MENTAL HEALTH SERVICE

Care Planning Standards Policy
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Foreword

From the Mental Health Management Board

This Care Planning Standards Policy provides the framework for all patients receiving care and treatment from the Isle of Man Mental Health Service, whether under the Care Programme Approach or, for those with less complex needs, Standard Care.

Arising from the earlier Care Programme Approach Policy (2007), this is the second version of the Care Planning Standards (CPS) Policy and incorporates changes arising from feedback received in training and policy review sessions in 2014 and 2015. This reviewed policy remains true to the UK policy and positive practice guidance contained in the ‘Refocussing the Care Programme Approach’ documents from the UK Dept of Health.

The Care Planning Standards Policy will assist staff to deliver personalised care, within an ethos of recovery, in all approaches to assessment, care planning, co-ordination and review. All staff will be expected to be familiar and comply with the policy and those with direct responsibility for the coordination/delivery of patient care will be audited against the Key Standards contained throughout the Policy.

March 2016.
1. **Related Mental Health Service Policies**

This Care Planning Standards Policy should be read in conjunction with the following related documents currently operating within the Mental Health Service:

- Principles and Guidelines in involving Carers
- Patients who Do Not Attend Appointments (DNA)
- Minimum Standards for Healthcare Records
- Mental Health Service Audit Policy
- Discharge Against Professional Advice (APA)
- Risk Management Policy
- Dual Diagnosis Policy
- Copying Correspondence to Patients

*And* the following Department of Health documents

- Service Standards
- Code of Practice for the Delivery of Services
2. **Background**

The Care Programme Approach (CPA) was introduced in England in 1990 as the framework for the care of people with mental illness. The key elements were the systematic assessment of individuals’ health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the patient’s changing needs. The importance of close working between health and social services was stressed, as was the need to involve patients and their carers. The Mental Health Act Code of Practice (DH & Welsh Office, 1993) made it clear that the CPA applied to all those receiving specialist mental health care, including detained and informal inpatients.

In more recent years in England CPA was revised following guidance from the UK Department of Health.\(^1\) This led to a more streamlined approach and a greater emphasis on patient and carer involvement in the assessment and care planning process.

Further review of CPA\(^2\) in 2006 led to revisions in England and Wales that concentrated, from 2008, the CPA framework on the patients who fell within the ‘Enhanced’ level of CPA\(^3\).

In 2007 the Care Programme Approach was introduced in the Isle of Man for adults of working age. At that time Standard and Enhanced Levels of CPA were used.

Locally in 2011, the process of extending Care Programme Approach to all areas of the Mental Health Service began, beyond the previous group of adults of working age.

In 2013 the Mental Health Service decided to follow the UK example of targeting the Care Programme Approach towards those patients with more complex needs (see Chapter 7 ‘Eligibility for Care Programme Approach’).

In following the UK ‘refocusing’ agenda, those patients receiving care or treatment from the Mental Health Service who are outside the scope of Care Programme Approach will be referred to as in receipt of ‘Standard Care’.

To accommodate these changes the revised Policy has been re-titled “The Care Planning Standards Policy”, in order to reflect both patients with more complex needs (who are subject to the Care Programme Approach) as well as those in receipt of Standard Care.

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\(^1\) Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, Department of Health, 1999

\(^2\) Reviewing the Care Programme Approach 2006. A consultation document CSIP. Department of Health, November 2006

\(^3\) Refocusing the Care Programme Approach on Policy and Positive Practice Guidance. Department of Health, March 2008
However, all patients of the Mental Health Service will have an individual care plan and risk management plan, which they have been involved in developing, and which is based on a thorough assessment of their health and social care needs. The patient and those involved in their care should receive a copy of that care plan (with consent from the patient where possible).

The majority of the key standards referred to throughout this policy have been adapted from the UK National Standards for CPA⁴.

**Key Standard**

**Management of the CPA:** A CPA Manager is identified and is accountable to senior management in the Mental Health Service.

**Management information regarding CPA** is reported to the Mental Health Management Board

**Mental Health Service Managers and Lead Clinicians** will also support and facilitate the development and implementation of policy related to the CPA.

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⁴ National Standards and CPA Association Audit Tool for the monitoring of the Care Programme Approach, July 2001
3. **Underpinning Values and Principles**

This chapter draws heavily on the 2008 UK Dept of Health guidance ‘Refocusing the Care Programme Approach’\(^5\)

The approach to individuals’ care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient second.

Care assessment and planning views a person holistically, seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

Carers may form a vital part of the support required to aid a person’s recovery. Their own needs should also be recognised and supported (see also Chapter 5 ‘Carers’).

The quality of the relationship between patient and the care co-ordinator is one of the most important determinants of success. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care.

Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

The previous IOM CPA policy emphasis on key documents such as ‘Making Recovery a Reality’\(^6\) and ‘A common purpose’\(^7\) may not always be best suited to Older Persons services. It is important that the underpinning values and principles enshrined within the Dignity agenda in such documents as ‘A New Ambition for Old Age’\(^8\), ‘Securing better mental health care for older adults’\(^9\) and ‘Everybody’s Business’\(^10\) are also considered.

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\(^7\) A common purpose; Recovery in future mental health services. SCIP/RCP/SCIE joint position paper. May 2007.

\(^8\) A New Ambition for Old Age: Next steps in implementing the National Service Framework for Older People. DOH April 2006

\(^9\) Securing better mental health for older adults. DOH July 2005

\(^10\) Everybody’s Business: Integrated mental health services for older adults – a service development guide. CSIP. DOH November 2005
4. Patient Engagement and Involvement

It has been demonstrated that where patients are involved in the care planning process they are happier with the care and services they receive. Factors which make a difference include getting the timing right, venue and attendance at review meetings, all of which can help or hinder patient involvement. A trusting relationship between patients and professionals is also seen as a key success factor.11

The increasing prominence of the Recovery Model12 13 14 15 in mental health services has at its core the emphasis on:-

- strengths rather than deficits
- people rather than services
- collaboration rather than coercion
- autonomy rather than dependence

in order to maximise the control that patients have about their own care.

Staff should always be mindful of the difficulties faced by some patients in articulating their needs or being able to contribute to meetings in which they may be surrounded by professionals. We have a responsibility to ensure that patients are meaningfully involved in assessing their needs and planning their care. In order to do this, it may be necessary to involve others identified by the patient who can help them in these processes.

Key Standard

All patients will be involved in their assessment, care planning and review process. They will have a named Care Co-ordinator or Lead Professional and will be encouraged to include any carer / relative / representative / friend they choose in the care delivery process.

11 User researchers in control, Mental Health Today, May 2005
12 Emerging Best Practices in Mental Health Recovery, NIMHE/SCH 2004
13 100 Ways to support recovery, Rethink 2009
5. Carers

Please refer also to the Mental Health Service document “Principle and Guidelines in involving Carers”.

People who provide informal (unpaid) care are often a vital source of support to patients. Many people performing this role experience hardship, social isolation and ill health as a result. Service providers must recognise the vital role informal carers play and involve them in the process of assessing needs and planning care, wherever this is appropriate.

To effectively involve carers in the delivery of care, the Care Co-ordinator must be aware of the names of the main carers, 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 patient the carer should be involved in all aspects of assessing, planning and delivering care.

Sharing information with carers

The sharing of information may be difficult, but is often crucial to the ongoing wellbeing of both patients and carers. If carers are excluded from important discussions and decisions involving the patient, this can have serious practical, financial and personal consequences for both the carer and the patient. Not being involved increases feelings of isolation, grief and loss which are common to many carers.

- The carer is often the one who knows the patient best. They may have regular, even daily, contact over many years, often with on-going responsibility for all aspects of the patient’s welfare.

- The carer is often the only constant support in the patient’s life, as friends lose touch and professionals move away. Many patients experience regular and sudden changes in the professional team caring for them. This can make the building of trusting relationships difficult and important information about the patient may be lost if the carer is not included in regular discussions.

- The changing nature of mental illness can cause sudden crises, often out of hours, to which the carer may have to respond. This can be very stressful as immediate and appropriate professional support is not always available. However, if the carer has knowledge and understanding of the crisis plan, they can often persuade the patient to follow it, for example by agreeing to contact their key worker or by taking prescribed medication.

- The wellbeing of the carer can be greatly improved if they are encouraged to feel part of a supportive team, with ready access to up-to-date information. Without this, the carer may feel unable to continue giving the practical and emotional support that is also important to the patient.
There may be instances where the patient does not consent to the sharing of information with the carer, or limits the information which may be shared. This will be respected.

However, even when the patient continues to withhold consent, carers can be given sufficient knowledge to enable them to provide effective care. This may include general information on a wide range of issues relating to mental illness, medication and treatment issues, legislation, benefits, rights for both patients and carers and of course local services and their availability. They can also be given the opportunity to discuss any difficulties they are experiencing in their caring role to help try and resolve these. The provision of general information about mental illness, emotional and practical support for carers does not breach confidentiality.

Work has been undertaken in the UK to look at effective ways for professionals to involve carers in information sharing. A summary chart of possible strategies is attached at Appendix 1.

**Assessment of carers needs**

Although there remains as yet no statutory framework requiring the assessment of carers needs locally on the Isle of Man, the Mental Health Service has developed its own guidance document ‘Principles and Guidelines in involving Carers’, as noted at the head of this Chapter.

The Department of Social Care, in partnership with other Government Departments and Third Sector organisations, is also currently undertaking public consultation on the introduction of a Carers Charter locally.

**Key Standard**

**Carers:** All patients of the Mental Health Service will be screened at assessment and review to identify informal carers who provide regular and substantive care.

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16 Positive and Inclusive? Effective ways for professionals to involve carers in information sharing. Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO), Autumn 2004
6. The Roles and Responsibilities of a Care Co-ordinator and Lead Professional

The role of the Care Co-ordinator is central to the effectiveness of the CPA.

The Care Co-ordinator’s core functions are to carry out:

- Comprehensive needs assessment;
- Risk assessment and management;
- Crisis planning and management;
- Consideration of carers’ needs where necessary and responding to those needs;
- Implementing a plan of care
- Reviewing the plan of care
- Transfer of care or discharge.

As part of their role the Care Co-ordinator will therefore need to:

- Ensure a comprehensive (if necessary, multi-disciplinary and multi-agency) assessment of the person’s health and social needs is carried out, including an assessment of risk and any specialist assessments;
- Co-ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them. Ensuring that the care plan is available to all concerned;
- Familiarise themselves with past and present records about the patient;
- Ensure that crisis and contingency plans, and risk management plans, are formulated, updated and made available;
- Ensure that the patient is equally involved and has choice, and assist him/her to identify his/her goals;
- Incorporate appropriate delivery of a range of psychological interventions
- Ensure that carers and other agencies are involved and consulted where appropriate;
- Ensure that the person knows how to contact the Care Co-ordinator, and who to contact if the Care Co-ordinator is not available;
- Organise and ensure that reviews of care take place, and that all those involved in the person’s case are invited, consulted, and informed of any outcomes.
- Arrange for someone to deputise if absent, and pass on the Care Co-ordinator role to someone else if no longer able to fulfil it;

Who Can Be a Care Co-ordinator?

The role of the CPA Care Co-ordinator should usually be taken by the person who is best placed to oversee care management and resource allocation and can be of any discipline depending on capability and caseload. The care co-ordinator will have the authority to coordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin. It is
important that they are able to support people with multiple needs to access the services they need.

However, it is not the intention that the care coordinator necessarily is the person that delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required. This approach supports the principles of New Ways of Working [17], which aims to use the skills of all in the most appropriate, effective and efficient manner.

For people who have had damaging experiences of sexual abuse or violence, choice of gender of the care co-ordinator may be a crucial factor in establishing trust and a therapeutic relationship.

Patients should also be afforded, where possible, a choice of care co-ordinator which takes account of any cultural or religious needs.

**The Lead Professional**

This is a new role introduced in ‘Refocusing the CPA’ for people who do not need CPA.

The Lead Professional will have responsibility for facilitating the delivery of care to the patient who has been identified as having less complex needs.

As part of their role, the Lead Professional will therefore need to:

- Conduct a full needs assessment which must include a comprehensive risk assessment, which will determine the nature of the clinical care to be delivered;
- Agree with the patient a care plan. This could be in a transferable format accessible to the patient such as the ‘Letter to GP as Mental Health Care Plan’;
- Ensure that the care plan is formulated, updated and circulated;
- Review the person’s progress on a regular basis with view to determining whether CPA is required or not;
- Identify and liaise with carers and consider their support needs, where appropriate;
- Maintain accurate record keeping;

**Key Standard**

**Care co-ordination:** The Care Co-ordinator is a competent worker who is trained and experienced in mental health. (S)he will be responsible for co-ordinating the assessment, planning, implementation, monitoring and review of the care of people using mental health services.

7. Eligibility for Care Programme Approach

The Isle of Man Mental Health Service will deliver care according to two levels of need, these being:

- Care Programme Approach (CPA)
- Standard Care

This is in line with ‘Re-focusing CPA’ initiative in England, where they have now reverted to one (Enhanced) level of CPA.

The difference between CPA or Standard Care is based on the nature and degree of assessed need when considered in terms of complexity, associated risk and extent of service intervention required by the patient.

A decision regarding eligibility for CPA or Standard Care should be made as soon after assessment as possible, when enough information is available to do so.

Where assessment is ongoing or incomplete (and it is felt that there is not yet enough information available to make a reliable decision), but the individual has been accepted for a service, they should be registered on Standard Care until such times as a more definite decision is reached.

While diagnosis (if known) is an important factor for practitioners to consider when deciding on CPA or Standard Care, it must not be regarded as the sole determinant.

Standard Care: Criteria

Many people referred to the Mental Health Service will have, following an assessment, needs identified which can easily be met, organised and delivered. They are likely to have some of the following characteristics:

- They require the support or intervention of one agency or discipline, or they require only low key support from more than one agency or discipline
- They are more able to self-manage their mental health problems
- They have an active informal support network
- They pose little danger to others
- They have little or manageable risk of self-injury
- They are more likely to maintain appropriate contact with services

Patients assessed as not requiring CPA

Patients who do not require the support of CPA and are therefore placed on Standard Care will still be assessed and care managed to ensure that needs are met, and that services are delivered efficiently and effectively.

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The key components associated with this are:

- The Lead Professional
- The Care Plan
- The Review

**Care Programme Approach: Criteria**

People with complex mental health and social needs, however, will require a higher degree of monitoring and co-ordination of care. They are likely to have some of the following characteristics:

- Be at risk of losing contact with services, where this would raise concerns as part of a relapse signature or suspected mental health deterioration.
- Pose a significant risk to themselves or others or have a history of serious self harm or violence
- Multiple care needs e.g. housing, employment, finances
- Require contact with, and coordination between, a number of agencies or professionals but may be willing to co-operate with only one
- Lack an informal support network
- Have addiction problems in addition to a primary diagnosis of mental illness
- Have mental health problems in addition to a primary diagnosis of an addiction.
- Children / Young People who are not in education and / or training due to a presenting mental health problem
- Children who are Looked After in addition to a primary diagnosis of a mental disorder, or where there are significant safeguarding concerns.

Care Programme Approach is also strongly indicated for those:

- Who are in-patients in a mental health facility/setting
- With an established psychosis
- With a long-standing, complex presentation
- With a history of treatment resistance or frequent presentations/referrals
- Exhibiting co-morbidity (e.g. Severe Depression and Personality Disorder; Complex physical health and mental health needs; Learning disability and mental illness)
- Who remain subject to Section 115 aftercare arrangements
- Children admitted to Nobles Hospital through the ‘Management of the Acutely Disturbed Child Pathway’ for psychiatric treatment

Because needs and level of support required by the patient can (and usually will) change during the course of contact with mental health services, it is recognised that the level of required care can also change accordingly between Standard Care and CPA.

The level of required care should be re-assessed on a regular basis as part of the wider review of care, to ensure that it is being appropriately applied. (See also chapter 11 “Review”).
Transfer between levels of care will usually occur within the context of a review of care, with the awareness and agreement of all those involved, including the patient (and carer, if appropriate).

The patient should be provided with an explanation of their level of care as part of the provision of their care package. It should also be clearly recorded on the care plan in RiO.

**Key Standard**

Following assessment all patients must have a recorded level of care - Standard Care or Care Programme Approach.
8. Assessment

Appropriate assessment lies at the heart of effective service delivery and should be an ongoing process rather than an isolated event.

Its purpose is to identify and evaluate an individual’s presenting needs and how they constrain or support his/her capacity to live a full and independent life. The process will always contain an assessment of risk. (See separate Chapter “Risk Assessment and Management”)

The assessment process should include consideration of the patient’s strengths, skills and existing coping strategies.

The assessment process should be explained to the patient to help ensure that it is needs led rather than service or resource driven.

The patient (and carer) will be an active partner in the assessment process wherever possible.

Assessment should assist the individual to:

- Gain a better understanding of their situation
- Identify options that are available for managing their own lives
- Agree outcomes required from any help that is provided
- Understand the basis on which decisions are reached

A health and social care needs assessment should be completed for all patients accepted by the Service.

The assessment should be recorded using agreed documentation.

All patients, except where doctors use the ‘Letter to GP as Mental Health Care Plan’, will have their needs and risk assessed at initial assessment using the CPA Needs and Risk Assessment documentation.

Where the ‘Letter to GP as Mental Health Care Plan’ format is used, the evidence of needs and risk assessment must be clearly documented in that, as well as the subsequent care plan and risk management plan. This can be printed as an ‘editable letter’ within RiO in the same way as the RiO/CPA Printable Care Plan and Review document.

The assessment should consider the following areas:

- Mental Health (symptoms; psychological and emotional features)
- Physical Health
- Social Functioning
- Risk
- Personal/Family Circumstances
- Child Care/Protection issues
- Employment, Vocational and Leisure needs
• Finances/Welfare Benefits
• Advocacy needs
• Accommodation
• Medication
• Religious and Spiritual needs
• Communication and Cultural needs

The depth and detail of the information recorded should always adequately reflect the nature and complexity of the individual presentation.

The assessment will usually involve at least one meeting with the patient (though it may require a number of contacts for those presenting with more complex needs) and should aim to gather sufficient information to make a judgement about:

• Eligibility for service
• Type of intervention/support required
• Level of service (Care Programme Approach or Standard Care)

Assessment Procedure

In most cases, assessment will be initiated at the first face-to-face contact with the Mental Health Service.

However information obtained via the initial referral and subsequent screening e.g. telephone contact with the referrer, will contribute to the assessment process.

One member of staff will usually undertake the CPA assessment. However where appropriate and/or practical, joint assessment involving both mental health staff and other specialists/services is desirable.

The assessment will aim to provide detailed information about all the needs of the patient from the perspectives of the patient, carer/family and assessor (clearly differentiating between these if and where they differ).

Needs assessment implies a focus on the person’s needs, rather than the services available. It is a continuous process based on the identification of strengths and vulnerabilities.

“Developing a shared understanding of the needs the patient has, the strengths and resources they have to manage them, and any potential risk to self and others is probably the most sophisticated part of this process; it is also believed to be the most important. The clearer the description of the need or issue the easier it is to formulate an action plan. If there is any disagreement over the formulation, then it is important that differences are discussed and, if not resolved, acknowledged and recorded.”

19 Re-focussing the Care Programme Approach: A learning resource for care-co-ordinators. CCAWI 2010
Key Standard

Each person who is referred and accepted into the Mental Health Service will receive a systematic holistic assessment of their needs carried out by a qualified mental health worker. Assessments must ensure that the strengths and maximum potential of the patient are identified and that the following issues are considered in addition to mental health needs:

- Carer’s needs (including young carers)
- Leisure/Social needs
- Physical Health needs
- Accommodation needs
- Disability related issues
- Communication needs
- Child Care issues
- Employment needs
- Financial needs (e.g: benefits)
- Views of families and carers should be included (if possible).
9.  Care Planning

“A care plan is a record of needs, actions and responsibilities written in an accessible and jargon free way. Care plans exist for the benefit of the person using the service, and should be based around their needs, not around the ability of the service to provide”.

The Care Plan will reflect the assessment detail, in that identified needs are met wherever possible within the plan. Formulation of the Care Plan should involve the patient, in addition to the people who will provide the delivery of care, including where appropriate the carer.

The patient will be offered a copy of their care plan, which will:

- Identify the interventions and anticipated outcomes
- Record all the actions necessary to achieve agreed goals
- In the event of disagreement, include reasons for this
- Describe frequency of planned interventions i.e. daily, weekly, etc
- Detail the contributions of all the agencies involved
- Include contingency and crisis plans where appropriate (all patients on the Care Programme Approach will have these as a required element of their care plan)

The Care Plan will focus on the patient’s strengths as well as his/her needs, and seek to promote recovery and independence. Recognising, reinforcing and promoting strengths at an individual, family and social level will be an explicit aspect of the Care Plan.

In order to promote social inclusion patients have a right to expect mental health services to take a view of their overall needs and not focus purely on their medical and psychological treatment. They should expect that such issues as housing, employment and needs relating to benefits, education and family role and commitments are given equal attention as other issues relating to their mental health needs.

A copy of the Care Plan will be available to all personnel directly responsible for care delivery and, with the consent of the patient, other relevant parties.

The Care Plan will clearly show the name of the Care Co-ordinator or Lead Professional and other providers involved in care delivery and the next review date.

Care Planning Documentation

Two formats for care planning in the community will be available in the Mental Health Service. These are the RiO/CPA Care Plan or the ‘Letter to GP as Mental Health Care Plan’.

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20 UK Care Standards Act 2000
It is required that all patients subject to the Care Programme Approach will have their care planning and risk management needs recorded by their Care Co-ordinator on the RiO/CPA format. This is then easily printable, along with Crisis and Contingency documents, for sharing with the patient and carer where appropriate.

For patients not subject to CPA (those on Standard Care) the option of either the RiO/CPA Care Plan or the Letter to GP as Mental Health Care Plan can be used. Where the latter is used it must be written using plain language and in a format that enables it to be easily understood by, and shared with, the patient. It is also crucial that sufficient information is provided about the care planning arrangements and risk management arrangements to satisfy the MHS Risk Management Policy and the CPA Policy requirements.

The Letter to GP as Mental Health Care Plan can be printed as an ‘editable letter’ within RiO in the same way as the RiO/CPA Printable Care Plan and Review document.

In line with the Care Planning Standards Policy requirements, a copy of that letter will also be sent to the patient at their preferred address for correspondence, unless they have specifically indicated they do not wish to receive copies of their Care Plan.

**Crisis and Contingency planning**

All patients in the community on the Care Programme Approach must have contingency and crisis plans as part of their care plan. These must be based around the individual circumstances of the patient.

It may be helpful to offer a brief definition from the Centre for Mental Health of contingency and crisis plans.

“Contingency plan: specifying action to be taken to prevent a crisis developing. Crisis plan: specifying the action to be taken in a crisis.”

**Contingency Planning:** The purpose of this is to prevent circumstances escalating into a crisis by detailing the alternative arrangements to be used at short notice in circumstances where, for example, the care co-ordinator is not available. The Contingency Plan should include the information necessary to continue implementing the Care Plan in an interim situation, e.g. by including the telephone numbers of service providers and the name and contact details of substitutes who can provide interim support.

**Crisis Planning:** The crisis plan is an explicit plan of action for implementation in a crisis or developing crisis situation. The crisis plan is an important part of the care plan that specifies action to be taken in a crisis.

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21 Sainsbury Centre for Mental Health. Briefing 29. The Care Programme Approach – Back on Track?
Crisis situations often occur out-of-hours and can result in emergency intervention being applied. The benefit of anticipating the nature of a crisis is to ensure that appropriate action is taken. Crisis plans could set out the action to be taken, based upon previous experience, if the patient is very ill, or their mental health is rapidly deteriorating.

Crisis plans, as a minimum, will ensure that all patients know how to contact the service out of hours.

These plans may include the following:

- Early warning and relapse indicators
- Who the patient is more responsive to
- How to contact that person
- Previous strategies which have been successful in improving responses or getting agreement for changed care/treatment, e.g. leaving them alone, calling the police, asking a carer to leave the home for a while, etc.

This information will be clearly stated in the Care Plan, which will be accessible at all times.

**Key Standards**

**Care Planning:** Every patient should have a written care plan, which they have been involved in developing. This will be based on a holistic and integrated assessment of need and strengths which identifies specific interventions, how and when these will be carried out, and by whom.

The care plan should identify the Care Co-ordinator or Lead Professional and all people involved in the care of the patient. This should include the actions for which the patient will take responsibility.

Alternative views in the care plan should be clearly recorded and all those involved in the care of the patient should receive a copy of the care plan.
10. Review

The purpose of a review is to reassess the patient’s and carer’s needs, consider the effectiveness of the care plan, amend the care plan if necessary, amend crisis and contingency plans as necessary, and focus on how the needs of the patient can continue to be met.

Review is a structured and flexible process as well as a planned periodic event. The standard on the Isle of Man is that all care plans will be reviewed at least every six months. The only exception to this is patients of the Memory Clinic identified as experiencing Mild Cognitive Impairment (MCI) and who are therefore open to the Older Persons Mental Health Service - the care for these patients must be reviewed at least every twelve months.

By maintaining regular contact with the patient, the Care Co-ordinator or Lead Professional will, in an informal manner, be reviewing and evaluating the Care Plan on an ongoing basis.

Large, formal, multi-disciplinary review meetings are not always the most appropriate format for enabling a review of existing care with patients.

In such cases it may be preferable for the Care Co-ordinator or Lead Professional to gather information from other professionals involved in the delivery of care, prior to meeting with the patient and anyone they want present to formally review ongoing care needs.

Flexibility and patient preference should be key in consideration of the venue for review meetings. For instance, if it is important that the GP is present at the review, consideration should be given to holding the review meeting in the GP surgery.

Alternatively, where a patient prefers, and it is practicable to do so, holding the review meeting in a venue of the patient’s choice could be considered.

Where the carer’s attendance at the review is essential, consideration should be given to the time and venue in order to best accommodate their availability.

Where a formal multi-disciplinary review meeting is the preferred option, all those involved in a patient’s care should be invited to the Review and given reasonable notice of the date and time.

Prior to a review meeting patients should be given the opportunity to prepare for the meeting. They should be advised that they may invite a friend or relative to participate in the meeting.

Whatever the arrangements, the review remains the responsibility of the Care Co-ordinator or Lead Professional, who must be satisfied that all those involved in the Care Plan have been consulted and had the opportunity to contribute. In all cases the patient’s wishes/preferences should be considered.
There may be occasions between formal reviews when more urgent action is needed. This should trigger an emergency review and can be initiated by any member of the care team, patient, carer etc. by contacting the Care Co-ordinator or Lead Professional.

Unscheduled reviews will normally be arranged by the Care Co-ordinator or Lead Professional in response to any significant change in the patient’s needs or circumstances requiring a possible change to the risk management and/or care plan.

Some examples of when an urgent review may be required include:

- The patient withdraws from the care plan or part of it and to do so increases the risks
- The patient discharges themselves from in-patient setting against professional advice or indicates a wish to do so
- There is rapid deterioration in mental state
- Identified risks increase and a multi-disciplinary response is required
- There are significant changes in a carer’s circumstances
- There are circumstances where information must be shared with carers, relatives, significant others if they are likely to be exposed to violent or aggressive behaviour or circumstances which pose a risk to them

**Outcomes of Reviews** may be to:

- Highlight unmet needs;
- Change the amount of support required, and update the care plan;
- Change the level of care planning;
- Discharge from services;
- Update the risk assessment, crisis or contingency plan
- Maintain the status quo

Wherever possible, at each review the date of the next review should be set and recorded.

Following the review, if the Care Plan has changed, a copy of the revised document should be provided to the patient, GP and other relevant parties.

Reviews should continue to be arranged and undertaken regardless of setting (i.e. in hospital, prison or residential placement).

**Key Standards**

*Regular contact is maintained with the patient and the care plan is reviewed in accordance with the Mental Health Service Care Planning Standards Policy.*
11. Risk Assessment and Management

Please refer to the Mental Health Service “Risk Management Policy”.

Risk assessment and risk management form an integral part of the care planning process. All patients will have an individual assessment of risk, resulting in a risk management plan.

- Risk assessment is an essential and on-going element of good mental health practice. Risk assessment is not, however, a simple mechanical process of completing a proforma. Risk assessment is an ongoing and essential part of the care planning process. All members of the team, when in contact with patients, have a responsibility to consider risk assessment and risk management as a vital part of their involvement, and to record those considerations.

- Risk cannot simply be considered an assessment of the danger an individual patient poses to themselves or others. Consideration also needs to be given to the patient’s social, family and welfare circumstances as well as the need for positive risk-taking. The outcome of such consideration will be one of the determinants of the level of multi-agency involvement.

- The aim of any intervention should be to maximise a patient’s rights and choices in order that they might live as independently as possible.

However it is recognised that mental ill health at times holds the potential to impact upon an individual’s ability to make choices and that statutory intervention may be required.

Risk should always be assessed in the context of a patient’s capacity to make an informed choice about the risks they are taking.

In undertaking risk assessment the gathering of information from all sources and interaction with the patient is crucial.

- Risk assessment and management is a multi-disciplinary responsibility and all professionals should ensure that they work within the following context:

  o Risks are identified, documented clearly and any decisions clearly communicated

  o Relevant legislation which may impact on the outcome of the assessment is considered (e.g. Mental Health Act 1998)

  o Risks are re-assessed when circumstances change

  o Protective risk factors are identified and patients are supported to make informed choices including identifying ways of reducing risk
Outcomes of risk assessments are communicated and shared appropriately

- When completing a risk assessment and risk management plan it is important to consider who else may have information that will be relevant or can corroborate information already gathered. Other staff and agencies may have valuable information, particularly the carers, those in the voluntary sector and agencies such as housing.

- Some patients may be vulnerable to abuse or exploitation by others and this should be considered as part of the risk assessment process. Where this risk is significant the Care Co-ordinator should refer to policies and procedures relating to the protection of vulnerable adults.

Positive risk

Risk management can often be a balance between encouraging patient autonomy and protecting the vulnerable or public.

The UK Dept of Health, in 2010 risk guidance in respect of people with dementia (but applicable to other groups), states;

“It is a challenge to tread the line between being over-protective (in an attempt to eliminate risk altogether) while respecting individual freedoms. The trick is giving people the opportunity to live life to the full, while at the same time making sure they are properly safeguarded.”

Key Standard

All patients will have an individual assessment of risk, resulting in a risk management plan.
12. Transition points in care

Summary

Transition points in the care of an individual are times when there is the potential for things to go wrong in terms of consistency and continuity of care, the transfer of responsibility and the exchange of important information. The management of these transition points is a crucial aspect of the work of care co-ordinators.

These changes may be geographical or involve a change in service personnel, system or specialism. A common transition is the admission to, or discharge from, hospital care. The factors that all these events have in common are the need for a smooth transfer of information, clarification of respective responsibilities and timely responses to the changes in circumstances. The care co-ordinator, as the name suggests, has the key responsibility in facilitating these transitions.

‘Mind the gap’

Transition points in care have the inherent capacity to interfere with continuity of care and services. They are vulnerable points where things can go wrong, sometimes with negative consequences for the patient. These transitions sometimes happen with very little warning to those involved and require a speedy response to ensure that the required information is communicated to those who need to know. On other occasions transitions are carefully planned over time, for example discharge from a secure hospital will usually involve detailed planning and preparation of services long before the actual date of discharge.

For smooth transitions to occur it is imperative that care co-ordinators and other services are aware of the people who need to know and what information should be exchanged. The care planning processes should provide the supporting framework and evidence for decisions relating to any kind of transition and it is important that the receiving team feel they have sufficient background information to aid their own assessment and care planning process.

Types of transition points

- Admission to, or discharge from, hospital or similar residential establishment
- Move to a different geographical location
- Containment in, or release from, the criminal justice system (could be remote from home)
- As a result of the Mental Health Act, including Supervised Discharge
- Switch from Child and Adolescent Mental Health Services (CAMHS) to Adult Services
- Switch from Adult services to Older People services
- Discontinuation of CPA processes following review
- Switch of care co-ordinator
- Switch of mental health team (specialism)
- Admission/discharge general hospital
- Referral to/from independent sector
As admission to In-patient services is one of the more common transition points, special consideration is given to that below.

**In-patient/ Community Interface**

An admission to a Mental Health Service in-patient facility for patients already known to the Service must not be seen as the end of one episode of care and the beginning of another. Admission to in-patient services is a change in the location of the delivery of care. Care Co-ordinator responsibility remains with the allocated community professional during the in-patient episode.

The Care Co-ordinator retains their responsibilities for maintaining contact with the patient and carer, maintaining communication with the others in the community involved in the care, treatment and support of the Patient including non-statutory organisations. Also, in conjunction with in-patient staff, reassessing the Patient’s needs and risk situation prior to discharge from the in-patient unit.

Patients admitted to in-patient services will always be placed on Care Programme Approach, even if previously on Standard Care, which may be reviewed and revised as part of the discharge planning processes and 5 day follow-up.

To ensure continuity of care planning arrangements, in-patient services will utilise the RiO CPA Care Plan and Risk Management Plan.

Those children admitted to Nobles Hospital through the ‘Management of the Acutely Disturbed Child Pathway’ for psychiatric treatment will automatically be subject to Care Programme Approach.

Good communication and robust working arrangements between hospital and community services is fundamental to the effective operation of CPA.

Patients admitted to the in-patient facilities are amongst the most vulnerable in the Mental Health Service. For this reason it is imperative that they are prioritised for community support at an early stage of their in-patient admission. Allocation to a community professional will therefore occur within 10 working days of referral, where indications are that such support may be needed. This will allow a Care Co-ordinator opportunity to build a relationship with the patient in preparation for the continuing support following discharge.

It is important that prior to planned discharge a full community CPA/RiO Care Plan and Risk Management Plan are in place.

Wherever possible therefore, a formal CPA Review will occur at the point of discharge from in-patient services. This will ensure involvement of the professional who will assume responsibility on the patient’s return to the community, as well as the availability of the community RiO/CPA Care Plan and Risk Management Plan for the patient and carer (where appropriate).

In situations of unplanned discharge the ‘Discharge Against Professional Advice’ pathway must be followed and a community CPA/RiO Care Plan and Risk
Management Plan developed at the earliest opportunity, but not later than 5 days after discharge.

In circumstances where it has not yet been possible for a community Care Co-ordinator to be allocated, the Crisis Response Home Treatment Team (CRHTT) will have responsibility for the CPA/RiO Care Plan and Risk Management Plan until transfer of care has been accepted.

In instances where a patient is being discharged from in-patient services and the community Care Co-ordinator is on leave or sick, the community team will arrange an alternative professional to cover until the allocated Care Co-ordinator is able to resume the role.

“A copy of the care plan, including written risk management plans, should be provided to patients and significant carers. It should be a matter of policy that such plans are discussed with carers and any concerns raised should inform and perhaps require the revision of the risk management section of the plan.”

**Discharge**

Discharge planning should begin at the point of admission. In planning discharge full consideration should be given to how best to facilitate a supportive move back into the community. This will involve close liaison with Carers and other providers of services involved in the Care Plan.

Carers and other providers of services should be kept fully aware of discharge dates and discharge planning arrangements and will be invited to the Discharge Planning Meeting.

Discharge planning should always include assessment of potential risk factors. Risk management plans on discharge must include clear crisis and contingency planning.

All patients will remain subject to the Care Programme Approach until their 5 day follow-up contact as a minimum, when a decision can be made as to continuing level of support (i.e. Care Programme Approach or Standard Care).

**Discharge Care Plans**

Patients discharged from an inpatient facility should have a clear RiO/CPA Care Plan and a Crisis and Contingency Plan. A copy of this plan should be provided to them on the day of discharge. At the time of discharge patients should have a pre-arranged follow-up appointment with the Care Co-ordinator within 5 days of discharge.

A copy of the Discharge Care Plan must be sent to the GP and other relevant parties within 5 working days.

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22 Inquest into the death of CJB. Coroner of Inquests. March 2013
If for any reason the patient has not been able to receive a copy of the Discharge Care Plan a copy should be sent to their home or postal address within 48 hours of discharge.

**Key Standard**

**Discharge from In-patient services:** All patients discharged will have a written copy of their RiO/ CPA Care Plan and Risk Management Plan detailing any care to be provided, crisis and contingency arrangements, and arrangements for face-to-face follow-up by a health professional. Where possible, this should also be shared with their carer.
13. Transfer of Patient Care Off-Island

This chapter should be read in conjunction with the Mental Health Service ‘Out of Area Treatments (OATS) Policy’.

“It is the responsibility of health and social care agencies to collaborate effectively to ensure proper, co-ordinated care is delivered to people with mental health needs. Each district Local Authority Social Services Department and Health Trust jointly operates a Care Programme Approach Policy to ensure a robust systematic framework for the care and treatment of people with mental health needs in line with department of Health Guidance.” 23

The geographic location of the Isle of Man and its status as a separate offshore crown dependency can at times hamper seamless handover or communication with the receiving UK Health Care Trust when a patient is moving off-Island.

A number of UK inquiries have highlighted the potential for interruption in continuity of care when patients move from one district to another.

Whilst it is recognised that the volume of patients making a permanent transfer to the UK or Eire is small, the following good practice guidance should be adhered to wherever possible;

Planned Moves

Where a patient moves off-Island and is in continuing need of mental health service provision, the patient’s consent should be obtained to make contact with services in the receiving area prior to the move. This can ensure that effective communication has taken place and detailed information has been made available to the appropriate professionals in the receiving team/service.

Such information should include:

- Assessment of need, including risk assessment, clearly identifying the nature, complexity and content of risk
- Care planning level
- Legal status
- Care Plan, including Crisis and Contingency plans, risk management plan, including indicators of relapse

This will help ensure prior to transfer, a new Care Co-ordinator has been identified and appropriate services have been set up in the receiving team/service. It is the responsibility of the transferring Care Co-ordinator to write to the patient, carer (where appropriate), and GP confirming the transfer and giving contact details of the new receiving teams Care Co-ordinator.

23 Good Practice in the Transfer of Patient Care Between Mental Health Districts, Care Programme Approach Association, 2002
**Moves where it has not been possible to plan transfer of care to another authority**

In limited cases some patients may move off the Island at short notice. In such cases, background information may need to be sent immediately to the new district and discussion take place between the teams at the earliest possible opportunity to affect formal handover. A decision regarding this course of action should be based on multidisciplinary consideration of risk factors relevant to the particular patient concerned, weighing the necessity to pass on information against the patient’s right to confidentiality. Such deliberation should be recorded on the patient’s record.

**Temporary Off-Island Placements**

See the Mental Health Service ‘Out of Area Treatments (OATS) Policy’.
14. Loss of Contact or Disengagement from Services

This chapter should be read in conjunction with the Mental Health Service “Patients Who Do Not Attend Appointments (DNA)” Policy.

Sometimes contact is lost with a patient. This can happen for a variety of reasons such as chaotic lifestyle, relapse of mental illness, sudden changes in circumstances, patient no longer wishing contact, or other problems.

Where there are significant concerns about risk, the lack of contact, for example, in the form of a missed appointment, should be discussed immediately within the multi-disciplinary team and with family/carers if appropriate. Necessary action can be considered, which may include informing the Police if substantive risk is indicated.

Patients may also choose to disengage from services although their location and physical and mental state are known. For those who are subject to Care Programme Approach or where there are concerns of risk, the refusal of engagement should be promptly discussed within the multi-disciplinary team and with family/carers. The outcome of these discussions should be communicated to the GP, with a CPA review meeting being convened as soon as possible. Consideration may need to be given to carrying out a Mental Health Act assessment with a view to possible compulsory admission to in-patient services.

In all cases, an action plan should be agreed and implemented. The action plan should be clearly documented in the RiO record.

Where available, information from existing Crisis or Contingency Plans should be utilised to aid decision-making and the formation of an action plan. An action plan drawn up in these circumstances is likely to require the following elements:

- A formal review of attempts to engage the patient with services
- Consideration should be made to making a referral to the Crisis Response Home Treatment Team and a representative from that Team be invited to the review to offer guidance and expertise
- Prior to the review there should be a wide-ranging consultation of people involved in the patient’s Care Plan
- A Multi Disciplinary Team decision on the minimum type of contact which can be deemed acceptable in terms of the patient’s welfare and the welfare of others
- Continuing consideration should be given to the carers of patients who are refusing contact with services

It is essential that the action plan be clearly communicated to carers and Primary Care providers.
15. Discharge from Care Programme Approach or Standard Care

“If CPA is to end, it should be a decision, not a withering away….which requires a CPA review in order that all potential players can express a view on the matter.” 24

Discharge for those on Standard Care will normally occur when:

- Treatment is complete and/or the patient is sufficiently well recovered to be managed in primary care
- The patient wishes to be discharged and it is safe to do so
- The patient has moved and transfer to a UK Trust has been completed
- The patient dies

Those on Care Programme Approach will normally be transferred to Standard Care for a period of further monitoring and support before being considered for discharge from Mental Health Services.

However discharge for those on Care Programme Approach could occur if:

- Treatment and recovery is sufficiently progressed to otherwise warrant transfer to Standard Care and the criteria for discharge from the latter are met

Or:

- The patient requests discharge and refuses transfer to Standard Care .

And:

- All reasonable attempts have been made to explore alternative strategies for maintaining engagement (see also chapter 16 ‘Loss of Contact or Disengagement from Services’)

And:

- A multidisciplinary review has been held and a risk management plan formulated and agreed

Or:

- The patient has moved and transfer to a UK Trust has been completed

Or:

- The patient dies

24 Independent Inquiry into the Care and Treatment of MN. A report commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority, June 2006
The decision to cease contact with the Mental Health Services should take place at the time of review and be recorded.

The intention to, and reasons for, discharge must be discussed with the patient and carer, if appropriate, and followed up in writing.

Patients and their carers should also be informed to contact their GP at a future date if the need for re-referral arises

**Mental Health Act Section 115**

Those patients subject to MH Act section 115 aftercare must not be discharged from Mental Health Service care, unless “…the Department is satisfied that the person concerned is no longer in need of such services.”  

In this instance the ending of section 115 must be recorded in RiO, along with the rationale for that decision.

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25 Mental Health Act 1998. Section 115(2)
16. Monitoring and Audit of Care Planning Standards

This chapter should be read in conjunction with the ‘Mental Health Service Audit Policy’ and the ‘Minimum Standards for Healthcare Records’.

The responsibility for the audit of care planning standards across Mental Health Service areas remains predominately with Operational Managers in caseload management discussions with staff. This should reflect discussion of the ‘quality’ of care plans as well as the minimum standards for health care records.

Additional audit of care planning standards will be undertaken on 100 Mental Health Service records each year by the Clinical Development and Risk Manager, who will report findings to the Mental Health Management Board. The Mental Health Act, Capacity and CPA Manager will also undertake a regular audit of 20 records on a rolling bi-monthly basis. The focus of this audit will be on a different MHS area at each bi-monthly occurrence.

The views of patients and carers on the effectiveness of care planning in providing the support they need, in ways they prefer, are an important component of care planning audit criteria. Where service areas wish to use them, copies of the following documents are available from the Mental Health Act, Capacity & Care Programme Approach Manager:

- UK DoH ‘Audit Pack for Monitoring the Care Programme Approach’
- The Care Programme Approach Association ‘National Standards and Audit Tool for the Monitoring of the Care Programme Approach’
- The Care Programme Approach Association ‘Carers Audit Tool’
17. Index of Footnotes

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Appendix 1  Information Sharing with Carers

Positive and Inclusive? Effective ways for professionals to involve carers in information sharing

Figure 7 Possible strategies for professionals when service user’s exercise their right to withhold consent to share ‘need to know’ information with carers

- Explain to service users the carer’s ‘need to know’ information (where appropriate) e.g. where carers are providing substantial practical support as part of the care plan
- Review consent at regular intervals with service user
- Explain to carers why information cannot be shared, giving a supportive explanation for this
- Alternative support for carer: - signpost to carer group - give general information - carer’s assessment - give information on training
- When decision taken to break confidentiality this must be: discussed with colleagues documented in notes - service user informed when

Service user exercises right to withhold consent to information sharing

- Assess capacity of service user
- Assess risks of not sharing information to service user and others
- Decision to break confidentiality based on; - Risk - Law e.g. order of court, S25 A-3 Mental Health Act

- Discuss issue of confidentiality with service user and carer together (where appropriate)
- Explore issue of consent i.e. help service user identify some aspects of their information they feel
- Explore possible ways of sharing. Explore possibilities that are acceptable to service user e.g. sharing with another closely involved person
- Make service user aware of consequences of not sharing e.g. psychiatrist decides not to discharge service user from hospital until service user agrees to share ‘need to know’ information with carer

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