SOCIAL SERVICES

Shirveishyn Y Theay

ISLE OF MAN MENTAL HEALTH SERVICE

Caring for the Nation ~ Jeeaghyn mysh yn Ashoon

CARE PROGRAMME APPROACH (CPA) POLICY

Social Services Division
(Version 12)

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Rheynn Slaynt as Shickyrys Y Theay

ISLE OF MAN CARE PROGRAMME APPROACH POLICY

CONTENTS

CHAPTER PAGE NO.

1 - Background 3

2 - Underpinning Values and Principles 5

3 – Scope 6

4 – Referral and Eligibility 7

5 - Service User and Carer Engagement and Involvement 8

6 – Carers 11

7 - The Role and Responsibilities of a Care Co-ordinator 13

8 – Level of CPA 16

9 – Assessment 18

10 – Care Planning 21

11 – Review 24

12 – Risk Assessment and Management 27

13 – In-patient/Community Interface 29

14 – Social Inclusion 31

15 – Transfer of Service User Care to UK **34**

16 – Loss of Contact or Disengagement from Services **37**

17 – Co-Occurring Substance Misuse and Mental Health Problems (Dual Diagnosis) **38**

18 – Mentally Disordered Offenders **40**

19 - Confidentiality and Information Sharing **42**

20 – Discharge from CPA **45**

21 – CPA Monitoring and Audit **47**

22 – Index of Footnotes **48**

Appendices

- ***Appendix 1 – Needs and Risk Assessment Form***
- ***Appendix 2 – Care Plan***
- ***Appendix 3 – CPA Review***
- ***Appendix 4 – Information sharing with carers***

Ratified By: **Social Services Leadership Team**
Active From: **May 2008**
Review: **May 2009**

When using this document please ensure that the version you are using is the most up to date, by checking on the Social Services Division Knowledge Bank.

1. 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 service user's changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users 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 the Isle of Man, Community Mental Health Teams (CMHT's) were introduced in 1999 and at that time the four key elements of CPA (assessment, care plan, review, named care co-ordinator) were built in to the CMHT Operational Policy. However a formalised CPA system was not extended to other areas of the Mental Health Service and assessment and care planning documentation was not standardised across the Service.

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 service user and carer involvement in the assessment and care planning process.

CPA was introduced in Scotland in 1992[2] and more recently, in Wales in 2004[3].

The majority of the key standards referred to throughout this policy have been adapted from the UK National Standards for CPA[4]

---

[1] Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach Department of Health,1999.

[2] Community Care Guidance on Care programmes for people with a mental illness including dementia: Scottish Office Home & Health department, 1992

[3] A National Service Framework for Wales - Adult Mental Health Services: Welsh Assembly Government, 2002

[4] National Standards and CPA Association Audit Tool for the monitoring of the Care Programme Approach, July 2003

Key Standard

Management of the CPA; A CPA Lead Officer is identified and is accountable to senior management in the Mental Health Services and Social Services Division.
Management information regarding CPA is routinely reported to the relevant committees.
Lead officers will also support and facilitate the development and implementation of policy related to the CPA.

2. Underpinning Values and Principles

The Care Programme Approach Association has formulated a set of values and principles, in response to the UK Department of Health CPA consultancy document in 2006[5]
These are;

'The CPA is a whole systems approach to mental health care which:-

- Is person-centred and promotes choice;
- Is consensual and based on partnerships between the service user, carers, and all agencies providing services;
- Promotes recovery and social inclusion wherever possible;
- Supports effective communication, information sharing and negotiation;
- Is simple, streamlined and supported, and
- Promotes safety and positive risk taking'

[5] Reviewing the Care Programme Approach 2006; A consultation document, Department of Health, 2006.

3. Scope

The Isle of Man Mental Health Service CPA Policy applies to adults of working age (16-65yrs) who are accepted for treatment by the Mental Health Service.

It has been agreed, following discussions with colleagues from the Older Persons Services, that the local CPA framework will not initially include clients of the Older Persons Assessment Service (OPAS). This is in view of the proposed development and introduction of the Single Assessment Process (SAP) framework in that service. However, this position will be subject to regular review, once the CPA framework is established for adults of working age; and dependent upon the impact of SAP for older persons.

Drug & Alcohol Team (DAT) service users presenting with co-morbidity issues of substance misuse and mental illness, where there is joint working, **will** be included in the CPA framework. Such clients are likely to present with complex needs and should therefore be subject to the Enhanced Level of CPA (See chapter 7).

Clients who are referred via the Central Referral Team for treatment from Occupational Therapists or Psychologists will be included in the CPA process, but not those referred only to the Counselling Service.

It is planned that mentally disordered offenders who are accepted for treatment by the Mental Health Service will be included in the CPA framework. For those in the prison environment the pathways for this to occur have yet to be determined, but will be agreed with colleagues from the Prison Healthcare Team, using the key guidance contained in 'Changing the Outlook'[6] and 'Offender Mental Health Care Pathway'[7] documents.

The CPA documentation developed to support the implementation of this Policy (See Appendix 1) is to be adopted throughout all service areas where the CPA framework is applicable. It is **not** designed to replace the full range of records detailing clinical delivery of care but is designed to include minimum information required to deliver the CPA objectives.

Key Standard

Operational procedures; There are agreed policies and procedures for the delivery and monitoring of the Care Programme Approach that reflect the main principals of the CPA and which are appropriately supported by administrative, managerial, training and audit structures.

---

[6] Changing the Outlook – A strategy for Developing and Modernising Mental Mental Health Services in Prisons, Department of Health, December 2001.

[7] Offender Mental Health Care Pathway, Department of Health, January 2005.

4. Referral and Eligibility

Referrals to the Mental Health Service are made from a variety of sources in a variety of ways but all, with the exception of DAT and CAMHS, are channelled through the joint, multi-disciplinary Central Referral Team.

Eligibility for service provision in UK Trusts uses the Fair Access to Care Services (FACS) framework to determine one of four tiers of need, being Critical, Substantial, Moderate or Low. Although this is not in place on the Island the Social Services Division is currently examining possible eligibility criteria and the Mental Health Service Central Referral Team undertake a screening response to all incoming referrals.

At the referral stage, sufficient information should be gathered on the basis of the needs that the person is presenting and the risks that are indicated, to decide whether a full CPA assessment is needed. The decision to assess a person should be inclusive rather than exclusive and should take into account the person's whole situation. There may be factors which increase a person's needs, vulnerability and risk, such as disabilities, communication problems, housing issues, and social and cultural isolation. If the person's needs are low, or a CPA assessment is not appropriate, then information should be given to the person and/or their referrer in writing about alternative support or services that are available, and if necessary, they should be helped to access them. They should also be made aware that re-referral is possible if their circumstances should change.

Key Standard

Access/Referral: The criteria for access and process of referral to Mental Health Service is clear, concise and available for any person involved in, or making contact with, the service. CPA standards apply to any person who is subject to the Care Programme Approach.

5. Service User and Carer Engagement and Involvement

"The co-operation and involvement of users and carers at all stages of the CPA is essential if individual programmes are to be effective. The implementation of the CPA should be carried out in such a way that users and carers see that others are working with them to develop individual care programmes, and not that the care programme is something that is imposed upon them" [8]

Service Users

It has been demonstrated that where service users **are** involved in the care planning process they are happier with the care and services they receive. Factors which make a difference include getting right the timing, venue and attendance at review meetings, all of which can help or hinder service user involvement. A trusting relationship between service users and the professionals was also seen as a key success factor. [9]

The increasing prominence of the Recovery Model[10] 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 service users have about their own care.

Staff should always be mindful of the difficulties faced by some users 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 users 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 service user who can help the user in these processes.

Additional related guidance in this area is included in the National Service Framework for Mental Health[11];

---

[8] Social Services Department's and the Care Programme Approach, Department of Health, 1996
[9] User researchers in control, Mental Health Today, May 2005
[10] Emerging Best Practices in Mental Health Recovery, NIMHE/CSH 2004
[11] National Service Framework for Mental Health, Department of Health, 1999

Standard 4 – All mental health service users on the Care Programme Approach should:-

- have a copy of a written care plan which includes the action to be taken in a crisis by service users, their carers and their care co-ordinator

Standard 5 – All those admitted to hospital should:-

- have a copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator and specifies the action to be taken in crisis

Key Standard

Service users; All service users will be involved in every aspect of their assessment, care planning and review process. They will have a named care co-ordinator and will be encouraged to include any carer/relative/representative/friend they choose in the CPA process.

Additionally, the Audit Criteria statements listed below reflect the future areas of audit that will be undertaken in terms of levels of service user involvement[12]

1. Information – I have sufficient information to know how services will support me, how they will keep information about me, and whom it will be shared with
2. Roles – I know who is responsible for supporting me on first contact, through assessment, monitoring my care plan and in an emergency
3. Assessment – My needs have been assessed, with my involvement and including those people I rely on for support (carers/relatives/neighbours/friends)
4. The Care Plan – I have a care plan which provides a statement of how I will be supported to stay well/get better and how all of us involved in it will recognise when I need more or less support
5. Services – I have services, which support me, understand my individual needs, and ensure I have the opportunity to contribute to how services develop
6. Reviews – I have reviews which are regularly arranged which include the people who support me, to revise my care plan and make decisions about future care

[12] An Audit Pack for Monitoring the Care Programme Approach, UK Department of Health, June 2001

7. Risk Management – I have a crisis plan agreed in advance with me, to help me when I am not well, and to prevent me causing harm to myself or others
8. Opportunities – I am given good opportunities to contribute to service development through audit, complaint procedures and training
9. Choice – Within the possibilities of my risk assessment I am given choices about the level of service I accept

6. Carers

People who provide informal (unpaid) care are often a vital source of support to service users. 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 CPA process 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 service user 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 service users and carers. If carers are excluded from important discussions and decisions involving the service user, this can have serious practical, financial and personal consequences for both the carer and the service user. 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 service user best. They may have regular, even daily, contact over many years, often with on-going responsibility for all aspects of the service user's welfare.

- The carer is often the only constant support in the service user's life, as friends lose touch and professionals move away. Many service users 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 service user 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 service user to follow it, for example by agreeing to contact their key worker or by taking the recommended 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 service user.

There may be instances where the service user 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 service user 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 service users 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[13]. A summary chart of possible strategies is attached at Appendix 4.

Assessment of carers needs

Standard 6 of the **National Service Framework (NSF) for Mental Health (1999)** states that all individuals who provide regular and substantial care for a person on CPA should:

- 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.

In the UK there is also a legislative framework that requires independent assessment of carers needs (**Carers Recognition and Services Act 1995, Carers Equal Opportunities Act 2004**.) Although this legislation does not currently exist in the Isle of Man, the DHSS is looking into the provision of carers assessments and an update is expected soon. (This policy chapter will be completed when those local arrangements are clarified.)

<u>Key Standard</u>
Carers: Support for carers complies with NSF Standard 6 and local legislative and policy framework regarding assessment of carers needs. All users of mental health services will be screened at assessment and review to identify informal carers who provide regular and substantive care.

---

[13] 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

7. The Role and Responsibilities of a Care Co-ordinator

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

"The Care Co-ordinator is responsible for keeping in close contact with the service user, and for advising the other members of the care team of changes in the circumstances of the service user which might require review or modification of the care plan. Where the user has standard needs and has contact with only one professional, the role of Care Co-ordinator should fall to this professional, whatever their discipline. The care Co-ordinator is responsible for updating of the service user's basic care plan and crisis plan."[1]

The role and responsibilities of a Care Co-ordinator have been enshrined in the Isle of Man Mental Health Service since the development of the Community Mental Health Team in 1999 and the remainder of this chapter is taken directly from the existing CMHT Operational Policy[19], with only minor amendments to fit the context of the wider Mental Health Service.

The Role and Responsibility of A Care Co-ordinator

A Care Co-ordinator is a member of a multidisciplinary team who carries accountability and responsibility for co-ordinating the package of care within the Mental Health Service being offered to a Service User, and where appropriate his/her carer.

Any qualified member of staff can be a Care Co-ordinator, following consultation and agreement with the professional concerned. Psychiatrists will only be a Care Co-ordinator if they are the only professional that the client is having contact with.

It is understood that the role may vary, as over time the needs of the client may change. A client with minimum needs may become a client with complex needs or vice-versa.

Responsibilities

1. To co-ordinate a package of care in conjunction with the client, their carers, significant others and the professional team.

2. To take responsibility for liaising with others involved in the client's care, ensuring common goals and effective communication.

---

[1] Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach, UK Department of Health, 1999

[19] Isle of Man Community Mental Health Team Operational Policy

3. To identify the need for specialist assessments and arrange these through the multi disciplinary team (MDT) process.

4. To call review meetings when appropriate, eliciting the opinions of others involved in the network of care.

5. For ensuring the accurate regular and comprehensive updating of Care Plan documentation.

6. To accept responsibility for ensuring the agreed package of care is followed through and to take appropriate action if it is not.

It is expected that the Care Co-ordinator will be available to work in close collaboration with the medical and nursing teams whilst the client is an in-patient. The aim is to provide continuity of care whether the client is living in the community, using day care facilities or being treated as an in-patient. However there will be occasions when the role of the care co-ordinator is transferred to the in patient area following negotiation and agreement.

Accountability

Practitioners working as Care Co-ordinators will act within their own profession's code of conduct and within the Adult Mental Health Service policy/operational requirements and will hold professional accountability for their actions.

Medical accountability does not rest with the client's Care Co-ordinator.

A Care Co-ordinator may consider it appropriate to negotiate a specific task or piece of work to another member of the team, but they will retain accountability to ensure that the task is completed.

Skills of a Care Co-ordinator

The Care Co-ordinator should be:-

1. A Communicator

   The Care Co-ordinator will need to be able to communicate effectively all information relating to the client's care. He/she will need to communicate with the client's relatives and other informal carers and be able to give clear explanations of the client's care and in addition have the necessary skill to explain the views and opinions of others.

2. An Assessor

   The Care Co-ordinator should have the ability to carry out assessments, including risk assessment. She/he should be aware of her/his limitations in assessing certain aspects of a client's needs, and have the skill and

knowledge to refer on to a more appropriate agency.

3. An Organiser

The Care Co-ordinator must be able to organise reviews and ensure that all who are required to attend are informed of the review. The Care Co-ordinator should be able to decide on the type of review that would be appropriate and organise it accordingly. The client should be informed in advance that there will be a review. The Care Co-ordinator must ensure that they are able to co-ordinate all aspects of the client's care and that all those involved in the client's care are aware of what is happening and of their responsibilities.

4. A Problem Solver

The Care Co-ordinator must be able to identify potential problems and be able to deal with them effectively, either personally or together with other members of the team, the client, their relatives and/or other informal carers.

5. A Time Manager

The Care Co-ordinator should be able to manage their time effectively to meet the needs of their caseload. They should ensure when setting review dates that all those involved in the client's care are given adequate notice. The Care Co-ordinator should ensure that clinical input to a client's care is not overtaken by administrative procedures, whilst maintaining safe and effective monitoring, co-ordination and recording of care. Care Co-ordinators should have a clear line of managerial access for problems.

6. A Care Planner

The Care Co-ordinator should be skilled in the care planning process in order to meet the needs of the client. The Care Co-ordinator should ensure that all those involved in the client's care are adequately consulted prior to the Care Plan being formulated or modified, and receive a copy of the current Care Plan. The Care Co-ordinator must ensure that all those providing care as identified in the agreed Care Plan are fulfilling the aspects of the plan for which they are responsible.

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 whether an inpatient or living in the community.

8. Level of CPA

In accordance with UK Department of Health guidance[1] plus existing practice in England and Wales, and in order to target resources effectively, the Isle of Man Mental Health Service will deliver CPA according to two levels of need, these being;

- Standard
- Enhanced

(It is recognised that CPA is being reviewed in the UK after this local Isle of Man Policy has been developed. Future proposed changes locally will therefore be considered during formal review of the Isle of Man CPA Implementation Project).

The difference between the two levels 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 service user.

A decision regarding CPA level 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 CPA** 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 level, it should not be regarded as the sole determinant.

Standard CPA : Criteria

Many people referred to the mental health services 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 deliberate self harm
- They are more likely to maintain appropriate contact with services

Enhanced CPA : Criteria

[1] Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach Department of Health, 1999

People with complex health and social needs, however, will require a higher degree of monitoring of their mental health 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 substance misuse difficulties in addition to their mental health problem(s)

Enhanced CPA is also strongly indicated for those:

- 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)
- Who remain subject to Section 115 aftercare arrangements

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

CPA level 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 CPA will usually occur within the context of a **review of care**, with the awareness and agreement of all those involved, including the user (and carer, if appropriate).

The user should be provided with an explanation of their CPA level as part of the provision of their care package. It should also be clearly recorded on all relevant documentation e.g. care plan and/or in the care file.

Key Standard

Following assessment all people who are subject to the Care Programme Approach for ongoing care must have a documented CPA level – Standard or Enhanced.

9. Assessment

"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 the carer, where appropriate, as central participants in the process. The service user must be given full information about the CPA process and a copy of the agreed care plan" [1]

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 service user's **strengths, skills** and existing **coping strategies.**

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

The service user (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 CPA **health and social care needs assessment** should be completed for **all** service users accepted by the service.

The CPA assessment should be recorded using agreed documentation.

The CPA assessment should **consider** the following areas:

- Mental Health (symptoms; psychological and emotional features)
- Physical Health
- Social Functioning
- Personal/Family Circumstances

---

[1] Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach, UK Department of Health, 1999

- Child Care/Protection issues and Adult Protection issues
- Employment, Vocational and Leisure needs
- Finances/Welfare Benefits
- Accommodation
- Medication
- Religious and Spiritual needs
- Communication and Cultural needs
- Advocacy needs
- Risk

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

The CPA assessment will usually involve at least one meeting with the user (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 CPA

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 and social care staff or other specialists/services is desirable.

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

Unmet Needs

"An important aspect of a fully global assessment is the accurate identification of needs that currently cannot be met. Generally these will be needs that go beyond current service provision. However, there are some grey areas concerning unmet needs, for example a service that is currently available but has no capacity to accommodate any more service users can be designated

as an unmet need"[15]

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. It is also necessary to identify **unmet needs**, as needs must be assessed whether resources are available or not. Collated records of areas of unmet need may also be able to contribute to business planning priorities for future service development.

The assessment therefore should identify and record any **unmet needs,** which arise:

- As the result of a lack of available services/resources
- Due to circumstances or expectations, which it is beyond the scope of mental health services to address

Key Standard

Each person who is subject to the Care Programme Approach 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 service user are identified and that the following issues are considered in addition to mental health needs:

Carers needs (including young carers)
Leisure/Social needs
Accommodation needs
Disability related issues
Communication needs
Child Care issues
Employment needs
Financial needs (eg: benefits)

Views of families and carers should be included (if possible).

[15] Mental Health Policy Guidance; The Care Programme Approach for Mental Health Service Users, NHS Wales, Feb 2003

10. 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"[16]

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

The service user will be provided with information about the Care Programme Approach and 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 service users on the Enhanced Care Programme Approach will have these as a required element of their care plan)

The Care Plan will focus on the service user'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 Service Users 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 provided to all personnel directly responsible for care delivery and, with the consent of the service user, other relevant parties.

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

[16] UK Care Standards Act 2000

Enhanced CPA Care Plan

All service users on the Enhanced 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 service user.

It may be helpful to offer a brief definition from the Sainsbury 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"[15]

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 integral part of the care plan that specifies action to be taken in a crisis.

Crisis situation 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 service user is very ill, or their mental health is rapidly deteriorating.

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

These plans may include the following:

- Early warning and relapse indicators
- Who the service user 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.

[15] Sainsbury Centre for Mental Health. Briefing 29. The Care Programme Approach – Back on Track?

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

Standard CPA Care Plan

In circumstances where the assessment has indicated the service user will be on Standard Level of CPA (see chapter 8; Level of CPA) the **letter sent to the GP** (following assessment) can constitute the Care Plan. It should be written using plain language and in a format that enables it to be easily understood by, and shared with, the user where such correspondence is used. It must indicate any risk management plan that is part of the overall care. The UK Department of Health has produced good practice guidance on copying the service users into correspondence[17]. Alternatively the Standard Care Plan template for the Mental Health Service should be used and should be copied to the service user.

Key Standards

Care Planning: Every service user will 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 and all people involved in the care of the service user. This should include the actions for which the service user will take responsibility.

Disagreements to the care plan should be clearly recorded and all those involved in the care of the service user should receive a copy of the care plan.

[17] "Copying letters to patients"; a report to the Department of Health and Draft Good Practice Guidelines for Consultation, UK DOH, 2002

11. Review

The purpose of a review is to reassess the service user'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 service user 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.

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

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

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

Flexibility and service user preference should be key in consideration of the venue for CPA 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 service user prefers, and it is practicable to do so, holding the Review meeting in a venue of the service users choice could be considered.

Where the carers 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 users care should be invited to the review and given reasonable notice of the date and time.

Prior to a review meeting service users 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, 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

service user's wishes/preferences should be considered.

There may be occasions between formal reviews when more urgent action is needed. This should trigger an emergency Care Programme Approach review and can be initiated by any member of the care team, service user, carer etc. by contacting the care co-ordinator.

Unscheduled reviews will normally be arranged by the Care Co-ordinator in response to any significant change in the user'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 service user withdraws from the care plan or part of it and to do so increases the risks
- The service user discharges themselves from hospital against medical 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 CPA;
- Discharge from services;
- Update the risk assessment, crisis or contingency plan

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

Following the review a copy of the revised Care Plan should be provided to the Service User, 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 service user and the care plan is reviewed in accordance with the Mental Health Service CPA Policy.

The reviews will determine the effectiveness and outcome of the service user's care plan in meeting their individual needs, and consider any disagreements about the care plan, which may have arisen. If a service user, or anyone else involved in the service user's care, requests an earlier CPA review immediate attention should be given to establishing the reason for the request, and if necessary, such a review should be arranged.

12. Risk Assessment and Management

Please refer to the Mental Health Service "Policy on the Assessment and Management of Clinical Risk"[18]

Risk assessment and risk management form and integral part of the CPA process. All service users subject to Enhanced CPA will have a 'Needs and Risk Assessment' plus 'CPA Care Plan' completed, which details the risk management plans. All other service users within the CPA framework will have at least a Mental Health Service Clinical Risk Indicator form completed to record risk.

Within the specific context of CPA, the UK DOH suggests:[1]

- 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 CPA process. All members of the team, when in contact with service users, 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 service user poses to themselves or others. Consideration also needs to be given to the user'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 Service User'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 service user'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 service user is crucial.

[18] Isle of Man Mental Health Services "Policy on the assessment and Management of Clinical Risk"

[1] Effective Care Co-ordination in Mental Health Service, UK Department of Health, 1999

- Risk assessment is a multi-disciplinary responsibility and all professionals should ensure that they work within the following context:
  - Risks are identified, documented clearly and any decisions clearly communicated
  - Relevant legislation which may impact on the outcome of the assessment is considered (e.g. Isle of Man Mental Health Act 1998)
  - Risks are re-assessed when circumstances change
  - Protective risk factors are identified and Service Users 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 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 Service Users 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[1].

Key Standard

Risk Assessment: A Risk Assessment must be completed and documented alongside or within the CPA assessments (in accordance with the Mental Health Service Risk Policy) and this should include an assessment as to the vulnerability of the service user. Any new information gained during the continuous assessment process, which affects the assessment of risk, must be clearly identified and documented.

[1] Effective Care Co-ordination in Mental Health Service, UK DOH, 1999

13. In-patient/Community Interface

(Please refer also to the MHS documents "Best Practice Guidelines for Admissions to In-patient Services via Community Mental Health Services"[17] and "Best Practice Guidelines for Pre-discharge Planning from a Mental Health Service In-patient Setting"[18]

CPA applies to all those adults of working age who have been accepted for treatment within the Mental Health Services (See Chapter 3 "Scope") irrespective of setting. All service users requiring care and treatment in hospital should have their admission and discharge managed in accordance with the procedures outlined in this policy.

An admission to an in-patient facility for service users already known to the secondary mental health service must not be seen as the end of one episode of care and the beginning of another. Admission to in-patient services is merely a change in the location of the delivery of care. The Care Co-ordinator retains their responsibilities for maintaining contact with the service user and carer, maintaining communication with the others involved in the care, treatment and support of the service user including non-statutory organisations. Also, in conjunction with in-patient staff reassessing the service user's needs and current risk situation.

Service Users admitted to in-patient services will usually be placed on Enhanced CPA, which may be reviewed and revised as part of the discharge planning processes.

Good communication and robust working arrangements between hospital and community services is fundamental to the effective operation of CPA. Locally, such robust arrangements are evidenced in the documents outlined in footnotes 17 and 18 above.

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.

---

[17] Isle of Man Mental Health Services "Best Practice Guidelines for Admissions to In-patient Services via Community Mental Health Services"
[18] Best Practice Guidelines for Pre-discharge Planning from a Mental Health Service In-patient Setting

Discharge planning should always include assessment of potential risk factors.

Multi-disciplinary discharge planning will consider the CPA level that will be appropriate at the point of discharge. The agreed criteria for Standard and Enhanced levels will apply, i.e. not just diagnosis but vulnerability and risk will determine the level of care provided. This level can readily be adjusted depending upon progress following discharge.

Discharge Care Plans

Service Users discharged from an inpatient facility should have a clear 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 service users should have a pre-arranged follow-up appointment with the Care Co-ordinator within 5 working days of discharge.

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

If for any reason the service user 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 service users discharged will have a written copy of a care plan detailing any care to be provided, crisis and contingency arrangements, and arrangements for face-to-face follow-up by a health or social services professional. Anyone entitled to aftercare under Section 115 of the Isle of Man Mental Health Act (1998) will have a jointly agreed health and social care plan (see separate policy).

14. Social Inclusion

"Millions of people suffer from mental health conditions some time in their lives. For a minority, these can be severe or long-lasting. Even now, with welcome new attitudes in society, those suffering mental distress still find themselves excluded from many aspects of life the rest of us take for granted – from jobs, family support, proper health care and community life.

This exclusion has a huge impact on the individuals concerned and our wider society. It frequently leads to a downward spiral of unemployment, poverty, family breakdown and deteriorating health. The costs to individuals, their families and the country are huge, not just now but also in the future. Disadvantage, too, often passes from one generation to the next."[21]

The Social Exclusion Unit in its report "Mental Health and Social Exclusion" suggests five main reasons why mental health problems too often lead to and reinforce social exclusion (p4). These are;

- **Stigma and discrimination** against people with mental health problems is pervasive throughout society. Despite a number of campaigns, there has been no significant change in attitudes. Fewer than four in ten employers say they would recruit someone with a mental health problem. Many people fear disclosing their condition, even to family and friends.

- Professionals across sectors too often have **low expectations** of what people with mental health problems can achieve. There is limited recognition in the NHS that returning to work and overcoming social isolation is associated with better health outcomes. Employment is not seen as a key objective for people with mental health problems by many health and social care professionals.

- There is a **lack of clear responsibility** for promoting vocational and social outcomes for adults with mental health problems. Services do not always work effectively together to meet individual needs and maximise the impact of available resources.

- People can **lack ongoing support to enable them to work**. £140 million a year in the UK is invested by health and social care in vocational and day services for people with mental health problems. But not all these promote social inclusion as effectively as they could, and links with Jobcentre Plus can be weak. People on benefits often do not believe they will end up

[21] Former UK Prime Minister Tony Blair in his foreword to the Social Exclusion Unit Report "Mental Health and Social Exclusion", ODPM, 2003

financially better off if they try to move into work. Many people lose jobs that they might have kept had they received better support.

- People face **barriers to engaging in the community**. They can struggle to access the basic services they need, in particular decent housing and transport. Education, arts, sports and leisure providers are often not aware of how they could make their services more accessible for this group. Many people do not want to participate in activities alone, but feel there is no one they can ask to go with them. People can also face exclusion by law from some community roles such as jury service.

Fortunately, here on the Isle of Man, with a prosperous economy and near-full employment, the proportion of our service users able to access full-time employment is substantially higher than in the UK.

Issues of social exclusion remain a challenge for many people experiencing mental ill-health even on the Isle of Man. Therefore it is important that effective care co-ordination within CPA should take a broad view and include housing, education, caring responsibilities, employment, benefits advice and leisure (see also chapter2 'Underpinning Values & Principles' and 3 'Assessment').

The Sainsbury Centre for Mental Health supports the need for vocational and social support to be embedded within the CPA process[22]. They suggest this might involve;

- establishing employment status on admission to hospital;
- supporting job retention;
- promoting involvement of carers and families;
- identifying a lead contact on vocational and social issues in secondary care teams;
- strengthening links to key local partners, in particular Jobcentre resources and education providers;
- promoting access to advice and support on benefits issues;
- monitoring vocational outcomes for people on CPA; and
- monitoring the employment rates of people with mental health problems within their own organisation.

Locally on the Isle of Man, vocational or occupational services for mental health service users are principally delivered through the Next Step Training Unit and Disability Employment Service. Both of these services aim to work closely with CPA Care Co-ordinators and should be considered if the outcome of needs assessment indicates evidence of need in this area.

---

[22] Sainsbury Centre for Mental health. Reviewing the CPA – A response, SCMH 2006

Next Step Training Unit

Next Step Training Unit endeavours to provide training and assistance to equip clients recovering from mental ill health with the means to obtain and hold gainful employment. For those clients who live with enduring mental ill health and are unable to return to employment currently, it provides a meaningful occupation and diversional activities.

The Disability Employment Service

This service helps to enable disabled people claiming benefits to find or retain sustained work. They work closely with employers in supporting and encouraging good employment practices and attitudes in the recruitment and the retention of disabled people. They also work closely with external organisations to improve mutual referral arrangements and employment related provision.

Employment Assessments are available for clients wishing to access employment opportunities through the links with the Disability Employment Service.

Housing

Recently, partnership arrangements are being developed with housing providers on the Island and a recent agreement from the Council of Ministers (COMIN) has even opened the door towards increasing supported housing opportunities.

Key Standard

Each person who is subject to the Care Programme Approach 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 service user are identified and that the following issues are considered in addition to mental health needs:

Carers' needs (including young carers)
Leisure/Social needs
Accommodation needs
Disability related issues
Communication needs
Child Care issues
Employment needs
Financial needs (eg: benefits)
Views of families and carers should be included (if possible)

15. Transfer of Service User Care Off-Island

"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 service user is moving off-Island.

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

Whilst it is recognised that the volume of service users 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 service user moves off-Island and is in continuing need of mental health service provision, the service users 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
- CPA level
- Legal status
- Care Plan, including Crisis and Contingency plans, risk management plan where this exists, 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.

[23] Good Practice in the Transfer of Service User Care Between Mental Health Districts, Care Programme Approach Association, 2002

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 teams Care Co-ordinator.

Moves where it has not been possible to plan transfer of care to another authority

Some service users may move in an unplanned way off the Island. 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 effect formal handover. A decision regarding this course of action should be based on multidisciplinary consideration of risk factors relevant to the particular service user concerned, weighing the necessity to pass on information against the user's right to confidentiality. Such deliberation should be appropriately recorded on the user's record for future reference.

Temporary Off-Island Placements

(The following guidance should be noted in conjunction with the document "Guidance for submission of requests for off-island assessment/treatment and follow-up of placements; issued by the Clinical Director in June 2007)

On some occasions it is necessary for service users normally resident on the island to access specialist residential placements in the UK.

Where this occurs it remains the responsibility of the Mental Health Service to closely monitor and review the placement to ensure that it remains the most appropriate and cost-effective option for care.

While the bulk of care will be planned and delivered directly by placement staff, the service user continues to require a named Care Co-ordinator based with the appropriate mental health team on the Island.

The responsibilities of this worker will be consistent with the requirements of a care co-ordinator to:

- Maintain regular contact with the service user and placement. (Routine telephone contact may be sufficient in some instances).
- Arrange and attend a regular review meeting at least every 6 months, at which the ongoing appropriateness of the placement is agreed and/or planning for resettlement in the community facilitated.
- Maintain contact with family/carers, in order to address any concerns and provide information where appropriate.
- Organise an urgent review should issues relating to the appropriateness or viability of the placement arise.

For transfer of detained patients, further complications arise relating to the legislative requirements of separate jurisdictions.

In these instances the Mental Health Act Manager should be consulted.

16. Loss of Contact or Disengagement from Services

Please refer also to the Mental Health Service "Clients Who Do Not Attend Appointments (DNA)" Policy.

Sometimes contact is lost with a service user. This can happen for a variety of reasons such as chaotic lifestyle, relapse of mental illness, sudden changes in circumstances, service user 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.

Service users may also choose to disengage from services although their location and physical and mental state are known. For those who are on Enhanced level of CPA 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 MDT notes.

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 service user with services
- Consideration should be made to making a referral to the Crisis Response Team and a representative from the Crisis Response Team should 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 Service User's Care Plan
- A Multi Disciplinary Team decision on the minimum type of contact which can be deemed acceptable in terms of the service user's welfare and the welfare of others
- Continuing consideration should be given to the carers of service users who are refusing contact with services

It is essential that the action plan be clearly communicated to carers and Primary Care providers.

17. Co-Occurring Substance Misuse and Mental Health Problems (Dual Diagnosis)

A significant number of individuals who experience mental health problems will also have ongoing problems of addiction or inappropriate substance use, whether the substance be alcohol or drugs. There is extensive evidence that this both exacerbates the symptoms of mental illness and also makes treatment more difficult. 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 higher clinical risk rating associated with this category, both in terms of suicide and harm to others.

In its 2002 key guidance document "Mental Health Policy Implementation Guide; Dual Diagnosis Good Practice Guide"[24] the UK Department of Health acknowledges that "service models for dual diagnosis are at an early stage of development (P4)".

This position remains true for the Isle of Man, although joint protocols and training initiatives have emerged from the Dual Diagnosis/Co-Morbidity working group. The Mental Health Service statement of intent for this group reads:

"The Mental Health Service will ensure that individuals with co-existing mental health and substance misuse issues will have their complex needs recognised and receive high quality integrated care."

Also, the specific Isle of Man protocol for "Collaborative working with co-morbid clients" has additionally been implemented from January 2008.

The relationship between mental illness and substance misuse is complex. Therefore, the CPA assessment should include consideration of the following:

- Assessment of patterns of substance misuse and degree of dependence
- Consideration of patterns of substance misuse and mental health problems
- Consideration of the interaction between medication and other substances
- Assessment of level of motivation to change
- The need for treatment of substance misuse

It is recognised that, in accordance with national guidelines for Co-Occurring/Dual Diagnosis issues, the Care Co-ordinator will usually reside

[24] "Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide", UK Department of Health, 2002

within mainstream 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 Drug and Alcohol Team to take this role. When Co-occurring issues are identified therefore, it is important that the clinical team agree which services should lead, and the Care Co-ordinator will come from that service. This must be clearly documented.

Key Standards

(These standards are not taken from the CPAA National Standards document but instead come from the Scottish Executive publication "Delivering for Mental Health - Mental Health and Substance Misuse"[25])

The needs of those who substance misuse and require interventions for mental illness should be met through a consultative and co-working arrangement between substance misuse and mental health services with agreement reached on the allocation of responsibilities between services which addresses all stages and transitions.

A shared protocol on the arrangements in place, including monitoring and review of performance and outcomes, should be agreed and published.

[25] "Delivering for Mental Health – Mental Health and Substance Misuse' Consultation Draft, Scottish Executive, June 2007

18. Mentally Disordered Offenders

"A significant number of individuals within the criminal justice system will need the support of the mental health system at some point in their lives. For some people with mental health problems, their first contact with mental health services will come through the criminal justice system. The CPA applies to these people regardless of setting. Where service users are the shared responsibility of mental health and criminal justice systems, close liaison and effective communication over care arrangements, including ongoing risk assessment and management, are essential."[1]

Services are provided to these clients in in-patient, community and criminal justice settings. Criminal Justice and Health and Social Care 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 mentally disordered offenders.

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 UK Criminal Justice and Court Services Acts (2000) and (2003)[26] established the local arrangements for MAPPA processes. On the Isle of Man these arrangements are co-ordinated by Probation Services.

Prisoners with mental health problems

The Care Programme Approach also applies to prisoners who have mental health problems. Remand in custody or sentence of imprisonment for anyone already in contact with secondary mental health services does not indicate an end to the responsibilities of the Mental Health Service. As with admissions to hospital or people residing in care homes etc. who retain contact with the secondary mental health service for treatment, the Mental Health Service retains a responsibility for contributing to the ongoing assessment of needs, planning care, review and monitoring of care and treatment.

People with mental health problems detained in prison are a significantly vulnerable group of service users. Where mental health problems are compounded by substance misuse, the attendant risks are increased. Homelessness, social isolation, substance misuse, self-harm and suicide attempts are areas of risk more likely to occur within this group.

[1] Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach, UK Department of Health, 1999

[26] Criminal Justice and Court Services Act 2000, HMSO

Prison health care services and the adult mental health services share responsibility for appropriate liaison to ensure sound discharge planning from prison for those service users subject to CPA, as well as for those people whose mental health needs are identified only after they are remanded or sentenced and will be referred from the prison. It is important that effective links are made to ensure sound discharge planning when inmates are released from prison.

The commissioning of a new prison on the Island at Jurby is progressing well. The new prison is scheduled to be fully operational by mid 2008. As detailed in Chapter 3 (Scope) of this document, the pathways for care of mentally disordered offenders in the prison environment will need to be agreed with colleagues from the Prison Health Care Team, using the key guidance contained in 'Changing the Outlook'[6] and 'Offender Mental Health Care Pathway'[7] documents.

---

[6] Changing the Outlook – A strategy for Developing and Modernising Mental Mental Health Services in Prisons, Department of Health, December 2001.

[7] Offender Mental Health Care Pathway, Department of Health, January 2005.

19. Confidentiality and Information Sharing

Please refer also to the Mental Health Service document "Your Guide to the Mental Health Service in the Isle of Man – Standards of Service we offer"[27], (page 7 'Confidentiality')

Also relevant is the local 'Policy statement on Case Recording'[28] as well as the 'IT Compliance Policy'[29] and the 'Policy and Procedures for the Security of Mental Health Case Notes'[30].

The sharing of relevant information is essential to the delivery of integrated care and to the provision of responsive, responsible and appropriate services. "Mental Health care will not work well unless information flows readily to the people who need it"[31].

Service User and Carer involvement in the planning and delivery of services enhances information sharing by enabling all parties to know what information is recorded, why it is relevant to others and how it will be shared.

Balanced against this is the requirement for the Division and its employees to respect the rights of individuals to have information about them protected. This will require making sure information is stored securely and shared responsibly on a 'need to know' basis.

Context

The relevant and appropriate sharing of information benefits the provision of services to people with mental illness in a number of ways:

- Facilitating close joint working between the various agencies and disciplines involved in the provision of services
- Reducing duplication and ensuring consistency
- Understanding the nature of risk, and acting appropriately to minimise risks
- Avoiding the need for service users to repeat information to a number of professionals involved
- Ensuring that assessment of need is comprehensive and complete

Consent

---

[27] Your Guide to the Mental Health Service in the Isle of Man Standards of Service we offer, November 2003

[28] Isle of Man Social Services Policy Statement on Case Recording. Sept 2005.

[29] Isle of Man Social Services IT Compliance Policy. November 2006

[30] Isle of Man Mental Health Service Policy and Procedures for the Security of Mental Health Case Notes. August 2006.

[31] The CPA Handbook. Care Programme Approach Association, April 2004

The sharing of information should be undertaken with the agreement of the service user, and requires:

- Workers to provide information to the service user about the conditions and limitations of confidentiality in line with local policy
- Service users to be actively involved in agreeing the specific nature and context of information to be shared
- Service users to be made aware of the confidentiality statement and be invited to sign the 'consent to share information' form. A copy of the signed statement should be maintained on case notes. If consent is withheld this should be noted on the form and copied to notes.
- Withholding or limiting consent does not preclude the sharing of information in certain circumstances. Practitioners may wish to seek managerial/legal advice in such circumstances.

Where consent has been withdrawn or limited, passing information on can be difficult. If consent is withdrawn it is good practice to discuss the reasons for this, and the implications of not passing information on. The UK Department of Health, in its guidance document "Developing Services for Carers and Families of People with Mental Illness"[32] suggests;

"The carer and the person cared for have the right to expect that information either provides will not be shared with other people without their consent. But issues around 'confidentiality' should not be used as a reason for not listening to carers, nor for not discussing fully with service users the need for carers to receive information so that they can continue to support them. Carers should be given sufficient information, in a way they can readily understand, to help them provide care effectively."

Exceptions

Conditions under which information can be shared between two agencies without the prior consent of the service user are where in the opinion of the person holding the information there is a 'pressing need', examples of which are:

- Where the service user lacks capacity to consent (in exceptional circumstances)
- Where there is concern for the safety of the individual or others
- Child protection issues
- By virtue of a Court Order (seek legal advice)

[32] Developing Services for Carers and Families of People with Mental Illness. UK DoH 2002.

- In respect of police investigations within certain conditions (seek legal advice)

The NHS Code of Practice relating to confidentiality[33] gives guidelines entitled 'Informing Patients Effectively – No Surprises' (pp21-22) including;

- Check that patients have seen the available information leaflets
- Make clear to patients when information is recorded or health records are assessed
- Make clear to patients when information is or may be disclosed to others
- Respect the right of patients to have access to their health records

Finally, robust standards for CPA require that protocols are agreed for the sharing of information with the police, probation service, local prison (if appropriate), court liaison, independent/voluntary sector agencies involved in care provision.

A protocol for the disclosure of records to the Police[34] has been established and it is intended that similar protocols for other agencies be developed in due course.

Key Standard

Information and Data Security;

Shared information systems will provide data relevant to people and agencies in accordance with public protection and data protection systems. Protocols will be agreed for the sharing of information with the police, probation service, local prison (if appropriate) and court liaison. Protocols will be agreed for the sharing of information with independent/voluntary sector agencies involved in care provision.

[33] Confidentiality – NHS Code of Practice, November 2003

[34] Isle of Man Social Services; Protocol for the Disclosure of Records to the Police, March 2004

20. Discharge from CPA

"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." [35]

Discharge for those on Standard CPA will normally occur when:

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

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

However discharge for those on Enhanced CPA could occur if:

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

Or:

- The service user requests discharge and refuses transfer to Standard CPA

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 service user has moved and transfer to a UK Trust has been completed

Or:

- The service user dies

The decision to cease contact with the Mental Health Services should take place at the time of review and be recorded.

---

[35] Independent Inquiry into the Care and Treatment of MN. A report commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority, June 2006

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

Service users and their carers should also be informed of how to contact services at a future date if their circumstances change.

21. CPA Monitoring and Audit

"Audit and monitoring remain essential components of successful implementation of the CPA. Organisations, locally and nationally, should be working to ensure that systems are in place to monitor the quality and impact of the CPA with the main focus on achieving desirable outcomes for those who use the services."[5]

Audit of CPA documentation including user and carer involvement, will be undertaken locally at least annually.

The results of audits will be reported to service areas through the established Audit Committee and Clinical Governance systems.

Key Standard

Audit; Reference must be made at all times to the (UK) Department of Health CPA Audit Tool standards for Service User focus and Professional Audit.

[5] Reviewing the Care Programme Approach 2006: A consultation document UK DOH, 2006

Isle of Man Mental Health Service CPA Policy

22. Index of Footnotes

Number	DOCUMENT REFERENCE
1	Effective Care Co-ordination in Mental Health Services Modernising the Care Programme Approach, UK Department of Health, 1999
2	Community Care Guidance on Care Programmes for people with a mental illness including dementia : Scottish Office Home & Health Department, 1992
3	A National Service Framework for Wales – Adult Mental Health Services : Welsh Assembly Government, 2002
4	National Standards and CPA Association Audit Tool for the monitoring of the Care Programme Approach, July 2003
5	Reviewing the Care Programme Approach 2006 ; A Consultation Document, Department of Health, 2006
6	Changing the Outlook – A Strategy for Developing and Modernising Mental Health Services in Prisons, Department of Health, December 2001
7	Offender Mental Health Care Pathway, Department of Health, January 2005
8	Social Services Department's and the Care Programme Approach, Department of Health, 1996
9	User Researcher in Control, Mental Health Today, May 2005
10	Emerging Best Practices in Mental Health Recovery, NIMHE/CSH, 2004
11	National Service Framework for Mental Health, Department of Health, 1999
12	An Audit Pack for Monitoring the Care Programme Approach, UK Department of Health, June 2001
13	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
14	Isle of Man Community Mental Health Team Policy
15	Sainsbury Centre for Mental Health. Briefing 29. The Care Programme Approach – Back on Track?
16	UK Care Standards Act, 2000
17	"Copying Letters to Patients" ; A Report to the Department of Health and Draft Good Practice Guidelines for Consultation, UK Department of Health, 2002
18	Isle of Man Mental Health Service " Policy on the Assessment and Management of Clinical Risk
19	Isle of Man Mental Health Service "Best Practice Guidelines for Admissions to In-patient Services via Community Mental Health Service"
20	Isle of Man Mental Health Service "Best Practice Guidelines for Pre-discharge Planning from a Mental Health Service In-patient setting"
21	Former Prime Minister Tony Blair in his foreword to the Social Exclusion Unit Report "Mental Health and Social Exclusion", OPDM, 2003
22	Sainsbury Centre for Mental Health ; Reviewing the CPA – A Response, SCMH, 2006

Number	DOCUMENT REFERENCE
23	Good Practice in the Transfer of Service User Care between Mental Health Districts ; Care Programme Approach Association, 2002
24	"Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide ", UK Department of Health, 2002
25	"Delivering for Mental Health and Substance Misuse" Consultation Draft, Scottish Executive, June 2007
26	Criminal Justice and Court Services Act 2000, HMSO
27	Your Guide to the Mental Health Service in the Isle of Man – Standards of Service We Offer
28	Isle of Man Social Services Policy Statement on Case Recording, September 2005
29	Isle of Man Social Services IT Compliance Policy, November 2006
30	Isle of Man Mental Health Service Policy and Procedures for the Security of Mental Health Care Notes
31	The CPA Handbook Care Programme Approach Association, April 2004
32	Developing Services for Carers and Families of People with Mental Illness, UK DOH, 2002
33	Confidentiality – NHS Code of Practice, November 2003
34	Isle of Man Social Services ; Protocol for the Disclosure of Records to the Police, March 2004
35	Independent Inquiry into the Care and Treatment of MN. A report commissioned by Avon, Gloucestershire and Wiltshire Strategic Health Authority, June 2006

SOCIAL SERVICES

Shirveishyn Y Theay

Mental Health Service - Care Programme Approach
Needs and Risk Assessment

Service Users ID Label here if available

Name:

Address: D.O.B:

CareFirst I.D: MH No:

Previously Known Yes/No

Service User Phone No:

Main Carer/Contact:
Phone Number:

GP:

Reason for referral (as per referrer)

Risks indicated by referrer and level of urgency

Client's View of Main Problems:

CPA Assessment

Service User Name .... **ID** ....

Safety/Risk Factors – *please check appropriately for all the following, and give details:*

Consider: SELF-NEGLECT (incl. vulnerability to exploitation – financial, residential, sexual); ENVIRONMENTAL RISK (incl. risk to worker); SELF-HARM; SUICIDE; HARM TO OTHERS (incl. to carers & children); RISK OF RELAPSE. Consider also: *History, Ideation, Plan, Intent, Strengths & Protective Factors*
Are there any warning markers on the electronic database?

Is there evidence of risk due to Self-Neglect?

Is there evidence of risk due to Self-Harm?

Is there evidence of Harm to Others?

Is there evidence of Environmental Risk?

CPA Assessment

Service User Name .... **ID** ....

Safety/Risk Factors Continued

Is there evidence of risk of suicide?

Is there evidence of risk of relapse?

Past history of risk and how managed?

Past or current forensic issues?

Is there a need to consider Child Protection issues? Yes ☐
Is there a need to consider Vulnerable Adult Procedures? Yes ☐ If so state the names and ages of those identified as vulnerable. Have relevant policies and procedures been followed?

Is a more in-depth assessment required in relation to identified risk? Yes ☐ No ☐

If yes please indicate the risk assessment tool used and the date completed;

CPA Assessment

Service User Name .... **ID** ....

Psychological Factors – *please describe any evidence of mental disorder, such as psychosis, depression,bipolar,anxiety cognitive impairment, significant life events etc. via the following;*

Consider: appearance & behaviour; speech; mood; thoughts & cognition; psychotic symptoms; medication & substance misuse

CPA Assessment

Service User Name.. **ID** ....

Social Circumstances – *please report only those difficulties which are relevant to the service users presentation and situation, within the domains indicated below. It may help to use sub-headings for clarity, and use another sheet of paper if more space needed.*

Personal care, domestic routines, home environment, family & social responsibilities: Childcare, Social Contacts, Accommodation, Money, Occupation, Leisure, Daily Structure, Stigma, Harassment, Language, Care of Home, Religion, Beliefs.

Carers: Physical or Psychological Problems relating to role as Carer; problems in carrying out Family, Domestic, Work or Social roles and responsibilities.

What support/information/education could be provided for the Carer?

CPA Assessment

Service User Name.. **ID** ....

Physical Health

Physical Health: (Including allergies)

Social/Psychiatric History:

CPA Assessment

Service User Name .... **ID** ....

Any other relevant information not included elsewhere:

Is a more detailed assessment required in terms of the service users needs? Yes ☐ No ☐
If so, please indicate the assessment tool used (i.e. KGV, Camberwell, SCL90, BDI)

Summary of Needs and Risk Assessment:

Clinical Impression/ICD 10 Code:

Outcome:
For service provision Yes/No OR signposted to ....

Or returned to referrer for discussion/discharge .... (Referrer notified in writing)

Assessment completed by; Name .... Signature ....

Date .... Area ....

There is no Policy requirement to copy this document to the CPA Office, service user, etc.

However, in those instances where it is copied, please indicate this below;

Not copied ☐ or Copied to...

Service Users ID Label here if available	
Name:	
Address:	
CareFirst I.D:	MH No:

DoB ..../........../.........

Consent to Sharing Information

Services are delivered by teams of professionals. It will be necessary for other members of the team, who may
be involved in your care, to have access to information about you, on a need to know basis. This can include your GP, medical staff, nurses, occupational therapists, social workers and psychologists.

In addition to those listed above I am happy for necessary information about me to be shared with the following people (e.g. Specific named family members, named voluntary bodies/workers):

If you change your mind and wish to alter those listed on this form then ask your Care Co-ordinator.

There may be some circumstances in the public interest that would require the Mental Health Service to disclose information that would otherwise be kept confidential. Examples of this include where a child is at risk, or where there is evidence of serious criminal activity.

Information will be stored on computers and/or on paper as part of your care record to enable the organisation to carry out the necessary management, administrative and other work required to deliver your care safely and effectively. You have a right to ask to see the records kept about you. If you would like further information regarding your records, please discuss this with the Mental Health Professional working with you.

The storage and use of information within the Mental Health Service is compliant with the requirements of the Date Protection Act 2002.

I confirm that I consent to the information collected throughout my ongoing care being shared by those involved in my care and those named above. If in the future I have any objection to information being shared I will make this known to the care co-ordinator or assessor to amend my records.

Signature **Date**

Name

Unable to gain consent ☐ **Reason:**

Care Co-ordinator Name: **Date**

SOCIAL SERVICES

Shirveishyn Y Theay

Mental Health Service - Care Programme Approach

Care Plan

Please state if this is Standard Level ☐ or Enhanced Level ☐

This Care Plan summarises your care needs which have been identified during the assessment. It gives details about the services to be provided to help you. The Care Plan is about you and your needs, and you will be given a copy to keep. (Your Care Co-ordinator will explain this to you in more detail)

Service Users ID Label here if available	
Name: Address: D.O.B: CareFirst I.D: MH No:	G.P: .... Tel: .... Practice: .... Main Carer/Contact: .... Address: .... Tel: ....

Overall aim of Care Plan (As summarised during completion of assessment form)

<u>Mental Health Act:</u> Is the service user subject to any provisions of the Mental Health Act? Yes No

If so please define (i.e. Section 28, Section 115, etc.)

Comments, compliments and complaints
if there is any aspect of services provided that you are not satisfied with, you can discuss it with any of the people named on this care plan.

Service User Name... **ID**..

Assessed needs	**Outcome expectation**
	List the goal and the objectives for each need
Risks Indicated	*Positive Factors/Strengths*

Additional History (recent or historic)

Service User Name.. **ID**...

Services/interventions and how they will be delivered	**Start/finish date**
Risk Management Plan	

Other Comments – of user, carer(s), assessor, other agency. Include any outstanding difference of view or unmet needs.

Service User Name.. **ID**...

People involved in the care plan			
Name	**Role**	**Copied**	**Location/Tel. No.**
	Service User/Patient		
	Carer		
	Care Co-ordinator		
	RMO		
	G.P		
	CPA Office		
GP Specific Information	**GP Specific Role**		

Contingency Plan	Name	Tel.No.
For general information contact		
Urgent service need contact		
Interim support available from		

What to do in a crisis	
Warning Indicators/Signs of Relapse	**Action Plan**(include strategy and what has worked previously)

Date of completion of care plan [ ] **Review Date (A date must be recorded)** [ ]

Signature Care Co-ordinator... **Signature Service User**......................................

Dates of any amendments made [ ] [ ] [ ] [ ] [ ] [ ]

Mental Health Service – CPA Review

SERVICE USERS ID LABEL HERE IF AVAILABLE Name: Address: D.O.B: CareFirst I.D: MH No:	**Carer/Contact Person:**.. **Care Co-ordinator:**.. **MHS Area:**.. **GP:**..

Date of Review:..	Location of Review:...
Legal Status:..	Standard Level ☐ Enhanced Level ☐

Reason for Review (tick as appropriate)

Planned Review ☐ Request of Client/Carer ☐ Significant changes/crisis ☐ Transfer off-Island ☐
Transfer of Care Co-ordinator ☐ Ready for discharge from CPA ☐ Discharge from in-patient Services ☐

Outline any significant events and changes since the Care Plan was agreed/revised.
Has the Risk element of Care Plan changed? If so how?
Outline what worked well/was helpful?
Which Positive Risks were successful?
Outline any changes needed to the Care Plan.
Outline changes to the Risk Management Plan.
Carers – how do carers or other significant people feel about the current Care Plan (if included)?
Are carers or other significant people in agreement with Risk Management Plan?

Persons Invited: Role	Name	Attended	Contributed	Copied

Other persons requiring notification of outcomes		Copied
CPA Manager		

Overall aim of Care Plan

Does the overall aim of the Plan remain appropriate? *Please delete* Yes/No

(If 'No' a re-assessment of service user needs should be undertaken and a new Care Plan completed)

Assessed Needs and Risk

Are the needs and risk of the service user still as detailed in the original Care Plan? *Please delete* Yes/No

Please comment as appropriate

(For minor changes in need, amend the Care Plan and note the reasons overleaf. For fundamental changes, consideration should be given to reassessing the service user's situation and formulating a new Care Plan)

Outcome of Review			
New Care Plan required		No change to Care Plan	
Discharge: From CPA		Change to MHA status	
Transfer off-Island		Admission to in-patient care	
Transfer to new Care co-ordinator		To whom?	

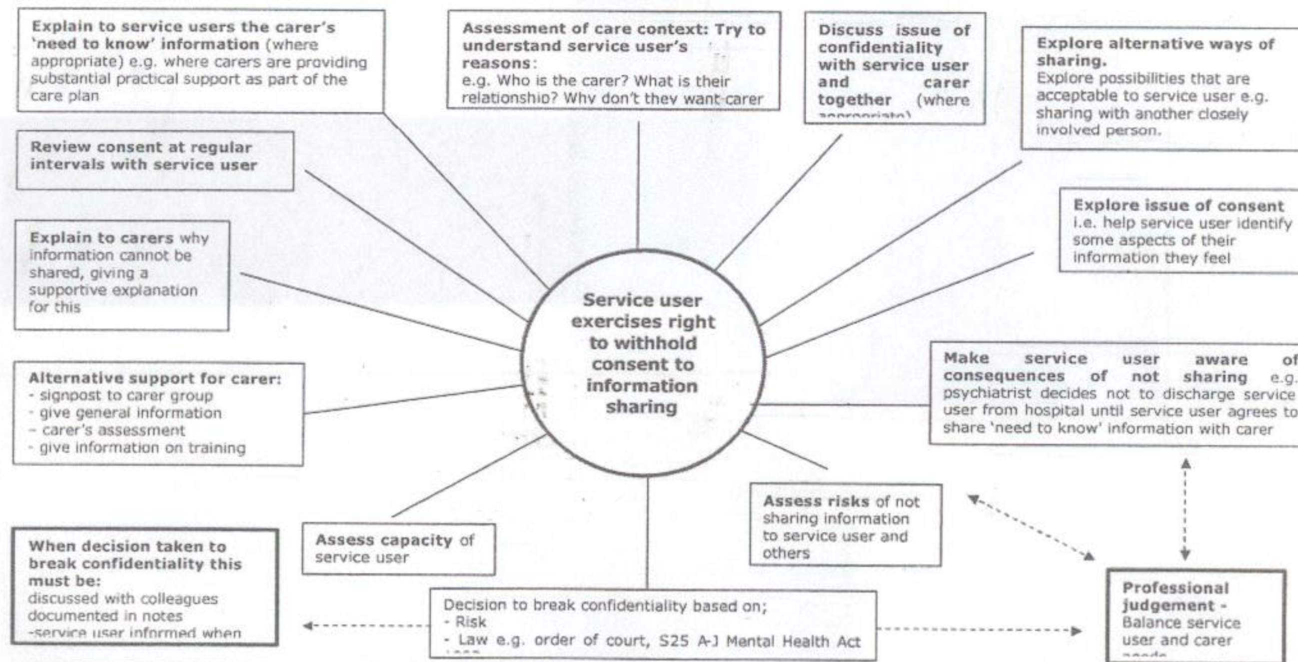
Date of next Review:..

Signed by Service user.. Date...................................

Signed by Care Co-ordinator.. Date...................................

Other Signature... Role/relationship....................................... Date.................

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



SOCIAL SERVICES

Shirveishyn Y Theay

This Policy can be presented in large print or audiotape on request.

Caring for the Nation ~ Jeeaghyn mysh yn Ashoon

DEPARTMENT OF HEALTH AND SECURITY

Social Services Division, Mental Health Service

The Lodge, Braddan, Strang, IM4 4RF

Website: www.gov.im/dhss

Rheynn Slaynt as Shickyrys Y Theay