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Why commissioners need to know about Section 136

The article by Patrick Keown[1] was a timely contribution to discussions currently taking place about the use of Section 136 between the Royal College of Psychiatrists, Home Office, Department of Health, Police, Health and Social Care Information Centre, and Care Quality Commission. A major and long-standing problem in understanding the trends in the use of this power has been the failure to collect complete information on the use of Section 136, as the author points out, referring to data collected in 2005–2006. We would like to draw attention to more recent data collected in 2011–2012: these show a dramatic increase in rates of detention under Section 136 – 43% in 6 years, from 16 500 to 23 569.[2] Although the number taken to custody suites has fallen from 11 500 (2005–2006) to 8667 (2011–2012), this figure still far exceeds the anticipated number if custody suites were used in 'exceptional circumstances only', as described in the Mental Health Act 1983 *Code of Practice*,[3] and reiterated in the Royal College of Psychiatrists' guidance.[4]

In 2012, the Association of Chief Police Officers (ACPO) collected information on the use of Section 136 in all 43 police areas and discovered that 37% of those detained under Section 136 continue to go to a custody suite, although this varies between force areas. Despite approximately £130 million of capital funding having been made available for Section 136 suites 7 years ago, there are several police forces in England that still do not have access to hospital places of safety 24 hours a day and/or when demand exceeds capacity. This unacceptable variability in provision is clearly a commissioning issue and in March this year the College produced guidance for local commissioners in order to help identify shortfalls in local service provision.[4]

The multi-agency Mental Health Act group chaired by the College is collecting more detailed information on local services and would be delighted to receive completed surveys (www.rcpsych.ac.uk/pdf/PS02_2013_survey.pdf) from members to inform further discussions.

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Getting it right for people with dementia

Steve Ilife's editorial is perceptive, diplomatic and hopefully not too late.[1] As he makes clear, dementia is not, for most people, a stand-alone condition. Once established it remains significant in determining quality of life and need for help and support right to the end of an individual's life. Every journey with dementia is unique and will not be constrained by a predictive pathway or tidied into convenient once-and-for-all time phases.

Our model of specialist involvement in primary care in Gnosall Memory Service, which is dismissed as third choice by psychiatrists in the South West, has the advantage of proven sustainability over nearly 7 years. The arrangements bring the specialist expertise of psychiatry into the practice and the practice retains the clinical responsibility for patients. Many are elderly and carry a number of illnesses for which they attend the practice: a memory problem is simply one of a spectrum of challenges, and attendance at a practice clinic is an acceptable addition to the patient's routine. Patients are seen as people with full lives with important social and family involvement. An integrated and collaborative approach achieves rapid access to assessment, diagnosis and care planning, with high satisfaction by all parties and reduced usage of other components of the mental health and general hospital economies.[2–4]

The Gnosall experiment was not intended to remain an isolated enterprise: several visiting teams have taken the essentials of the model and begun similar services elsewhere. We have described a three-tier model which foresees the integration of the work in primary care within a reorganised district memory service as a component of the old age psychiatry service.[5]

We are currently working with commissioners, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, and a federation of over 30 primary care outlets that cover 360 000 patients, with a view to implementing this vision over a wider area. This is not a pathway to loss of special skills, independence or status, but the logical way to deliver a sensitive, comprehensive and affordable service for every individual and every family with dementia in the UK in the 21st century.

Declaration of interest
All authors contribute to the work of the Gnosall Memory Service.

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Commissioning dementia services

Iliffe[1] makes important points about complex conditions but offers a very limited view of the possibilities for commissioning dementia services.

Any qualified provider broadens the options and there is no reason why the whole system needs to be commissioned from a single provider. In acute hospitals, services may be provided by liaison psychiatry or physicians or both. Liaison psychiatry could extend into the community[2] or intermediate care services. In care homes, where frailty is common, there might be an alliance of community geriatrics and old age psychiatry with the independent sector. Home treatment may include joint health and social care, memory services, and care advisors.

What is crucial is that the whole system has to be commissioned and commissioners see the whole system and bind the component parts together. This point is made in the National Institute for Health and Care Excellence dementia commissioning guide with reference to dementia clinical networks.[3] Networks define a whole system where local providers are clearly identified to meet local need and operate a unified, interactive dialogue, not a care pathway that patients do not follow.

The new commissioning environment creates an exciting opportunity to think more imaginatively and this will be needed to meet the dementia challenge. This has to be more than the 'is it the GP or the specialist?' question.

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Dementia commissioning – a missed opportunity

Professor Iliffe finishes his editorial with a question,[1] but does not address a much more important issue in dementia care in this country – that although dementia is considered a public health priority by the World Health Organization,[2] the Department of Health's dementia commissioning pack does not prioritise dementia.

According to the Alzheimer's Society, more than half of cases of dementia continue to remain undiagnosed in the UK (www.alzheimers.org.uk). Significant resource allocation is needed to address poor diagnosis rates in the population via public mental health campaigns. This should also address the still prevailing stigma about dementia and highlight the potential prevention strategies.

The Royal College of Psychiatrists and the Royal College of General Practitioners have tried to address this by producing the Joint Commissioning Panel for Public Mental Health (JCPMH); however, most health and well-being boards responsible for delivering the public health agenda do not have statutory representations from mental health trusts.

The Commissioning for Quality Innovation and Prevention (CQUIN) schemes for 2013–2014 have allocated resources for integrated/collaborative care in dementia but the funding is non-recurrent. The chronic underfunding of old age services to the tune of over approximately £2 billion needs to be addressed. Most consultants working in an older people's mental health service have a catchment population twice the upper limit suggested by the Royal College of Psychiatrists.[3]

General practitioners need to remain the focal point of coordinating dementia care and need further training in complex care rather than financial incentivisation under the Quality and Outcomes Framework.

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Author's response

In the 'quick and dirty' poll I carried out among psychiatrists in the South West, the least popular option for reconfigured services for people with dementia was the Gnosall model, described in greater detail by Susan Benbow and colleagues. This model inverts the natural world, putting the general practitioners (GPs) in charge while fostering 'interactive dialogue', and is surely an example of the more imaginative thinking that David Anderson hopes commissioners will display. Its attractiveness remains to be seen, as it is now at the point where its methods must be picked up from the 'innovator' group which created it, and used by less determined but perhaps more typical 'early adopters'. We shall see whether this happens. Since 90% of care homes are outside the public sector (even if they receive enough public funds to be inside the public domain), the second most popular option also fits David Anderson's suggestion about an 'alliance of community geriatrics and old age psychiatry with the independent sector'. This is a difficult option, because it could bring the specialist alliance into conflict with generalists over who is the clinical lead for people with dementia, with an uncertain outcome when clinical commissioning groups are heavily influenced by GPs, and are very aware of the need to reduce costs. Even more imaginative ideas about multiple providers seem to many to simply replicate the current fragmented system; curing fragmentation of provision by further fragmentation sounds counterintuitive to many, unless the whole process is to be led by consumers under a 'personalisation' agenda.