



Royal College of Psychiatrists in Wales and The Association of Directors for Social Services Joint Consultation Response

RESPONSE OF: THE RCPsych in WALES and the ADSS Cymru

RESPONSE TO: Draft Code of Practice on Parts 2 and 3 of the Mental Health (Wales) Measure, 2010

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales.

We are pleased to respond jointly to Part 2 of the consultation. Parts 3 and 4 were prepared by the Royal College of Psychiatrists in Wales.

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We would like to thank you for the opportunity to comment on the draft Code of Practice covering parts 2 and 3 of the Mental Health (Wales) Measure. The Royal College of Psychiatrists in Wales and the Association of Directors of Social Services Cymru have again come together to issue a joint response to the draft Code. We believe that joint working between healthcare and social service professionals is paramount to ensuring the success of the Measure and we feel this should take place at every given opportunity.

We find the Code is by and large a comprehensive guidance to assist Care Coordinators in their role under the Measure but we feel that there are areas where improvements can be made. Our main concern is that the draft Code does not sufficiently cover the responsibilities of the mental health service providers and as a result, the importance of their roles, particularly in terms of clinical governance and joined-up working between the Local Authorities and Local Health Boards, is undermined.

We are pleased that the Welsh Government has produced an Order to attempt to define secondary mental health services and we look forward to providing you with our comments in due course. Yet we feel that, in order to provide a truly valid response to the consultation on the draft Code of Practice, it would have been helpful if at the outset of the consultation it was clear which services would be covered by parts 2 and 3 of the Measure. As of yet, it is difficult to understand the impact that the Measure will have on our services and in particular on the pressures of Care Coordinators.

Sincerely,

Dr Helen Matthews and Mr Stewart Greenwell

Consultation response form

The Draft Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

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If you are a representative of a group or organisation, please tell us a little bit about that organisation or group –

The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the United Kingdom. RCPsych in Wales represents the Members, Fellows and Inceptors of the College in Wales at the Royal College of Psychiatrists.

The Association of Directors of Social Services Cymru is the professional leadership organisation for social services and social services in Wales. It represents the statutory directors of social services and senior operational heads of service who are responsible for adults, children and business social services across the 22 Local Authorities in Wales.

Consultation questions on the draft Code of Practice

Question 1

Do you agree with the structure, style and tone of the draft Code?

Yes

No

Comments –

We welcome the Welsh Government's intention to publish a Code of Practice.

The draft Code of Practice is designed to provide guidance to Local Authorities, Local Health Boards and Care Coordinators in relation to their functions under the Measure (Paragraph ii). We believe the guidance is comprehensive but only in terms of the roles and responsibilities of the Care Coordinator (our specific comments on the guidance are written below) and not with regard to Local Health Boards and Local Authorities. We believe that the Code should stress the importance of good clinical governance and effective top-down arrangements through the strengthening of partnerships between health and social services with robust and formal working arrangements, particularly the need to develop joint assessments. The Code instead places the responsibility of this entirely on Care Coordinators. We question whether this level of authority is appropriate, particularly as the Code provides very little in terms of support to care coordinators (paragraphs 3.34 – 3.38).

We are equally concerned that the draft Code of Practice implies that there are two separate mental health providers. Although the Measure gives a clear obligation that Local Health Boards and Local Authorities work together, there appears to be little requirement for integrated working between these mental health providers. The partnership between health and social services needs greater emphasis.

The tone of the Code is intended to be age-neutral however the Code is not appropriate for children, in highlighting their development needs or needs of the family.

We welcome the emphasis on the 'Recovery Model' as it provides a challenge to the

traditional idea that people with mental health conditions (such as schizophrenia or bi-polar depression, and others) will inevitably deteriorate. We know from research and clinical experience that individuals can demonstrate a wide range of different outcomes which allow them to resume some personal, social and vocational activities. [Davidson et Al, 2006]¹.

However, reference to a recovery model must also take into account that the model may have some limitations for individuals whose mental health problems relate to pervasive developmental disorders such as Autism and Attention Deficit Disorder and to those with Acquired Brain Injury and Personality Disorders.

We must reiterate that the Code does not, as yet, define fundamental issues such as what is meant by a user of secondary Mental Health Services. In this context it is challenging to state that “departures from the Code could give rise to legal challenge” (paragraph iv). Such a stance can only realistically be taken once the fundamental purpose of the act has been adequately defined.

Question 2

Are the guiding principles in Chapter 1 suitable for the Code? If not, how could they be improved?

Yes

No

Comments –

The guiding principles are clear and we welcome the importance placed on the service user as central to service.

We agree with them but believe that to a large extent these are already incorporated into current arrangements for the planning of patient care and treatment. We applaud the holistic approach taken, but question if enshrining the CPA in legislation will lead to consistent application of CPA across Wales

¹ Davidson, L., O’Connell, M.Tondora, et al. (2006) The top ten concerns about recovery encountered in mental health system transformations. *Psychiatric Services*, 57, 640-645.

There is an emphasis on CPA and Care Co-ordinators which is understandable in the context of Mental Illness services, but fails to recognise that CPA is not extensively used in Learning Disability services. There needs to be due consideration of the interface between the new care planning arrangements and existing UA requirements.

Paragraph 1.5 addresses planning of future care. Future planning is appropriate when the nature or chronicity of a mental disorder warrants it but it is not universally appropriate. Care planning cannot cover all possible eventualities. This section may be seen to imply long term problems with mental disorder (such as chronicity, deterioration leading to incapacity or the inevitable need for hospital care) – in marked contrast to the overall emphasis on recovery.

Paragraph 1.9 refers to care planning being developmentally appropriate for children. This sentence is clumsy. We would suggest that this principle is expanded to covering needs that are age and development appropriate – and is separated from the separate principle of needs assessment in multiple needs domains. This would also cover older adults and those with learning disability.

We are concerned regarding the wording within section 4 *Care and treatment planning should be proportionate to need and risk*, which falsely implies that Care Coordinators can “control” the level of bureaucracy that is generated simply through a proper risk vs. need assessment (paragraph 1.13). The Measure increases the level of responsibility for Care Coordinators, and this coupled with the introduction of the Care and Treatment Plan will inevitably and unavoidably lead to an increase in bureaucracy, hence, the workload of the care coordinators. However, we do welcome that the Code introduces a principle of proportionality. Not all patients requiring specialist mental health services will have multiple complex needs or high levels of risk, and subsequently not all will need complex care plans.

The Duty to Assess is in the NHS & Community Care Act, so we believe that assessments should not be prescribed, but what should be clear is the need to identify outcomes for the patient/service user in the Care Plan. (See response to Q4)

The arrangements around the duty to assess may vary across LHBs and Local Authorities.

Finally, paragraph 4.31 refers explicitly to “wishes, feelings and experiences of patients” influencing recorded outcomes but in an objective manner. At the end of the section it indicates that all partners including patients should “make a commitment” to change. This statement is a major principle of care planning and should be incorporated in Chapter 1 and not half way through the Code. Patients, carers, professionals and authorities have unique responsibilities to facilitate and support change.

Question 3

Are issues relating to the Welsh language adequately covered? If not, what could be added or improved? Yes No

Comments –

The emphasis on the use of the Welsh Language is based on the ‘need’ of the user, not on a ‘want’. We believe that services should be in the language of the service user’s choice, and such a choice contributes positively to the health and well-being outcomes of that individual. However, the lack of availability of personnel able to communicate in the language of choice should not in any way delay access to services that are otherwise appropriate.

Question 4

Does the draft Code provide sufficient guidance in relation to planning outcomes for the care and treatment plan? If not in what way could it be improved? Yes No

Comments –

Holistic approach to preparation of treatment plans

There is a duty placed on the Care Coordinator to determine what services are and are not available. Yet is unclear from the draft Code how the Care Coordinator must both factor and record unmet needs of the patient in general. The code provides at best conflicting guidelines for the preparation of C&T Plans for patients who require services that are not available. Paragraph 1.9 states that, “In formulating the care

and treatment plan care coordinators need to focus on the needs of the individual, *rather than the services that currently exist* and could therefore be provided.” Yet paragraph 3.34 specifically states that “...care coordinators *will need to give consideration to* [service demand and delivery] when planning the delivery of care and treatment, and the potential identification of unmet needs due to availability of practitioners and services.” Eligibility criteria varies across Local Authorities, and most are set at ‘critical/substantial’, therefore, it is likely that services may not be available for particular individuals with low or moderate need in a particular area, but these must be recognised and recorded. This is poorly done at present and there is a need for adequate systematic recording of unmet need.

Paragraph 2.9 covers the standard “needs domains” in the Care and Treatment plan. Some of these domains are currently poorly covered in assessment for a variety of reasons: lack of awareness or sensitivity, lack of training and perhaps, most important, the lack of any clear available service or intervention to meet identified needs. There are particular problems with accommodation, employment and spiritual needs, as examples. The Code needs to emphasise the responsibility of statutory bodies to have an adequate range of resources to meet identified needs. There is also a need for uniform (but not necessarily identical) training for all staff to undertake full and adequate assessments.

We would recommend adding to the existing list of aspects of an individual’s life that must be considered during assessment and when considering desired outcomes: “Communication and/or sensory needs” (this is too important a component of care to relegate to “any other business”); and “strategies for behavioural modification” (as well as psychological interventions (h)). In situations where direct physical intervention is likely to be part of the care plan then this should be explicitly discussed with the patient if possible.

It is important to note here that there is a conflict between person-focussed care (whereby patients cannot expressly dictate their own care, but can collaborate in it) and the finite resources of all agencies in the public sector. There is concern that both the NHS and Local Authorities will be open to legal challenge where patients

can demand costly services that are available but unaffordable.

Assessment of Risk in Secondary Mental Health Services

Risk assessment is vital to developing a patient's care and treatment plan. Current CPA guidelines require that risks are assessed and that crises are properly managed. Paragraph 2.13 of the draft Code states that the care and treatment plans should "contain steps to mitigate these risks [identified during assessment], and so contribute to the setting of outcomes on the patient's plan". However, the Care and Treatment Plan itself does not provide for risk assessment or contingency. With the draft Code and the Plan as they stand, it is unclear where the risks to a person's recovery should be recorded.

The draft Code attempts to explain in paragraph 2.15: "In practice terms assessment of risk is an aid rather than a substitute for decision making about what outcomes need to be achieved, and assessments should be translated into a formulation of any risks, and subsequent management of those risks. All care and treatment planning processes should take into account risk management arrangements." This could be written more clearly and resolutely.

Paragraph 4.28 states that the care and treatment plan should only "*reflect* the findings of any assessment of need and risk that has been undertaken" and again nowhere on the plan can these unmet needs or possible risks be recorded.

Outcome Planning

We welcome the emphasis on outcomes planning, and view the measures of outcome to be firmly centred on the concept of both clinical and social care interventions within the care pathways approach.

Paragraph 4.30 indicates that outcomes must be addressed in one or more of the eight outcome domains. We prefer this option to a requirement that all outcome domains are addressed. This would be an over-prescriptive requirement; a Code of Practice should allow discretion for those using its guidance.

Outcomes are naturally assumed to be positive, for example “a return to work” or “full resolution of symptoms”. The reality for many is that, while much recovery can occur, residual difficulties or disabilities will persist. For some individuals maintaining present recovery and avoiding decline or relapse may be an entirely appropriate primary outcome (while not losing sight of the possibility of more positive change). It might be useful for the Code of Practice to address this as it allows patients, carers and professionals to draw up more honest, realistic and achievable care plans.

The UAP in the CPA has 12 domains, but they can fit into the 8 areas in the Code.

Accommodation

Paragraph 4.41 gives guidance on the accommodation needs in hospital. We feel the guidance should recommend that, when considering a patient’s discharge from hospital the Care Coordinator consult with IMCAs when it is not possible to identify an alternative suitable statutory consultee.

Personal care and physical wellbeing

We welcome that, following assessments, outcomes can include systematic health screening, access to health promotion and so on (paragraph 4.46) but it must be emphasised that screening alone is insufficient. It is the development and implementation of a subsequent health action plan based upon the findings of the screening process which is critical to optimum health care.

Copies of the care and treatment plan

For individuals with a learning disability, we would suggest “citizen’s advocates” be added to the list of recipients receiving a copy of the care and treatment plan (paragraph 4.77).

Coordination of the provision of services

In paragraph 5.10, reference is made to collaborative care in cases of complex need. However, this refers purely to concurrent substance misuse and it would appear equally important to recognise the complex issues arising in relation to patients with a Mental Illness in the context of Autistic Spectrum Disorders and/or epilepsy.

Entitlement to assessment

It is stated in paragraph 8.18 that a carer is not entitled to request re-assessment unless they are “a donee or deputy under the Mental Capacity Act 2005”. If this were specifically restricted to court appointed deputies then this could prove a significant barrier to review for individuals with significant levels of learning disability where carers have not taken out formal powers.

Section 117

We are unclear as to what the role of the Care Coordinator is in relation to Section 117 of the Mental Health Act.

Question 5

Do you think that the guidance set out regarding the carrying out of reviews is adequate? If not, what could be added or improved?

Yes

No

Comments –

Yes, however, this is already part of current established practice.

Question 6

Does the Code provide sufficient guidance on the Role and Functions of Care Coordinators? If not what should be added or improved?

Yes

No

Comments –

At present, on admission to Tier 4 CAMHS inpatient units, an inpatient team member carries out the care co-ordinator role. It will benefit young people for the Community CAMHS care co-ordinator to retain this role as described in Code of Practice as this will facilitate ongoing involvement of community workers throughout inpatient treatment.

Question 7

Is the guidance in relation to “frivolous or vexatious

Yes

No

requests” in Chapter 8 clear? If not, what would improve the guidance? _____

Comments –

The guidance is reasonably clear but there needs to be greater clarification of the words ‘frivolous’ or ‘vexatious”, as some individuals presenting mental health problems may ostensibly be vexatious due to the nature of their mental health condition. It would be helpful to have some indicators or reference point so that people in genuine need and distress are not turned away, and get the support that they need. Otherwise, their needs may escalate.

Question 8

Are there any issues that the draft Code ought to cover, but doesn't?

Yes

No

Comments –

As stated in our response to Q1, it is vital to delineate and define secondary mental health services. We understand that the secondary care services are to be ‘defined’ by the introduction of the Secondary Services Order under the Part 1 scheme of the Mental Health Measure by listing primary care services so that anything that is not listed is viewed as a ‘secondary care service’. It would be helpful to include a definition of Secondary Mental Health Services in the draft Code to avoid confusion, particularly as certain aspects of care e.g. memory assessment centres and some psychotherapeutic input does not fit neatly into the CPA/secondary care rubric, although these are resourced out of secondary care. Additionally it is unclear if specialist LD, liaison or substance misuse services are “secondary mental health care”.

The draft Code does not make clear how eligible and ineligible unmet needs will be managed.

Paragraph 4.14, 4.23 and 4.24 implicitly cover consent issues. The phrase “nature, risks, implications and purpose” (paragraph. 4.14) could apply to consent for any health intervention and the requirement to document decisions also implies a

consent process. Is this what those drafting the Code intended? If so we feel this should be made more explicit. In this context, it would be helpful to distinguish consultation with others, in which confidential information about a patient is disclosed, and consultations where information is received from others. There is often confusion in this area. Disclosure of information is bound by professional confidentiality and consent is required in all but extreme cases.

The draft Code must cover guidance in situations where disputes could arise between Local Authorities and between Local Health Boards, in particular over the responsibility for patients who are transferred between areas (paragraph 5.16). We are concerned, because this is particularly relevant for individuals with a learning disability or acquired brain injury who may be incapable of making an autonomous decision over their area of residence and can therefore be subject to disagreement between services as to whom holds responsibility, especially in relation to longstanding health needs. This can be particularly problematic when the decision to move is made without adequate dialogue between professionals from the exporting and receiving districts.

We are concerned that the draft Code places undue responsibility on the Care Coordinator for bridging situations where there is a known lack of comprehensive transition arrangements (paragraph 7.13). This issue needs to be addressed at a higher level and not left for the Care Coordinator to resolve in isolation.

The draft Code needs to address in paragraph 7.15 the implications for Adult and LD services taking on young people over 18 years who previously had access to CAMHS secondary care within three years of their 18th birthday. Adult services will need to assess and treat some young people, who accessed secondary mental health care, with CAMHS eligibility criteria. Examples include patients with ADHD, Asperger's, and emerging borderline personality disorder.

The terminology in the draft Code needs tightening, as it is confusing when words are used interchangeably. For example, the word 'usual' residency is interchanged with 'ordinary residency'. The latter is a term with a specific meaning (ref:

Hammersmith Judgement on S117), but the former is not.

Question 9

Is there material in the draft Code that could be cut down, left out or could more appropriately and usefully be covered in other guidance?

Yes

No

Comments –

It would be helpful if the following areas could be covered in the guidance:

1. Transitional periods.
2. Non-eligible unmet needs such as education and access to community services can be signposted. Eligible unmet needs (critical and substantial) must be met e.g. access to appropriate accommodation. These need to be evidenced in the Care & Treatment Plan.

Question 10

We would welcome your views on the potential impact of the draft Code on:

- a) Disability
- b) Race
- c) Gender and gender reassignment
- d) Age
- e) Religion and belief and non-belief
- f) Sexual orientation
- g) Human Rights

We believe that Human Rights covers all the other factors (a to f above). The MH (Wales) Measure is essentially about responding well to an individual's needs, wishes and wants, appropriate to specific categories of people. The same basic values of Human Rights (akin to the protective characteristics of the Equality Act), are applicable to all individuals presenting mental health problems.

To ensure that Human Rights is taken seriously, arrangements for advocacy should be in place. Our view is that all practitioners and clinicians should have an understanding of the impact of, and how to promote diversity.

Question 11

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Comments –

Relevant mental health service provider for children

Paragraph 3.9 outlines the circumstances in which the relevant mental health service provider is identified. Where the relevant patient is under 18 and looked after by a Local Authority, or where the 'relevant child' qualifies for advice and assistance from their Local Authority or in special school, the draft Code states that the *Local Authority* has a duty to appoint the care co-ordinator. This is a departure of current practice where the Local Authority is not seen as the mental health service provider. Local Authorities must be supported to understand and embrace this new role.

Involvement, engagement and consultation

In paragraph 4.3, reference is made to the need for clarity within the care plan and, if necessary, access to interpreters and/or specialists in communication. Consideration should also be given to the development of easy-read materials and other augmentative strategies.

Coordination of the provision of services

We believe that if patients move around, their care and care coordination must be transferred to the receiving area, or there is the risk that some services will be stretched by unforeseen travelling for professionals. We recommend that as outlined by the statutory requirements under the Measure, the Welsh Government specifically monitors transfers to determine if some areas become net importers or exporters of patients, and the resource implications which follow (paragraph 5.14 – 5.19). We have found that there is great disparity across Wales in the flexibility of services and

professionals to accept transfer of care for patients who move area.
Anything that could make this a more systematic and less arduous process
would be welcome.

Confidentiality

Responses to consultations may be made public – on the internet or
in a report. If you would prefer your response to be kept confidential,
please tick here:

Returning this form

The closing date for replies is the 16th of January 2012.

Please send this completed form to:

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If you are sending your response by email, please mark the subject of your
email: **Consultation on Draft Code of Practice.**