

Royal College of Psychiatrists

Consultation Response

RESPONSE TO: NATIONAL FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE'S CONTINUING CARE – INFORMAL CONSULTATION

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.

We are pleased to respond to this consultation. This consultation was prepared by the Royal College of Psychiatrists in Wales

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RESPONSE FORM

NATIONAL FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE'S CONTINUING CARE – INFORMAL CONSULTATION

Please respond by 23 May 2011

Consultation questions (please insert your responses in the box below each question)

1. Are the areas covered within the draft Continuing Care guidance comprehensive and pertinent?

We welcome the draft National Framework which provides guidance for Welsh LHBs, Local Authorities and their partners, who until now have been following the English guidance, on which this has been largely based. The Framework is child-centred and highlights the importance of consulting with child/family as well as highlighting the role of the Multi Disciplinary Team and DST.

However, we are concerned that the Framework does not capture the process of assessing children who may have complex continuing care needs and that it may instead be over-inclusive in its interpretation of "problems", which could result in inappropriate provision of care.

The wishes and needs of the family and the young person must somehow be met using current limited resources. The Framework may raise people's expectation for a service that may not be deliverable. We welcome the concept of pooling resources, particularly under current financial constraints. This would enable agencies to develop local services.

Specific comments regarding the Framework are outlined below:

- Part 2.2, para. 33: It is very helpful that a key principle of the guidance specifies that the package of continuing care should not be budget or finance led, rather the primary consideration should be supporting the child or young person's assessed needs.
- Part 2.3, para. 42: We welcome that the needs of the child are taken into consideration when setting timelines. However, there is concern that the timelines given in the document may not be achievable for those children requiring specialist assessment.
- Part 2.7: The information given in this section covering dispute resolution is not adequate and refers to adult examples, which may not be appropriate.
- Part 2.7, para. 68 advises that LHBs and local authorities work together on a regional or sub-regional basis to establish and manage the review process, which we believe would be cost-effective.
- Part 2.8: Transition from child to adult services is a very important section. It is imperative that we recognise that severe or complex mental health problems frequently present to specialist CAMHS between 14 and 18 years and many at 17 years. The most high risk cases presenting to Tier 4 CAMHS inpatient units can often require

CHC into early adulthood. Some are presenting at cusp of the child's 18th birthday and for this reason there needs to be a clear forum for decision making where assessment is being carried out under 18 years for provision over 18 years.

- Annex A, para. 3: Reference is made to children with mental health needs, such as acquired brain injury or neuro-cognitive problems. This is very important. However, we feel that reference should be made to the high-risk complex young people with emerging borderline personality disorder and associated very high levels of self harm and suicidal behaviour requiring specialist residential placements through late adolescence into early adulthood. Another high-cost/high-risk group are young people moving from medium secure adolescent psychiatric units to highly supported specialist residential settings as opposed to adult low secure units. These young people present risk to others as well as to themselves in the context of mental health problems and probable challenging behaviour. They frequently require CHC packages.
- Annex A, para 3: There is no consideration given to the role of mental health in children with learning disabilities. It is discriminatory to include "challenging behaviours" under learning disability as it wrongly implies that only children with learning disabilities exhibit behaviours that are challenging.
- Annex A, para. 16: We welcome the requirement that the child's assessment must include risk factors faced by the whole family.
- Annex A, para. 21:
 - The list of Care Domains begins with "Challenging Behaviour", which is a pejorative term. We suggest the Framework adopt the term used in the adult DST ("Behaviour").
 - "Psychological and emotional needs domain" clearly refers to able children attending mainstream CAMHS services. There is concern that it may miss children with learning disabilities and mental health needs, who instead fall into the "challenging behaviour" domain. There is a high risk that an accurate assessment of their needs may be missed.
- Annex A, page 28, Diagram showing the domains in the Decision Support Tool: The diagram includes "cognition" as a domain, although cognition is not mentioned elsewhere in the Framework. We feel it should be included, particularly as in some cases children with a degenerative condition may also show progressive cognitive impairment.
- Annex A, pages 30 – 39: For each domain it would be useful to include trigger questions to help identify the nature, intensity and complexity of care needs for the child, similarly to the adult DST.

2. Are the timescales between referral and the decision making process realistic?

If each LHB has a designated multi-agency decision making forum that sits each week, then timescale is realistic and from the clinical point of view, desirable.

3. Is the requirement to notify the family within 5 working days of decision by the multi-agency decision making forum realistic?

Yes, if the system is well organised.

4. Are the roles and responsibilities of key people sufficiently clear?

It is appropriate for the **LHB** to be the lead for completing this process as in the case of adults.

It should be made clear that the lead for **CHC** and the **lead authority** are one and the same.

The role of the child's **GP** has not been mentioned. Their role is key particularly in the transfer of care to the GP where the child is placed.

Page 11, paragraph 36 covers the identification of a **named first point of contact** for the planning and delivery of the care process. This needs more clarity as there may be more than one named individual for children with differing needs, eg CAMHS lead/Children with physical health need.

There is lack of clarity in the make-up of **the multi-agency decision making forum**. The document refers to multidisciplinary team and multiagency team but does not expand on their membership. It is important to have senior representation from social care, education, community/acute paediatrics, specialist CAMHS and CAMHSLD and adult mental health/LD when transition arrangements are pertinent. A senior representative from the LHB as nominated budget holder will be key.

Consultation Response from:

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Response forms should be sent to the following address:

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