CARE PROGRAMME APPROACH POLICY

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<table>
<thead>
<tr>
<th>Version Number</th>
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</thead>
<tbody>
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</tbody>
</table>


# CARE PROGRAMME APPROACH POLICY

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2  Policy statement</td>
<td>4</td>
</tr>
<tr>
<td>3  Objectives</td>
<td>5</td>
</tr>
<tr>
<td>4  Scope</td>
<td>5</td>
</tr>
<tr>
<td>5  Roles and Responsibilities</td>
<td>7</td>
</tr>
<tr>
<td>6  Implementing the Care Programme Approach</td>
<td>7</td>
</tr>
<tr>
<td>7  Assessment and Review</td>
<td>10</td>
</tr>
<tr>
<td>8  Co-occurring Substance Misuse and Mental Health Problems</td>
<td>12</td>
</tr>
<tr>
<td>9  The role of the Care Co-ordinator</td>
<td>13</td>
</tr>
<tr>
<td>10 Carer Involvement</td>
<td>14</td>
</tr>
<tr>
<td>11 Service Users Admitted to or Discharged from Hospital</td>
<td>16</td>
</tr>
<tr>
<td>12 Section 117 of the Mental Health Act 1983</td>
<td>16</td>
</tr>
<tr>
<td>13 Mentally Disordered Offenders</td>
<td>16</td>
</tr>
<tr>
<td>14 Service Users Moving between Teams /Mental Health Districts</td>
<td>18</td>
</tr>
<tr>
<td>15 Planned Moves</td>
<td>18</td>
</tr>
<tr>
<td>16 Unplanned Moves</td>
<td>19</td>
</tr>
<tr>
<td>17 Refusal to Maintain or Loss of Contact with Services</td>
<td>20</td>
</tr>
<tr>
<td>18 Discharge from CPA</td>
<td>21</td>
</tr>
<tr>
<td>19 Confidentiality</td>
<td>21</td>
</tr>
<tr>
<td>20 Resources</td>
<td>22</td>
</tr>
<tr>
<td>21 Training</td>
<td>22</td>
</tr>
<tr>
<td>22 Implementation</td>
<td>22</td>
</tr>
<tr>
<td>23 Further information</td>
<td>22</td>
</tr>
<tr>
<td>24 Equality impact and assessment</td>
<td>23</td>
</tr>
<tr>
<td>25 Audit</td>
<td>24</td>
</tr>
<tr>
<td>26 Review</td>
<td>24</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

This policy will represent the commitments and requirements of the revised Adult Mental Health National Service Framework (Raising the Standard, 2005). Key actions to standard 7 of this framework make reference to the introduction of the Care Programme Approach (CPA) across Wales for all people with serious mental health problems and / or complex enduring needs. The purpose of which will be to provide a systematic arrangement for assessing the needs of people accepted into mental health services.

November 2010 saw the passing of the Mental Health (Wales) Measure by the National Assembly for Wales; this measure was subsequently given Royal Approval in December 2010.

Part 2 of this measure is concerned with the coordination of care and treatment planning for secondary mental health service users.

The Mental Health (Wales) Measure will have a substantial impact on the procedures and regulations of care and treatment planning and the role of the care coordinator. This policy is to be used with immediate effect; however there is the understanding that there will be further review and refinement in accordance with the full implementation of the measure.

The Care Programme Approach has existed in Wales since 2003; it was implemented across Cardiff and Vale NHS Trust, now Cardiff and Vale University Health Board, in March 2005.

The Welsh Assembly Government issued guidance on CPA in 2003; this was replaced by the 'Interim Guidance for Delivering the Care Programme Approach in Wales' in July 2010.

The Mental Capacity Act 2005 was implemented in October 2007

Since implementation of the CPA in Wales there have been numerous local and national audits (Delivery and Support Unit and NLIAH in full 2009, NPSA in full 2009) and focus via Strategic and Financial Frameworks (SaFF) and Annual Operating Framework (AOF) targets.

The Annual Quality Framework for Wales (AQF) 2011 / 2012 has the expectation of ‘…full compliance with the Care Programme Approach across all age groups’.

2. POLICY STATEMENT

Cardiff and Vale University Health Board is committed to using the framework of the Care Programme Approach to deliver dedicated support to all users of its secondary mental health services.
This policy includes key elements of statute, policy and guidance and takes account of published audit results into the effectiveness of CPA. This policy aims to ensure that CPA:

- Is an approach which is service user focused and appropriate to the individual and which recognises the strengths, expectations and vocational / occupational aspirations of each service user.

- Is a framework for the assessment and delivery of care which will facilitate the movement of service users through the health and social care system according to need and availability; it aims to prevent service users being lost to services.

- Recognises the role of carers and the support that they may require.

- Embraces best practice in the delivery of care and treatment, by adopting a multi-agency approach based on full integration of Health and Local Authority care in conjunction with voluntary sectors and other appropriate community resources.

- Ensures the provision of a care plan which will include the identification of unmet needs, and will include risk assessment, contingency and crisis planning.

- Is a process which provides the central focus for individual clinical information, and one which will support sound professional advice.

- Is a process that will minimise bureaucracy and reduce paperwork, ensuring it is appropriate to need and functions. This will streamline clinical functions and processes to the benefit of clinical practice and record keeping.

- Embraces the recovery approach which will ensure the care planning process will focus on promoting engagement, social inclusion, self management and progress towards personal goals. The process of defining problems and goals will be collaborative and written in the language of the service user rather than jargon and couched in terms of diagnosis.

- Is a process that fully complies with relevant legislations such as the Mental Health Act 1983, Mental Capacity Act 2005, and Mental Health (Wales) Measure 2010.

- Is a process that can be audited for adherence to these guiding principles.
3. OBJECTIVES

Through the introduction of this policy, staff will be able to identify how to apply the five components of the CPA to individuals allocated to areas of care and will be able to identify the service users who meet the criteria of ‘Standard’ or ‘Enhanced’ care, the two levels of CPA delivery.

The policy outlines and describes the process for delivery of CPA to service users, and through this process provides consistent high quality care in accordance with the National Service Framework for Wales, The Mental Health (Wales) Measure, the Annual Quality Framework, and other relevant legislation including Mental Health Act 1983, Mental Capacity Act 2005.

4. SCOPE

This policy will apply to all those who are accepted for care and treatment within the secondary mental health service group and will include:

People who are currently in contact with social care staff working within the Mental Health Integrated Teams. CPA is an integrated approach within mental health services spanning across health and social care and should minimise distress and confusion for the service user.

People in both hospital and community settings and also to those in other day or residential settings who are in contact with mental health services (including older people in residential and nursing homes, people in prison, plus specialist mental health services including neuropsychiatry and addictions).

People who have recently been discharged from hospital and are subject to aftercare and follow-up arrangements under Section 117 of the Mental Health Act.

People who fail to attend appointments, or who are reluctant to engage with services, particularly where a significant level of risk is identified.

To all those using specialist mental health services, irrespective of ethnicity, gender, cultural background or disability.

The CPA documentation, which has been developed to support the implementation of this policy, will be adopted throughout the Mental Health Service Division.

This documentation will be incorporated into electronic records which will provide the clinical and managerial information necessary to underpin the overall policy.

While respecting the need for confidentiality of certain personal information, CPA information should be shared between agencies on a “need to know” basis.
This includes the requirement to share information with the relevant Local Authority departments when issues of adult (or child) abuse are disclosed or suspected. This may be necessary even if consent is not given.

Where contact is required with key statutory or independent sector agencies e.g. police, probation, housing, employers – local information sharing protocols should be developed and agreed.

5. ROLES AND RESPONSIBILITIES

All clinicians have their own professional responsibilities towards the correct implementation of the Care Programme Approach for their service user.

In addition, the management of the UHB and Local Authority have responsibilities towards ensuring the Care Programme Approach is vigorously implemented and undertaken in accordance with this Policy.

Unmet needs of individual service users should be recorded and notified to the relevant Team Manager this report should be sent to the CPA Lead at the CPA office. The CPA Lead will compile a report on a quarterly basis for the relevant managers on an anonymous basis. This report should be discussed in the appropriate Care Forums and raised through the appropriate channels to influence service development.

6. IMPLEMENTING THE CARE PROGRAMME APPROACH

CPA Levels

In accordance with Welsh Assembly Government guidelines (Mental Health Policy Guidance – the Care Programme Approach for Mental Health Service Users, A Unified & Fair System for Assessment and Managing Care – February 2003, Delivering the Care Programme Approach in Wales – Interim Policy Guidance –July 2010), there are two levels of CPA in Wales: ‘Standard’ and ‘Enhanced’.

This criterion will form the basis for the decision regarding level of CPA to be applied by staff for the service users within the UHB placing emphasis on criteria being needs based and not service based. These decisions will be made on the basis of the initial assessment or following CPA review. Service users may move between the levels according to their need, but the decision as to the level of CPA will be determined through a comprehensive review process. A service user will remain subject to CPA for the duration of the time that they access secondary mental health services.

Most people on Standard CPA will be expected to be considered “low risk” to independence using Local Authority Eligibility criteria under “Fair Access to Care” guidance. Conversely, most people on Enhanced CPA will be expected to be considered “substantial” or “critical” risk to independence. (“Moderate risk” may fall into either category).
Standard CPA

Standard CPA is designed to meet the needs of service users who:

- Require the support or intervention of one agency or discipline
  or, require low key support from more than one agency or discipline

- Be more able to self-manage their mental health

- Have an informal support network

- Pose little danger to themselves and/or others

- Be more likely to maintain contact with services

This level of care will involve the service user keeping in touch with one or more mental health workers, one of whom will fulfil the role of Care Co-ordinator.

The care to be provided will be documented in a care plan, a copy of this must be offered to the service user. ‘An individual service user’s care plan must be based on a thorough assessment of their health and social care needs. This assessment will involve the user and carer, where appropriate, as central participants in the process’ (NHSE 1999)

If the service user lacks the mental capacity to participate in the formulation of the care plan, their best interests must be determined as set out in the Mental Capacity Act 2005

This care plan should either be recorded in the appropriate care plan format or in the accepted format (for Consultant Psychiatrists).

The care plan should be agreed and signed by both the service user and the Care Coordinator.

Suggest starting – If the service user cannot, does not wish to or refuses to .........., the reason for this must be recorded.......It must be clearly recorded the reasons why the service user cannot or does not wish to sign the care plan, where they have the capacity to do so, this may include any disagreements.

It is essential that the care plan is reviewed and amended as necessary, but the period between reviews should not exceed twelve months.

The need for a contingency, or crisis plan must also be considered and it is vital this includes details of what action(s) should be taken by the service user, carer(s) and GP in a crisis.

Enhanced CPA

Enhanced CPA is designed to meet the needs of the service users who present with all or some of the following:
• Multiple care needs, including housing, employment etc requiring inter agency co-ordination.

• Willing to co-operate with one professional or agency, but have multiple care needs.

• May be in contact with a number of agencies (including the Criminal Justice System).

• Likely to require more frequent and intensive interventions.

• More likely to have mental health problems co-existing with other problems such as substance misuse.

• More likely to be at risk of harming themselves and/or others.

• More likely to disengage with services.

**What does Enhanced CPA involve?**

All service users assessed as requiring to be placed on Enhanced Care Programme Approach will:-

Receive a holistic initial assessment of their needs, which includes a risk assessment.

Receive a comprehensive multi-disciplinary/multi-agency care plan as appropriate to meet their needs, agreed between the team, the service user, where they have the capacity to do so (and carer/s where appropriate) and this will include detailed contingency and crisis plans.

Receive a copy of their care plan.

Have a Care Co-ordinator allocated with clear responsibilities and tasks as agreed by the care team.

Have regular reviews, frequency of which will be determined by the service users needs. However a review will be required to be performed automatically if one has not taken place within any 12 month period.

It must be noted that all service users admitted to mental health inpatient services will be required to be cared for under Enhanced Care Programme Approach at least for the duration of the in-patient episode.

It must also be noted that a practitioner may deem it appropriate to place a service user on Enhanced Care Programme Approach who does not meet the above criteria. In such circumstances the reasoning behind this decision must be fully documented.
7. ASSESSMENT AND REVIEW

All users of mental health services will be assessed using the Unified Assessment / CPA assessment framework set out in the agreed UA/CPA documentation. Service users should be routinely involved in the planning and provision of his/her own care. Where possible, carers should also be a part of this assessment. This includes an analysis of the presenting problem, a consideration of needs for services (including substance misuse) and a risk assessment.

“The care and treatment plan should be regularly reviewed to ensure that it continues to meet the individuals assessed needs…a care and treatment plan should be preceded by reassessment of need and risk” (WAG 2010).

The CPA documentation also includes:

- Care Plan
- Contingency Plan
- Crisis Plan
- Unmet needs
- Assessment of risk

There is no set format for CPA reviews. Some may take place within routine clinical meetings (e.g. ward rounds), others may take place independently.

All those involved in the service users care, including carers, voluntary sector workers and GPs, are obliged to be invited to CPA review meetings, as far as possible, in line with service users wishes. Those invited should be given reasonable notice in advance of date and time and a note should be kept of who attended.

Where key individuals are not able to attend CPA reviews, the Care Co-ordinator should seek their opinion and feed it into the discussions.

Once agreed, a copy of the care plan is to be given to the service users (and carer where appropriate) and sent to the GP and all other agencies involved in the service users care, within 7 working days of completion.

Although there is no requirement for nationally determined review periods, it is good practice to undertake a first review within three months of the initial care plan, and within the first month of discharge from hospital. Frequency of the reviews will be determined by service user needs, however ‘…in all cases a formal review of the care and treatment plan must take place at least annually (i.e. once in any 12 month period) and should be clearly documented’ (WAG 2010).

Major changes in the service user’s condition, circumstances (e.g. admission to hospital) risk or Mental Health Act status should trigger an early review. It is particularly important to review the CPA as part of discharge planning arrangements. This review could be in conjunction with a Section 117 review.
At each review meeting the date of the next review must be set and recorded

The Care and Treatment Plan
The Mental Health Measure provides Welsh ministers with powers to make
regulations prescribing the “form and content of care and treatment plans”; this
guidance will be updated according to the outcome of Part 2 of the Measure.

The Mental Health Measure requires that a care and treatment plan must be
agreed to achieve outcomes in one or more of the following areas:

- finance and money
- accommodation
- personal care and physical wellbeing
- education and training
- work and occupation
- parenting or caring relationships
- social, cultural or spiritual
- medical and other forms of treatment including psychological
  interventions.

The care plan will be in writing and signed by the care co-ordinator, and where
possible the service user.

The Mental Health (Wales) Measure 2010 places duties on care co-ordinators
to consult with relevant persons in the preparation, review and revision of the
care plan.

Those who may be consulted in preparing and reviewing or revising care and
treatment plans include:

- Service user,
- The Responsible Clinician,
- Carers of the relevant service user,
- Persons with Parental Responsibility
- The service user’s guardian (if appointed
- The managing authority and supervisory body, where a person is subject
to urgent or standard authorisations under the Deprivation of Liberty
Safeguards of the Mental Capacity Act 2005
- A donee or deputy appointed for the person where matters to be
  considered fall within the scope of their decision making powers
- An independent Mental Capacity Advocate who has been appointed for
  the person

The care co-ordinator may also consult any person that they believe ought to be
consulted in order to facilitate the carrying out of their functions, and any person
the service user wishes to be consulted, providing the care co-ordinator
believes this is in the service user’s best interests.
The care co-ordinator may consult with a person against the wishes of the service user. This may only happen following due consideration of the views of the service users and a clear record of that consideration must be made.

Care plans must be copied (where able) to the service user and relevant others as soon as reasonably practicable after completion, the Welsh Assembly Interim CPA policy guidance states that:

“Copies of care and treatment plans should be provided to the service user, members of the care delivery team and other relevant parties as soon as it is made, and in any case within seven days of it being agreed.” (WAG 2010)

8. CO-OCCURRING SUBSTANCE MISUSE AND MENTAL HEALTH PROBLEMS

A significant number of individuals who experience mental health problems will also have ongoing problems of addiction or inappropriate substance use, whether the substance is alcohol or drugs. There is extensive evidence that this both exacerbates the symptoms of mental illness and also makes them harder to treat. It is also known that individuals who fall into the “Co-Occurring” category are often more difficult to engage in treatment and are more likely to disengage from treatment programmes and lose contact with services. There is also a high clinical risk rating associated with this category, both in terms of suicide and harm to others.

All patients who are recognised as falling into this category must be managed by CPA, either at Standard or Enhanced Level. There will be “Co-Occurring” guidelines available which will include a formal definition of this category. The CPA assessment must include consideration of the following:

- Assessment of patterns of substance misuse and degree of dependence
- Consideration of the relationship between substance misuse and mental health problems
- Consideration of the interaction between medication and other substances
- Assessment of the knowledge of “harm minimisation” in relation to substance misuse
- Assessment of level of motivation to change
- The need for treatment of substance misuse

The Community Addiction Unit/ Community Drug and Alcohol Team may be contacted for advice / involvement regarding the above.
It is recognised that, in accordance with national guidelines for Co-Occurring/Dual Diagnosis issues, the Care Co-ordinator will usually reside within Adult Mental Health Services. However, each case must be assessed on its individual merits and it is possible that in some instances it will be more appropriate for clinicians in the Community Addiction Unit to take this role.

When Co-Occurring issues are identified therefore, it is important that the clinical team has a discussion about who the lead service should be, and this must be clearly documented.

9. **THE ROLE OF THE CARE CO-ORDINATOR**

The term Care Co-ordinator is specific to the person who in collaboration with the service user designs and oversees the care plan.

“The care co-ordinator is central to the effective delivery of the CPA. The Care Co-ordinator is responsible for ensuring a care and treatment plan is developed and delivered and where necessary, reviewed and revised.” (WAG 2010)

It is the responsibility of the Care Co-ordinator to ensure that the five components of the CPA, assessment, planning of care and treatment, delivery of care and treatment, monitoring and review and discharge and being delivered.

The Care Co-ordinator must be agreed as soon as practicable after the service user is in first contact with services.

'It is not appropriate or safe, for service users to be without a Care co-ordinator once they have been accepted into services’ (WAG 2010)

The Care Co-ordinator must be a qualified health professional employed by Cardiff and Vale University Health Board or a qualified and registered social care professional working within the integrated Mental Health teams with suitable knowledge/experience to undertake the role of Care Co-ordinator, e.g. Mental Health Nurse, Social Worker, Psychiatrist, Psychologist, Occupational Therapist.

Those not identified as a care coordinator would usually be:

- General Practitioners
- Unqualified / Unregistered health or social care workers
- Advocates

The Care Co-ordinator will normally be the qualified professional who has the highest level of involvement with the client. Unqualified staff – support workers, trainees, students, – may take on certain roles in relation to care coordination if delegated by qualified staff. However, they cannot act as formal Care Coordinators.
Where service users are involved with the voluntary sector or other outside agencies it is essential this key agency is invited to and participate in reviews.

The Care Co-ordinator must maintain regular contact with the service user and any significant others in the life of the service user so that changes in health and social circumstances are acknowledged and appropriate action is taken.

The Care Co-ordinator remains actively involved in the service user’s care and oversees the care process regardless of setting. This may include inpatient admissions unless other local arrangements are agreed between services. The Care Co-ordinator should also maintain contact with the service user during admission to a non mental health ward, this is to ensure support continues for the person and may also provide support to non mental health staff in delivering care.

If the client goes to hospital, the Care Co-ordinator must remain in regular contact and be actively involved in discharge planning. The Care Co-ordinator and named nurse must keep in regular contact during admission to plan and implement care.

If there is no allocated care coordinator prior to hospital admission or the hospital admission will be for a prolonged period of time i.e. over 3 months, an appropriate member of the inpatient team may fulfil the role of care coordinator until alternative arrangements are made.

In the case of service users on Standard CPA, where there is contact with only one professional (e.g. a psychiatrist) the role of Care Co-ordinator will be undertaken by that professional.

Any changes to the appointed care coordinator must be clearly recorded and communicated to the service user, carer and professionals involved in the care delivery.

10. CARER INVOLVEMENT

A carer can be defined as a friend or relative who is involved in caring for a person with a severe mental illness. Carers provide invaluable support to the people they care for. Statutory services may need to provide support and services to enable carers to continue caring and to meet their own health needs.

Within the Carer’s Act (1995) carers are defined as “individuals who provide or intend to provide emotional or practical support to a family member, friend or partner who is ill, has a disability, is experiencing mental distress or is affected by substance misuse”.

A person under the age of 18 who provides support in the context of the above paragraph is defined as a young carer. Where a young carer is identified, referral to Children and Family Services should be made.
A person aged 18 or over who provides support in the context of the above paragraph is defined as an **adult carer**.

Carers of service users, including young carers, should be offered their own assessment and, if required, a care plan which takes account of their own mental and physical health needs and their ability to continue to provide care including work and family commitments. It is the responsibility of the Care Co-ordinator to undertake this assessment.

**Standard 2 – Key action 8** of the *Revised National Service Framework (NSF) for Mental Health (2005)* states: ‘Carers have a statutory right to their own assessment and if eligible for support, a written care plan. The special needs of young carers are to be taken into account.

Those identified as carers for people subject to the CPA will:

- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- Have their own written care plan which is given to them and implemented in discussion with them.
- The assessment is the responsibility of the statutory services to arrange, usually through the Care Co-ordinator, and should be reviewed on, at least, an annual basis. The carer has a right to an independent assessment even if the service user they care for has refused an assessment.

To effectively involve carers in the CPA process the Care Co-ordinator should be aware of the names of the main carers and how to contact them and should endeavour to maintain regular contact. The carer should have a contact number for the Care Co-ordinator. With the agreement of the service user the carer should be involved in all aspects of assessing, planning and delivering care.

Of particular concern are the needs of young carers (i.e. those under 16 years of age). It cannot be assumed that the young carer can undertake the necessary caring responsibilities. The needs of young carers must be considered on a multi-agency basis. Young carers must be supported to develop fully – socially, emotionally and educationally – and assistance should not reinforce the role of the young person as a carer.

> “Professionals need to be aware of the childcare responsibilities of service users. Mental illness may affect the user’s capacity to meet the needs of children in their care”. Adult Mental Health Services for Wales’ Welsh Assembly Government (September 2001).
11. SERVICE USERS ADMITTED TO OR DISCHARGED FROM HOSPITAL

Service users may be admitted to hospital for inpatient care. The CPA process must provide a system of seamless care between community and inpatient units and there must be clear identification at all times of the Care Co-ordinator.

A CPA review should be held at the earliest opportunity following admission, preferably within one week. A CPA review must be undertaken prior to discharge from hospital.

The National Policy on delivering the CPA in Wales states:

“Care coordinators should ensure that any service user discharged from hospital, but who will be remaining in secondary care is seen within five working days of discharge by a mental health professional….where an inpatient has discharged themselves against medical advice, effort should be made to contact that person in the community as expediently as possible.” (WAG 2010)

A further CPA review must be undertaken within the first three months of discharge from hospital. The subsequent review date will be decided on at this review, but will be no longer than 12 months.

12. SECTION 117 OF THE MENTAL HEALTH ACT 1983

Section 117 of the Mental Health Act 1983 imposes a duty on Local Authority and Health Authorities to provide aftercare services for patients who have been detained in hospital under Sections 3, 37, 45A, 47 or 48 of the Act.

Entitlement to aftercare services begins when a patient ceases to be detained under any of the above sections, whether or not the patient is discharged immediately or continues to accept informal admission prior to discharge from hospital.

All service users who are entitled to after care under the provisions of Section 117 will have their needs assessed and care planned within the provisions of CPA, this will be a joint process. For further guidance refer to the Joint Policy/Procedure on Section 117 aftercare.

13. MENTALLY DISORDERED OFFENDERS

Services are provided to these clients in NHS secure, Multi Disciplinary Team community and criminal justice settings. These agencies share responsibilities for ensuring appropriate communication, liaison and joint working in providing care of mentally disordered offenders. It is important that effective links are made to ensure sound care planning for clients cared for within the criminal justice system and appropriate diversion to NHS care when required. Establishing effective links are equally important between NHS providers of secure and forensic services.
The Lord Bradley review of people with mental health problems and learning disabilities in the criminal justice system (DoH 2009) identifies that the CPA has been developed as the fundamental process for ensuring continuity and care of people with mental health problems and states: “Such an approach is vital within the prison environment and then through release and into resettlement” (DoH 2009).

As well as meeting the therapeutic needs of patients, the security and public safety issues need to be addressed. The multi agency protection arrangements legislation and regulations from the Criminal Justice and Court Services Acts (2000) and (2003) established the local arrangements for Multi Agency Public Protection Arrangement processes. These are organised within the low secure Community Services with an overview from a South Wales strategic management board.

Protocol for providing continuity of psychiatric care for people entering and leaving custody

The primary responsibility for the treatment and care of people in custody is with the Healthcare Service for Prisoners (HCSP), which provides primary care services to prisoners. The precise name of this service and its relationship to NHS services will vary from prison to prison. However, regardless of which organisations provide this service its functions include identifying the need for aftercare on release, which will be provided by local general or forensic services, according to the following protocol. The local services responsible will be determined according to the National Guidelines on determining district of residence (i.e. according to the service user’s home address or if homeless, the district where the offence was committed, or the location of the court hearing the case).

Prison service health care centres and NHS mental health services share responsibilities for ensuring appropriate liaison for the care of mentally ill prisoners. It is important that effective links are made to ensure sound discharge planning when inmates are released from prison.

Care Co-ordinators for people subject to CPA must:

Take steps to ensure that they remain in contact with service users who enter prison.

In particular they should make sure that they are, wherever possible, aware of the location and likely release date of the person, so that appropriate care can be planned for the release.

Persons Entering Custody

Those already in psychiatric care – the responsible consultant and CPA Care Co-ordinator will ensure that adequate information as to treatment and current care plans are provided to the health care or prison In reach team for that treatment to continue while the service user is in custody. This is likely
to indicate the type of aftercare which may be required, and a named contact e.g. Consultant or CPA Care Co-ordinator, with who to make arrangements for release.

**Persons not in psychiatric care at time of arrest, but such need is identified during the criminal justice process (e.g. in the course of psychiatric report preparation)** – while there is no formal guidance on the responsibility of the psychiatrist preparing court reports, good practice should include that if the report indicates the need for psychiatric interventions, the person preparing the report should ensure that assessment and report is communicated to the HCSP.

Where that assessment is likely to lead to transfer from prison or a psychiatric disposal at court, the psychiatrist will assist HCSP in facilitating this process.

### 14. SERVICE USERS MOVING BETWEEN TEAMS /MENTAL HEALTH DISTRICTS

When the Mental Health Care of a service user needs to transfer to a different Community Mental Health Team, a CPA review meeting must be undertaken for all those service users prior to transfer to ensure that there is an effective handover of care and that a new Care Coordinator is allocated. Any funding implications for Health and Local Authority must be agreed prior to transfer of responsibility, and preferably before the service user moves area.

### 15. PLANNED MOVES

Service users who move out of one area to another remain the active responsibility of the original authority until a formal handover can be arranged.

The decision to transfer responsibility for the care of a service user to another district should take place in a CPA review meeting, unless exceptional circumstances prevent this. The service user should be encouraged to register with a GP in the new area as soon as possible.

This review should include consideration of the risks associated with the move, and a judgement made about whether the service user will make contact themselves with the services in the new area, or whether this will be carried out by the original Care Co-ordinator.

Appropriate representatives of the receiving district should be invited to contribute to the Review by attending the meeting or by other means if this is not possible.

The transferring Care Co-ordinator should ensure a timescale for the transfer is drawn up and that complete and accurate records are made of the discussions surrounding the move along with ensuring that the following has been agreed before the transfer:
The receiving team / service has identified a new Care Co-ordinator who accepts responsibility for them.

Appropriate services have been set up with the receiving team / service to meet the needs before the transfer takes place, where possible.

Effective communication has taken place and detailed information has been made available to the appropriate professionals in the receiving team / service.

Where there is Local Authority/LHB responsibility for funding local guidance must be followed on the hand over for cases that move out of area.

Detailed information must include, assessment of need, including risk assessment, clearly identifying the nature, complexity and content of risk, CPA level, legal status, care plan, including contingency plans, risk management plans where this exists and indicators of relapse.

The transferring Care Co-ordinator must also ensure that there is documented proof that this information has been sent.

The receiving district should acknowledge transfer of Care Co-ordinator within fourteen days of receipt of documentation.

It is the responsibility of the transferring Care Co-ordinator to write to the service user, carer, where appropriate, and GP confirming the transfer and giving contact details of the new receiving Care Coordinator.

Details must be entered on both the transferring and receiving mental health services databases.

Arrangements will need to be in place to ensure a system of rapid transfer back to the original system if the service user moves back to the originating district. In this case, ideally, the original Care Co-ordinator and team should resume responsibility for patient care, based on level of need, risk and availability. The principles of information sharing, and ensuring that arrangements for receiving the service is in place should be followed by the transferring area.

16. UNPLANNED MOVES

Some service users will move in an unplanned way between districts. Where this is local and the original district is aware of this, it should continue working with the service user, if this is possible within service resources, until formal handover arrangements described above can take place.

Where the move is at some distance and it would be impractical for the originating district to do this, then background information should be sent immediately to the new district and discussion should take place between the teams at the earliest opportunity to enable formal handover.
The above should be based on team-based consideration of risk factors relevant to the particular service user concerned, weighing the necessity to pass on information against the service user’s right to confidentiality. Such deliberation must be appropriately recorded on the service user’s records for future reference.

17. REFUSAL TO MAINTAIN OR LOSS OF CONTACT WITH SERVICES

Every effort should be made to maintain contact with service users either directly or indirectly. If a service user on Standard CPA who only attends OPA in full disengages from services then protocols should be adhered to as in ‘The guide to good practice’.

This procedure applies to service users on Enhanced CPA whose whereabouts and physical wellbeing is known and who have made it clear that they refuse to engage with services.

Refusal of engagement should rapidly be discussed with the Community Mental Health Team and communicated to the GP. An assessment of the risks to self that the service user presents (including risk of self neglect) and/or others should be undertaken and plans made accordingly.

This may include consideration in the carrying out of a Mental Health Act Assessment.

In some circumstances consultation with other relevant services may be appropriate. Where a level of risk to the service user or to others is identified, appropriate judgements should be made about the breadth and depth of circulation of personal information within the local and / or non-local areas.

This action plan is likely to include the following elements:

A review during the initial six months following attempts to engage the service user in services.

Prior to this there should be a wide-ranging consultation of people involved in the service user’s care/support, which might include some or all of the following: team members, GP, carer/s and family members and other relevant agencies as appropriate, i.e. housing associations, housing officers and voluntary sector agencies.

A full risk assessment should be completed.

A contingency crisis plan for access to services should be agreed. Relevant service managers should be informed and involved in this process. The Care Co-ordinator, after discussion with their line manager, will make the locally appropriate Crisis Team, and other services e.g. Accident and Emergency, Local Authority, aware of the person’s details.
Where it is suspected that a person might be located in another mental health service area, then the Care Co-ordinator must consult the manager of his or her own mental health service that acts as the point of contact for distributing and receiving Missing Persons Alerts, and follow the appropriate course of action, referring to missing person’s procedure.

In exceptional circumstances a service user may be discharged from Enhanced CPA when there has been no contact for a significant period of time (twelve months for example). This step should be fully discussed by the Community Mental Health Team, documented in the clinical notes and recorded. The Care Co-ordinator should ensure that the GP and relevant formal and informal carer/s are made aware of any such decision. This discharge procedure will form part of a review process.

18. DISCHARGE FROM CPA

When a service user on Standard or Enhanced CPA is discharged from the service, the Care Co-ordinator must ensure this is formally documented in the notes and a letter is sent to all those named on the care plan.

The service user / carer should be given information about how to re-contact the service if required. The Mental Health Measure 2010 will require arrangements in place for assessments of former users of secondary mental health services. Regulations on the timescales for undertaking such assessments are currently under consultation by the Welsh Government.

When a service user moves to another area, the Care Co-ordinator should agree and record the arrangements for the transfer of care. If the service user is subject to Section 117 then a joint Section117 / CPA review should take place prior to transfer.

19. CONFIDENTIALITY

Joint working will facilitate the sharing of information between both health and social care partners, ultimately improving service user care.

“Personal information is required in order to deliver individual care and treatment, and members of the care team are required to obtain the consent of the service user before such information is shared….where a service user refuses to give consent to the sharing of personal information about them, such information cannot be shared other than in prescribed circumstances regulated by legislation as well as the common law duty of confidentiality” (WAG 2010)

Guidance on sharing personal information can be sought from the Wales Accord on the Sharing of Personal Information. (WASPI)

There is a well established common law of confidence covering service user information. If the information is held on computer then the Data Protection Act 1998 is applicable. Local protocols regarding confidentiality must be adhered to.
As a general rule, information given for one purpose may not be disclosed to a third party or used for a different purpose without the consent of the service user. Building Bridges (1996) states;

‘Usually it is a good idea if the patient and his or her closest relative are fully involved in his or her care. However if a patient specifically asks that his family and carers are not involved, his or her wishes must be respected unless they have been appointed by a Court to manage his or her affairs, or there is a public interest ground to give the information (e.g. if they are at risk of violence)’.

20. RESOURCES

All currently identified actions within the document will be undertaken within the resource restraints of the identified current budgets. Any additional cost needs identified as a result of new or specific policy needs will be brought to the Board for justification as separate items.

21. TRAINING

All staff involved in the delivery of the CPA for individuals will be required to attend training. Training will be co-ordinated and delivered via the CPA department. All staff members will be individually responsible for ensuring that they are applying up to date knowledge and skills in practice and must identify any training needs to their line managers.

22. IMPLEMENTATION

Responsibility for implementing this policy will be overseen by the Joint CPA Implementation Group.

Clinical teams, service users, carers and professional groups across the UHB and Local Authority will be consulted and will participate in the ongoing development of the CPA.

23. FURTHER INFORMATION

As stated in Section 3 above, this policy includes key elements of statute, policy and guidance, and takes account of published research into the effectiveness of CPA.

These include:

Mental Health Act (1983)

Carers (Recognition and Services) Act (1995)

‘Adult Mental Health Services; A National Service Framework’ (April 2002) Welsh Assembly Government

‘Adult Mental Health Services for Wales’ (September 2001) Welsh Assembly Government
24. EQUALITY IMPACT AND ASSESSMENT

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups.

We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other characteristics.

The assessment found that there was little impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any
stated impact to ensure that we meet our responsibilities under the equalities legislation

25. AUDIT
The CPA will be audited via the Annual Quality Framework (target 15). Subsequent audits may be undertaken as required. The CPA audit criteria will be reviewed upon implementation of the Mental Health (Wales) Measure 2010.

26. REVIEW
This policy will be superseded by the document which is currently under development to ensure the appropriate implementation of the Mental Health (Wales) Measure 2010.