Royal College of Psychiatrists
Consultation Response

DATE: 27th April 2010
RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS, WELSH DIVISION

RESPONSE TO: Proposed Mental Health (Wales) Measure

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, Welsh Division

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Thank you for the opportunity to provide evidence to the Legislation Committee 3 concerning the proposed Mental Health (Wales) Measure.

Question 1:

Is there a need for a proposed Measure to deliver the following aims:

a) providing local primary mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health, and in some cases, reduce the need for inpatient treatment and compulsory detention;
b) ensure that all individuals accepted into secondary mental health services in Wales have a dedicated care coordinator and receive a care and treatment plan, and that service users previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
c) extending mental health advocacy provision beyond current arrangements?

Response:

1. The College welcomes the high profile afforded to mental health by inclusion in the Legislative programme. However, there are no guarantees that legislation will lead to fundamental changes in practice; examples include the limited impact of the Mental Capacity Act and Deprivation of Liberty Safeguards. A clear statistic is the low number of referrals to Independent Mental Capacity Advocates (IMCA) concerning serious medical treatment – the subject of a subsequent Ministerial letter to health organisations.

2. Preventative and proactive approaches are fundamental to improving the health of a population. We are delighted there are initiatives to genuinely implement public health principles. We would urge caution in the implicit assumption that planning the new primary care service will dramatically change the workload of secondary care. Whilst it is true that most mental health needs are met in primary care this is also true for physical health needs – mainly coughs and colds that either get better by themselves or with low levels of additional help. Any schemes set up are likely to represent current unmet need. If the schemes are of a high quality meeting the needs of a new population, demand is likely to increase. If after assessment no

current service is available what are the mechanisms of recording and collating unmet needs? Public expectations are potentially high due to the description of the LCO as a "rights" initiative.

3. Robust care coordination is fundamental to the progress of people with complex mental health needs. The College has contributed to reviews of the implementation of the Care Programme Approach (CPA) in Wales, and has had concerns about the quality and equity of care planning. Valuable information on potential impact of the Measure could be obtained by examining the impact of individual care plans before and after Community Treatment Order (CTO) implementation. CTO high uptake may be due to the stronger monitoring frameworks for Mental Health Act usage.

4. There is a clear need to develop and strengthen primary care mental health services, both in terms of knowledge and skills, and capacity to assess and treat. The RCPsych is involved in the training of General Practitioners. Wales Mental Health in Primary Care (WMHinPC) under the RCGP is actively working to improve the confidence and competence of primary care staff.

5. The question of making care planning and care coordination a statutory obligation for professionals and organisations in respect of *all* patients in secondary care is a more complex issue. The principals of care planning and coordination as defined by the Care Programme Approach (CPA) are no different in principle to those which apply generally to health and social care. If this Measure is enacted as currently written *secondary* mental health services will be the only branch of statutory care which have such an obligation. This is not an obligation of other areas of complex care (e.g. cancer services) or chronic illness care. The Measure will set a significant precedent. It may have unintended perverse effects: act as a barrier to acceptance by secondary care, increase the level of statutory bureaucracy, and most importantly increase stigmatisation of Mental Health services as a formal legal service.

6. The College has an established track record in promoting advocacy. The proposals to extend advocacy to those with mental disorder in all inpatient settings potentially promotes fundamental change in interaction between patients and clinicians.

7. It is unreasonable that mental health advocacy is available only to detained patients and then only to those detained for longer periods. Many informal patients have the same needs for advocacy as detained patients yet are denied this at present.

Question 2:

How will the proposed Measure change existing arrangements, and what impact will such changes make?

Response:

1. The establishment of the Local Health Boards clearly allows proactive management of the interfaces between Primary and Secondary Health & Social Care. The implementation of the Measure tests the Board's ability to deliver on this key area without manufacturing more divisions/barriers.

2. The proposed Measure gives a clear requirement for Health Boards and Local Authorities to work together. Such integrated working could lead to further future joint management arrangements.

3. The proposed provision under Section 2(1) requires Local Health Boards and Local Authorities to take all reasonable steps to agree a scheme which identifies local primary mental health treatment and secures its provision. There is however no direction as to what such treatments should be or how they should be agreed. This Measure leaves local provision to local organisations, as at present, and does little to promote wider or more uniform treatment options across Wales.

4. If local mental health partners agree a scheme which is inadequate from a professional perspective there is no additional formal means to challenge its quality. Only if the partners 'cannot agree' would the provisions of section 4 come into play; the LHB would have default responsibility and the Welsh Ministers *may* determine a scheme. There could therefore be an incentive for partners to agree a scheme at a 'low' level to avoid any challenge or referral under this Measure.

5. This Measure does not provide a direct requirement that local authorities are *equal and active partners*. Section 2(4) (a) and 4(2) (a) allow for one partner to provide all support and for the

Local Health Board to be the default provider. There is widespread concern that local authorities do not generally give as high a priority to mental health services as statutory health services do; the resulting gaps in important social care services reduce the effectiveness of health treatments for individuals with mental disorder.

6. Successful implementation of Statutory arrangements requires clear local implementation support, internal monitoring and external inspection.

7. Mental Health and Learning Disability services are experienced with working with a range of advocacy approaches. The Measure will bring advocacy approaches into less familiar settings, e.g. custody suites (if used for Section 136), district general hospitals.

Questions 3 and 4:

We have considered the separate elements of the proposed Measure under question 3 and included consideration of the barriers within each element by answering questions 3 and 4 together.

Question 3:

Are the sections of the proposed Measure appropriate in terms of achieving the stated aims?
In consideration of this question, respondents may wish to consider the nature of the provisions in the proposed Measure that:

a) Provide that there will be local primary case mental health services throughout Wales delivered by local health boards and local authorities working in partnership (part 1, sections 1-10).

Response:

1. Primary health care is increasingly provided in a range of settings. Would it be appropriate for 'out of hours' services to refer into the primary care mental health service?

2. Health services for prisoners are being increasingly improved and integrated into the NHS. Will such an enhanced scheme be available in prisons?

3. The Measure appears to limit gate-keeping into new primary care mental health services to GPs and NHS (Wales) Act 2006 Section 50 services (Sections 6 and 7). This would exclude direct referrals from other competent agencies (e.g. social services departments, forensic medical examiners) who currently have direct access into mental health services. Why should referrals be legally restricted to these routes?

4. Such restriction means that the quality of referrals to primary mental health services will depend heavily on the assessment and decision making of GPs. Efficient and appropriate access to these services may not increase without active development of GP skills for recognition, assessment and referral.

5. The enhanced service will need to have a basic competence in assessing people with a wide range of presentations, e.g. people with Learning Difficulties and disabilities, substance misuse, cognitive decline (possible dementia). These issues have not been embraced by current gateway schemes. If the basic assessment cannot sign-post appropriately and effectively they will be deemed ineffective. Alternatively, precious primary care resources will be used when there is little chance of efficacy. Current clinical training for secondary care practitioner schemes do not train clinicians across this heterogeneous picture.

6. Referrals need to be possible out of secondary care to the planned primary care service. Particularly there needs to be provision for practitioners in liaison psychiatric roles to directly refer. Difficulties will arise if secondary care referrers have unrealistic expectations of the capacity and competency of the primary care service.

7. Clear care pathways need to be in place to allow efficient use of all elements. Clarity is needed on indications for referral to the enhanced service and also indicators for direct referral to secondary care.

8. Providers of substance misuse services work with both primary and secondary care. These are commissioned separately from the Local Health Boards. Careful consideration of the Measure for this client group is required.

9. For the new care practitioners to function effectively, they need to be practicing in a clear professional framework. Unfortunately,

the provision of psychological approaches is patchy across Wales with obvious limitations to providing professional networks, supervision and provision of more complex psychological interventions.

10. 'Local primary mental health treatment' (Section 5 (1) (b)) is simply defined as 'treatment which might improve or prevent deterioration in …mental health' as identified in the assessment, yet there is a preceding obligation on local mental health partners to agree its provision as part of 'local primary mental health support services' (Section 2 (1)). The wording of this section is ambiguous. It appears to be (and could be interpreted as) a requirement that local partners plan and provide any and all treatments that may (could) be recommended through assessments, or it could be interpreted in a more limited fashion as restricting the treatments available to adults identified as needing treatment. How will a full and effective range of mental health treatments be determined and made available? It is not clear how this Measure will improve current treatment provision other than through legal challenge to failure and fulfill a statutory obligation.

11. We wish to emphasise that the current human resource (capacity and competence) and financial impacts of the proposals appear to lack detail and adequate sophistication. Failure to do this at this early stage could result in diversion of resources from secondary care to meet short term central targets and overall dissatisfaction from the wider population.

12. There have been difficulties in recruiting doctors to Wales for psychiatry. There has been a 77% drop in applicants for 2010 compared to 2009's difficult position. General Practice also has recruitment difficulties.

Question 3:

b) Provide for care and treatment plan for individuals receiving secondary mental health care (part 2, sections 11-17)

Response:

1. Secondary care services have changed over the last decade with the development of functional teams, e.g. Personality Disorder Services, Dual Diagnosis Teams, Assertive Outreach, Early Onset

Psychosis, etc. Not all teams have embraced CPA. There is sometimes confusion if people in such services are in or out of secondary mental health services.

2. Crisis Resolution Teams (CRT) are developing across Wales. Currently involvement of CRT alone does not signify the person is accepted into secondary care for CPA. What will be the relationship between CRTs and the new services?

3. CPA has not been implemented widely in specialist Learning Disability and Psychiatry of Old Age services despite these client groups having high rates of complex mental health needs. Clear guidance is required on which elements or situations constitute 'secondary mental health services' merely describing criteria as CMHT users will not be sufficient. Otherwise there will remain real issues for some of the most high risk groups.

4. In some areas of Wales there are difficulties in providing care coordinators. Implementation of the Measure could result in greater difficulties in getting patients accepted into secondary care and more precipitous inappropriate discharge.

5. There appears to be some inconsistency in the drafting. For adults accepted (for the first time) into secondary mental health services, care coordinators would be required to record a '(care and treatment) plan in writing' and 'in a single document' (sections 17 (1) (b) and (6)); there would be a separate legal requirement to provide entitled former users with a 'copy of (the assessment) report' (section 25 (2) (b)).

6. There are significant concerns about the level of bureaucracy that has accompanied the CPA. Psychiatrists are concerned about the ill-considered imposition of inappropriate bureaucracy and paperwork for individuals with simple needs and care plans. As it stands the above requirement in the Measure would be met by good medical notes and correspondence. However, there is no reference in the Measure to CPA and CPA guidance would need to be reviewed if this obligation were to be effectively implemented.

7. The Explanatory Memorandum suggests that the aim of these proposals to encourage 'greater involvement of services users in decision making' (para 155). It is not entirely clear how a

statutory obligation will improve the quality of engagement by and with 'service users'.

Question 3:

c) Provide an entitlement to assessment by the providers of secondary mental health services for previous service users in particular circumstances (part 3, sections 18-28)

Response:

1. Some of the comments regarding clarity on the definition of secondary care services equally apply to this section. Services would rapidly become overwhelmed if all people with contact with secondary care had a right to re-assessment in secondary care.

2. There will be obvious difficulties in establishing if people are eligible for this rapid assessment route, e.g. in urban transitory environments, university towns.

3. People with mental health and learning disabilities may have difficulties in obtaining treatment for their physical health needs. These difficulties occur at many levels. Psychiatrists particularly within sub-specialties have concerns that important urgent physical health needs could be present as a request for secondary mental health assessment, e.g. elderly people with dementia and superimposed delirium due to infection.

4. The provisions in the Measure make no allowance for clinical judgment as to the appropriateness of self re-referral and do not allow the option to signpost individuals to other services which may seem more appropriate. Many individuals who have had services from secondary mental health services and who have been discharged appropriately could have further episodes of illness treated in primary care; this Measure may act as a disincentive for primary care services to develop resources to manage such relapsing chronic illnesses.

5. There appears to be an assumption within the Measure that an individual who has had a previous episode of mental illness and been in contact with secondary mental health service will present with the same illness and need the same level of care. This is analogous to a patient who has had one admission with a heart

attack having direct access to specialist cardiac services for a further episode of pain with no screening in accident and emergency services or primary care.

6. Para 37 of the Explanatory Memorandum implies that the driver for this proposal in the Measure is primarily to encourage *discharge* from rather than to facilitate re-admission to services. There are many barriers to discharge (e.g. inefficient caseload management, inappropriate needs assessment, inappropriate professional commitment) which could be productively addressed without a statutory measure.

7. Many individuals with severe mental disorders lack insight and may neglect to refer themselves when appropriate. These individuals tend to have more serious illness and will rely on others to make referrals. This Measure provides no entitlement to re-assessment under these circumstances. It therefore fails to provide for the most vulnerable patient group.

8. Prompt access to secondary mental health services should be a universal entitlement not restricted to those who have previous contact. This Measure may act as a perverse incentive to prioritise this group with a statutory entitlement over others, either those with no previous contact or those discharged outside the relevant discharge period.

9. Statutory prioritisation may also carry clinical risk. Some self-referred individuals may have lower levels of risk and need than unknown referrals yet they may be arbitrarily prioritised.

Question 3:

d) Make provision in relation to Independent Mental Health Advocacy schemes in respect of patients subject to the compulsory powers of the Mental Health Act 1983, and 'informal patients' (part 4, sections 29-37).

Response:

1. An obvious consequence of this element is the significant expansion to offer an advocacy service 'out of hours' within time limitations especially for Sections 136, 5 (2) and to all inpatients. Before embarking on such a costly initiative it would be prudent to evaluate the impact of recent advocacy expansion IMCA &

IMHA schemes; particularly important would be evaluation of the impact on individual patients' clinical journeys.

2. Admissions to secondary general health care includes significant numbers of people with mental disorders. General services do not have a strong track record in meeting their needs. The Measure could make a significant difference to the quality of their outcomes including making an impact on delayed transfers of care. However, there is evidence that general health services fail to recognise mental disorders.

3. Advocates working in general health settings will have to have an additional set of competencies due to their cultural and organisational differences from mental health/learning disability services.

4. The proposed provision of advocacy for individuals detained under emergency short term needs to be considered carefully. Decisions under these sections often need to be taken quickly and there is potential for assessment and decision making to be impeded. The Code of Practice for Wales recommends that assessment under section 136 should begin as soon as practical. This may be compromised if an individual chooses to request an advocate or if there is an obligation to involve and advocate as well as an AMHP and section 12 doctor. Paradoxically, an individual's detention may in fact be extended and made more complex by the provision of an advocate; prompt assessment may result in earlier discharge.

Question 5:

What are the financial implications of the proposed Measure for organisations, if any?

Response:

1. The comment made in answer to question 3, 4 a) 11 is made again for emphasis.

2. As indicated above, successful initiatives require infrastructure for implementation, recognition of good practice and deficiencies. This will be especially important in areas where there is no history of legislative approaches on a day to day basis, e.g. primary care, general health care. No costings are

apparently included in the financial impact for either Health Boards, Local Authorities or the regulatory bodies, e.g. HIW.

3. Implementation of a mandatory care plan should theoretically be cost neutral. Surely the deficits in recent reviews suggest a requirement to ring-fence/allocate monies to the development of high quality care coordination, e.g. appropriate clinical supervision arrangements for care coordinators.

4. Development of enhanced/new primary mental health services will require additional funding for additional staff and training of those existing primary care staff who will be responsible for referral to these new services. This would be borne by Local Health Boards and local authorities.

5. We are aware that there are plans to revise arrangements for supporting people arrested on Section 136 orders. Would it be appropriate to clearly integrate any enhanced advocacy arrangements within this work? Otherwise there are risks of setting up costly complex systems around existing arrangements which would be superseded within a very short time period.

Question 6:

Are there any other comments you wish to make about specific sections of the proposed Measure?

Response:

1. The Measure only applies to adults. A significant number of mental disorders present in childhood and adolescence. The Mental Health Act is required to be implemented at times in the assessment and treatment of under 18 year olds. Therefore, to allow an equal position for children and adults and to implement truly preventative approaches the Measure should make reference to and be applicable and relevant to under 18 year olds.

2. In addition to the monitoring requirements indicated under Q 5.1 above it would be recommended that a rigorous external evaluation of the measure's impact is put in place. Possibly this could be reflected in strategic research priorities.