For better
mental health

Health and Social Care Bill:
Amendment 236B

Amendment 236B amends Clause 37 of the Health and Social Care Bill. That clause addresses section 117 of the Mental Health Act 1983, as it applies in England, under which aftercare for patients who have been detained is provided free of charge. We propose to delete the current Clause 37 and replace it with following version.

Amendment 236B
Lord Patel of Bradford:

Page 72, delete clause 37 in its entirety and substitute:

37 After-care

(1) Section 117 of the Mental Health Act 1983 (after-care) is amended as follows.

(2) In subsection (2) –

(a) after "duty of the" insert "clinical commissioning group or",
(b) omit "Primary Care Trust or" in each place it appears,
(c) for "such time as the" substitute "such time as (in relation to England) the clinical commissioning group or".

(3) After subsection (2C) insert –

"(2D) Subsection (2) above, in its application to the clinical commissioning group, has effect as if for "to provide" there were substituted "to arrange for the provision of".

(2E) The Secretary of State may by regulations provide that the duty imposed on the clinical commissioning group by subsection (2) above is, in the circumstances or to the extent prescribed by the regulations, to be imposed instead on another clinical commissioning group or the National Health Service Commissioning Board.

(2F) Where regulations under subsection (2E) above provide that the duty imposed by subsection (2) above is to be imposed on the National Health Service Commissioning Board, subsections (2D) and (2E) above have effect as if references to the clinical

commissioning group were references to the National Health Service Commissioning Board.

(2G) Section 272(7) and (8) of the National Health Service Act 2006 applies to the power to make regulations under subsection (2E) above as it applies to a power to make regulations under that Act."

(4) In subsection (3) –

(a) after "section "the" insert "clinical commissioning group or",
(b) omit "Primary Care Trust or" in each place it appears, and
(c) after "means the", in the first place it appears, insert "clinical commissioning group or".

(5) In consequence of the repeals made by subsections (2)(b) and (5)(b), omit paragraph 47 of Schedule 2 to the National Health Service Reform and Health Care Professions Act 2002.

Briefing materials

Section 117 MHA - what is it now?

It is a freestanding duty to provide after-care services to patients who leave hospital after being detained under the treatment sections of the MHA (sections 3, 45A, 47, 48 and 37), and to those people living in the community under Community Treatment
It is a **freestanding** duty, existing alongside the duty to provide health and social care under the NHS Act. Crucially, it is a **joint** duty requiring Primary Care Trusts and local authority social services to work together to provide the necessary aftercare. After-care services are free of charge, because those who receive them are exceptionally vulnerable.

Examples of after-care may include visits from a Community Psychiatric Nurse, attending a day centre, access to a befriending service, administering medication, counselling services or accommodation within the community.

A patient wishing to ensure that they get the appropriate after-care package can expect either the PCT or the local authority to put the package in place, and to sort out funding between them. The services currently cannot be withdrawn until both are satisfied that the patient no longer needs them. In practice, this joint duty means that the patient is more likely to get access to the health and social care services they need. The patient would be able to bring a claim (should there be any dispute) against either provider in order to get services put in place.

What would the current Clause 37 do?

The main effect of Clause 37, as it is currently written, is to transfer the duty on PCTs to the new Clinical Commissioning Groups ('CCGs'). This is not contentious.

However, Mind has concerns about other aspects of the clause and has sought advice from Stephen Knafler QC and Timothy Baldwin. They have confirmed that CCGs and LAs will no longer have a **joint duty** to provide after-care, and this will have a profound effect on the provision of after-care services.

Clause 37 alters the wording of s117(2) of the Mental Health Act 1983 so that:

- The joint duty to provide after-care services is split between health (CCGs) and social care (social services authorities) and each can separately decide when to withdraw its own services without requiring the agreement of the other. (Clause 37 (2) (c), (e) and (f)).

- CCGs will no longer be under a duty to arrange aftercare in co-operation with relevant voluntary organisations. (Clause 37, line 8)

- CCG's duty to commission healthcare services will be limited to 'services of a kind that must be provided under s 3 of the NHS Act 2006 or may be provided under s 3A of the NHS Act'.

- S117 will be treated as a duty under s 3 of the NHS Act 2006 and will be provided under the same duties as other healthcare – which opens up the possibility of charging for certain services and means that the special provisions that apply to section 117 after-care will no longer apply to healthcare.

Effect of this on people in receipt of s 117 aftercare

By splitting the joint duty, clause 37 creates a real risk that those in need may fall between the gaps. There are likely to be disputes about who is responsible for which services.

CCGs will be able to stop providing 'health care' services when they decide that the person no longer needs them, and local authorities will be able to stop providing 'social care' services when they feel it is appropriate – they will not have to reach this decision together as they do now.

Our view is that free, joined up after-care services promote compliance. A seamless joint duty is the clearest way of ensuring that health and social services work together for the benefit of vulnerable patients with mental health problems. S 117 is in practice a good example of how to achieve truly integrated services that 'wrap around' the patient. Indeed the overlap is acknowledged in paragraph 422 of the Bill's Explanatory Notes. By splitting the duty, Clause 37 seems to be in stark contrast to the focus on 'integrated services' that we have been promised.

The changes also mean that for the first time s 117 after-care health services can be charged for, in circumstances where the NHS Act allows for charging. So medication provided on prescription might be charged for (unless the person is in an exempt category).

Furthermore, the Law Commission is consulting on changes to adult social care law, including possible changes to section 117. If clause 37 is passed, this will tie the hands of the draftsman and as a result there will be no proper debate on these issues.

Mind's proposal

Our amendment would still allow for the wording 'Primary Care Trusts' to be replaced with 'clinical commissioning groups' in the Mental Health Act, and for consequential amendments resulting from the abolition of PCTs. However, our amendment would

- Retain the joint duty on CCGs and social services authorities,
- ensure that CCGs continue to arrange for provision of services under s117 in co-operation with relevant voluntary agencies
- ensure that the arrangement of services by CCGs under s117 are **not** limited to services arranged under section 3 or section 3A of the NHS Act (by deleting proposed subsection (2E)),
- ensure that the duty on CCGs will **not** be regarded as a duty under section 3 NHS Act. This means it remains a freestanding duty under section 117 MHA, and the possibility of charging for aftercare is removed (by deleting proposed subsection (2F)).

Any further changes to the joint s117 duty can then take place openly and fully when discussing the forthcoming Adult Social Care Bill.

Example 1

Mr A has a diagnosis of frontal lobe syndrome following a stroke and had been detained under s 3 MHA for over a year. He had recently been transferred to a care home in North London under s117, and was appointed a social worker who was employed jointly by the NHS Foundation Trust and the local authority.

Mr A wished to return to live with his wife in their council flat. His care team agreed to allow Mr A to return home up to 3 times a week with a view to monitoring his progress. The journey from the care home to his own flat took over an hour by public transport. Because of his diagnosis, Mr A was extremely anxious when travelling on public transport - even with a care worker present - and there was a risk that he could become aggressive.

Although a community care assessment confirmed that Mr A would require a high level of after-care, he was told that he would that if he wanted to use taxis instead he would have to pay for them himself. This came to over £100 a week, which was completely unaffordable to Mr A. His solicitor wrote a letter to both the local authority and the Trust. The social worker replied and

confirmed that the local authority would not fund the cost of taxis, although they would provide Mr A with a freedom pass. After nearly six weeks, when the family had run up over £500, an application was made to the court on the grounds that the social services authority and the trust had jointly failed to provide aftercare. Within 12 hours, solicitors acting for the Trust contacted Mr A's solicitors and confirmed the Trust would cover the cost of private transport and reimburse the family for fares to date.

Without the joint duty each authority would only be responsible for their own costs and could not influence the other. The existence of the joint duty over-rides any argument between the authorities about who is responsible for what.

Example 2

A is a patient who was previously in 1996 when unwell. Since that time he has been stable and in receipt of joint supervision and support by the health authority and social services. He resides in a north London borough and qualifies for s117 after-care as he was previously detained under s37 Mental Health Act. He resides in a supported placement funded by social services. Recently however the social services care coordinator has indicated that he could be discharged from the care home and there should be a review of the duty to provide after-care under s117. The Health Service Psychiatrist has strongly opposed this move indicating the patient's condition is only partially controlled by medication and that he continues to have challenging behaviour as a result of his disorder. He strongly feels that the joint duty needs to remain as does the funding under s117 as he needs the supervision provided within the care home. As a result that duty to the patient has remained and he continues to reside in the care home.

This clearly shows that the effectiveness of the healthcare being provided was directly dependent on the social care. Social services saw only that he was managing in the supported setting, leading to the suggestion that he move on. Without the joint duty, this decision could be taken regardless of the view of his medical team.

Example 3

Mr B had a diagnosis of schizoaffective disorder, and was unable to read or write due to learning disabilities. He had a history of being detained under the MHA, being discharged with a s117 after-care package and withdrawing from services in due course, but then relapsing and returning to hospital.

His after-care package comprised a care worker from his Community Mental Health Team (CMHT) who spent about two hours every two weeks helping him with paperwork and medical appointments, and a Community Psychiatric Nurse who administered depot medication (slow release injection of medication).

On health grounds, the health authority decided CMHT support was to be withdrawn but made no provision for further support with paperwork or appointments. Without that support, Mr B felt he would not manage his tenancy, bills or appointments, and he found it difficult to get to his GP surgery for his medication. He was very worried that without the additional support he would relapse again.

There had been no recent assessment of his needs by social services, and they had not agreed to a withdrawal of services. With the help of his advocate Mr B was able to argue that the s117 after-care that was in place should not be withdrawn without the agreement of social services. The support was therefore left in place, and social services agreed to review his needs before any further decisions could be made.

The existence of the joint duty led to everyone involved sitting down to discuss his needs overall. Without this Mr B would have been left without support and most probably his mental health would have deteriorated again very quickly.

Scenario under proposed regime

A patient is discharged from section 3, with an after-care package including medication administered by a CPN and weekly counselling sessions arranged by the health authority. He is going to live with a family member and so no social services are required. After 6 months, he is no longer able to live with his family and needs a place in a local authority hostel. Social services had not been involved in providing after-care and appear not to be able to provide a seamless service, without the patient having to go through a complex set of assessment procedures.

For more information please contact
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