

Recent government policy and legislation: an overview

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This is the last in a series of articles that have been published serially in the *Psychiatric Bulletin* on recent government policy and legislation. Previous articles have covered the NHS and Community Care Act, the Care Programme Approach, Fundholding and Commissioning General Practitioners, NHS Trusts, Community Care Plans and the Mental Illness Specific Grant, the Health of the Nation, EEC Psychiatry, Mentally Disordered Offenders, the Purchaser Provider Split and Supervision Registers. The series was commissioned by Dr Sara Davies with assistance from Dr Jeanette Smith, Trainee Editors at the *Psychiatric Bulletin*.

There has been much recent government legislation affecting mental health services. Some relates to the delivery of general health and social services, of which mental health care forms only a part, and some specifically to the delivery of mental health care. The complex interplay of the legislation is explored and there are suggestions for the further involvement of psychiatrists.

In the last five years there has been a plethora of government policy and legislation that has affected psychiatric practice. The trainee or consultant psychiatrist is faced with an ever changing context in which to attempt to practise psychiatry against the backdrop of an accelerating shift in the patterns of mental health care with the closure of the large mental asylums and the transfer of large numbers of psychiatric patients to the community.

The recent government policy and legislation falls into two distinct categories: that which relates to the delivery of general health and social services in this country, of which mental health care forms only a part, and that which relates specifically to the delivery of mental health care. The reforms in the former category have led to dramatic changes in the delivery of psychiatric care as a consequence of the implementation of legislation not specifically designed to deal with mental health services. Simultaneously, the government has increasingly developed policy and circulated guidance aimed explicitly at mental health services. There have therefore been two sets of pressures on mental health services which have sometimes appeared inconsistent or incompatible. This paper will highlight some of these tensions.

General health care legislation

The most important legislation that affected general health and social services delivery was

the 1990 NHS and Community Care Act (Thornicroft, 1994). This implemented measures to establish NHS trusts and fund-holding general practices. It also restructured the financial arrangements for community care provision for the most vulnerable members of society, including people with severe mental illness (SMI) and introduced the concept of care management. These proposals established the separation of purchaser and provider roles in both health care and social services (Ward, 1994), with the potential purchase of mental health services by health authorities and social services departments (on a population basis) and GP fund-holders and care managers (on an individual basis). The relationship between purchaser and provider is to be conducted through contracts.

One major impact of the NHS and Community Care Act is the emphasis on assessment of need, which becomes one of the significant functions of purchasers. Assessments of need for psychiatric services based on traditional public health approaches provide only very approximate calculations of the quantity of need and indicate little about the quality of need (Hayward *et al*, 1993). Simultaneously, purchasers have increasingly been urged to involve patients and the public in purchasing decisions and the assessment of need. The role of users within the planning and management of the mental health system has developed rapidly over the last ten years. To some extent therefore, mental health has become the pilot site for innovative practice in health and social care planning which gives users, carers and voluntary organisations an increased say in the planning and the design of services (Smith & Peck, 1994). This is a major shift away from previous practice which was dominated by professional views. It represents a challenge to psychiatrists which is not yet being experienced

to the same extent by their colleagues in other medical disciplines.

This population based needs assessment and planning process seems to be threatened by the extension of general practice (GP) fund-holding, which is often regarded as the 'wild card' of the NHS reforms (Kendrick, 1994). Contracting was designed for services that are organised in single episodes of in-patient care, such as elective 'cold' surgery where GP fund-holders would shop around for the shortest waiting list or the keenest price. In elective surgery, GP fund-holders have not so far challenged national or health authority priorities in the manner which is becoming common in mental health care, such that services designed on the basis of population needs are being undermined by GP fund-holders securing specific services for the patients that present in their surgery. Furthermore, no GPs have recruited nurse or lay surgeons to undertake elective surgery in the practice in the fashion in which they have bought independent community psychiatric nurses and counsellors to deliver mental health services. If these health professionals then do not concentrate on treating the severely mentally ill (SMI), these trends constitute major threats both to the realisation of the priority accorded to the SMI by the government and to the integrated community mental health teams that are the method favoured for the delivery of services to that group (Peck, 1994).

Fund-holding GPs are therefore in a powerful position as commissioners of services to dictate the type of secondary care that they will buy from mental health service providers. The NHS Executive has to ensure that guidance issued to GP fund-holders, encouraging them to buy comprehensive services for the long-term mentally ill from community teams, is observed. Psychiatrists and other mental health professionals need to forge links with their fund-holding GPs and other commissioners of services to ensure that the needs of the severely mentally ill are not neglected in this complex purchaser/provider system which was originally conceived for hip replacements rather than for the care of the severely mentally ill.

One of the problems faced by all purchasers and providers in the development of contracts for psychiatry rather than elective surgery is that it is often more difficult to define episodes of illness, effective treatments and measures of outcome. Ideally people with SMI have their needs assessed followed by the design of specific packages of care from both health and social services, with a particular emphasis in the case of social services on the development of delegated budgets to enable care managers to buy a unique package from a range of providers. Health purchasers are struggling to construct population based contracts from which health services for individuals

can be accessed while many social services departments are pursuing the concept of the individual purchase of social care from statutory, voluntary and informal sources. The development of collaboration between health and social service purchasers is particularly difficult in the field of mental health in these circumstances.

Another result of the NHS and Community Care Act, perhaps the one most palpable to clinicians, is the shifting pattern of relationship and power between managers and health professionals in the new purchaser/provider age (Peck, 1991). The language of the 1990s health care is one that is alien to most clinicians. It is managerially and financially driven, and hospital managers now have reserved spaces in the hospital car park instead of hospital consultants. Until psychiatrists and other health care professionals can feel more comfortable in this new world, be proactive and grasp the nettle of management and service development, it will be more difficult to directly affect the care that they can provide for their patients. Mental health professionals need to use their skills and clinical knowledge to inform the contracting and commissioning process and secure better services for their patients.

Specific mental health care legislation

Alternatively, the legislation that is focused specifically on mental health services acknowledges the unique effects that community forms of care and the purchaser/provider split have had on the care of psychiatric patients. The Mental Illness Specific Grant (Doodson & Davies, 1994) aims to address the obstacles to joint planning between different agencies by assisting the joint purchasing of mental health services between different providers. The care programme approach relates to other legislation specifically for the mentally ill such as the Mental Health Act (1983) and attempts to secure effective and comprehensive care for vulnerable psychiatric patients. The recent focus has been on the discharge and aftercare procedures including supervision registers for the most vulnerable mentally ill (Holloway, 1994). This legislation is aimed at improving specifically mental health services for the long-term mentally ill and is an attempt to secure an equivalent or better range and standard of care than was previously provided in psychiatric institutions. The focus on the aftercare of vulnerable psychiatric patients is appropriate and ideally motivated by a desire to provide a better service to psychiatric patients rather than by political concern of media coverage of recent dramatic failures of care (Ritchie *et al*, 1994). But whether supervision registers, without any extra financial resources for their implementation and with their associated ethical

and human rights issues, is the best way to do this remains to be seen (Holloway, 1994). A user with a care programme or on a supervision register in a locality without a comprehensive and coordinated set of health and social services, is perhaps no better off than a user without such safeguards in similar circumstances.

There appears to be a massive discrepancy between government legislation and guidelines for the care of vulnerable psychiatric patients and current routine practice. Lady Runciman of the Mental Health Foundation commenting on the draft guidelines on hospital discharge and continuing care for mentally disordered offenders and the care of people who are seriously mentally ill (Health Select Committee, 1994), said "It is an estimable document, it is like a motherhood statement, there is nothing in it one could possibly disapprove of, or, indeed, not support wholeheartedly, but when you compare that document with what is being faced in acute care at the moment the gap is simply breathtaking". Until there is assistance in the practical implementation of the care programme approach and the new supervision registers, it will be difficult to evaluate their effectiveness.

The future

There is a wealth of current legislation, some of which has been implemented more easily than others. It is unclear how effective the legislation will be for the care that is provided to psychiatric patients and how it will inter-relate. The recent general reforms were focused on achieving cultural change, on stimulating progress on a journey without a predetermined destination. Mental health services have embarked on that journey earlier, and gone further, than perhaps any other specialist health service. However, the direction is not always clear, nor are all the passengers on the same vehicle. The recent mental health specific reforms, in contrast, have been prescriptive and procedural. This creates anxiety among the doctors who perceive their parameters for clinical judgement being narrowed but who remain responsible for the care of individuals with a serious mental illness. Unless the government addresses the tension between the national priority for the SMI and the local discretion being exercised by GP fund-holders, then health providers will continue to fall over themselves in the attempt to dance for two pipers playing different tunes at the same time.

Practical future focuses for psychiatrists include:

- (a) consideration of the training needs of junior and consultant psychiatrists in the recent legislation and its practical implementation, at a local and national level
- (b) as the Mental Health Act (1993) legislation is currently, the recent legislation could be a specific part of the examinations for the membership of the Royal College of Psychiatrists
- (c) more discussion of management issues and legislation in the psychiatric literature, rather than in specialist health service focused journals
- (d) Department of Health guidance on the practical implementation of the care programme approach and the establishment of supervision registers if there is going to be effective national implementation
- (e) a careful evaluation of the clinical and cost effectiveness of the different parts of the recent legislation so that psychiatrists can inform the legislative process
- (f) research aimed at evaluating the effectiveness of the care that is provided for psychiatric patients.

Otherwise the result may be a loss of the decision-making power that psychiatrists appropriately have on how to care for their patients and a widespread backlash against community forms of care for psychiatric patients which they overwhelmingly seem to prefer (Campbell, 1993).

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Rescinding responsibilities as nearest relative and displacing the nearest relative

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A case report is presented which highlights two important, but rarely evoked, aspects of mental health law. In this case, the mentally ill person's nearest relative did not wish to act as such and rescinded his responsibility in favour of another. This other person objected to the use of section 3 of the Mental Health Act 1983 and displacement of her as nearest relative was considered. Some cases from the literature are cited to help clarify the meaning of "unreasonable objection" as used in the Mental Health Act 1983.

Case

Mr AB is a middle-aged man with a long history of psychotic episodes characterised by delusions and hallucinations. These symptoms have been responsive to medication but Mr AB has never been compliant with treatment for any significant period. He arrived on the ward very threatening and aggressive and was obviously deluded and hallucinated. Since Mr AB was well known to the services, the psychiatric team felt that section 3 of the Mental Health Act (1983) was appropriate.

Mr AB's parents live apart. His father is the older of the two and, therefore, legally is the nearest relative. Mr AB's mother, however, was much more involved in his care so she was contacted regarding the use of section 3. She was adamant that this was inappropriate and felt that her son was not suffering from a mental illness. She believed that any medication would be both addictive and harmful. The team persuaded her that to help her son's mental disorder, and to come to a compromise, section 2

should be applied in the acute and difficult situation.

Mr AB applied to the Mental Health Review Tribunal for his discharge from section 2. His mother fought vociferously on his behalf but the section was upheld. The team considered section 3 as a management option. Mr AB's mother objected to a section 3, still thinking her son was not mentally ill. His father did appreciate that his son was unwell but would not oppose his ex-wife's opinion. He then officially relinquished his position as Mr AB's nearest relative to his ex-wife. In order for a section 3 to be implemented the team investigated the possibility of displacing Mr AB's mother as nearest relative.

Discussion

Two specific points that arise from this case are concerning the rescinding the responsibilities of being the nearest relative and the displacement of the nearest relative.

Rescinding the responsibilities of being the nearest relative

Section 26 of the Mental health Act 1983 (s. 26(1)) states that the nearest relative is the first surviving person in the following list:

- (a) husband or wife
- (b) son or daughter
- (c) father or mother
- (d) brother or sister
- (e) grandparent