



Royal College of Psychiatrists and The Association of Directors for Social Services

Joint Consultation Response

RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS in WALES

RESPONSE TO: Mental Health (Wales) Measure Parts 2, 3 and 4 Regulations

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.

For further information please contact:

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We thank you for the opportunity to comment on the Regulations covering Parts 2, 3 and 4 of the Mental Health (Wales) Measure 2010. On this occasion, the Royal College of Psychiatrists in Wales and the Association of Directors for Social Services Cymru (ADSS Cymru) have taken the opportunity to issue a joint response to Regulations pertaining to part 2 of the Measure: Care Coordination and Care and Treatment Planning. The College's response to parts 3 and 4 are also attached. The Royal College of Psychiatrists and the Association of Directors for Social Services Cymru have issued a joint response because we recognise that the Measure's success relies largely on: 1. joined-up working between Local Health Boards and Local Authorities; and 2. on the joint and shared responsibility between primary and secondary care, along with Community Care Services within Local Authorities for providing and commissioning high quality mental health services. Most service users accessing mental health services work with a variety of mental health professionals in the statutory and third sectors. Those involved with a service-user's care and recovery must work together, through improved relations, sharing of information, and learning from best practice. It is paramount that we improve current governance structures to enable us to work together to put the interests of service users first.

Overall, we feel the Regulations in parts 2, 3, and 4 are well-intentioned, allowing service-users greater control over their care. However, through consultation with the Members of the College and following the joint considerations of the College and ADSS Cymru, there remains realistic anxiety regarding the implementation of the Regulations, outlined below.

- We do not yet know the overall impact the Measure will have on secondary care mental health services but we are concerned that all three Regulations would result in a significant increase in workload to professionals providing care. Regulations in Parts 2 and 4 of the Measure extend both groups of people who require care coordination and treatment plans and the support of Independent Mental Health Advocates, and Part 3 would result in more people returning to secondary care services and more quickly.
- With no additional funding provided to support the increase in workload, we fear that practitioners will be forced to spend less time focussing on all patients, including those with the most need. There is a serious danger that patient care will be compromised and not improved, as intended by the Regulations.
- A great deal will depend on how "secondary mental health services" and "relevant patient" are defined in practical terms and the Assembly needs to be explicit which patients and what services are

included in the Measure. For example, would substance misuse services be included?

- These measures will only succeed if primary care is substantially developed and reinforced. It is regrettable that Part 1 of the Measure is being introduced last. There is a serious risk that the perverse effect of the Measure and these Regulations will be to make specialist services more reluctant to accept new patients/service users, rather than facilitating access to mental health care.

Please find at the end of our response a more detailed response from the Learning Disability Faculty to your questions.

Consultation response form

The Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011

Please use this section to tell us about yourself –

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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 for Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales.

Consultation questions on the draft Regulations

Question 1

Are the proposed arrangements for identifying the service provider with responsibility for appointment of a care coordinator, in cases where both the LHB and the Local Authority provide services, appropriate (Regulation 3)?

Yes No

We believe the above arrangements for identifying the service provider with responsibility to be heavily weighted towards Local Health Boards. We are concerned that there is a risk that a health-based care coordinator will continue to be the preferred and default option, particularly in areas where health and social care are not integrated or jointly managed, and that this become entrenched under the regulations as they are currently framed. The service provision should be highlighted as a shared responsibility between NHS and local government

Question 2

Do you agree with the eligibility requirements for care coordinators set out in Regulation 4 and Schedule 1?

Yes No

Comments –

Question 3

Should other persons also be included as eligible to be appointed as a care coordinator, or should particular requirements (such as training, experience, competence) be included, and if so what requirements would you wish to see included?

Yes No

In addition to the proposed list of professional requirements listed in Schedule 1, we would like to add

1. Speech and Language Therapists, who may have a significant role in the treatment of individuals with communication disorders associated with autistic spectrum disorders or acquired brain injury.
2. Physiotherapists

Question 4

Do you agree that there should be a prescribed form for care and treatment plans, such as that set out in Regulation 5 and Schedule 2?

Yes

No

We do not believe that the prescribed form for care and treatment plans adds any value to patient care, particularly as the plan does not serve to either replace current Care Programme Arrangements, nor does it appear to add value to existing practices.

We are concerned that the production, review and revision of care and treatment plans place an unnecessary, additional administrative burden on appointed care coordinators. If all patients currently seen only by psychiatrists in specialist services are deemed to be “relevant patients” and thus entitled to a service from a secondary mental health service provider, it will prove difficult to meet the requirement for psychiatrists to assume the new statutory responsibilities of care coordination.

It appears that there is a belief that prescribing forms to govern the quality of a clinician’s work will drive good practice. Clinicians/practitioners in all professions should be relied on and expected to do a good job, and if they do not, they should be subject to the professional, organisational and legal strictures that already exist.

We believe that, when carried out properly, CPA is an effective tool in providing steps toward patient recovery. The focus should be on the strengthening, monitoring and delivering of the CPA rather than adding to it. We favour the most flexible approach possible; one that enables coordinators to process information efficiently and quickly, enabling them to operate effectively. If this is not possible the medical resources, which are already less than recommended by the Royal College of Psychiatrists, will not be able to meet local needs. The same issue faces practitioners in local authorities

If the care and treatment plan were to be adopted, we emphasise the need to consider the following:

- implications of working with individuals with limited or absent capacity to consent to some or all of their treatment plan. We would suggest that the list of designated outcomes include reference to the need for reasonable adjustment under the Disability Discrimination Act and consideration of communication problems. Neurodevelopmental clinics (e.g. for ADHD/Autism)
- Exclude in-reach services, memory assessment services and liaison services.
- LHB’s and LA’s have a clear understanding of who a “relevant patient” is in order to avoid confusion. In particular, there has been confusion regarding Substance Misuse services being a part of CPA although Assembly Government policy intent is clear that Substance Misuse is not to be included in the CPA Framework. This again needs to be made more explicit with respect to the Regulations. At the same time, the concern is whether people with substance misuse problems that have a mental disorder as well, be able to access the mental health services as defined by the measure.

If the overall purpose of the care coordination plan is to provide cohesive, focussed cross-discipline working between health and social care professionals, we believe

this is better achieved through improving clinical governance across Wales. For example, we would recommend that Local Health Boards and Local Authorities operate an integrated information system accessible by professionals and all staff involved with the overall care of service users, similar to the Assembly's Integrated Family Support Service (IFFS). Not least, such a system would negate the onerous task of form filling and further bureaucracy, thus leaving more time to focus on patient care.

Question 5

Are there any further matters, over and above those set out in Regulation 5(3), which should be included in all care and treatment plans?

Yes No

The role of the voluntary sector in providing care, support and the promotion of well-being for people with mental health and learning disabilities is vital to the overall improvement of service-provision. This must be reflected in the plan.

Question 6

Regulation 6 contains a list of persons who must be consulted in agreeing the outcomes of services provision, agreeing the care and treatment plan or reviewing and revising that plan.

- (i) Have the correct persons been identified in this Regulation? Yes No
- (ii) Should further persons be included in this Regulation? Yes No
- (iii) Do you agree with the proposed circumstances in which the relevant patient may withhold their consent to consultation with certain persons? Yes No
- (iv) Do you agree that certain persons may decline to receive a copy of the plan? Yes No

(i) Yes, however, the Mental Capacity Act already provides this in great detail for patients who lack capacity. In the event of a service user having capacity, they should be asked who they prefer to have consulted about their care.

Question 7

Do you agree with the arrangements for reviewing and revising care and treatment plans (Regulation 7)?

Yes No

Yes, although these conditions already apply to care coordinators. In many cases,

the arrangements for reviewing and revising patient care plans take place more frequently than what is recommended by the Regulations. This is determined mainly by the needs of the person, along with the discretion of the professional/s involved in the person's recovery.

However, when the Measure is implemented and care coordinators become responsible for reviewing and revising care and treatment plans for all "relevant patients", this timeframe may need to be reconsidered to allow for the increase in their workload.

Question 8

Regulation 8 contains a list of persons who must be provided with a copy of the care and treatment plan when it is made or revised.

- (i) Have the correct persons been identified in this Regulation? Yes No
- (ii) Should further persons be included in this Regulation? Yes No
- (iii) Do you agree with the proposed circumstances in which the relevant patient may withhold their consent to certain persons receiving a copy of the plan? Yes No

See response to question 6.

Question 9

Has all of the information which must be provided to a patient on their discharge from secondary mental health services been identified in Regulation 10? Yes No

Yes, all relevant information provided to the patient upon discharge has been identified.

However, we are concerned that subsections 5 and 6, regarding the responsibilities of the Local Health Boards and the Local Authorities respectively, assume that separate mental health services are to be provided by LHB's and LA's and this may be inadvertently enshrined by the Regulations.

We also believe the Regulations must take into account the accessibility of information for people who are unable to comprehend written information due to their disability.

Question 10

In relation to the transitional provisions set out in Regulation 11 – _____

- (i) Are the proposed arrangements, including timescales, for appointing eligible care coordinators appropriate (see Regulation 11(2) and (3))? Yes No
- (ii) Do you agree with the arrangements, including timescales, for agreeing outcomes of services and recording the care and treatment plan for patients without any plan at the time of the regulations coming into force (see Regulations 11(4) and (5))? Yes No
- (iii) Do you agree with the arrangements for reviewing existing care and treatment plans, and preparing a new care and treatment plan in Regulation 11(6)? Yes No
- (iv) Are there any other relevant matters which should be covered within the transitional provisions of this Regulation? Yes No

Before the Measure comes into force, it is difficult to comment on the appropriateness of the transition provisions until it is clear how many “relevant patients” there are requiring coordinators against the number of care coordinators appointed. At this stage, we are concerned because the number of people who currently fall into the category of “relevant patient” is significant..

Regarding patients with Learning Disabilities, it is important to recognise that most Learning Disability services across Wales do not have CPA and are instead working within the Unified Assessment process. The relevant information systems may lie within local authority services rather than NHS. There would, therefore, be huge potential implications for resources (technical, managerial, personal, financial) were a significant number of people with Learning Disability to be included within the remit of these measures. In addition, there are significant political issues that would need to be addressed. Many Learning Disability nurses are currently working in a “mixed mode”; i.e. providing care management to the local authority whilst also carrying out some professional nursing duties. Were these individuals to become care co-ordinators within a health context, clarification would be required as to whether they would still carry out their local authority case management duties in relation to UA or transfer to the care co-ordination role under the new regulations. The relationship between UA and care co-ordination clearly needs to be addressed as a matter of some urgency. Essentially the measure highlights the current parallel pattern of service provision for adults with learning disability. The college is anxious to ensure that people with learning disabilities and often complex mental health needs are not excluded from the potential benefits of the measure.

Children may have their mental health needs met by services other than CAMHS; services include community paediatrics, specialists working in education and secure social care settings.

Regarding children transitioning from child to adult services, we believe that care coordinators must allow for the maximum time available to formulate, discuss, and prepare plans to make seamless arrangements to suitable follow-on services and to avoid creating gaps in service provision. We recommend that timescales are not

prescribed to chronological age as set in the Regulations, and that chronological age does not legislate the types of services a person receives - a young person who has recently become an adult may still require the safeguards set in place for children and young people, particularly those with Learning Disabilities. We must ultimately do whatever is best for the person who is most vulnerable.

Consultation questions on the draft Explanatory Memorandum and Regulatory Impact Assessment

Question 11

Is there sufficient information in the Explanatory Memorandum to understand the purpose and effect of these Regulations?

Yes No

The purpose and intent of care and treatment planning is stated clearly in paragraph 13, that planning will “lead to the greater involvement of service users in decisions which are made in relation to their care and treatment, and better outcomes for them”. However, it is unclear exactly how this will increase patient involvement. Our concern is that providing care coordination for all “relevant patients” will impact on the care for more vulnerable service users; those with long standing, complex mental disorders.

Paragraph 14 states that the plan will foster more cohesive, focussed and effective cross-discipline working amongst professionals, yet we believe the plan will add little value to existing arrangements (see response to question 4). We are unsure exactly how the plan will improve cross-discipline working.

Question 12

Do you agree with the preferred option in the Regulatory Impact Assessment (option 2 – make regulations)? If not, please provide further details.

Yes No

We agree in part. Please see above for detailed comments, concerns and recommendations for improvements.

Question 13

Are you content with the estimated costs/benefits regarding the implementation of these Regulations? If not, please supply evidence in the box below to support your views.

Yes No

We believe that it is unlikely that this will be cost neutral. There will be training costs as well as hidden costs in time spent on formal paperwork resulting in possible increase in waiting times (especially with an aging population), in turn costing the NHS and local government. Will the assembly invest in monitoring clinicians'/practitioners' case loads and apportioning resources to ensure that services can cope with the additional work of these regulations?

We do believe that it is vital to 'invest to save' in the future and refer back to our recommendation outlined in our response to Question 4 regarding a shared IT/information system. We believe that this would be an investment leading to savings in the future and an improvement in cross-disciplinary working, which is an overall aim of the Measure.

There is an undertaking to evaluate the impact of the measure. We would suggest that some of the evaluation includes an action research methodology to allow early recognition of successes and problems in implementation.

Equality Impact Assessment

Question 14

We would welcome your views on the potential impact of the draft Regulations 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

The Regulations are not equality-neutral. Unless there is particular concern given to those overlooked (for example those with Learning Disabilities and older adults) and the Regulations tackle inequalities in terms of the above, the clinicians/practitioners are relied upon to embrace diversity and accept this in their work.

The college fully supports the provision of culturally sensitive services; specifically in the past year it has been involved in initiatives to recognise specific Welsh issues.

Other issues

Question 15

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:

In terms of identifying “relevant patient”, the Assembly needs to be clear that Addictions/Substance Misuse is not part of the Mental Health measure when talking about Addictions being the only and main problem with a patient. Indeed the Mental Health Act itself, excludes Substance Misuse and the Mental Health Measure is for people primarily with Mental Disorder (as defined within the act).

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 16 May 2011.

Please send this completed form to:

Mental Health Legislation Team
Welsh Assembly Government
Cathays Park
Cardiff
CF10 3NQ

Email: mentalhealthandvulnerablegroups@wales.gsi.gov.uk

If you are sending your response by email, please mark the subject of your email:
Consultation on Part 2 Regulations

Consultation response form

The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011

Please use this section to tell us about yourself –

Name:	Dr Helen Matthews
Organisation (if applicable):	Royal College of Psychiatrists Division in Wales
Email	helen.matthews@wales.nhs.uk
Telephone number	029 2048 9006
Address	Baltic House, Mount Stuart Square, Cardiff CF10 5FH

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

Consultation questions on the draft Regulations

Question 1

Do you agree that the relevant discharge period should be set at three years, from the date the individual is discharged from secondary mental health services (Regulation 3(1))?

Yes No

Comments –

Question 2

Are there any events or circumstances which should end the relevant discharge period, other than the expiry of the three year period? Yes No

There appears to be an assumption that it is always appropriate to provide reassessment. Individuals are sometimes discharged from a specific service because it is no longer appropriate for the therapeutic relationship to continue. For example, the individual may be more appropriately cared for in other services because of clinical skill mix or for reasons of risk management (e.g. moving on to a Forensic service). In these circumstances an individual may wish to engage with a particular service, but they may feel that it is more appropriate for the individual to be seen within an alternative service. Presumably, there is a need for a mechanism to identify and resolve such disagreements.

Question 3

Regulation 4 provides that a copy of an assessment report must be provided to the assessed person within 10 working days of completion of the assessment – is this an appropriate maximum period? Yes No

The length of time within which an assessment needs to be completed depends, to some degree, on the nature of assessment. A simple report from a single professional can clearly be provided much more quickly than a complex multidisciplinary document.

Service users who were discharged from secondary mental health services outside of Wales who now reside in Wales are covered by the Regulations. For these patients (particularly those who lived outside of the UK), ten working days to provide a completed assessment may be inadequate.

Question 4

Is the method of establishing usual residence in cases of dispute set out in Regulation 5 appropriate? Yes No

This is again based on the assumption that an individual's place of residence is something that they themselves decide. For example many individuals with a Learning Disability, especially those with more challenging presentations, they may have been placed in a particular area by their Local Health Board and / or Local Authority without significant participation in the decision making process. The receiving Local Health Board may not even know that the individual is moving into their area until demands are made for service provision. This issue has been debated, but has remained unresolved over many years. When a number of individuals with significant challenges are placed in a single area this can have a significant destabilising effect upon the services within the receiving area, as there is

frequently little preparatory discussion and resources do not typically follow the “exported” individual. The regulations for determination of usual residents, as described, make brief reference to what appears to be a voluntary agreement within Subsection 4, but no clarification of the position where (as is usually the case) “exporting” and “receiving” Health Boards have not reached an agreement on responsibility for service provision.

The above pattern is mirrored for some children placed in care settings and increasingly for adults with complex mental disorders placed in specialist third sector placements.

Question 5

Have all the relevant matters been identified within the transitional provisions set out in Regulation 6?

Yes

No

Comments –

Consultation questions on the draft Explanatory Memorandum and Regulatory Impact Assessment

Question 6

Is there sufficient information in the Explanatory Memorandum to understand the purpose and effect of these Regulations?

Yes

No

Comments –

Question 7

Do you agree with the preferred option in the Regulatory Impact Assessment (option 2 – make regulations)?

Yes

No

Comments –

Question 8

Are you content with the estimated costs/benefits regarding the implementation of these Regulations? If not, please supply evidence in the box below to support your views.

Yes

No

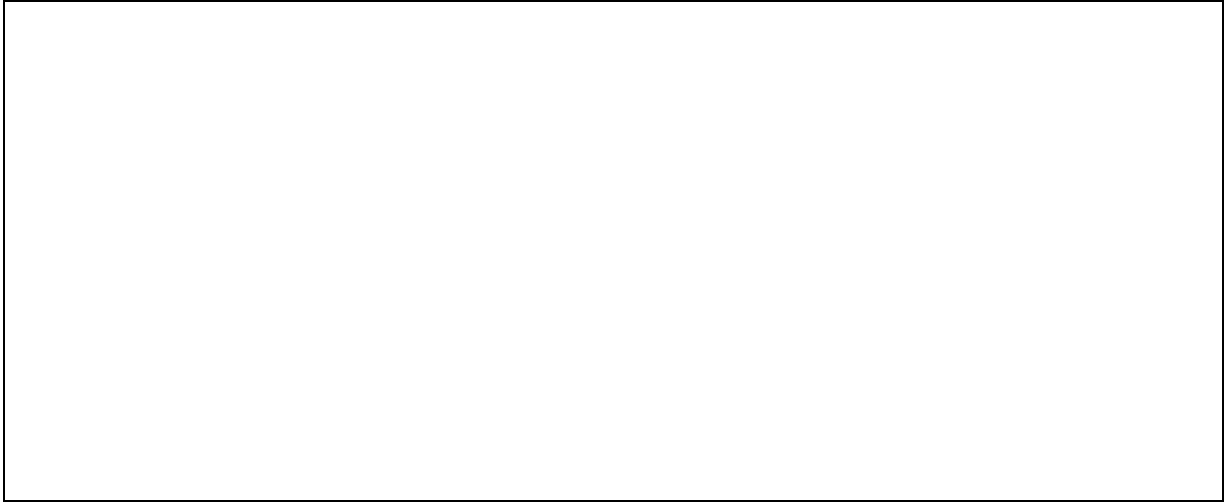
Comments –

Equality Impact Assessment

Question 9

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

- h) Disability
- i) Race
- j) Gender and gender reassignment
- k) Age
- l) Religion and belief and non-belief
- m) Sexual orientation
- n) Human Rights



Other issues

Question 10

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:

We believe it could be negligent for a discharged patient not to see the GP in case there are other issues. This is particularly important for the elderly.

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CF10 3NQ

Email: mentalhealthandvulnerablegroups@wales.gsi.gov.uk

If you are sending your response by email, please mark the subject of your email:
Consultation on Part 3 Regulations.

Consultation response form

The Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011

Please use this section to tell us about yourself –

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Telephone number	029 2048 9006
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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 –

Consultation questions on the draft Regulations

Question 1

Do you agree that Local Health Boards should be responsible for making arrangements for independent mental health advocacy? If not, who do you think ought to be given this responsibility, and what are the reasons for your views?

Yes No

Health Boards are starting to increasingly recognise their roles as both commissioners, contractors & providers. A fundamental requirement of the commissioning agency is a knowledge of relevant issues. Therefore, if a Local Health Board has staff with the requisite skills or is able to obtain the appropriate advice through clear consultation mechanisms then they should be able to fulfil this role. Accusations of conflicts of interest could arise whichever agency is chosen. It may be helpful to issue guidance on good practice in commissioning & contracting for this service.

Question 2

Are the arrangements set out in Regulation 3(1) and 3(2) clear, so that LHBs may make comprehensive provision for independent mental health advocacy for qualifying patients in their area?

Yes

No

There are significant questions as to what group of patients (Serious Mental Illness versus wider Mental Disorder) and in which settings (hospital versus hospice versus homes registered under Care Standards etc.) these regulations apply. Whilst reference is regularly made to “Welsh qualifying patients”, there is less clarity over responsibility for patients who may have been “moved” within Wales. I am referring to individuals who lack the ability to make autonomous decisions over their care settings, but are placed by their Local Authority and / or Local Health Board in care facilities in other health regions often with an expectation that the receiving authority will provide significant elements of the individual’s health and social care needs. This is a longstanding issue which has never been adequately resolved.

Question 3

Are the appointment requirements set out in Regulation 4 sufficiently robust? Should Independent Mental Health Advocates (“IMHAs”) have to meet different or further requirements?

Yes

No

Clearly, it is essential that anyone acting as an IMHA is of good character and has passed relevant statutory screening procedures. However, the current training is (understandably) extremely heavily weighted towards mental illness issues. However, in keeping with the Academy of Royal Colleges’ “No Health without Mental Health” campaign (led by the Royal College of Psychiatrists) there is an increasing understanding of the importance of considering physical, as well as mental, health needs of patients. This is critically important for individuals with a Learning Disability or other mental health disorders e.g. dementia where the diagnostic interface between physical and mental health problems can be unclear. Therefore, it is essential that IMHAs have at least some components of their training which specifically address (a) Learning Disability, and (b) physical health needs of mental health patients.

Question 4

Regulation 5 sets out the independence requirements for IMHAs; are these practical and appropriate? Should further requirements be made?

Yes

No

Comments –

Question 5

Do you agree that the IMHA should be able to visit and interview the persons set out in Regulation 6?

Yes

No

Comments –

Question 6

Are there any other persons, over and above those professionally concerned with the medical treatment of patient (as set out in the 1983 Act) and those in Regulation 6, which the IMHA should be able to visit and interview?

Yes

No

Comments –

Consultation questions on the draft Explanatory Memorandum and Regulatory Impact Assessment

Question 7

Is there sufficient information in the Explanatory Memorandum to understand the purpose and effect of these Regulations?

Yes

No

The nature and, therefore, extent of these Regulations appear to be dependent upon the interpretation of eligibility. It is, therefore, impossible to comment upon the potential impact until it is clear for whom these Regulations will apply and in what context. The Measure could be, for people with Learning Disability or dementia, anything from a massive boost in the fight against current health inequalities but, alternatively, could be an innovation which places even greater strain upon limited advocacy resources.

Question 8

Do you agree with the preferred option in the Regulatory Impact Assessment (option 2 – make regulations)? If not, please provide further details.

Yes

No

Comments –

Question 9

Are you content with the estimated costs/benefits regarding the implementation of these Regulations? If not, please supply evidence in the box below to support your views.

Yes

No

Comments –

Equality Impact Assessment

Question 10

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

- o) Disability
- p) Race
- q) Gender and gender reassignment
- r) Age
- s) Religion and belief and non-belief
- t) Sexual orientation
- u) Human Rights

Other issues

Question 11

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Consultation on the IMHA Regulations.

Annex 1

Consultation on draft regulations on the Mental Health (Wales) Measure Regulations from the Learning Disability Faculty

It is now openly acknowledged that when these measures were drawn up, the issue of individuals with a learning disability was overlooked. Therefore, there is a need to clarify what patients receiving “secondary mental health services” means in the context of an individual with learning disability. It is also clear that these regulations were drawn up to provide statutory framework for a pre-existing CPA approach in a service based on a recovery model; i.e. finite episodes of care as opposed to a Learning Disability Service whose community structure is largely defined by local authority and whose patients typically have a life-long disorders requiring ongoing holistic care. It is therefore a little difficult to give definite comments upon a document when one does not know which elements of the Learning Disability population will be involved. One option may of course be that having a Learning Disability is an exclusion criterion from these regulations. However, as that would bar people with Learning Disability from measures designed to enhance the quality of services it would undoubtedly fail the WAG Equality Impact Assessment. An attempt to limit it to individuals with “serious mental illness” is also fraught with difficulty. As this is traditionally taken to mean Schizophrenia or severe mood disorders, would one still include an individual with severe Learning Disability and challenging behaviour where communication barriers preclude the definitive diagnosis of mental illness? Similarly, would one also include an individual with an Autistic Spectrum Disorder and severe agitation of unclear aetiology? (One could paint a whole series of similar scenarios where simplistic discussion of serious mental illness may exclude individuals to very high levels of care need). That being said, a decision to include all individuals with an Learning Disability who are in contact with secondary Learning Disability services may be equally over-inclusive. One is perhaps needing to explore the addition of a rider as per the Mental Health Act 2007, that the effect of the Act as it relates to people with Learning Disability is limited to those with “abnormally aggressive or seriously irresponsible conduct”. However, one would then need to acknowledge that many vulnerable people with Learning Disability may be excluded from beneficial elements of the order. This must be a matter for wider debate but unfortunately there appears to be an assumption among many professionals that the measures related to people with serious mental illness rather than having relevance for people with Learning Disability and the agencies that serve them.

To answer the questions that you have so helpfully laid out in your user-friendly word document:

Care Coordination and Care and Treatment Planning Wales

Question 1:

The fundamental issue here is the definition of “Secondary Mental Health Services”. Clearly, if an individual with Learning Disability is already cared for by existing “mental illness” services, then this is less complicated. However, for many people with Learning Disability, specialist Learning Disability Services may be catering for their mental health needs (mental illness, autism, ADDH, Dyspraxia, etc.) but may also be involved in neuro-psychiatric aspects, such as treatment of Epilepsy. Would an individual with extremely unstable epilepsy be included or would they also need to have associated mental illness and/or challenging behaviour?

Question 2/3:

The professional requirements as set out, appear reasonable but are again produced without consideration of Learning Disability or wider neuro-psychiatric services. Specifically, they appear to have excluded Speech and Language Therapists, who may have a significant role in the treatment of individuals with communication disorders associated with autistic spectrum disorders or acquired brain injury, etc.

Question 4:

I would agree with the benefit of a statutory frame work for treatment plans. However, I would emphasise the need to consider implications of working with individuals with limited or absent capacity to consent to some or all of their treatment plan. I would also suggest that the list of designated outcomes should include reference to the need for reasonable adjustment under the Disability Discrimination Act and consideration of communication problems. There would also appear to be a need for consideration of risk assessment / management.

Question 8:

When considering the sharing of information, one must also consider the various models of care provided for people with Learning Disability, including ones such as Adult Family Placement which may not be so common in Serious Mental Illness Services.

Question 9:

Has consideration been given to the accessibility of the information provided to patients on discharge?

Question 10:

It is very difficult to comment upon the appropriateness of the transition provisions until one knows how many people are eligible and therefore the nature and complexities of the task. One must recognise that most Learning Disability services across Wales do not have CPA and are instead working within the Unified Assessment process. We must also recognise that the relevant computer frameworks lie within local authority services rather than health. There would therefore be massive potential implications for resources (technical, managerial, personal, financial) were a significant number of people with Learning Disability to be included within the remit of these measures. One must also recognise that there are significant political issues that would need to be addressed. Many Learning Disability nurses are currently working in a “mixed mode”; i.e. providing care management to the local authority whilst also carrying out some professional nursing duties. Were these individuals to become care co-ordinators within a health context, then clarification would be required as to whether they would still carry out their local authority case management duties in relation to UA or transfer to the care co-ordination role under the new regulations. The relationship between UA and care co-ordination clearly needs to be addressed as a matter of some urgency.

Within these discussions it would be important to clarify whether an existing UA report would be deemed an acceptable transitional care and treatment plan as this would be significant implication on the interval over which the new plan could be prepared (12 months versus 60 days). The sooner this is clarified, the better, especially if services are going to need to develop more detailed Care Plans on a large number of patients.

Question 12:

As I have outlined above, the assumption of cost neutrality was based upon purely setting an existing CPA onto a statutory framework. This is not the case in Learning Disability

services, and dependent upon where one “sets the bar” for entry to these measures, there may be significant resource implications in relation to the development of CPA within Learning Disability services. One would also need to recognise that whilst mental illness services may well be “moving, planning to an holistic outcome focused recovery centred approach”. This is not likely to be the case for individuals with pervasive developmental disorders where, although care is traditionally holistic, there is no prospect of “recovery” and the individuals are likely to require support over a considerable period of time. Adult Mental Illness Services should also themselves be considering the enduring needs of individuals with Pervasive Developmental Disorders, and indeed those with Personality Disorders, who, though they have a Mental Disorder, may not necessarily have been provided with a service up until now.

The Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011

The first thing that strikes one when considering these documents is that they are written from the view point of individuals who are capable of making autonomous decisions over their own care. Clearly, for most individuals with a Learning Disability it will be those caring for them who would be in the position of negotiating with services for a re-evaluation on their behalf (whilst acknowledging that the individual with a Learning Disability would also be able to participate in these negotiations to the limit of their understanding and communication). Similarly, the assumptions based within a “recovery model” relate to individuals with serious Mental Illness rather than those with other mental disorders such as Learning Disability and Pervasive Developmental Disorders (autism, Aspergers, ADHD etc.). There may, therefore, be a tension between an assumption that “open cases represents an adverse impact on operational capacity”, as opposed to a perception by many professionals and users of Learning Disability services that an enduring model of holistic care may be a more realistic reaction to current care needs and service provision.

Question 2:

There appears to be an assumption that it is always appropriate to provide reassessment. Individuals are sometimes discharged from a specific service because it is no longer appropriate for the therapeutic relationship to continue. For example, the individual may be

more appropriately cared for in other services because of clinical skill mix or for reasons of risk management (e.g. moving on to a Forensic service). In these circumstances an individual may wish to engage with a particular service, but they may feel that it is more appropriate for the individual to be seen within an alternative service. Presumably, there is a need for a mechanism to identify and resolve such disagreements.

Question 3:

The length of time within which an assessment needs to be completed depends, to some degree, on the nature of assessment. A simple report from a single professional can clearly be provided much more quickly than a complex multidisciplinary document.

Question 4:

This is again based on the assumption that an individual's place of residence is something that they themselves decide. For many individuals with a Learning Disability, especially those with more challenging presentations, they may have been placed in a particular area by their Local Health Board and / or Local Authority without significant participation in the decision making process. The receiving Local Health Board may not even know that the individual is moving into their area until demands are made for service provision. This issue has been debated, but has remained unresolved over many years. When a number of individuals with significant challenges are placed in a single area this can have a significant destabilising effect upon the services within the receiving area, as there is frequently little preparatory discussion and resources do not typically follow the "exported" individual. The regulations for determination of usual residents, as described, make brief reference to what appears to be a voluntary agreement within Subsection 4, but no clarification of the position where (as is usually the case) "exporting" and "receiving" Health Boards have not reached an agreement on responsibility for service provision.

Mental Health (Independent Mental Health Advocates) (Wales)

This would appear to be another area of the legislation where a lack of clarity over the eligibility of patients with a Learning Disability could have major implications for its implementation. There is some variation in terminology within the documentation, especially the Memorandum and Regulatory Impact Assessment which requires clarification. Under Section 4, Subsection 8, reference is made to "Mental Disorder". Under the terms of the

1983 Act this clearly includes individuals with a Learning Disability. Under Subsection 9, it states that “qualifying patients” are those receiving “assessment or treatment under the 1983 Act”. Assessment and treatment in the act can be very broad and include many aspects of day-to-day care. Under Subsection 11 reference is made to the expansion of statutory advocacy services to “the majority of inpatients receiving treatment for *mental ill-health*, whether subject to compulsion or not”. What does mental ill-health mean? This question is critical as many individuals with a Learning Disability, especially those exhibiting emotional distress, often appear to be denied necessary treatment in general hospitals. Similar issues arise in relation to the care of individuals with dementia and, to a lesser degree, other forms of serious Mental Illness. Therefore, depending upon interpretation of these new guidelines, one may be suggesting that any individual with a Learning Disability accessing any hospital (general or psychiatric) showing any degree of emotional distress should be provided with advocacy services “to ensure that the rights of this often vulnerable group of patients are safeguarded”. (Subsection 11). Therefore, these measures could potentially offer significant additional statutory support to patients with a Learning Disability in a variety of health settings. An alternative interpretation which would stay strictly to the serious Mental Illness agenda may inadvertently disadvantage patients with a Learning Disability if this expansion in mental health advocacy leads to any corresponding diminution of the citizen advocacy programmes currently provided by Local Authorities to assist an individual with Learning Disability in all aspects of their lives.

To answer this specific consultation questions:

Question 1:

A fundamental requirement of the commissioning agency is a knowledge of relevant issues. Therefore, if a Local Health Board has staff with the requisite skills or is able to obtain the appropriate advice through clear consultation mechanisms then they should be able to fulfil this role. Accusations of conflicts of interest could arise whichever agency is chosen.

Question 2:

As I outlined above there are significant questions as to what group of patients (Serious Mental Illness versus wider Mental Disorder) and in which settings (hospital versus hospice versus homes registered under Care Standards etc.) these regulations apply. Whilst reference is regularly made to “Welsh qualifying patients”, there is less clarity over responsibility for

patients who may have been “moved” within Wales. I am referring to individuals who lack the ability to make autonomous decisions over their care settings, but are placed by their Local Authority and / or Local Health Board in care facilities in other health regions often within expectation that the receiving authority will provide significant elements of the individual’s health and social care needs. This is a longstanding issue which has never been adequately resolved.

Question 3:

Clearly, it is essential that anyone acting as an IMHA is of good character and has passed relevant statutory screening procedures. However, the current training is (understandably) extremely heavily weighted towards mental illness issues. However, in keeping with the Academy of Royal Colleges’ No Health without Mental Health campaign (led by the Royal College of Psychiatrist) there is an increasing understanding of the importance of considering physical, as well as mental, health needs of patients. This is critically important for individuals with a Learning Disability or other mental health disorders where the diagnostic interface between physical and mental health problems can be unclear. Therefore, it is essential that IMHAs have at least some components of their training which specifically address (a) Learning Disability, and (b) physical health needs of mental health patients.

Question 7/8:

The nature and, therefore, extent of these measures appears to be dependent upon the interpretation of eligibility. It is, therefore, impossible to comment upon the potential impact until it is clear for whom these measures will apply and in what context. As outlined above, these measures could be, for people with Learning Disability, anything from a massive boost in the fight against current health inequalities but, alternatively, could be an innovation which places even greater strain upon limited advocacy resources.
