Workforce Issues

The many professional bodies who have joined the Alliance have expressed their concerns on the effect of the proposals both in terms of the nature of their likely future work and also the undermining impact of the bill on their therapeutic relationship with patients. For many professionals, this feels counter-productive to the current emphasis on choice within mental health and to a more user-focussed mental health service.

The Alliance is convinced that, as a result of the inevitable increase in the numbers of people under compulsion which it will entail, the draft bill will have significant resource and workforce implications.

A thorough examination of the proposals for workforce implications, with detailed explanation of the assumptions made, is needed.

Paragraphs 47-54 of the Regulatory Impact Assessment outline the anticipated additional resource(s) required. It is extremely difficult to understand the rationale which has been applied to calculate these figures.

Tribunals

There will be a significant increase in tribunal hearings. There will also be a vast expansion in the types of decisions that tribunals will be empowered to consider, such as authorising care plans, displacing nominated persons, authorising ECT and examining whether the relevant conditions apply. This will require a huge change in the culture of mental health tribunals. It is likely that hearings will be significantly longer and there will be massive implications for recruitment and training. The present Mental Health Review Tribunal system is struggling to manage the present level of demand, with appeals being cancelled and delayed. We have grave concerns about whether the new, expanded system is realistic and practicable.[1]

This increase in workload and the numbers of hearings will require a large cohort of new members to carry out the additional work.[2] There will also be a need to fully train the additional members of the tribunal as well as provide additional training for all current members to enable them to deal with the new remit. There are major concerns about the availability of sufficient applicants willing to work full time. We are not aware of any research being conducted on the availability of candidates for such posts and there are considerable doubts whether such posts would be attractive.

This view was expressed by the Regional Chairmen of the Mental Health Review Tribunals who described the proposed new tribunal structure as "*unwieldy, unnecessary and unworkable*."

"We also believe that the tribunal workforce requirements are in any event an underestimate as they fail to take sufficient account of the likely increased length of tribunal hearings; of the likely implications of the recent European Court ruling in the case of H.L v UK, 5th October 2004 Appl. 45508/99; of the fact that there are increasing disincentives to doctors to offer their services to engage in the tribunal as Expert Panel members or clinical members; and of the fact that no reliable evidence has been produced

---

[1] For further discussion on the issue, we refer you to the evidence of the Sainsbury Centre for Mental Health, *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* November 2004, Ev.

[2] Recruitment may also be necessary to fill the places of those members expected to resign, for reasons such as the increased workload, for ethical reasons or because they will be asked to sit alone determining largely medical matters without the benefit of expert advice.

to give us confidence that there are sufficient number of lawyers who would wish to avail themselves of the opportunity to join this new tribunal, as legal members."[3]

Advocacy

The Alliance would question the additional number of advocates required, which suggests the need for just 140 new staff. At present, most mental health advocates work across a range of health and social care environments and not just in the compulsory arena. Access to an advocate is a significant safeguard, but becomes meaningless if the person under compulsion is unable to access an advocate when they need them.

Given that there are some 50,000 uses of the Mental Health Act each year, the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative. We urge the Department of Health to release information on how this figure was arrived at and to ensure that further detailed work on this is undertaken in partnership with advocacy providers and other stakeholders.

Effects on existing community services and clinicians

Reduction in community support for patients not in crisis

In addition to the newly identified resources, we would highlight the effect the new proposals would have upon the existing workloads on many clinicians and community services. In human terms this is likely to lead to a reduction in support for those patients who are not considered to be in "crisis" but for whom early intervention and community-based support could prevent subsequent compulsion.

Greater workload for psychiatrists and community psychiatric nurses

According to the Department of Health's own figures there are significant vacancy rates in England among consultant psychiatrists (9.6 per cent or 334 whole time equivalents (WTEs)) [4], yet it estimates that the new legislation will need an additional 130 psychiatrists.[5] There are also shortages of psychiatric nurses, with the Department of Health figures showing community psychiatric nurses with 1.9 per cent vacancies (235 WTEs) and *"other psychiatry"* nursing staff with 4.7 per cent vacancies (1,282 WTEs) in England. Should the bill become law, community psychiatric nurses would have a major role in monitoring whether people subject to compulsion in the community were adhering to their care plans.

The extra demands on consultant psychiatrists' time include: more tribunals and appeals; increased numbers of patients subject to the Act; all patients to have formal care plans; expert appeal doctors required after 28 days (rather than 3 months as currently); increased care planning; consultation; and information sharing. The Royal College of Psychiatrists has stated that:

"Such medical provision could only be acquired at the expense of patient care, particularly to those patients at earlier, less severe stages of illness or not requiring compulsion."[6]

---

[3] Professor Jeremy Cooper, Mrs Carolyn Kirby, His Honour Judge Philip Sycamore and Mr John Wright, Report of the Joint Committee on the Draft Mental Health Bill: Volume II, Nov 2004. Ev 428, para 8.

[4] NHS Workforce Vacancy Survey, March 2004.

[5] Explanatory Notes to the Bill, p.134.

[6] Royal College of Psychiatrists, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II*, Ev 50, para 72.

The creation of the AMHP role will reflect falling numbers of ASWs and put pressure on nursing staff

Similarly, the British Association of Social Workers has stated:

"*The Government's assumption about the present number of ASWs who will transfer to AMHP posts is grossly optimistic and flies in the face of recent research evidence, which shows that numbers are still falling rapidly and are likely to continue to do so.*"[7]

The Sainsbury Centre for Mental Health has warned that the creation of AMHPs could be problematic in the short term:

"*The existing shortage of ASWs will be exacerbated by the need to train them in the new role and the likely wastage from that process of those nearing retirement. That will place the greatest pressure on nursing staff, for whom the transition to AMHP status will require considerable training, and whose former roles will need to be back-filled*."[8]

Non-resident orders

The creation of non-resident orders (NROs) will have a dramatic impact on community mental health teams. The brunt of enforcing NROs could fall on assertive outreach teams, who work with people other services find hard to engage. These teams, recently established across the county, work on the basis of encouraging people to comply with care plans voluntarily. Much of the value of assertive outreach is in building the confidence of clients and helping them get back to an ordinary life. Imposing compulsion in these circumstances could damage those relationships and undermine the basis on which services are currently provided.

Alliance position

The Alliance recognises that our own proposals have cost implications, and that any system will have both an administrative and a resource burden. However, if resources are allocated to prevent compulsion being needed, and the conditions are appropriately set so that compulsion is seen as a last resort, then the resource implications would be more proportionate.

The implications of training and fully implementing the new Act are significant. A key lesson from the 1983 Act was the failure to implement the measures consistently. The proposals in the draft bill have far-reaching consequences. They will require a very significant recruitment of new types of staff (AMHPs and advocates), each of whom will need to be developed. There will also be a significant amount of training for the current mental health workforce and at the local level new bodies will need to be created. This will require considerable time and money. The amount of both will need to be considered carefully in any plans to implement a new Act.

[7] British Association of Social Workers, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Ev. 580, para.21.

[8] Sainsbury Centre for Mental Health, November 2004. *Report of the Joint Committee on the Draft Mental Health Bill: Volume II,* Ev 262, para 10.3.