", so that he or she could be placed in an asylum. The application had to be accompanied by medical evidence and, according to Brenda Hoggett's summary of the history of mental health legislation,[1] doctors often shrank from using this power, because of the stigma involved. It has been suggested that this then meant that when patients were, finally, certified, it was too late for treatment to be of any help. It also meant that there was little, if any, provision for those suffering from mental disorder falling short of "lunacy", unless they were able to pay as a private patient. The Board of Control (known up to 1913 as the Lunacy Commissioners) was empowered to supervise standards and protect patients in both public and private institutions.

The *Mental Treatment Act 1930* introduced for the first time the idea of "voluntary" patients in public institutions (formerly the Maudsley hospital was the only hospital permitted to accept non-paying patients without certification). The Act thus began to move the emphasis of psychiatric care towards informal admission and treatment, and away from mere institutional containment. As a result of the 1930 Act, there were from then on three categories of patient: "certified" patients under the 1890 Act, "temporary" patients (non-voluntary patients requiring treatment for less than a year) and voluntary patients (those able to make a written application to be treated in hospital). Asylums were also renamed "hospitals" and "lunatics" became "persons of unsound mind". However, "persons of unsound mind" who had been certified under the 1890 *Lunacy Act* could still only be placed in "designated" public mental hospitals, "registered" hospitals or "licensed" private nursing homes, and thus psychiatric institutions continued to develop quite separately from mainstream hospital provision.

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[1] Brenda Hoggett, *Mental Health Law*, 1990 p.8

The 1959 Act was described by Hoggett as "revolutionary". It enabled mentally ill patients to be admitted to hospital like any other patient (with compulsory admission and compulsory treatment only to be used where strictly necessary); it enabled mentally ill patients to be admitted to any public hospital, rather than being kept separate in designated institutions; it brought the legislation governing those with mental illness and those with learning disabilities together; and it aimed to reduce the stigma of being labelled mentally ill. Kathleen Jones, in *Asylums and After*[2] sums up the provisions of the 1959 Act as follows:

> "1. The Act repealed all previous lunacy, mental treatment and mental deficiency legislation, and provided a single code for all types of mental disorder.
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> 2. 'Mental disorder' was defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind'.
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> 3. The Board of Control was abolished, existing officers being transferred to the Ministry of Health. The Board's functions of inspection and review were transferred to local health authorities.
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> 4. Local health authority mental health services provided under section 28 of the *National Health Service Act 1946* might include the provision of residential accommodation, centres for training and occupation, the appointment of mental welfare officers, the exercise of the functions of guardianship and 'the provision of any ancillary or supplementary services'.
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> 5. Mental Health Review Tribunals, organised on a regional basis, took over the 'watchdog' functions of the Board of Control in individual cases of compulsory detention. They were to consist of legal members, medical members, and 'members having such experience in administration, such knowledge of the social services, or such other qualifications and experience as the Lord Chancellor considers suitable', to be appointed by joint consultation between the Lord Chancellor and the Minister of Health. The chairman of the Tribunal, and the chairman of any particular panel, was always to be a legal member. Tribunals were given the power to discharge patients from compulsory detention or from guardianship.
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> 6. Patients could be admitted to any hospital or mental nursing home without formalities of any kind, and without liability to detention. This clause, which is phrased negatively ('Nothing in this Act shall be construed as preventing ...') replaced the previous arrangements for voluntary treatment in the *Mental Treatment Act 1930*. Since the patient's volition was no longer required, this clause made it possible for patients who had no power of volition to be admitted informally, provided that they did not positively object.

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[2] Jones, *Asylums and After*, 1993 pp 156-157

> 7. Compulsory admission was of three kinds: an observation order, requiring two medical certificates, and lasting 28 days; a treatment order, requiring two medical certificates, and with a duration of one year for the first three consecutive occasions, and then two years at a time; and an emergency order, requiring an application from a mental welfare officer or relative, and one medical certificate, lasting only three days (but renewable in the form of an observation order or a treatment order). These clauses conformed to existing practice, except that a magistrate's order was no longer required for admission for treatment.
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> 8. Informal patients could discharge themselves at any time. Compulsorily detained patients would be discharged when an order lapsed without renewal. They could also be discharged by the responsible medical officer, by the managers of the hospital or nursing home, by a Mental Health Review Tribunal after application and hearing, or by the nearest relative after giving seventy two hours' notice, provided that the responsible medical officer did not issue a barring certificate."

Much of the above has been carried forward into the *Mental Health Act 1983* and still applies today. However, the *Mental Health Amendment Act 1982* (which was consolidated with the 1959 Act in the 1983 Act) made a number of changes. These are summarised, again, by Jones as follows:

> "*1.Definition of mental disorder.* This was narrowed in three respects. First, a new category of 'severe mental impairment' applies only to those mentally handicapped people who exhibit 'abnormally aggressive or seriously irresponsible conduct'. The effect is to remove nearly all mentally handicapped people from the provisions of the Act, and to restrict its operation substantially to mental illness. Second, psychopathy and severe mental impairment are subject to the 'treatability' criterion: formal detention in hospital is only applicable if treatment for the condition exists, and is available. Third, the clause of the 1959 Act providing that no-one could be dealt with under the Act 'by reason only of promiscuity or other immoral conduct' is strengthened by the specific exclusion of sexual deviance, alcoholism or drug abuse unless there is also evidence of demonstrable mental disorder.
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> *2.Compulsory admission to hospital.* The three principal forms of admission in the 1959 Act are retained, but with modifications. An Assessment Order (section 2, duration 28 days) specifically includes provision for 'treatment' as well as 'observation'. The duration of a Treatment Order (section 3) is halved from one year, one year and then two years at a time to six months, six months and then one year at a time. An Emergency Order (section 4, duration 72 hours) is restricted so that it can only be used in genuine emergencies: the

petition may be made by an Approved Social Worker or the nearest relative (no longer by any relative); the petitioner is required to have seen the patient personally within the previous 24 hours, and the patient must be admitted to hospital within 24 hours of the doctor's examination and certificate: the previous provision allowed three days for either process.

3.Discharge from hospital. Provisions for discharge are extended: patients admitted on Assessment Orders or Treatment Orders may be discharged by the Responsible Medical Officer (RMO), that is, the consultant psychiatrist in charge of the patient's case; by the nearest relative; by the hospital managers; or by a Mental Health Review Tribunal. Patients have an automatic right to regular review by a Mental Health Review Tribunal (previously, the patient had to apply). The nearest relative's power is still subject to a 72 hour barring certificate if the RMO takes the view that the patient is 'likely to act in a manner dangerous to other persons or to himself'. Nurses have a new 'holding power' for six hours if the RMO is not immediately available.

4.Consent to treatment. These clauses are new. Patients detained under Assessment or Treatment Orders may be treated without their consent for the first three months after admission (a notable concession to the Royal College of Psychiatrists, since most patients are discharged within three months. This greatly reduced the number of second opinions). 'Treatment' in this case refers primarily to ECT [electro-convulsive therapy] or medication. If the patient remains in hospital for more than three months, and is incapable of consent or refuses consent, section 58 provides that treatment may only be given with the written approval of a 'second opinion doctor', an independent psychiatrist who must consult two other persons concerned in the patient's treatment, one a nurse, and one neither a medical practitioner nor a nurse (in practice, usually a social worker, but the Act does not specify this).

Psychosurgery and other 'irreversible or hazardous' treatment, as defined by the Secretary of State require the patient's consent and the confirmation of this consent by three people appointed by the Mental Health Act Commission: one a medical practitioner and two who are not medical practitioners. The medical practitioner must consult two other persons concerned in the patient's treatment, one a nurse, and the other neither a nurse nor a medical practitioner, before confirming that treatment 'has the likelihood ... of alleviating or preventing a deterioration of the patient's condition'. 'Irreversible or hazardous' treatments are relatively rare, and carried out in only a few specialist hospital units.

Section 58, the usual 'second opinion' procedure, applies only to formally detained patients. Section 57, the procedure for 'irreversible and hazardous' treatments, applies to all patients, formal or informal. The procedures for non-medical consultation were described by one Member of Parliament during the

second reading of the *Mental Health Amendment Bill* as resembling the complexities of the Hampton Court Maze.

5.Guardianship. The concept of guardianship, seen as 'a way of protecting persons who are vulnerable because of their mental disorder from exploitation, ill-treatment or neglect, and ensuring that a responsible person is empowered to make important decisions on their behalf', had been introduced in relation to mentally ill people in the 1959 Act, but had been little used. Guardianship may be exercised by a relative or other suitable person, or by a local authority. The local authority Social Services Department has a duty to act as guardian when no other suitable guardian is available. The powers of guardians are limited to control of where the patient resides, requiring him or her to attend centres for treatment, education, occupation or training, and requiring access to the patient to be given to medical practitioners or Approved Social Workers. The guardianship order confers no other powers on the guardian, and the only sanction is that the patient may be 'taken into custody' and brought back if the residence requirement is broken.

6.The Mental Health Act Commission. The MHAC is a special health authority, an independent inspectorate which inherits some of the responsibilities of the Lunacy Commissioners and the Board of Control. The Board of Control had been abolished in 1959, with the establishment of Mental Health Review Tribunals; but though Mental Health Review Tribunals dealt with applications for discharge from hospital, and there were other inspecting bodies, they did not replace the Board's function in relation to the rights of the individual patient while in hospital.

The MHAC consists of some eighty to ninety people drawn primarily from the medical, legal, nursing, psychology and social work professions. Its remit is confined to detained patients in hospital, though the Secretary of State has the power to extend the remit to informal patients. Members have a duty to visit and interview detained patients in private, and to investigate complaints from patients or other interested parties. The MHAC is also responsible for appointing 'second opinion' doctors and other persons concerned in consent to treatment; for reviewing the 'second opinion' procedure, and for publishing an annual report on its activities, to be laid before Parliament. Its initial duties included the preparation of a Code of Practice on the operation of compulsory admission and treatment.

7.Social work responsibilities. Social Services Departments of local authorities are required to appoint 'a sufficient number' of Approved Social Workers 'having appropriate competence in dealing with persons who are suffering from mental disorder'. The qualifications of ASWs must be approved by the Central Council for Education and Training in Social Work. The ASW has a duty to make application for a patient to be detained in hospital under the procedure for an Assessment Order or a Treatment Order where this is not

> done by the nearest relative. Before making such an application, the ASW must interview the patient 'in a suitable manner', and be satisfied that there is no other practicable way of providing the necessary care and treatment (the least restrictive alternative). The ASW, like the Duly Authorized Officer under the 1890 Act and the Mental Welfare Officer under the 1959 Act, has a duty to convey the patient to hospital. ASWs may enter and inspect premises where a patient is thought to be housed (with a magistrate's warrant, and accompanied by a constable and a doctor) and the patient may be removed to a 'place of safety'.
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> The Act also requires hospital authorities to inform Social Services authorities of patients admitted on petition by the nearest relative, and requires social workers (not necessarily ASWs) to provide the managers 'as soon as practicable' with a report on the patient's social circumstances.
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> Health and Social Services authorities have a duty to provide after-care for patients who have been detained on a Treatment Order and certain categories of offender patient. Arrangements are to be made in co-operation with voluntary agencies."[3]

It can be seen from the above descriptions of the powers of the 1959 and 1983 Acts that although there has been a major shift in attitude to people with mental health problems since the *Lunacy Act* was first passed, the relevant legislation is still very much concerned with the *containment* of mentally ill people (when they can be detained, when they can be treated against their will and so on), rather than with the sort of care they should receive. The statutory requirements to provide specific forms of care are limited: the 1983 Act only places on health and social services authorities the duty to provide "after-care" services for patients who have been discharged after detention under the Act,[4] but neither specifies the kind of aftercare services to be provided, nor requires Health Authorities to provide particular forms of in-patient care.

The only other relevant statutory provision is the very broad duty of the Secretary of State to "continue the promotion in England and Wales for a comprehensive health service designed to secure improvement … in the physical and mental health of the people of those countries".[5] Case law has established that this duty must be understood to include the rider "within available resources" and that failure to provide a particular patient with a particular service because of shortage of funding does not constitute a failure on the part of the Secretary of State to fulfil his duty.[6] The statutory position has two effects: firstly it means that changes in patterns of care, such as the emphasis on care in the community rather than in institutions, can be made without the need for legislative change; and secondly it means that

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3 Jones, *Asylums and after*, 1993 pp 206-210
4 section 117 of the 1983 Act
5 section 1 of the *National Health Service Act 1977*
6 eg *R.v. The Secretary of State ex parte Hincks* (1979) 123 S.J.436

patients have no enforceable rights to a particular form of care. One of the aims of Dr. Julian Lewis MP's *Mental Health (Amendment) Bill*[7] is to address this second point by strengthening the requirements on Health Authorities to provide sufficient in-patient psychiatric facilities for their local populations. Dr. Lewis's Bill is discussed further in Parts IV and V below.

[7] Bill 8 of 1997-98

III The balance between hospital care and care in the community

A. Care in the community

It is often assumed that the policy of "care in the community" for people with mental health problems dates from the *National Health Service and Community Care Act 1990*. In fact, while this Act certainly gave added stimulus to the idea that care in individuals' homes was, where possible, preferable to care in institutions, the major changes it introduced affected older and disabled people far more than those suffering from mental disorders. The official policy of "care in the community" for mentally ill people dates back considerably further to shortly after the passing of the 1959 Act. In 1961 the then health minister, Enoch Powell MP made a speech to the National Association for Mental Health, predicting that in fifteen years the number of beds needed for psychiatric patients would have halved, and that these would be found not in isolated Victorian-style asylums, but in wards or wings of district general hospitals.[8] He famously described the existing psychiatric hospitals as "isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity." The term "water-tower" hospitals has since become a generally accepted term with which to refer to large asylum-type hospitals, catering only for psychiatric patients, as opposed to the provision of psychiatric beds in ordinary district general hospitals.

There were two major implications in Mr. Powell's speech: firstly that many patients currently in long-term hospital care could be cared for in the community instead; and secondly that it would be preferable for in-patient beds, where these were still necessary, to be provided in ordinary hospitals, not in institutions segregated from the rest of the health service. Both principles could be seen as being in harmony with the changes brought about by the 1959 Act with its emphasis on de-stigmatising mental illness and removing the barriers between the psychiatric service and the rest of the NHS. However, from the very beginning, doubt was cast on the Government's ability or intention to fund an adequate community service to replace the existing hospital provision. A summary of mental health policy by Niall Dickson, published in the *Health Service Journal,* suggested that over the next 30 years very little happened apart from planning blight on the old institutions: bed closures certainly took place, but alternative community provision in the form of day centres and hostels was "at best … patchy, at worst non-existent".[9] The *Journal* article went on to suggest that it was really only in the 1990s, after a series of high-profile incidents such as murders by discharged psychiatric patients,[10] that the Department of Health paid serious attention to how the policy

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8 *Report of the Annual Conference of the National Association for Mental Health*, 1961 pp 4-10, quoted in Jones, *op.cit*. p.160

9 "All talk and no action", *Health Service Journal*, 1 February 1996 pp 12-13

10 for example the much publicised murder of Jonathan Zito by the discharged psychiatric patient Christopher Clunis in December 1992

of community care was working in practice. In the last few years, a considerable amount of guidance has been issued on the form community services should take, the need for co-operative working between the various statutory authorities and the considerations which should be taken into account when deciding if it is safe to discharge a patient from hospital care. The work initiated under the previous Government to improve community care is discussed in an earlier Library Paper.[11]

There does appear to be a general consensus that the *policy* that people with mental health problems should, wherever possible, receive care in the community, is the right policy. However, there is much more disagreement as to how the policy is working in practice. In particular, there have been concerns as to whether psychiatric beds have been closed too quickly, with the result that when people with mental health problems do need emergency admission to hospital, there are insufficient beds available. Another major area of concern is the funding of community care services: caring for someone in the community is not necessarily any cheaper than providing services in a hospital, and clearly if care in the community is to work, patients need adequate community support services. Inadequate community care services may lead to patients "falling through the net" altogether, with the ultimate danger of them harming themselves or others. In less dramatic, but nonetheless distressing cases, a lack of services may lead to such individuals having a quality of life which is unacceptably low. Thirdly, there has been a considerable amount of public concern as to whether people with mental health problems are being discharged too quickly from hospital into the community and may consequently present a danger either to themselves or others.

The appropriateness of hospital discharge and the cost of community services were touched upon in my earlier Paper; the remainder of this section will therefore concentrate on the adequacy of the number of psychiatric beds available.

B. Availability of in-patient beds

One basic question posed when discussing the success or otherwise of the policy of care in the community is: are there enough in-patient beds left for those who need them? Two quite separate groups of patients needing access to beds can be identified: those who still need 24 hour care or supervision on a long-term basis; and those who are able to cope living in the community most of the time but who may periodically need "acute" or "respite" hospital care for a short period, for example if they are aware that they are in danger of suffering a relapse in their condition. It is worth highlighting that the distinctions between "care in the community" and "in-patient" care are not absolute: long-term 24-hour nursing care may be provided "in the community" in non-institutional surroundings and different commentators may refer to these as community services or as in-patient services respectively.

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[11] *The Mental Health (Patients in the Community) Bill*, Library Research Paper 95/71, 7 June 1995

It could be argued that closing down long-term asylum-type hospitals should not necessarily have an effect on the provision of relatively short-term acute beds: the old-fashioned "water-tower" mental hospitals could, in theory, be closed down, to be replaced by community provision (including 24-hour nursing care in the community), without affecting the level of short-term psychiatric in-patient provision in district general hospitals. However, the increased pressure on acute psychiatric beds certainly seems to have accompanied the shift to care in the community. Increasingly it is being suggested not only that patients who could benefit from acute hospital care cannot be admitted, but that beds also cannot be found for those desperately in need of such care, either for their own protection or for that of the general public.

There is no doubt about the fact of this pressure on beds, in London at least: quite apart from regular anecdotal reports in the press of patients being turned away from hospitals,[12] both the Royal College of Psychiatrists and the King's Fund have published damning surveys on the availability of beds in London. The Royal College carried out five surveys between 1994 and 1997, the last of which showed that on one day in January 1997, "admission unit occupancy" in London was 111% and "true bed occupancy" was 123%. In other words, for every 100 patients admitted to in-patient beds on that day, there were 11 more actually on the admissions list due to be admitted, and in total 23 patients should have been in admission beds, but were elsewhere (eg in private hospitals, in non-psychiatric beds, at home or in policy custody) because all available beds were occupied.[13] "Admission beds" is the term used by the Royal College for patients needing short-term admissions (up to three months) from the community. The Royal College recommends a maximum occupancy rate of 85% in order to provide an efficient service,[14]while official figures show that, on average, 91% of acute psychiatric beds were occupied at any one time during 1996-97.[15] This last figure is lower than those cited in the RCP surveys, as it only includes those patients who are admitted and not those who are turned away or sent elsewhere because of lack of bed space.

The King's Fund report into mental health services in London, *London's mental health: the report to the King's Fund London Commission*,[16] also cited bed occupancy rates up to 125%, together with high rates of assault and violence on in-patient wards, and a proportion of detained patients to voluntary patients higher than the national average (implying levels of more severe mental illness). This last point was taken up in a recent report by the Sainsbury Centre for Mental Health and the Mental Health Act Commission[17] which emphasised that inpatient psychiatric wards are now caring for an increased number of patients with more severe mental illness and that this placed a heavy burden on the nursing staff.

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12 eg "Violent patients turned away by full-up hospitals", *The Independent*, 25 October 1996 & "Violent patient 'needed to commit assault to get help'", *The Independent*, 21 October 1996 p.4

13 Royal College of Psychiatrists, *Monitoring inner London mental illness services* (*MILMIS*) *V*, 7 May 1997

14 Royal College of Psychiatrists, *Mental health of the nation: the contribution of psychiatry*, 1992 p.29

15 Department of Health, *Bed availability and occupancy*, England 1996-97

16 King's Fund, *London's mental health: the report to the King's Fund London Commission*, 1997

17 Sainsbury Centre & Mental Health Act Commission, *The national visit*, 1997

Recommendations have also been made by the Royal College of Psychiatrists (RCP) as to the appropriate number of psychiatric beds per head of population, and these are considerably higher than the number of beds actually available. In 1992, the RCP estimated that the national requirement for adult psychiatric beds was in the region of 44 acute and medium-stay beds and 90 long stay and rehabilitation beds per 100,000 population.[18] Applied to current population estimates[19], this implies a need for around 21,500 acute beds and 44,000 long stay and rehabilitation beds in England. Currently, there are around 14,500 acute beds[20] and 27,000 long term and rehabilitation beds (around three quarters of which are provided outside of the NHS)[21] available.

Most of the evidence of pressure on psychiatric beds cited above has concentrated on what the Royal College of Psychiatrists term "admission beds": temporary hospital provision for people generally resident in the community. There is also some evidence of pressure on longer-term beds, however. In June 1995, the Department of Health published a document on the future of the "Special Hospitals" (Broadmoor, Rampton and Ashworth hospitals, which provide very high security care for psychiatric patients) which recognised that one reason why many patients remained inappropriately placed in these hospitals was because of a lack of available long-term beds in less secure surroundings.[22] The report suggested that less than half of all patients in the Special Hospitals (750 out of 1520) needed the level of security these hospitals are designed to provide: 490 patients could be satisfactorily catered for in long-term medium security units and 150 could be looked after in long term low security care. Eighty patients were estimated not to need "secure" care at all. These findings suggest that an adequate number of places in less secure hospitals are not available, with the knock-on effect that some patients are being cared for in unnecessarily secure surroundings while others in need of very secure care cannot be admitted.

The average number of in-patient beds available on a daily basis in NHS mental illness wards has dropped from 87,396 in 1980 to 37,624 in 1996/97.[23] However, as implied above, this fall alone would not automatically explain the well-documented pressure on psychiatric beds, if all long-term bed closures had been replaced by appropriate services in the community. A range of reasons have been suggested to explain the current pressure on beds described above, including:

- community services (including long-term 24-hour nursing provision in the community and out-of-hours crisis services which would help avoid emergency admissions) have not always adequately replaced former asylum provision;

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18 RCP, *The mental health of the nation: the contribution of psychiatry*, 1992 p.33
19 ONS mid-1996 population estimates
20 Department of Health, *Bed availability and occupancy*, England 1996-97
21 HL Deb 6 November 1997 cc 304-6WA
22 NHS Executive, *High security psychiatric services: changes in funding and organisation*, June 1995
23 HC Deb 27 November 1997 cc 653-4W

- the fact that there are fewer beds overall means there is less slack in the system for emergencies;

- people who formerly lived in psychiatric hospitals (or would have done 10 years ago) but are now in the community may have intermittent crisis periods, during which in-patient care is needed, but that these needs haven't been adequately built into the planning process;

- there has been an emphasis on increased "through-put" of patients and decreased length of stay in hospital which has gradually taken place in all specialties, not just psychiatry.

A recent article in the *British Medical Journal*, reporting a survey of 38 acute psychiatric units across England, supports the first of these points in that it suggested that a significant cause of pressure on acute beds could be solved by reducing the level of inappropriate admissions.[24] As many as one in four patients in acute beds were judged by hospital staff not to need to remain in acute care, but could not be discharged because of either a lack of housing and domiciliary care, a lack of long-term rehabilitation places or a lack of specialist or higher security provision. The authors conclude that "if all the patients who are inappropriately placed on acute admission wards could be relocated then the problem of over-occupancy would be solved" and suggest that the solution to the shortage of acute beds may best be found through the development of other types of hospital, residential and community care. The Royal College of Psychiatrists endorses this view, emphasising in particular the shortage of 24-hour nursed beds in the community: patients who would once have been moved to medium-stay psychiatric units are now trapped in acute wards because neither the old-style beds nor new 24-hour services are available.[25]

Two broad approaches have been suggested for dealing with the issue of pressure on beds. The first, which has been endorsed by the current Government, is to set up procedures which aim to prevent hospitals closing before adequate community services are in place. The second, which is embodied in Dr. Julian Lewis's *Mental Health (Amendment) Bill*, is to strengthen the duty to provide hospital beds to those in need of admission, thus forcing Health Authorities (to whom the Secretary of State's statutory duty to provide a comprehensive health service is delegated) to give this form of care a higher priority. The actions of the current and previous Governments are discussed in section IIID below, while Dr. Lewis's Bill and the responses to it are summarised in sections IV and V.

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[24] "Relation between bed use, social deprivation and overall bed availability in acute psychiatric units", *British Medical Journal (314)*, 25 January 1997 pp 262-266

[25] Royal College of Psychiatrists, response to the *Mental Health (Amendment) Bill*, 4 December 1997

C. Conditions in psychiatric hospitals

Quite apart from concerns about the difficulties encountered in finding a bed for a patient in need of in-patient care, the conditions in some psychiatric units have long been the subject of criticism. A recent report by the Sainsbury Centre for Mental Health[26] highlighted differences in standards between NHS hospital wards and community homes in London, suggesting that the former were significantly lower. While community homes tended to be clean and well-decorated and allowed residents some independence and privacy, hospital units were found in old institutionalised buildings which were in a poor state of repair and had consequent hygiene problems. Residents in the hospital units were also more likely to be isolated, with fewer opportunities for recreation and little privacy.

A report published in 1996 by the Royal College of Psychiatrists[27] made similar points both about the conditions in NHS psychiatric units and the standards of care:

> "Psychiatric wards are subject to considerable wear and tear and frequently degrade rapidly. The in-patient environment is often drab and the standard of décor poor. Levels of domestic services are often rudimentary, resulting in unhygienic surroundings polluted with dirt, smoke and noise. Food is often prepared off-site to reduce costs; choice is poor and the meals themselves frequently cold, unappetising, and alien, particularly to ethnic minority groups.
> …
> There are considerable difficulties recruiting high quality nursing staff to inner-city hospitals … As the staff:patient ratio diminishes it is well known that the atmosphere of the ward becomes more custodial with increasing amounts of sedative medication being employed to reduce demands on an overstretched staff. Inadequate numbers of nurses, compounded by shortages of occupational therapy staff, mean that ward activities are frequently non-existent."

The College went on to suggest that a code of clinical standards should be established which NHS trusts and Health Authorities would have to espouse. Areas to be covered by such a code would include hygiene, safety, privacy, access to high quality medical and nursing care, respect for patients' cultural backgrounds, and access to a therapeutic environment.

Two other issues which generate even more concern are those of the safety of women patients and general violence on wards. The Mental Health Act Commission has the statutory duty of keeping the care and treatment of patients detained under the 1983 Act under review

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[26] Sainsbury Centre for Mental Health, *Inside residential care*, 1996
[27] Royal College of Psychiatrists, *Wish you were here?*, 1996

and makes regular visits to hospitals and nursing homes every year in order to fulfil this obligation. On 21 November 1996 the Commission organised a one-off unannounced "national visit" on one day to 309 wards in 118 NHS trusts in England and Wales in order to collect systematic information on a number of issues, including the treatment of women patients.[28] The Commission found that:

- only one third of women had access to self-contained "women only" sleeping areas, toilets and bathing facilities;
- over half of women patients had to share toilets with male patients or had to walk through or past male areas in order to use baths, showers or toilets;
- 71 women (3% of those in the survey) had to share sleeping areas with male patients;
- just over half the wards visited had identified problems of sexual harassment of women patients by male patients;
- a majority of the wards visited had specific procedures relating to the safety of women.

In conclusion, the Commission stated that:

> "Few women were accommodated in completely self-contained sleeping, bathing and toilet areas. The current government policy of providing such facilities throughout the NHS clearly deserves support. There was, for example, evidence that over half of the wards had experienced incidents of sexual harassment, some serious. Government, policy makers, local purchasers and NHS trusts will have to establish plans to enable a considerable shift in ward structures for this policy to be fulfilled. It seems inevitable that there will be a cost attached."

As implied by the Commission, the previous administration had declared on a number of occasions that mixed sex accommodation was not acceptable in the NHS and must be phased out as quickly as possible.[29] The new Government has restated this policy, with the Health Minister, Baroness Jay, requiring a report by Christmas setting out the progress made by Health Authorities in achieving it.[30]

On the issue of violence, the King's Fund report, *London's Mental Health*, alluded to in Part IIB above, described the number of assaults and cases of sexual harassment on in-patient wards as "unacceptably high".[31] The report cited the Royal College of Psychiatrists' surveys on conditions in London's psychiatric units as evidence for this concern: over the period of a fortnight in January 1995, 131 assaults were committed by patients in London's psychiatric

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[28] Sainsbury Centre for Mental Health & Mental Health Act Commission, *The national visit*, 1997

[29] for example in Department of Health press notice 97/19, 27 January 1997 & Department of Health circular EL(97)3

[30] Department of Health press notice 97/190, 6 August 1997

[31] King's Fund, *London's mental health*, 1997 p.1

units, of which 4 resulted in "major physical injuries".[32] When the survey was repeated in May 1997, the figure was 126 assaults, of which 13 caused major physical injuries.[33] Most of the assaults were against nursing staff or other patients. Not only is this level of violence a serious cause of concern in itself; it also raises the question of the extent to which psychiatric units can provide a safe, therapeutic environment for other patients. The Royal College of Psychiatrists has suggested that this lack of a therapeutic environment has led to patients becoming increasingly unwilling to be admitted to hospital on a voluntary basis and that compulsory admissions are increasing accordingly.[34]

D. Government action

In the past 18 months, there have been a number of indications that the Department of Health (under both Conservative and Labour administrations) is taking concerns about the availability of in-patient care very seriously and is anxious that the "pendulum" of care in the community should not be seen to have swung too far.

1. Conservative Government

In February 1996, the then Secretary of State for Health, Stephen Dorrell, made a major announcement on mental health services, emphasising the need for a "spectrum of care" for people with mental illness.[35] In his speech, he stated that the policy of "care in the community" had never meant the abandonment of all residential care and acknowledged that there would remain a small group of severely mentally ill people for whom long-term 24 hour nursing care would be necessary. This care however, should not be in hospitals, but should be in home-like surroundings with no more than 20 residents; such homes should also provide "high quality healthcare in a therapeutic environment" and not just simply a place to live.[36] In the same speech, Mr. Dorrell announced the publication of a draft charter for mentally ill people, gave further details of special funding for community based mental health services through the Mental Illness Specific Grant and the new Mental Health Challenge Fund, launched an audit pack to help health service professionals monitor the quality of care provided to patients discharged from hospital, and announced the publication of a review of health authorities' plans for developing mental health services.[37]

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32 *ibid* p.179
33 Royal College of Psychiatrists, *Monitoring inner London mental illness services (MILMIS) V*, 7 May 1997
34 Royal College of Psychiatrists, response to *Mental Health (Amendment) Bill*, 4 December 1997
35 HC Deb 20 February 1996 cc 175-177
36 NHS Executive, *24 hour nursed care for people with severe and enduring mental illness*, 1996
37 Dept of Health press notice 96/48, 20 February 1996

In July 1996, a letter from the then Prime Minister to the Secretary of State for Health was leaked to the press, apparently suggesting both that the hospital closure programme may have gone too far, and that consideration should be given to creating new mental health authorities to co-ordinate the planning and funding of mental health services (currently spending on mental health is split between health authorities and local authority social services departments).[38] A Green Paper, *Developing partnerships in mental health*[39] was published by the Department of Health on 4 February this year, proposing four possible ways forward to improve joint working between health and social services. The four possible options are:

- creating new mental health and social care authorities to plan and purchase mental health and social care services;
- giving either health or local authorities "single authority responsibility" for purchasing these services; health authorities are the most likely contenders;
- establishing a joint health and social care body with a shared budget to fund mental health and social care services;
- agree delegation between health and local authorities of particular functions or responsibilities, with appropriate transfer of funds.

Comment on the options identified in the Green Paper was invited by the previous Government, with a deadline of 9 May 1997. No further announcements have yet been made by the new Government specifically on the proposals in the Paper, but according to press comment in June 1997, the idea of "pooled budgets" is regarded favourably by Ministers.[40]

2. Labour Government

In response to Stephen Dorrell's announcement in February 1996, the then Shadow Secretary of State for Health, Harriet Harman set out a "four-point plan" for action on mental health services:

> "Will the Secretary of State accept Labour's challenge and introduce a four-point action plan to begin to tackle the problems of mental health? Will he halt further psychiatric bed closures until community services are in place? Will he ensure not only the immediate implementation in all areas of the care programme approach [which requires patients who have been detained under the 1983 Act to be given a key worker and a care plan when they are

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38 "Major in mental health rethink", *The Independent*, 16 July 1996 p.1
39 Cm 3555
40 "Pooling resources for mental health", *Health Service Journal*, 19 June 1997 p.15

> discharged], but greater consistency in its development? Will he take action to address staff shortages? Will he change the mental health funding allocation formula, so that over time cash ends up going where it is most needed?"[41]

Since the election, Ministers have announced the creation of an "Independent Reference Group" to advise them on whether sufficient community care facilities are in place before long-stay hospitals close.[42] Membership of this group includes representatives from voluntary groups such as SANE and MIND, the health professions, such as the Royal College of Psychiatrists and the Royal College of Nursing, and individual Health Authorities and NHS Regional Offices. According to the press notice announcing the formation of the group:

> "The reprovision schemes - the closure of long-stay hospitals and provision of support in the community -will be looked at against a set of criteria drawn up by the IRG. The criteria will be used to assess, for example, effectiveness of service planning; planning for individuals including community support; investment in and monitoring of resources; the level of consultation with interested parties; the degree of management control of schemes; and the level of support for the staff involved."

While the creation of the committee was generally welcomed by mental health groups, it has been suggested that the difference in approach and philosophy of many of the members may make it difficult for them to come to agreement.[43]

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41 HC Deb 20 February 1996 c.179

42 Department of Health press notice 97/222, 12 September 1997

43 "Labour grasps mental care nettle", *The Guardian*, 13 September 1997 p.13

IV The Mental Health (Amendment) Bill

The *Mental Health (Amendment) Bill*[44] was introduced into the Commons by Dr. Julian Lewis MP on 18 June 1997[45] and is due to have its Second Reading on 12 December 1997. Dr. Lewis's co-sponsors include members of the Labour and Liberal Democrat parties, as well as fellow Conservatives. Dr. Lewis described the purpose of his Bill as being "to ensure provision of, and access to skilled care and sanctuary, including in-patient care" for a range of people in need of such care: people with serious long-term illnesses such as schizophrenia, those who have suffered a "break-down", those liable to suffer relapses, and those whose condition falls short of the criteria for emergency admission, but who are urgently in need of sanctuary care.[46]

Clause 1 of the Bill would create a new section 142A in the *Mental Health Act 1983*, requiring all Health Authorities in England and Wales to prepare a strategy for the provision of in-patient facilities for those patients deemed to need in-patient care by a doctor "approved" under the *Mental Health Act 1983* (ie specialising in mental disorder). Health Authorities would then be required to monitor their progress towards the implementation of their strategy and make an annual report on their progress to the Secretary of State for Health. The strategy must specifically allow for patients to be cared for in "separate and therapeutic environments".

Clause 2 would created a new section 142B in the 1983 Act, requiring all Health Authorities in England and Wales to provide single-sex ward areas in all existing psychiatric hospitals. All room and ward doors should also have security devices fitted to prevent unauthorised intrusions.

Clause 3 would insert a new section 142C in the 1983 Act, requiring Health Authorities to ensure, as far as is practicable, that any future psychiatric units are designed and constructed in such a way that they will meet the requirements of sections 142A and 142B. In other words, future psychiatric units must accord with the Health Authority's strategy for in-patient beds, provide single-sex accommodation and be secure against intrusion.

Clause 4 defines "psychiatric unit" as "any hospital or mental nursing home which provides treatment for mentally disordered persons". This would include both NHS and private provision, and facilities both for those detained under the *Mental Health Act 1983* and for those in hospitals or nursing homes on a voluntary basis.

Clause 5 sets out the short title and commencement: the Act would come into force six months from the date on which it is passed.

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44 Bill 8 of 1997-98
45 HC Deb 18 June 1997 c.345
46 "Mental Health (Amendment) Bill, *The House Magazine*, Special Supplement, 23 June 1997 p.2

V Responses to the Bill

The Bill has had a slightly mixed response from organisations representing mentally ill people, although there is general support for what it is aiming to do. The organisations Mind (the National Association for Mental Health), SANE (Schizophrenia - A National Emergency) and the National Schizophrenia Fellowship all fully support the clauses dealing with single-sex wards, but have conflicting views on the value of clause 1. Mind does not believe that it will have the desired effect:

> "In relation to Clause 1 of the Bill, Mind does not believe that the duty proposed [ie of preparing a strategy on the provision of in-patient care] is either a necessary or effective way of ensuring that all patients are treated in an environment appropriate to their needs. We are also concerned that the proposal may divert more resources in to one particular area of service and create unnecessary bureaucracy."[47]

The National Schizophrenia Fellowship (NSF), on the other hand, agrees with all the requirements set down in Clause 1, suggesting further that the monitoring of Health Authorities' strategies should be carried out by a group involving service users and carers.[48] SANE welcomes the recognition implicit in the Bill that there are current gaps in provision and supports the aim to provide entitlement to an in-patient bed when necessary; in particular it welcomes the principle that patients should be cared for in "separate and therapeutic environments", instead of patients with very different disorders being placed together in the same ward. It does, however, express some doubts about the drafting of the clause, suggesting that too many elements are included in one clause and also that it would be helpful to have some indication as to the mechanism to be used to trigger the process for admission.[49]

On clauses 2 and 3, all three organisations warmly welcome the principle of single-sex wards; MIND in particular cites examples of rape and harassment of women on mixed wards to emphasise the distress caused by the current lack of entitlement to single-sex provision. NSF also comments specifically on the second part of clause 2, which would require appropriate security devices to be fitted to all room and ward doors, stating that:

> "NSF agrees with the principle of providing security within psychiatric units but would again encourage active consultation with those using the facility in order to ensure a therapeutic environment which might be lessened by over-zealous security measures."

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47 Mind, response to *Mental Health (Amendment) Bill*, 8 December 1997
48 NSF, Parliamentary Briefing, 8 December 1997
49 SANE, response to *Mental Health (Amendment) Bill*, 9 December 1997

SANE similarly welcomes the idea of improving security arrangements, acknowledging that the idea of locks on patients' doors may give rise to some debate about the risks involved where patients have a history of self-harm or are suicidal, but arguing that if staff have master keys to all locks this should not constitute a serious problem.

A number of other organisations have commented generally on mental health services without making specific comments on the Bill's clauses. The British Medical Association expressed its belief that the philosophy of adequately supported community care is "a good philosophy", but emphasised that where this is not a viable option, patients "should be able to have access to appropriate care". The Association goes on to call for a fundamental review of the *Mental Health Act 1983* in order to take account of the radical changes which have taken place in mental health services since the Act was first passed.[50] The Royal College of Psychiatrists likewise made no direct comments on the clauses of Dr. Lewis's Bill but emphasised the current pressure on acute beds, the lack of alternative community facilities and the need for proper standards in in-patient units, including the importance of providing privacy and lockable rooms for patients.[51]

No formal comment on the Bill has yet been made by the Labour, Conservative or Liberal Democrat parties. The policies of the previous and current administrations were discussed in Part IIID above. A press notice issued by the Liberal Democrats after Stephen Dorrell's announcement on mental health services in February 1996 suggested that "until the Government explicitly recognise that urban areas must be allocated resources to match the high numbers of mentally ill, there are still likely to be insufficient beds and care available" and went on to call for a "meaningful charter of specific patient's rights".[52]

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50 British Medical Association, response to the *Mental Health (Amendment) Bill*, 4 December 1997

51 Royal College of Psychiatrists, response to the *Mental Health (Amendment) Bill*, 4 December 1997

52 Liberal Democrats press notice, 20 February 1996