

IMHA project team response to Depart of Health Consultation on Options for Funding Allocations for IMHA services

We responded as the research team for the first national study of the quality of IMHA services, funded by the Department of Health Policy Research Programme, as cited in the consultation document.

For more information, see:

http://www.uclan.ac.uk/schools/school_of_health/the_right_to_be_heard.php

We limited our response to commenting on the proposals for funding allocations for IMHA services, reflecting our expertise and knowledge of this area. However, we are concerned that the consultation period was shortened to meet the October deadline for the Armed Forces. In our view this seems too short a consultation period on something as important as IMHA provision.

General comments

We would have liked to see more information that would enable people to understand where the figures come from, although we welcomed the transparency of providing the detail in Annex A. Providing sufficient detail is particularly important if those people who are most likely to be affected by these decisions, i.e. mental health service users, are to be genuinely involved in the consultation. Thus, there are some curious anomalies that we did not understand and think need explaining – Leeds benefitting from Option 1 and Kensington and Chelsea benefitting from Option 2. We were unsure whether this was an anomaly or based on real need. We think some case study style examples would have been helpful.

We made two recommendations from our research that we think should have been taken into account in developing these proposals:

1. That commissioning is based on better quality information that takes account of need and differential occupancy rates by different sectors of the population.
2. That IMHA services should be provided on an opt-out rather than opt-in basis to overcome the barriers to access that we identified and in particular gatekeeping by staff or IMHA services in the context of inadequate levels of resourcing.

Finally there is nothing in the consultation document about reviewing the impact of the decision on allocation.

Response to Options

As our report makes clear, the failure to assess mental health need in relation to the allocation of funding for IMHA provision is seriously concerning and we concluded that this perpetuates discrimination against the most disadvantaged groups, for whom the need for IMHA services is arguably higher. This needs to be placed in the context of the MH Act as a legal provision that involves imposing restrictions on people's liberty and therefore we believe should be given the most careful thought.

Therefore, we have major reservations about both options because we think both formulae are too simplistic and disregard mental health need, for which there is data readily available in respect of the MH Act. Furthermore although on the face of it, Option 2 appears marginally better, we are not convinced that it is possible to read across from the needs for social care to the need for IMHA services, which are circumscribed by the MH Act.

Our main concerns are:

1. There are certain groups within the population that are more likely to be detained under the MH Act. Information about this and the adverse experiences and outcomes of particular groups, specifically people from BME communities, has been systematically collected for the past five years by the CQC and confirmed by longitudinal research (see our response to the next question for some detail). As a consequence, there are barriers to access that may mean those areas in which there are higher rates of detention or bed occupancy of people from BME communities will need to look at ways of outreaching to those communities. This has resource implications and will also be an issue for other minority groups, which would be clarified through an adequate equality analysis.
2. From our research, it was evident that the provision of IMHA services is more complicated in inner city areas with higher rates of turnover and a different population profile – more co-morbidity, ethnic profile etc – that will have implications for IMHA provision. Furthermore, in some areas, the rates of detention under the MH Act (including the use of Compulsory Treatment Orders) were increasing. This should be factored in to the funding allocations by considering the historical trends.
3. No account is being taken of the position of those Local Authorities that have specialist units, usually in the independent sector, in their area. As has been noted by the CQC, ourselves and consistently reported by the advocacy sector, the commissioning arrangements for IMHA provision for people placed out of area is often confused. On balance, we recommend that it should be the responsibility of the local IMHA service to provide this, and therefore if the expectation is that these costs are then met by the corresponding local authority, this needs to be factored into their allocation.

We therefore recommend that basis for allocating funding is the detention rates under the MH Act by Local authority area on the basis that all qualifying patients should be offered the opportunity to access the service.

Equality impact

We are very clear that both options will impact negatively on the availability of IMHA provision for BME groups in particular and would like to see a full equality impact assessment undertaken, as we understood is required by the Equality Act. We think that we have provided some of the necessary detail in our research that now needs to be acted on. For example, section 9.4 discusses this :

“People from African and Caribbean communities are two to six times more likely to occupy a bed in hospital and have higher rates of detention under the MH Act (CQC, 2011), more likely to be readmitted within a year of their first involuntary admission (Priebe, Katsakou, Amos et al, 2009), more likely to be placed in seclusion, with people from Caribbean communities also more likely to stay in hospital longer (CQC, 2011a). Furthermore, the emergent findings from the AESOP study confirm a picture of poor outcomes and negative experiences of people from Black Caribbean and Black African communities (Morgan, 2012). The higher occupancy rates for certain BME groups are reflected in the disproportionately high numbers on CTOs (CQC, 2011a; NHS Information Centre, 2011c).

All this points to the need to tailor IMHA provision for specific communities in order to address these issues and advocacy has been highlighted as a mechanism to potentially change this experience. Several reports have pointed to an urgent need for advocacy for BME communities, particularly for people from African and Caribbean communities, reflecting concerns about over-representation in inpatient wards, overuse of medication and low use of psychological therapies and inquiries into the deaths of African and Caribbean men in mental health services (Keating, Robertson, McCulloch et al., 2002; Department of Health, 2005; Centre for Social Justice, 2011).”

Although the proposal cites our report it does not refer to any positive action to ensure availability for IMHA provision for minority groups and enable IMHA provision to be a safeguard as intended. Arguably, the only group to benefit under the proposals would be older people if Option 2 was adopted. However, the need in this group will be lower than that for other groups, particularly those from BME communities.

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