Title: **Pandemic Influenza and its Implications for the Mental Health Act 1983** **Lead department or agency:** Department of Health **Other departments or agencies:** Ministry of Justice	**Impact Assessment (IA)** **IA No:** 7000 **Date:** 05/05/2011 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

The Mental Health Act 1983 (the 1983 Act) might become ineffective in the face of staff shortages where the pandemic has a severe and prolonged effect on services. We have therefore drawn up a package of possible temporary changes that we might need to make to the 1983 Act and its associated secondary legislation to enable it to continue to operate as Parliament intended in such circumstances. This would require legislative change which can only be achieved by central Government intervention.

What are the policy objectives and the intended effects?

The proposed contingency provisions aim to enable mental health professionals to continue to operate the 1983 Act in the interests of the health and safety of patients and for the protection of others in exceptional circumstances. They are designed to ensure that it will still be possible for people who need to be detained under the 1983 Act to receive the care and treatment they require in the event of exceptional levels of staff absence in the context of a severe and prolonged pandemic.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

We have a choice of leaving the 1983 Act as it is, hoping that staff and patients will be able to cope without legislative change, or preparing a number of changes that could be brought into force if necessary. We have concluded that we should be ready to make a number of possible changes which we have finalised in the light of comments from a formal public consultation. We feel that we need to be able to respond should a situation arise in which the working of the Mental Health Act 1983 would otherwise break down in the face a severe and prolonged pandemic.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 1/2016 **What is the basis for this review?** Sunset clause. **If applicable, set sunset clause date:** 1/2016	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes

SELECT SIGNATORY Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible SELECT SIGNATORY: _____ Date: 12/6/11

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Summary: Analysis and Evidence

Policy Option 1

Description:

Pandemic Influenza and its Implications for the Mental Health Act 1983

Price Base Year 2010	PV Base Year N/A	Time Period Years <1	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate: 1.1**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A		N/A	**N/A**
High	N/A		N/A	**N/A**
Best Estimate	£1.7		N/A	**£1.7**

Description and scale of key monetised costs by 'main affected groups'

Local health and social care bodies will incur a small cost for training potential temporary AMHPs and approved clinicians which will be part of their pandemic preparedness activity. Total costs are around £0.7m (of which around £0.158 are realcosts) with an opportunity cost of around £1.7m.

Other key non-monetised costs by 'main affected groups'

There are also some additional costs of preparing and printing the appropriate forms but the se are negligible and therefore not rpesented.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A		N/A	**N/A**
High	N/A		N/A	**N/A**
Best Estimate	£2.8		N/A	**£2.8**

Description and scale of key monetised benefits by 'main affected groups'

Savings from reduced fees are around £93k with an opportunity cost of around £223k. Also, there are around £2.6m in QALY gains.

Other key non-monetised benefits by 'main affected groups'

Benefits do not include the potential benefits from reduced risk of homicides and suicides if changes do take place, which would lead to more net benefits.

Key assumptions/sensitivities/risks **Discount rate (%)**

We have made many assumptions which are presented in the main evidence base.
We have assumed that training occurs when PI has started and the possibility of redeploying existing staff is not possible.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs: N/A	**Benefits:** N/A	**Net:** N/A	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			Not known		
Which organisation(s) will enforce the policy?			Local NHS and social care bodies; CQC; DH; and MoJ		
What is the annual change in enforcement cost (£m)?			Negligible		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			No		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** Nilo	**Non-traded:** Nil	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** N/A	**Benefits:** N/A	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro** Nil	**< 20** Nil	**Small** Nil	**Medium** Nil	**Large** Nil
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	No	14
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	N/A
Small firms Small Firms Impact Test guidance	No	N/A
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	N/A
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	N/A
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	5
Human rights Human Rights Impact Test guidance	Yes	5
Justice system Justice Impact Test guidance	No	5
Rural proofing Rural Proofing Impact Test guidance	No	N/A
Sustainable development Sustainable Development Impact Test guidance	No	N/A

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	Mental Health Act 1983 C. 20
2	Pandemic Influenza and the Mental Health Act 1983: Consultation of Proposed Changes to the Mental Health Act 1983 and its Associated Secondary Legislation
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs										
Annual recurring cost										
Total annual costs										
Transition benefits										
Annual recurring benefits										
Total annual benefits										

* For non-monetised benefits please see summary pages and main evidence base section

Microsoft Office
Excel Worksheet

Evidence Base (for summary sheets)

1. The Mental Health Act 1983 (the 1983 Act) might become ineffective in the face of staff shortages where a pandemic has a severe and prolonged effect on services. We have a choice between leaving the 1983 Act as it is, hoping that staff and patients will be able to cope without legislative change, or preparing a number of changes that could be brought into force if necessary.

2. We therefore drew up a package of possible temporary changes that we might need to make to the 1983 Act and its associated secondary legisaltion to enable it to continue to operate as Parliament intended in such circumstances. This would require legislative change which can only be achieved by central Government intervention. We consulted on these peoposals between 10 September and 7 October 2009.

3. We have concluded that we should be ready to make the temporary changes on which we consulted. In the light of the consultation response we have decided to include some additional changes to section 5 of the 1983 Act. These are to extend the period of time during which current in-patients can be kept in hospital pending a decision on whether to detain them for assessment and, if appropriate, treatment under section 2 or for treatment under section 3 and to broaden the number of mental health professionals who can make these decisions. These additional measures should reduce the risk of people leaving hospital inappropriately during periods of severe staff shortage.

4. These proposals are intended to be brought in only in the event of a pandemic which has a severe and prolonged Impact on services that significantly exacerbates staff shortages. The proposals will therefore have little, if any, long-term impact of any kind. Because the aim is to preserve, as far as possible, the effect of the 1983 Act during an influenza pandemic, most measures should be cost neutral and some involving the reduction of the number of staff required to discharge certain statutory functions might save a modest amount. For the same reason they should make no difference to people's human rights or, where applicable, their treatment by the criminal justice system. Details of the individual proposals are set out at Annex A.

5. The risk of failing to take contingency measures in these exceptional circumstances is that the operation of the 1983 Act may break down. This would mean that people would not be detained when they should be for the benefit of their own health and safety or for the protection of others. For people who have come into contact with the criminal justice system, failure to take these measures could result in people being kept in prison rather than being cared for or treated in a hospital environment. This adverse impact would affect both patients and the public in general.

6. Where the requirements for second opinion appointed doctor (SOAD) opinions were suspended during the height of an influenza pandemic, provision would be made so that as things get back to normal, patients who were subject to the 1983 Act would be seen by a SOAD as quickly as possible. Any financial saving while the requirement was suspended would be largely counterbalanced by the cost of additional staff resource for the transitional period. There might be a small overall saving from a few cases no longer requiring second opinions by the time they are reached after the pandemic has passed its zenith.

7. A few additional staff costs may be incurred where people are brought back into organisations to act as temporary approved clinicians or approved mental health professionals (AMHPs) but not where current employees merely revert to a former role - probably only for a very short period when a high proportion of staff are off sick or caring for sick relatives. These costs should be small and the need to incur them would probably be unavoidable in the circumstances. In the event of a severe and prolonged pandemic in which a significant number of mental health staff die, there may be greater costs associated with keeping some of the temporary approved mental health professionals and approved clinicians in post for longer. There may be the extra costs of training a larger number of permanent replacements than would be needed in normal circumstances. Those costs would, however, be caused by the impact of the pandemic, not by these proposals.

8. There will be a small cost associated with identifying people to act as temporary approved clinicians and AMHPs and arranging for them to receive some preparedness training.

9. Other potential financial implications will depend on which of the contingency provisions are used in practice and how often. These implications are expected to be small. In all cases where the number of medical opinions required is reduced from two to one there might be a small saving in locum costs which might otherwise have to be incurred. The cost to the Care Quality Commission, if they agree to set up the oversight group, is likely to be small. There may also be a negligible cost of printing a few temporary forms.

10. In addition to the human costs identified at paragraph 2 above, there may also be financial costs if we fail to adopt the contingency measures. Failures to detain people for their own health or safety could increase the costs of care and treatment where their conditions subsequently deteriorate further. Costs of these kinds may similarly be incurred where people who are in contact with the criminal justice system are detained in inappropriate settings. Accommodating people in prisons who should be held in a more clinically appropriate hospital setting would also place an additional financial cost on the prison service.

11. It will be essential to gather the data that will be required to inform decisions in Parliament and elsewhere about the need to bring the temporary changes into force, keep them in force (if appropriate) and return to normal after the need for them has passed. This will entail a small cost to central Government Departments and (if it were to set up the proposed oversight group) to CQC. These seem more likely to be incurred as opportunity costs rather than additional financial burdens (i.e. people in post would carry out these functions instead of other work).

12. A pandemic will require Government Departments, the NHS and social services to have put suitable reporting mechanisms in place for a range of pandemic-related issues. Information on mental health services will be an important element of the traffic on that system. There will be a small cost at the local level of collecting and collating details of the use made of the contingency measures. Again, this is more likely to be an opportunity cost rather than an additional financial burden.

Analysis of Costs and Savings

13. Given the low probability of an influenza pandemic occurring (4%) and the lack of available information, we constructed the following model to identify potential costs and benefits. We had to use a number of assumptions, which are explicit in the following note.

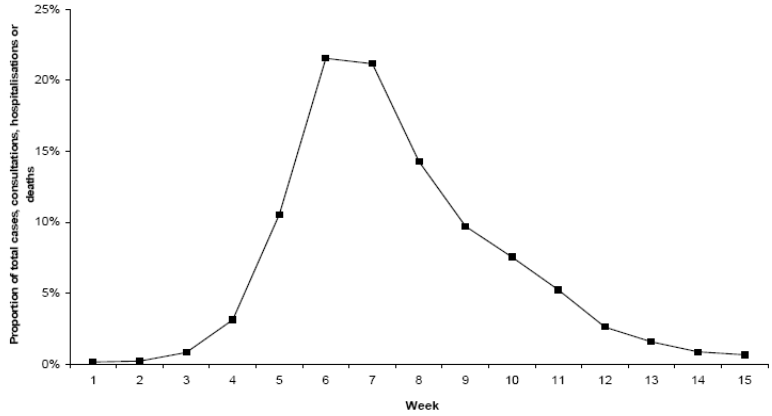
14. The following graph shows the associated cost and benefits of temporary changes to the 1983 Act compared to the “Do Nothing” Option at the two stages of an influenza pandemic; onset and peak.

Graph 1: Costs and Benefits of temporary changes to the Mental Health Act 1983 compared to no changes

Stage 1: Pandemic Influenza Onset	**Stage 2: Pandemic Influenza Peak**
Temporary Changes: Cost of Training including opportunity cost (-)	**Temporary Changes: Doctor fees saved (+)**
	Do nothing: QALY loss of cases not being dealt with (-) Increased probability of suicides and homicides (-) Costs of reassigning staff to cover for staff (-)

15. There is no clear information on how long an influenza pandemic will last and how it affects the population. We looked at different scenarios of PI but present findings using the most expensive realistic scenario. This is when there is a short peak (i.e. large number of people getting ill all at the same time for a short period). This would imply that we would need to provide training to a large number of people to cover for large absence rates.

Indicative profile of weekly national numbers of cases, hospitalisations, deaths etc. as proportion of total over single wave pandemic - Department of Health (2005).



16. According to this scenario, the whole pandemic influenza lasts 15 weeks. We have assumed that from week 5 the system starts not coping well (training starts) and week 6 and 7 is the peak of the influenza pandemic. Therefore, the period of the intervention according to this model lasts 5 weeks (week 5 to week 9).

Number of professionals affected by an influenza pandemic (staff absence)

17. As we do not have any available information, we made some assumptions using various sources, to calculate the number of professionals associated with the assessment of patients under the 1983 Act. The following table shows the workforce associated with detains and the source of the information:

AMHPs	3900 wte	ADASS 2005 Adult Social Workforce Survey
Doctors and approved clinicians	4236	http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1999--2009-medical-and-dental

18. Using the ratio from NHS Workforce statistics for professionals working in psychiatry, the 3,900 wte translates to around 4,200 individuals. In total, the workforce associated with assessments is estimated to be just above 8,000 professionals.

19. According to Scientific Pandemic Influenza Advisory Committee (SPI): Subgroup on Modelling around 12% of the workforce can be affected and absent from work at the peak of an influenza pandemic. This implies around 1,000 professionals will be absent from work during the influenza pandemic peak.

Number of patients (assessment) affected by staff absence due to an influenza pandemic

20. In order to calculate the number of patients affected by a possible breakdown of the system we used estimates on the number of assessments in a year. There are around 49,417 detentions[1] in a year; as the patient is assessed by two doctors, either separately or at the same time, this implies around 100,000 assessments. In addition, we have assumed that there are around 50,000 assessments[2] in a year that do not lead to a person being detained.

21. Assuming that the number of assessments is spread equally across the year; this implies that during the period of the influenza pandemic (5 weeks) there would be around 15,000 assessments.

22. As mentioned in paragraph 20, patients receive two assessments, which implies around 7,000 patients being assessed in this period.

23. Not all of these assessments (patients) will be affected by the influenza pandemic. We have assumed a linear relationship between absenteeism in the workforce (12%) and the number of assessments not able to be completed. This implies around 1,700 assessments (around 850 patients) affected by staff absence due to an influenza pandemic.

Costs, savings and benefits associated with temporary changes to the MH Act 1983

Costs

24. Some of the legislative changes rely on being able to train people to step up when needed to replace the professionals who will be absent in the case of an influenza pandemic.

[1] Information Centre October 2010

[2] assessments that do not lead to detention represent around a third of the cases - personal communication with policy colleagues.

25. Again, we need to make a series of assumptions to calculate the number of people who we would need to train. Some of these people would be recently retired doctors who would be willing to step in.

26. According to the Royal College of Psychiatrists there are 8,390 psychiatrists in England, 5,319 consultants; 3,071 in training grades; this implies around 210 retiring each year (assuming a career of 40 years). The three years out of service limit means we would be looking at a pool of 630 former RMOs/approved clinicians. On the basis that half would volunteer to act again in a temporary capacity this would give us 315 retired doctors who might return to temporary service. Perhaps another 10% would be added from other sources, a total of about 350. If we assume a similar number of former ASWs/AMHPs that gives an overall number of additional professionals of about 700 (around 70% of the number of professionals affected). The costs of providing training to these professionals is around **£0.158m (**2008/9 prices**)**.

27. We have used information from PSSRU's publication "Unit Costs of Health and Social Care" to calculate the opportunity costs associated with providing training for the above mentioned professionals. For AMHPs we used the unit cost per hour for a social care worker (£30 per hour[3]) and for GPs the unit cost per surgery/clinic minute. Using the assumption that around 700 professionals will be able to volunteer and therefore be trained, the opportunity cost is around **£0.54m** (2008/9 prices).

28. There are also some additional costs of preparing and printing the appropriate forms but these are negligible and therefore not presented.

Savings

29. As we are able to provide training to cover for 70% of the workforce affected by the influenza pandemic, and assuming a linear relationship between the effect on workforce and on the patients, 30% of the cases will have to be seen by only one doctor-260 patients will have only one assessment instead of two. As mentioned previously fees are around £181, therefore savings to the NHS are around **£0.093m**.

Benefits

30. If the temporary legislative measures were not put in place, employing authorities would have to find some practical means of covering for the 12% staff absences in order to avoid delays. This would seem likely to mean paying additional sessions (i.e. overtime), reassigning staff onto assessment from other tasks (opportunity cost).

31. We have assumed that around 850 patients will be affected by staff absences and therefore not receive any assessment (or services) for this 5 week period when they are most in need.

32. There will be some inappropriate failures to detain and some voluntary admissions that would have happened following an assessment would also be missed. This would leave some people out in the community whose clinical condition is such that they should be (and normally would have been) in hospital.

33. According to calculations based on "Developing New Approaches to measuring NHS Output and Productivity" (Dianne Dawson et al) the QALY loss for a delay of for psychiatric disorders treatment in an inpatient setting is around 0.05 per patient.

[3] PSSRU unit cost for health and social care, 2009

34. This implies a QALY loss of around **£2.6m** (£60,000 x 850 x 0.05)[4] if there are no temporary changes to the 1983 Act and half of the patients do not get assessed and treated in the 5 weeks of the influenza pandemic's peak.

35. The missed stays in hospital would lead to a small increased risk of avoidable suicides in those cases. There would also be a very small risk of an increase in homicides. It is very difficult to quantify the loss from these events as we have no information on the probability of these events happening. However, both are associated with large costs.

Conclusion

36. The following table shows the costs and savings associated with temporary changes.

37. Following Department of Health Impact Assessment Technical Guidance, costs and savings are also presented as opportunity costs. These are calculated according to a standard formula by mulitplying costs and savings by a factor of 2.4).

	£ (2008/9 prices)
Costs	
Training of professionals	£0.158m
Time of professionals foregone to be trained (monetary equivalent)	£0.540m
Total Cost	£0.698m
Opportunity Cost	£1.7m (£0.698m x 2.4)
Savings	
Savings from reduced fees	£0.093m
Opportunity cost	£0.223m (£0.093m x 2.4)
Benefits	
QALY gained	£2.6m

38. The costs associated with temporary changes to the 1983 Act are around £0.7m (of which around £0.158m are real costs) with an opportunity cost of around £1.7m.

39. There are also some additional costs of preparing and printing the appropriate forms but these are negligible and therefore not presented.

40. Savings from reduced fees are around £0.093k with an opportunity cost of around £0.223k.

41. In addition, as noted at paragraph 34 above, there are around £2.6m in QALY gains. By adding this to savings of £0.223m we arrive at the overall figure of £2.8m quoted as an overall benefit in the summary above.

[4] a QALY is valuated at £60k

42. The benefits described here do not include the potential benefits from reduced risk of homicides and suicides if changes do take place, which would lead to more net benefits.

43. Finally, as mentioned at paragraph 13 above, due to lack of available information, we had to make a number of assumptions, which have all been clearly stated in the document.

Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review: [The basis of the review could be statutory (forming part of the legislation), i.e. a sunset clause or a duty to review , or there could be a political commitment to review (PIR)]; The review would be undertaken only after it had become necessary to bring some or allof the temporary changes into force.
Review objective: [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?] The objective of the review would be to ascertain, as far as possible, how much use had been made of each of the temporary changes, where, and how helpful they had been in enabling the continued operation of the 1983 Act.
Review approach and rationale: [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach] Any review would be informed by such information as we were able to collect on the use made of the various temporary changes, and on consultation with stakeholders.
Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured] The use of the temporary changes will be optional and their effect will be measured against the extent to which they were used.
Success criteria: [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives] The success of the policy will be measured by the extent to which the temporary changes were used once they had been brought into effect.
Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review] Information will be required centrally to answer three questions – whether the severity of staff absences is so great that emergency measures should be introduced or (if introduced already) should remain in force; how much use has been made of each of the emergency measures; and where. Mental Health Act administrators are well-placed to gather information on the use made of the various temporary changes to the 1983 Act. Information gathering and reporting systems which monitor pressures in the NHS, as well as social care services, are to be reviewed as part of the overall lessons learnt exercise in relation to the H1N1 2009 swine flu pandemic. This review will include the need for some information on Mental Health service provision and resilience, but will take into account the principle of minimising the data reporting burden (where possible) and using existing reporting systems where appropriate.
Reasons for not planning a review: [If there is no plan to do a PIR please provide reasons here] Not applicable.

Annex 2: Proposals requiring legislative change

A2.1 Allowing just one medical recommendation on an application by an approved mental health professional (AMHP) for someone to be detained under section 2 or 3 of the 1983 Act

A2.2 To facilitate A1 above, preparing special forms A2A and A6A to record detention on the strength of a single medical recommendation

A2.3 Changing the number of doctors involved in decisions to transfer people from prison to hospital under Part 3 of the 1983 Act

A2.4 Suspending the obligation to obtain second opinion appointed doctor's (SOAD) opinions on medication

A2.5 Suspending time limits on conveying people and admitting them to hospital under Part 3 of the 1983 Act

A2.6 Suspending time limits on warrants for transferring people from prison to hospital

A2.7 Giving courts discretion to renew remands under the 1983 Act beyond the normal 12 week maximum

A2.8 Allowing strategic health authorities the flexibility to approve former responsible medical officers (RMO) and former approved clinicians to be temporary approved clinicians

A2.9 Allowing strategic health authorities the flexibility to approve current section 12 doctors who have not previously acted as RMOs to be temporary approved clinicians

A2.10 Seeking a three-month transitional period for SOAD second opinions

A2.11 If there should be a large number of staff deaths, keeping the contingency measures for temporarily approved AMHPs and approved clinicians in place until fully trained replacements can be approved

A2.12 Extending the periods of emergency detention permitted under section 5(2) (emergency detention of a hospital in-patient by a doctor or approved clinician) from up to 72 hours to up to 120 hours.

A2.13 Extending the periods of emergency detention permitted under section 5(4) (emergency detention of a hospital in-patient by a nurse with special expertise in mental health or learning disability) from up to 6 hours to up to 12 hours.

A2.14 Allowing any approved clinician or registered medical practitioner to detain a hospital in-patient under section 5(2) rather than just the one in charge of the case.

A2.15 To facilitate A14 above, preparing special form H1A for use by an approved clinician or doctor who is not in charge of the case.

Annex 3: Equality Impact Assessment

Pandemic Influenza and its Implications for the Mental Health Act 1983
Description of policy: This policy sets out a number of temporary changes that could be made to the 1983 Act and some of its associated secondary legislation to enable it to continue to operate in the face of staff shortages where a pandemic has a severe and prolonged impact on services. The changes would be made to ensure that mental health professionals could continue to operate the 1983 Act in the best interests of the health and safety of patients and for the protection of others in these exceptional circumstances. The contingency provisions proposed are designed to ensure that it will still be possible to for people who need to be detained under Mental Health Act 1983 (the 1983 Act) to receive the care and treatment they require in the event of a severe staff shortage. By reducing the number of mental health staff required to take specified decisions under the 1983 Act and enabling local authorities and strategic health authorities to approve additional staff to undertake certain defined roles, these contingency measures will largely preserve the effect of the 1983 Act in circumstances in which its operation (and hence many of the Department's strategic objectives for mental health) could otherwise break down. The risk of failing to take contingency measures in exceptional circumstances would be that the operation of the 1983 Act could break down. This would mean that people would not be detained when they should be for the benefit of their own health and safety or for the protection of others. For people who have come into contact with the criminal justice system, failure to take these measures could result in people being kept in prison rather than being cared for or treated in a more appropriate hospital environment. This adverse impact would affect both patients and the wider public. Because the proposals in this consultation document are intended to be brought in only where staff shortages result from a pandemic which has a severe and prolonged impact on services, they will have little, if any, long-term impact of any kind.

Evidence – Sources of evidence
How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the groups?
By preserving as far as possible the practical effect of the 1983 Act the policy should make no difference to the promotion of equality or the elimination of discrimination on grounds of age, disability, ethnicity, gender, religion or belief, sexual orientation or socio-economic disadvantage. None of the contingency measures proposed affects the criteria to be satisfied before a person can be made subject to any of the provisions in the 1983 Act. They will continue to be equally applicable to everyone irrespective of background. Ensuring that more than one person would still have to agree to any decision to make someone subject to the 1983 Act will reduce the risk of it being inappropriately influenced by their belonging to any particular group.

How will the policy meet the needs of **different communities** and groups?
There continues to be some concern that members of some groups, in particular if they come from minority ethnic backgrounds, are more likely to find themselves subject to compulsory measures under the Act than the population as a whole. We are not aware of any empirical evidence that they are more likely to be detained inappropriately. The underlying reasons for this are complex and these contingency measures do not seek to address them. But equally, these contingency measures are not expected to affect the proportions of people from different sections of the community who come under any of the 1983 Act's provisions.
Give details of any **consultation** that has already been done which is relevant to this policy.
The Department of Health undertook a public consultation exercise between 10 September and 7 October 2009. We asked 18 consultation questions about temporary changes to the 1983 Act, the circumstances in which it would be appropriate to introduce those changes and the information that would be required to satisfy Parliament that temporary measures should be introduced, continued or (in due course) withdrawn. There were no consultation comments suggesting that any of the proposals would impact unfairly on members of any particular group. Eleven out of 120 consultation responses queried whether the proposals impinged upon the human rights of people with mental disorders. For example the Law Society thought that the proposal to suspend the time limits on warrants for transferring people from prison to hospital might lead to circumstances giving rise to a claim under Article 3 of the European Convention on Human Rights (ECHR). The Mental Health Alliance reported that some of their member organisations were suggesting that it was possible that the proposals on single medical recommendations and the suspension of SOAD requirements could breach the ECHR. The Equality and Human Rights Commission expressed the view that these two changes, in particular, would be proportionate in Human Rights Act terms only insofar as they are strictly necessary and are subject to strict limits of situation and duration. Maintaining the compatibility of the 1983 Act with the ECHR was one of our four key considerations in drawing up the consultation proposals. In particular, ensuring that more than one person would still have to agree to any decision to make someone subject to the 1983 Act will reduce the risk of it being inappropriately influenced by their belonging to any particular group.
Give examples of existing **good practice** in this area, for example measures to make it easier for people in particular groups to influence policy.

Good practice will be encouraged by ensuring that these measures are implemented only when absolutely necessary. The Government would require convincing evidence of the need to introduce these changes before seeking Parliamentary approval for bringing the revised temporary legislation into force.

The consultation on the changes to the 1983 Act includes a proposal to ask the Care Quality Commission to convene an oversight group with representation from national mental health service user and professional bodies. This would advise on progress and the need for ongoing contingency measures. It would provide a forum for any concerns that stakeholder groups may have over the implementation of the temporary changes to the 1983 Act. We will work with CQC to finalise details about how this group would work and who would be invited to be its members. As a listed public body under equality legislation, CQC will have due regard to its equality responsibilities when convening the oversight group.

Evidence – Key facts

How is the policy likely to affect the **promotion of equality** and the **elimination of discrimination** in **each** of the areas?

By preserving as far as possible the practical effect of the 1983 Act the policy is not expected by itself to make difference to the promotion of equality or the elimination of discrimination on grounds of age, disability, ethnicity, gender, religion or belief, sexual orientation or socio-economic disadvantage.

The suspension of the obligation to obtain second opinions in specified circumstances means that patients will receive medication without the benefit of a second opinion during the pandemic and during the period in which SOADs are catching up for longer than would happen normally. This proposal reflects a judgment that the medical time freed up by suspending this obligation would be redeployed to tasks which address more serious risks. As noted above, people from minority ethnic backgrounds are more likely to find themselves subject to compulsory measures under the 1983 Act than the population as a whole, so are more likely to be affected by this change.

Details of second opinion referrals for members of different ethnic groups are given in figures 21 and 29 in the Care Quality Commission publication "Monitoring the Use of the Mental Health Act in 2009/10" which can be found at: http://www.cqc.org.uk/mentalhealthactannualreport2009-10.cfm. The footnote to Figure 21 says that the proportion of patients referred for a second opinion who come from ethnic minorities is higher than in the overall detained population. This indicates that suspension of the SOAD role would delay receipt of second opinions for a higher proportion of detained patients from ethnic minority groups. The change would nevertheless be equally applicable to any patient subject to compulsory measures but not consenting to treatment, irrespective of their membership of any minority group.

Challenges and opportunities

What measures does the policy include, or what could it include, to address existing patterns of **discrimination**, **harassment** or **inequality**?

Preserving as far as possible the practical effect of the Mental Health Act 1983 will reduce the probability of people being left in the community without appropriate support when they ought to be in hospital. This will avoid an increase in people visibly manifesting the effects of untreated mental disorders and minimise the risk of people with mental disorders harming themselves or others in community settings. By reducing these risks we also reduce the risk of increasing the stigma associated with mental health problems within the community generally.

What impact will the policy have on **helping different groups of people** to get on well together to **improve community relations**

The policy is designed to ensure that as far as possible people are made subject (or not as the case may be) to the same provisions in 1983 Act as they would have been under more normal circumstances. Thus it should ensure that mental disorder would not be a factor leading to any worsening of relations between different groups in the course of a pandemic.

If the policy is likely to have a **negative** impact, what are the reasons?

There is a risk that implementing temporary changes to the 1983 Act could draw attention to mental disorders in a stigmatising way. This would be a particular risk if the 1983 Act were to be the only primary legislation to be changed in response to a pandemic. Our judgement is that the potential consequences of not being able to take these measures in extreme circumstances would be worse.

Some people would see all these proposals as having a negative impact. But they would only ever be introduced in circumstances where there is an unacceptable risk of the operation of the 1983 Act otherwise breaking down. In those circumstances, whilst there would be a negative impact compared to the normal situation, their impact compared to the alternative at the height of a pandemic would be positive. This is because the contingency proposals would enable people to be cared for and treated where necessary in the same way as would have happened under the 1983 Act in more normal conditions.

Where provisions are suspended during the height of the influenza pandemic, for example those relating to second opinion appointed doctors, transitional arrangements when that period ends could be used to help ensure that any short-term impact on patients who had been subject to the 1983 Act during that period will be redressed in an orderly way as quickly as possible.

What **practical changes** will help reduce any adverse impact on particular groups?
The contingency measures provide a framework for minimising the practical effects of an influenza pandemic on the provision of services to mentally disordered people. The main practical steps in relation to the contingency measures themselves would be a requirement for Parliamentary approval prior to their introduction and oversight arrangements (including the CQC group and Parliamentary review as appropriate) to ensure they do not remain in place for longer than absolutely necessary. If any of the temporary changes were, unexpectedly, to impact adversely on any group in any place, the problem could be addressed immediately by local management action as none of the measures would be compulsory.

What will be done to **improve access** to, and **take-up** of, services and **understanding the policy**?

The objective of the policy is to maintain the usual access to and take-up of services. The policy will be promulgated initially through the Department's formal consultation response.

What can you do to **promote equality** and **eliminate discrimination** when you procure goods and services?

The proposals do not concern the procurement of goods or services.

Equality Impact Assessment

As the aim of these temporary changes would be to preserve the effect of the 1983 Act, as far as possible both during and in the aftermath of a pandemic, no great adverse or positive impact is likely.

None of the contingency measures proposed affects the criteria to be satisfied before a person can be made subject to any of the provisions in the 1983 Act. The law is equally applicable to all and these proposed temporary changes to the law will alter it in the same way for everyone, irrespective of age, disability, ethnicity, gender, religion or belief or sexual orientation.

A race equality impact assessment undertaken for the Mental Health Bill 2006 reflected the advice of an expert group. It considered changes to the 1983 Act which have since come into force. In discussing the introduction of SCT the SOAD aspect did not get a mention. The only directly relevant issue it did discuss was equalities training for those temporarily appointed to undertake professional roles. This consultation response notes that approving bodies should have confidence in the ability and suitability of any section 12 approved doctors they saw fit to approve temporarily as approved clinicians and would need to ensure that they were properly prepared and professionally supervised. As listed public bodies under equality legislation, the approving bodies will have due regard to their equality responsibilities when making these temporary appointments.

We acknowledge that the suspension of the SOAD provisions in specified circumstances would lead to some patients receiving medication without the benefit of a second opinion for longer than would happen normally. This proposal reflects a judgment that the medical time freed up by suspending this obligation would be redeployed to tasks which address more serious risks.

The ultimate justification for these measures, however, is that the risk of not taking them in such exceptional circumstances would lead to a breakdown in the operation of the 1983 Act. This would create a serious inequality between the treatment of patients in normal circumstances and their treatment during a pandemic. People would not be detained in hospital when they should be for the benefit of their own health and safety or for the protection of others.

Failure to take these measures could also result in people who have come into contact with the criminal justice system being kept in prison rather than being cared for or treated in a hospital environment.

These adverse impacts would affect both patients and the wider public.

Action plan
We will need to ensure that the need for information on pressures and resilience in all NHS services during an emergency takes into account the principle of minimising the data reporting burden (where possible) and using existing systems where appropriate.. We will also need to ensure that, once the need for them has been established, we have robust arrangements in place to enable us to seek Parliamentary approval for the legislative changes as swiftly as possible. This will need to be informed by robust information gathering on the effects of the pandemic, in particular on the impact of staff absence levels. (Staff absence levels will also inform decisions on whether these changes need to remain in force.) We will review procedures for obtaining the best possible information in such extreme circumstances on the use made of the various contingency changes. This additional evidence would also be critical in informing decisions on whether or not some or all of these changes would need to remain in force. Finally, following any period during which the temporary measures had been in force, we would work with relevant stakeholders to review how well the temporary changes had worked and what lessons should be learnt for the future.

Health Impact Assessment Screening Questions

A. Are the potential positive and/or negative health and well-being impacts likely to affect specific sub groups disproportionately compared with the whole population?

Only a minority of the population will come under the provisions of the 1983 Act at any time. The changes envisaged are intended to ensure that they are able to receive the same treatment that they would have done in normal circumstances.

B. Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates?

By preserving the practical effect of the 1983 Act when its operation might otherwise break down the changes should have no discernible overall effect on the health treatments people receive. But they will have a beneficial impact on the health of the people concerned compared to what could happen if the changes were not introduced.

C. Are there likely to be public or community concerns about potential health impacts of this policy change?

There are always concerns about any changes that are made to mental health legislation. As the aim of these temporary changes is to preserve the effects of the 1983 Act in extreme circumstances there should be few legitimate concerns about its effect on people's health. These changes should make no practical difference to that but should ensure that no one's health suffers unnecessarily.