



briefing

Health, Risk and Regulatory - November 2009

Recommendations for the provision of mental health services in Wales

A recent Healthcare Inspectorate Wales (“HIW”), commissioned by the Welsh Assembly Government, has reviewed the provision of mental health services to Mr E following a homicide committed in August 2007. Mr E stabbed an acquaintance, Mr V, five times; Mr V died of his injuries (“the Review”).

The Review looked at the delivery of services to Mr E in the Gwent area. However, the Review recommendations are relevant to all new Local Health Boards (“LHBs”) across Wales.

Background to the Review

Mr E was first referred to the Community Adult Mental Health Services Team in July 2002 by his GP with depression. Mr E failed to attend the appointment offered by the Community Mental Health Teams (CMHT) and he was discharged. Another GP referral was made but Mr E was again discharged for non-attendance.

The Review questioned the policy of the CMHT at that time, of discharging a patient for failing to attend an initial appointment and suggested that there should have been some discussion with the GP practice about the referral. It also suggested that the second referral should have prompted a home visit. The early failure to follow up failed appointments is a feature criticised by HIW as being indicative of the lack of an assertive approach.

Mr E suffered an accidental overdose on 2003 whereupon contact with the CMHT was established. The Review felt that if CMHT were more proactive in 2002, Mr E could have been receiving treatment earlier, and before his overdose. The Review found that the

contact with CMHT was for short periods (during which Mr E declined contact), up to the time when he inflicted the fatal injuries on Mr V. His occasional non-compliance with medication was known to staff in CMHT but not robustly followed up.

The Review expressed concern about the absence of Consultant Psychiatrist care of Mr E’s, who HIW believe was seriously ill. The CMHT diagnosed Mr E with depression and psychosis but he was diagnosed with schizophrenia following the homicide. The Review considered that an earlier diagnosis of schizophrenia could have brought about a more assertive approach to treatment, including admission to hospital, even on a compulsory basis under the Mental Health Act 1983.

The Review also noted that it was significant that the CMHT did not make Mr E subject to enhanced Care Programme Approach (“CPA”) arrangements. This meant that there was no failsafe arrangement for Mr E’s care to be discussed by the whole CMHT. The Review concluded that Mr E’s parents were not consulted by the mental health services about arrangements for their son, and were not offered social work support; CPA could have remedied this. Risk assessments were in place but were not reviewed on a frequent basis.

The Review is critical of the systems and procedures within the CMHT. The record systems was regarded to be poor and basic management data was not available.

The recommendations of the review are as follows:

Leadership and management

1. Systems should be in place to inform senior managers in LHBs and Local Authorities, about workload, team capacity and performance management. Leadership and management resources within the CMHT needed to be improved, particularly when leaders within CMHT are expected to undertake wider corporate roles. Leaders needed the appropriate authority to undertake the role.
2. An effective and robust caseload management supervision policy should be developed and implemented.
3. A strategy for seamless, integrated services to mental health service users is needed.
4. The need for assertive care and treatment should be emphasised. LHBs and Local Authorities need to ensure that policies and procedures, together with resources such as Home Treatment Teams, address the need for assertive management, including at the referral stage, when appropriate.

Quality of planning for care and treatment using CPA

5. LHBs should ensure that CPA is implemented and that monitoring/auditing arrangements are in place to ensure compliance.
6. Staff training should be focused on developing the skills required to deliver care within CPA. Guidance to staff should be developed to ensure that staff are aware when enhanced CPA should be used, and this should reflect WAG policy.
7. Risk management must be integrated into CPA process.

Risk assessment and management

8. LHBs need to be clear about risk assessment and management of patient care. If LHBs use the services of the Welsh Applied Risk Research Network, necessary resources must be secured and the necessary training must be put in place.

Co-operation

9. LHBs need to develop clear written guidance for staff about dealing with patient families, including how to engage them into appropriate collaboration with care and treatment of patients and how families can be supported. Guidance will need to cover issues relating to confidentiality. The guidance should assist staff to be confident and assertive in engaging patients' families.
10. LHBs need to audit the use of carers' assessments and the implementation of action plans arising out of the carers' assessments. This is to ensure that assessments are carried out at an early stage and consideration is given to CPA.
11. LHBs should review its arrangements for sharing information and ensure active liaison between primary and secondary care services in relation to mental health patients. There should be specific responsibility within CMHTs to liaise with Primary Care (GPs) to ensure that some patients do not slip through the nets of mental health services. Good communication and regular medication reviews are recommended to be carried out both by Primary and Secondary Care services.

More information

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