



## **Draft Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010**

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## INTRODUCTION

- i. This Code has been prepared and is issued under section 44 of the Mental Health (Wales) Measure 2010 (“the Measure”) by the Welsh Ministers after consulting such persons as appeared to them to be appropriate, and having been laid before the National Assembly for Wales. The Code will come into force on [date].

## Purpose and status of the Code of Practice

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- ii. The Code is provided as guidance to local authorities, Local Health Boards, and care coordinators and any other persons in relation to their functions under Parts 2 and 3 of the Measure. These Parts make provision in relation to care and treatment planning and care coordination for users of secondary mental health services, and in relation to the provision of assessments for former users of secondary mental health services.
- iii. This Code also gives guidance to LHBs, Local Authorities, their staff, and care coordinators, in connection with the operation of these Parts of the Measure and the subordinate legislation which has been made in connection with it.
- iv. Local authorities, Local Health Boards and care coordinators are required to have regard to this Code in carrying out their relevant functions under the Measure. Departures from the Code could give rise to legal challenge and a court, in reviewing any departure from the Code, will scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances. It is good practice to ensure any such reasons are appropriately evidenced.
- v. In addition to the provision of guidance to the agencies or bodies with statutory duties under the Measure, the Code also serves to inform patients, their families carers and advocates of the duties as they apply to people who fall within the scope of the measure.
- vi. The Code is available in both English and Welsh.

## Presentation

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- vii. Throughout the Code, the Mental Health (Wales) Measure 2010 is referred to as ‘the Measure’. Where there are references to other statutes, the relevant Act or Measure is clearly indicated.
- viii. The Code also takes account of the *Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011* relating to Part 2 of the Measure and the *Mental Health (Assessment of former users of Secondary Mental Health Services (Wales) Regulations 2011* relating to Part 3 of the Measure. These are referred to in this Code as ‘the Part 2 Regulations’ or ‘the Part 3 Regulations’ accordingly. Where there are references to other

subordinate legislation, the relevant Regulations, Rules, Directions or Orders are clearly indicated.

- ix. The Measure and the Regulations set out the legal framework, and the Code of Practice provides the principles and guidance on how the legislation should be applied in practice. The Code shows, where relevant, the connections between the Measure and other legislation, such as the Mental Health Act 1983.
- x. This Code provides context and positive practice guidance to care coordinators in undertaking their functions under the Measure and associated Regulations. It identifies a number of important care and treatment planning issues for patients and their carers. The Code seeks to guide care coordinators toward delivery of comprehensive and outcome focused care and treatment planning.

### **Terms used in this Code**

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- xi. The term 'service user' is often used for people accessing services for care and treatment of their mental ill-health. Some people prefer the terms 'survivor', 'client', 'consumer' and 'recipient'. This Code uses the term 'patient' in line with the term used in Part 2 of the Measure.
- xii. This Code uses the terms 'child' and 'children' for people aged less than 18 years, while acknowledging that 'young person' or 'adolescent' might sometimes be more appropriate.
- xiii. There are references throughout this Code to the Mental Health Act 1983 and the Mental Capacity Act 2005. The Code assumes that its readers are familiar with the main provisions of those Acts, as they relate to the assessment, care and treatment of people with mental disorders. Guidance on both Acts are given in their respective own Codes of Practice.
- xiv. A list of key words and phrases used in this Code is given in appendix A.

## CHAPTER 1 – GUIDING PRINCIPLES

- 1.1 This chapter provides a set of guiding principles which should be considered when exercising functions under Parts 2 or 3 of the Measure. All of the chapters of this Code of Practice should be read in light of these principles.

### **Patients and their carers should be involved in the planning, development and delivery of the patient's care and treatment to the fullest extent possible**

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- 1.2 People accessing mental health services should be involved in planning their care and treatment, where practicable. This means that mental health professionals should engage with patients to identify and plan the delivery of a range of services to meet their needs. Engagement should include the co-production of a care and treatment plan between the patient, their mental health service providers and their care coordinator, as well as the setting of goals to achieve the agreed outcomes within the plan. It should also include the monitoring of the delivery of services included within the care and treatment plan, and amendment to plans, where necessary through the review process. Engagement ideally should apply also to the families and/or other significant people in the lives of the patient, subject to their ongoing agreement and consent.
- 1.3 The principles identified in this Code also apply when patients either choose not to take an active role in the planning process or are unable to do so. The ongoing and purposeful seeking of engagement (where none has previously been forthcoming) should be undertaken routinely. Seeking smaller more manageable engagement steps with the aim of increasing confidence and promoting a sense of recovery is a major feature of positive care coordination.
- 1.4 The particular issues of engagement for patients belonging to vulnerable groups such as children and young people, patients with a co-occurring mental health problem and a learning disability, and older people should be a focus of care coordinator activity. The tailoring of care coordination to meet the specific needs of such groups requires a coordinator's careful attention, including the consideration of language needs.
- 1.5 It is good practice within care and treatment planning to explore what a patient might wish to happen in relation to their health and social care at some point in the future, for example planning for a time when admission to hospital may occur, planning for a time when mental capacity may be lost or setting out what treatments a person would prefer.

**Clear communication in terms of language and culture is essential to ensure patients and carers are truly involved, and receive the best possible care and treatment. In Wales, this means bilingual (Welsh and English) services should, where possible, be available**

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- 1.6 Effective engagement is based upon good communication. Mental health practitioners, including care coordinators, shall ensure therefore that, where possible, effective communication takes place between themselves, patients and any one else involved in the care or support of patients. They shall ensure that everything possible is done to overcome any barriers that may exist to communication in an appropriate manner.
- 1.7 The Welsh Language Measure (2011) places duties on public bodies to provide services, which it is expected will be provided in accordance with the duties placed on such bodies by their respective Welsh language schemes<sup>1</sup>. Mental health services in Wales must be underpinned by the principle that the Welsh and English languages shall be treated on an equitable basis. The Welsh Government is positive about the Welsh language and the benefits of bilingualism, and recognises that bilingual services are essential in providing a world-class service in terms of effective assessment, treatment and care planning.
- 1.8 People in Wales should, where possible, be given the option of assessment, treatment and provision of information in Welsh. Within the remit of their Welsh language schemes, all possible steps should be taken to ensure that services are available for Welsh speakers in the language that best meets their individual needs, and that services are suitably developed and supported to be delivered through the medium of English and Welsh. Local Health Boards and local authorities should promote the bilingual services that are already available and increase capacity for providing bilingual services where there is a shortfall of Welsh speaking staff. The onus is on Health Boards and Local Authorities to provide the appropriate service rather for an individual to have to ask for it.
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### **Care and treatment should be comprehensive, holistic and person-focussed**

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- 1.9 In order to ensure that care and treatment is most effective in maximising recovery, the assessment, planning and delivery of that care is to be holistic, addressing a broad range of medical, psychological, social, physical and spiritual needs that in the case of children are developmentally appropriate. In formulating the care and treatment plan care coordinators need to focus on the needs of the individual, rather than the services that currently exist and could therefore be provided. In addition to services available in specialist mental health services, consideration should also be given to broader services such as

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<sup>1</sup> It should be noted that from the 1st of April 2012 the Welsh Language Commissioner will start work and will be responsible for drawing up standards that will replace Welsh language schemes. However the Welsh language schemes will still be operational until the standards have been drawn up and implemented.

education, training, employment and leisure services that may assist in a person's recovery.

- 1.10 Recovery in this context means regaining mental health to the maximum extent possible and achieving the best possible quality of life, lived as independently as possible.
- 1.11 People with mental health problems, and their carers, should live as fulfilled a life as possible, with additional support delivered in a timely manner through evidence based interventions, where possible, to help them achieve this goal. Care and treatment plans for all individuals within secondary mental health services should focus upon the minimisation of the impact of their mental health problems on living as fulfilled a life as possible and the maximisation of their independence, community integration, mental and physical health and wellbeing. Care and treatment planning should therefore be based upon a recovery approach.
- 1.12 This requires a positive, strengths-based approach taking incremental steps to achieve long term goals. It should be recognised that for some people these may only be small steps and that for some, especially those people with degenerative disorders, the focus may centre on maximising a person's functioning within a process of gradual decline.

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### **Care and treatment planning should be proportionate to need and risk**

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- 1.13 Whilst the development of an effective care and treatment plan is essential to meet the requirements of the Measure and the Part 2 Regulations, plans ought to be proportionate to need and risk, as they are tools to assist in the delivery of effective care and for the review of outcomes. In some cases this may require a detailed plan reflecting the complexity of the patient's need. However for many patients the plan of care may be relatively un-complicated. It is important, in order to ensure that the delivery of treatment and care is maximised, that the care and treatment planning process reduces the burden of bureaucracy whilst ensuring good quality planning, monitoring review and recording.

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### **Care and treatment should be integrated and coordinated**

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- 1.14 Local Health Boards and Local Authority must work together in a coordinated and integrated way to provide effective services for an individual. They should also work with any voluntary organisations that provide services to an individual, to ensure the services provided by the statutory organisations are coordinated with those of the 3<sup>rd</sup> Sector.
- 1.15 Due regard should be given not only to services available in statutory and third sector specialist mental health services but also to other statutory and non-statutory services available in other sectors for example employment support services, schools and colleges, justice agencies, etc. Ideally, other services such as substance misuse services and Integrated Family Support Service should work collaboratively with specialist mental health services to ensure the most efficient use of resources and the most effective outcome for patients and their families.

## **CHAPTER 2 – ASSESSMENT WITHIN SECONDARY MENTAL HEALTH SERVICES**

- 2.1 This chapter gives guidance on the purpose and focus of assessment within secondary mental health services as part of the process for developing outcomes to be achieved that will be recorded in the care and treatment plan.

### **Purpose of assessment**

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- 2.2 Part 2 of the Measure does not prescribe a particular assessment process, nor place duties on mental health service providers to undertake assessments. Indeed the duties under Part 2 only have effect once an individual is a 'relevant patient'.
- 2.3 A relevant patient is defined in the Measure as an individual for whom a mental health service provider is responsible for providing a secondary mental health service. This is irrespective of whether the individual is cooperating with the provision of such services.
- 2.4 In addition a person who is under the guardianship of a local authority in Wales (within the meaning of the Mental Health Act 1983) is a relevant patient for the purposes of Part 2.
- 2.5 For individuals deemed to have needs that should be addressed by secondary mental health services, the assessment process for agreeing the outcomes to be achieved will identify needs and risks (including vulnerability), alongside the personal strengths of individuals. Such an approach maximises the opportunity for recovery and independence. Recognising, reinforcing and promoting strengths at an individual, family and social level should be a key aspect of the assessment process.
- 2.6 The aim is for the assessment process to establish information from which care and treatment planning and future work, can take place.

### **Holistic Assessment of need**

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- 2.7 Where an individual is a 'relevant patient' within the meaning of Part 2, their assessment will identify, describe and evaluate an individual's presenting needs and strengths and how they constrain or support the person's capacity to live a full and independent life. This is integral to setting outcomes and formulating the care and treatment plan, as provided by section 18 of the Measure.
- 2.8 Assessment as part of the process for producing a care and treatment plan should take into account the individual's level of understanding and capacity to consent to and engage in, the process. In the case of assessments undertaken with children the cognitive maturity and legal status should also be taken into account. It is necessary that professionals engaged in the assessment process are competent to evaluate these factors.



2.9 In order to agree the outcomes for the care plan a full assessment will need to consider the following aspects of an individual's life –

- a) finance and money;
- b) accommodation;
- c) personal care and physical well-being;
- d) education and training;
- e) work and occupation;
- f) parenting or caring relationships;
- g) social, cultural or spiritual;
- h) medical and other forms of treatment including psychological interventions.

This is not an exhaustive list and there may also be areas in addition to the above which emerge through the assessment process and need consideration.

2.10 In order to establish whether an individual has needs, strengths or risks in these areas each should be considered during the initial, and all subsequent, assessments.

2.11 The assessment process should also ensure that the patient is encouraged and facilitated to make clear their views and their ambitions for the future. It is crucial in the co production of a care and treatment plan that, where possible, the assessment process engages the patient collaboratively. Only in circumstances such as where a patient lacks the capacity or refuses to cooperate in the assessment process should the process not include this level of collaboration. Where practicable and appropriate the views of any carers or significant others may also be sought and recorded.

2.12 In relation to the assessment of children and young people (within the context of Part 2 of the Measure), practitioners undertaking assessments should consider the child in the context of their developmental level and seek to view problems and issues in the ways in which children experience them. In addition they should empower good parenting, include a focus on prevention and health promotion and ideally develop relationships that aid children in tackling their problems. Consideration needs to be given to establishing –

- a) who has parental responsibility for the child; and
- b) the ability of the child to make their own decisions in terms of emotional maturity, intellectual capacity, mental state and their competence.

## **Assessment of risk**

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2.13 Assessment of risk forms a part of the necessary first step to setting outcomes and formulating the care and treatment plan, as provided by section 18 of the Measure. In all cases the assessment process ought to seek to identify any risks the patient may be exposed to and any risks they may present to themselves or others. The care and treatment plan should contain steps to

mitigate these risks, and so contribute to the setting of outcomes on the patient's plan.

2.14 Whilst the Measure does not prescribe a particular risk assessment process or tool LHBs and Local Authorities should ensure that in all cases risk assessments should seek to identify and minimise the potential for:

- a) social vulnerabilities
- b) harm to self (including deliberate self harm);
- c) suicide;
- d) harm to others (including violence);
- e) self neglect;
- f) neglect or abuse of children
- g) neglect or abuse of adults for whom they provide care
- h) adverse risks associated with the abuse of alcohol or substance.
- i) risk of becoming institutionalised

2.15 In practice terms assessment of risk is an aid rather than a substitute for decision making about what outcomes need to be achieved, and assessments should be translated into a formulation of any risks, and subsequent management of those risks. All care and treatment planning processes should take into account risk management arrangements.

2.16 The assessment of risk and the planning for risk management is an essential part of the review of care and treatment plans (see Chapter 6 below).

## **CHAPTER 3 – CARE COORDINATORS**

- 3.1 The care coordinator is central to the individual's journey through secondary mental health services; the Measure requires a care coordinator to be appointed as soon as reasonably practicable for each person upon becoming a relevant patient. This chapter outlines the role of the care coordinator, and also details their duties and functions under the Measure and the Part 2 Regulations.
- 3.2 This chapter also provides guidance on the appointment of care coordinators, and organisational responsibilities in supporting the care coordinator.

### **Role of the care coordinator**

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- 3.3 The role of the care coordinator is a distinct one within the care and treatment planning process, not exactly separate from the professional functions that practitioners have but nevertheless with its own responsibilities. There may be many people involved in a patient's care in secondary mental health services but there will be only one care coordinator acting at any one time.
- 3.4 The care coordinator is responsible for working with the relevant patient and the patient's mental health service providers to seek to agree the outcomes which the provision of mental health services are designed to achieve for the patient. In addition, the care coordinator must seek to ensure that a care and treatment plan is developed and written and where necessary reviewed and revised. They are also responsible for providing advice to service providers on the effective coordination of the care which is delivered. The care coordinator is responsible for keeping in touch with the patient. They are the principle source of information for the patient and are responsible for seeking their active involvement and engagement in the care planning process. They also have a significant role in managing relationships with a wider range of partners in the care and treatment process. The care coordinator may also deliver certain components of the care and treatment plan themselves.

### **Appointment**

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#### **Duty to appoint a care coordinator**

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- 3.5 Section 14 of the Measure places a duty upon the 'relevant mental health service provider' (see below) to appoint a care coordinator for the individual receiving secondary mental health services as soon as reasonably practicable after the individual becomes a relevant patient (or after an existing care coordinator permanently ceases to be appointed). In practice this means that the appointment must take place as soon as practicable after the individual has been accepted into secondary mental health services, or their existing care coordinator ceases to be appointed or they have become subject to guardianship. It is not appropriate, or safe, for patients to be without a care

coordinator once they have been accepted into services. For this reason it is recommended that a care coordinator is appointed for a patient when the individual is accepted into services, or very soon afterwards, and certainly within a few weeks.

- 3.6 A person can only be appointed as a care coordinator if they meet the eligibility requirements set out in the Regulations made under Part 2 of the Measure (see below).
- 3.7 The relevant mental health service provider may appoint a care coordinator from amongst the staff of another organisation, provided that the consent of the other organisation is obtained. For example, an LHB could appoint an eligible person from an independent hospital to be the care coordinator if the relevant patient in that independent hospital. Other examples could include a local authority appointing an eligible health professional, with the agreement of the employing LHB. A care coordinator acts on behalf of the mental health service provider who appointed them.
- 3.8 Organisations who work together in multiagency teams to deliver secondary mental health services may consider the development of joint protocols relating to the appointment of care coordinators.

### **Relevant mental health service provider**

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- 3.9 Care and treatment provision within secondary mental health services is often undertaken by a range of different professionals and via a number of agencies, reflecting the complex and sometimes enduring needs that users of those services may have. This complexity of provision is recognised in the Measure and associated Part 2 Regulations, which establishes a mechanism for identifying the provider with a duty to appoint a care coordinator. This is set out in the table below –

<b>Circumstances</b>	<b>Relevant mental health service provider</b>
The relevant patient receives secondary mental health services from only a Local Health Board	The Local Health Board
The relevant patient receives secondary mental health services from only a Local Authority	The Local Authority
The relevant patient is under guardianship (within the meaning of the 1983 Act)	The Local Authority
The relevant patient is under 18 and is looked after by a local authority <sup>2</sup>	The Local Authority
The relevant patient is under 18 and is a 'relevant child' <sup>3</sup>	The Local Authority

<sup>2</sup> within the meaning of section 22(1) of the Children Act 1989

<sup>3</sup> within the meaning of section 23A of the Children Act 1989

The relevant patient is under 18 and qualifies for advice and assistance under certain provisions of the Children Act 1989 <sup>4</sup>	The Local Authority
The relevant patient is under 18 and is admitted to a school in accordance with a statement of special education needs <sup>5</sup> that names the school	The Local Authority
The relevant patient receives secondary mental health services provided by the Welsh Ministers <sup>6</sup>	The Welsh Ministers
All other cases, including where the relevant patient receives services from both a LHB and a Local Authority	The Local Health Board

3.10 Although the duty to appoint sits with the relevant mental health service provider, an LHB or Local Authority may delegate the function (but not the responsibility) of appointment to another LHB or Local Authority.

3.11 LHBs and Local Authorities should identify the officers within their organisations who may perform the function of appointment on their behalf, and include this in their Schemes of Delegation. The Schemes should also make clear the circumstances when an LHB or Local Authority may delegate their function of appointment to another LHB or Authority, as the case may be.

### **Temporary appointments of a care coordinator**

3.12 There may be occasions when the care coordinator is, temporarily, unable to act as such. For example, they have been taken ill and are away from work for a period of time. In such cases the relevant mental health service provider may appoint a temporary care coordinator. The temporary care coordinator is able to perform all of the functions of the usual care coordinator.

3.13 A person should only be appointed as a temporary care coordinator if they meet the eligibility requirements established in the Part 2 Regulations for care coordinators (see below)

3.14 Temporary appointments cease when the relevant mental health service provider considers that the usual care coordinator has regained the ability to undertake their functions. There is no need for a fresh appointment of the usual care coordinator to be made, as their previous appointment will simply recommence.

<sup>4</sup> i.e. qualifies under section 24(1A) or 24(1B) of the Children Act 1989

<sup>5</sup> made under section 324 of the Education Act 1996

<sup>6</sup> The Welsh Ministers have general and specific powers under the National Health Service (Wales) Act 2006 to provide services. Section 13(2) of the Mental Health (Wales) Measure 2010 makes clear that where an LHB is providing a service under a function in relation to which directions have made the function exercisable by the LHB, the service is to be treated as being provided by the LHB and not the Welsh Ministers

- 3.15 Whenever a temporary appointment is made, it is good practice for the relevant patient and their carer to be informed of the temporary arrangements. It is unlikely that there will be a need to make revisions to care and treatment plans, or undertake reviews of such plans where the only change is the appointment of a temporary care coordinator.

### **Changes in the appointment of the care coordinator**

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- 3.16 Over time the care coordinator for an individual may need to change, perhaps to reflect the changing needs of the person receiving services. Where this happens the duty on the relevant mental health service provider continues.
- 3.17 It is recognised that care coordinators are likely to develop close therapeutic relationships with patients, and as such, any change in appointment may well be a disruptive event for the individual concerned. In line with the guiding principles set out above, the reasons for any change should be discussed with both the patient and the wider care team. If possible, the patient should be involved in discussions about potential replacements.
- 3.18 When there is a planned change in care coordinator, there should usually be a clear handover of information (for example, case summary, need and risk assessments, and the care and treatment plan itself). It is important that, where possible, the patient is involved in decisions about changes in responsibility for their care coordination, and the transfer of information.
- 3.19 Where a patient requests a change of care coordinator this should be considered by the relevant mental health service provider and where possible accommodated.

### **Termination of appointment of the care coordinator**

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- 3.20 A relevant mental health service provider may terminate the appointment of an individual appointed as a care coordinator at any time. However, where the patient remains a relevant patient (within the meaning of Part 2 of the Measure), the relevant mental health service provider must ensure that a new care coordinator is appointed as soon as is reasonably practicable.
- 3.21 An individual's appointment as a care coordinator does not come to an end as a result of a change in a relevant patient's relevant mental health service provider.

### **Eligibility to act as a care coordinator**

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- 3.22 In every case the relevant mental health service provider may only appoint a care coordinator who is eligible to be appointed; eligibility criteria are set out in the Regulations made under Part 2 of the Measure. Under these Regulations a person is only eligible to be appointed if that person –

- a) meets one or more of the professional requirements (see below); and
- b) demonstrates to the satisfaction of the appointing organisation that he or she has appropriate experience, skills or training, or appropriate combination of experience, skills and training to undertake the functions of a care coordinator.

3.23 The appointing organisation should be satisfied that the care coordinator is skilled to their satisfaction in communicating and negotiating care and treatment plans with patients, carers, multi-disciplinary and multi-agency care providers. It is not assumed that experience, in terms of years served as a mental health practitioner is an adequate benchmark for skills of this complex and challenging role. As a minimum, it is expected that the care coordinator should be skilled in active involvement of patients, carers and other workers in the care planning process.

3.24 The professional requirements are that the potential care coordinator is:

- a) a qualified social worker (registered with either the Care Council for Wales or the General Social Care Council);
- b) a first or second level mental health or learning disabilities nurse (registered in Sub-part 1 or Sub-part 2 of the Register maintained under article 5 of the Nursing and Midwifery Order 2001<sup>7</sup>);
- c) an occupational therapist (registered in Part 6 of the Register maintained under article 5 of the Health Professions Order 2001<sup>8</sup>);
- d) a practitioner psychologist (registered in Part 14 of the Register maintained under article 5 of the Health Professions Order 2001);
- e) a registered medical practitioner;
- f) a dietician (registered in Part 4 of the Register maintained under article 5 of the Health Professions Order 2001);
- g) a physiotherapist (registered in Part 9 of the Register maintained under article 5 of the Health Professions Order 2001); or
- h) a speech and language therapist (registered in under Part 12 of the Register maintained under article 5 of the Health Professions Order 2001).

3.25 When considering whether a person has the appropriate experience, skills or training (or combination of experience, skills and training), the relevant mental health service provider ought to consider –

- a) the experience, skills and training of the person and how these compare to the needs of the patient;
- b) the potential level of input into care that the person will provide, and their relationship with the patient;
- c) the language and communication needs of the patient, and the experience, skills or training of the person to meet these.

3.26 It is also good practice for consideration to be given to:

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<sup>7</sup> S.I. 200/253

<sup>8</sup> S.I. 2002/254

- a) the preference and choice of the patient as to who their care coordinator may be
- b) the current caseload of the person being considered for appointment, including other duties they may be required to perform (for example, working on an Approved Mental Health Professional (AMHP) duty rota); and
- c) any issues that might give rise to a conflict of interest which may influence a care coordinator's judgement or practice.

3.27 The care coordinator need not be the person who has the most involvement with the patient, although in practice this is often the case. Whilst direct therapeutic involvement may be provided by a number of practitioners, good practice would be to ensure that the person with the most appropriate skills and experience usually is appointed as the care coordinator.

3.28 It is important that care coordinators have the necessary authority to undertake their functions. Service providers who appoint care coordinators should ensure that such individuals have the necessary authority to perform their functions under the Measure and to:

- a) coordinate service provision on behalf of the service providers, including accessing resources;
- b) monitor service provision;
- c) call and hold reviews;
- d) access other members of the patient's care team.

## **Duties and functions of the care coordinator**

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3.29 At the most fundamental level the care coordinator must work with the relevant patient, and the patient's mental health service providers, with a view to –

- a) agreeing the outcomes which the provision of mental health services for the patient are designed to achieve; and
- b) agreeing a care and treatment plan for achieving those outcomes, and putting that plan into writing on the prescribed form.

3.30 The care coordinator must also work with the relevant patient and the service providers in connection with the review and revision of the care and treatment plan. In certain circumstances the care coordinator has discretion over whether or not the plan should be reviewed or revised.

3.31 In preparing the care and treatment plan, the care coordinator must also consult certain other persons. Once the plan is complete, the care coordinator must, if appropriate, provide copies of that plan to the relevant patient and to certain other persons. Further guidance is given in Chapter 4 below.



- 3.32 Mental health service providers are under a duty to take all reasonable steps to coordinate the provision of mental health services to a patient; the aim of such coordination is to improve the effectiveness of those services. Mental health service providers may seek the views of the care coordinator as to how the provider can meet this duty, and the care coordinator may, at any time, give advice to service providers on this.
- 3.33 In undertaking their functions, and meeting their duties, care coordinators in partnership with patients will need to –
- a) ensure that comprehensive need and risk assessments have been undertaken for all relevant patients for whom they have responsibilities as part of the process for agreeing the outcomes which the provision of mental health services are designed to achieve under section 18. This can include arranging specialist assessments where required, and keeping these assessments under review to ensure they remain up to date and accurate;
  - b) maintain regular contact with the patient and any significant others in the life of the patient (parents, partners, carers, etc), so that changes in the patient's health and social circumstances are known, and appropriate action taken where required;
  - c) remain actively involved in the care and treatment of the patient throughout the time that they remain in receipt of secondary mental health services, including during admission or discharge from hospital;
  - d) record and seek resolution of any disagreements which may arise during the care and treatment planning process;
  - e) keep the patient's care and treatment plan under review, based on ongoing assessment, including whether actions recorded in care and treatment plans are completed within the agreed timescale(s) and revise the plan as necessary;
  - f) develop and maintain relationships with carers which are supportive of their role, and which values their contribution, treating them as equal partners in the care relationship;
  - g) maintain contemporaneous, accurate and lawful records in a manner proportionate to a case's level of complexity;
  - h) support the delivery of care and treatment in a way which is consistent with a recovery ethos;
  - i) maintain relationships with the patient, and any agencies which are delivering care or treatment during transition/transfer phases between organisations and sectors of the care delivery service.

## Supporting care coordinators

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- 3.34 Service providers should ensure that there are clear arrangements in place to manage service demand and delivery. These arrangements should support the appointment, and effective caseload management, of care coordinators. Similarly, care coordinators will need to give consideration to such matters when planning the delivery of care and treatment, and the potential identification of unmet needs due to availability of practitioners and services.
- 3.35 Care coordinators should have access to clinical and also caseload supervision as part of their role as care coordinators. Supervision can be defined as a regular and protected time where a practitioner can reflect, learn, explain and refine their understanding of mental health practice. Additionally it provides opportunities for care coordinators to monitor the complex relationships required to coordinate and oversee complex care packages and seek resolutions to on-going challenges.
- 3.36 Care coordinators should also be supported by effective training to undertake their functions. As well as training and education in relation to the practical aspects of assessment, planning, and liaising, this should include understanding the importance of maximising opportunities for recovery and achieving a better quality of life for the patient.
- 3.37 Training may include a mixture of process training (for example, ensuring documentation and record keeping is consistent with requirements of the legislation) and values-based practice resources which support the recovery ethos of Parts 2 and 3 of the Measure.
- 3.38 Responding to the needs of patients is central to mental health practice and consequently it is important that, where possible, training opportunities for care coordinators and other members of the care and treatment planning team has the active involvement of patients as co-trainers/facilitators.

## **CHAPTER 4 – CARE AND TREATMENT PLANNING**

- 4.1 Part 2 of the Measure, and the associated Part 2 Regulations, place duties on mental health service providers and care coordinators, regarding the preparation, content, consultation and review of care and treatment plans. These plans must be provided for all relevant patients.
- 4.2 The Part 2 Regulations also prescribe the content and the form of the care and treatment plan which all care coordinators are required to use.

### **Involvement, engagement and consultation**

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- 4.3 The Measure requires the care coordinator to collaborate with the relevant patient and the patient's mental health service providers to agree outcomes, and prepare the care and treatment plan. The importance of ensuring, where possible, appropriate engagement is essential if a patient's rights are to be respected and they are to participate in the co production of their care and treatment plan. Encouragement for involvement in care and treatment planning should be clear and unambiguous. Technical language and jargon should be avoided in the planning process and encouragement for involvement and engagement should be made, where possible, in the patient's preferred language. The patient's ability to understand issues, and any communication difficulties they may have, should be considered, and where required, access to interpreters and/or persons with specialist skills in communication should be considered.
- 4.4 In some cases the patient may wish to nominate a representative to be engaged in the planning process on their behalf. In some cases the care coordinator may need to take action to ensure that there is appropriate support for a patient in developing the care and treatment plan, for example suggesting that an advocate could provide help and support to the patient. Every opportunity should be taken to overcome barriers to involvement and engagement. If a patient does not accept a need for involvement this should not be seen as a definitive statement of this position; involvement and engagement in care and treatment planning may fluctuate and so the patient's preferred level of inclusion should be subject to regular and on-going review.
- 4.5 Where a relevant patient is an inpatient in hospital, or subject to relevant provisions of the Mental Health Act 1983, they are eligible to receive help and support from an Independent Mental Health Advocate (IMHA). The IMHA may provide help and support in relation to care and treatment generally or more specifically - for example helping (by way of representation or otherwise) those patients who wish to be involved in decisions made about their care and treatment. Where an IMHA is involved, the care coordinator and members of the care and treatment team should respect the independence of the IMHA and

seek to work openly and collaboratively to achieve the best treatment plan and actions for the patient. One of the ways this can be achieved is engagement in care and treatment planning meetings. Under the 1983 Act an IMHA may have access to the health and social care records of the relevant patient, subject to certain conditions. Further information on the role, duties and powers of the IMHA is available in the *Mental Health Act 1983 Code of Practice for Wales*.

## **Working with the relevant patient**

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- 4.6 The Measure places a duty upon the care coordinator to collaborate with the relevant patient, and that patient's mental health service providers, with a view to
- a) agreeing the outcomes which the provision of mental health services are designed to achieve.
  - b) agreeing the care and treatment plan, and
  - c) reviewing and if necessary revising the plan.
- 4.7 There will be circumstances where either a patient does not wish to take an active part in the care and treatment planning or where they do not agree with either the full plan or parts of the plan. Effective coordination is built on a belief in partnership and collaborative working arrangements. A desire to disengage should be viewed as a temporary statement and on-going efforts on the part of the care coordinator should be made to engage the patient. Where a patient does not agree with the plan, or parts of it, the care coordinator should make on-going efforts to negotiate a plan, based on assessment, which all care and treatment participants are in agreement.
- 4.8 If a person lacks the capacity to make decisions about their care and the outcomes to be achieved in the care and treatment plan then they should still be at the centre of the care planning process with their capacity to be involved maximised. Decisions made in the care planning process should be made under the framework of the Mental Capacity Act 2005 with assessments of capacity documented and the determination of best interests evidenced.
- 4.9 The views of the patient on the content of the care and treatment plan can be recorded on the care plan itself including views on the mental health services to be provided and any future arrangements that ought to be considered. If no views are expressed or no views can be ascertained then this should be recorded.
- 4.10 It is a requirement on the care plan itself that a record is made of whether the plan has been agreed with the patient. If the patient has not agreed the care and treatment plan, or is in disagreement with the plan then the reasons for this should be recorded. Good practice would suggest that the reasons could be recorded on the care plan itself where a patient is able to record their views on the care and treatment plan, the mental health services to be provided and any future arrangements that ought to be recorded.

## Consultation with others

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- 4.11 Part 2 of the Measure requires the care coordinator to work with the relevant patient and the mental health service providers with a view to agreeing outcomes, and preparing, reviewing or revising care and treatment plans.
- 4.12 In addition, the Part 2 Regulations also require the care coordinator to take all reasonable steps to consult the following persons, where they are identified in relation to the relevant patient –
- a) all persons with parental responsibility for the relevant patient;
  - b) all the relevant patient's carers and adult placement carers;
  - c) the relevant patient's responsible clinician;
  - d) the patient's guardian (within the meaning of the Mental Health Act 1983);
  - e) a donee or deputy the relevant patient, where the matters to be considered in the consultation fall within the scope of their decision making powers;
  - f) an independent mental capacity advocate who has been appointed for the relevant patient;
  - g) the managing authority and supervisory body where the relevant patient is subject to urgent or standard authorisations under the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005, together with any 'relevant persons representative', under those provisions.

A full explanation of all of these terms (and persons listed) is given in the glossary of terms at Appendix A.

- 4.13 The care coordinator may also consult any other person who they wish to consult, in order to facilitate the carrying out of their functions as a care coordinator.
- 4.14 Before consulting any of these persons the care coordinator must take account of the views of the relevant patient about whether these persons or individuals ought to be consulted. The relevant patient should be given support and information to help them understand the nature, risks, implications and purpose of consulting with others. The care coordinator may consult persons against the wishes of the patient provided they have given due consideration to the views of the patient. Good practice would suggest that such decisions and evidence of due consideration being given are clearly recorded.
- 4.15 The care coordinator may also consult any other person who the relevant patient wishes to be consulted.
- 4.16 It is essential that the care coordinator, and where appropriate the patient, communicate regularly and in a timely manner with any consultees. The avoidance of technical language and jargon also applies to communication with the wider care team and other consultees. The care coordinator should ensure that there is a clear understanding of each individual's and agency's contribution to the plan and where the accountability for delivery of services

sits. The care coordinator function is to oversee this involvement. Where agreed actions are not being delivered this is the responsibility of the mental health service provider concerned but it would be good practice for the care coordinator to seek to find a resolution as this may require a review or revision of the care and treatment plan.

### **Engagement with the care team**

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- 4.17 Within the care and treatment planning process, the importance of team work, regular communication and review of outcomes should form part of care plan discussion and review. This is particularly important where there may be conflicts about any proposed treatments or interventions. Negotiation between practitioners and patients involved in the care plan is a necessary process in developing a coherent and systematic approach to outcome planning in care and treatment.
- 4.18 Information sharing between professionals is often an essential part of coordinated care and treatment plans, particularly where a number of professionals and organisations are involved. It is the responsibility of the care coordinator to discuss and seek the agreement of the patient to relevant information being shared. The rationale for information sharing should be clearly presented and the maintenance of confidentiality within the immediate care and treatment planning team assured.
- 4.19 Those involved in making decisions regarding the provision of services need to be empowered to make commitments on behalf of their agency. If approval for plans needs to be obtained from more senior officials (for example, for funding) it is important that, where possible, this does not delay implementing the care and treatment plan. Where such a plan is concerned with the patient's discharge from hospital, this is particularly important.
- 4.20 For patients placed in services away from their place of usual residence, services from the patient's 'home' area should continue to be engaged. The patient's 'home' area should remain involved through appropriate attendance at care planning meetings, and regular involvement in other discussions.

### **Engagement with family, friends and carers supporting the relevant patient**

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- 4.21 The patient may wish to nominate family, friends and/or carers to support the delivery of the care and treatment plan; these supporters can play a major role in providing practical assistance in the delivery of the care and treatment plan. It is the responsibility of the care coordinator, subject to the agreement of the patient, to ensure that timely and clear information about the care plan is provided to carers and family members where they have a formal role within the care and treatment plan.
- 4.22 The care coordinator may make exceptions to this, if they have reason to believe that the involvement of the individual may be detrimental to the health

and wellbeing of the patients or where the nominated individual refuses a nominated role.

## **Engagement with carers**

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- 4.23 Carers can be important members of the care delivery team, even in certain circumstances when their involvement is not requested by the patient. The Regulations require care coordinators to take all practicable steps to consult with any carer(s) who may have a caring relationship with the patient during the preparation or review of the care plan. Before any such consultation takes place, the care co-ordinator is required to take account of the views of the patient as to whether the carer should be consulted with. However, where the patient has indicated that they do not wish the carer to be consulted, the care co-ordinator may still consult against the patient's wishes so long as they have given due consideration to the views of the patient.
- 4.24 The regulations also require care co-ordinators to provide the patient's carer(s) with a copy of the care and treatment plan when it has been produced, and any revised versions of the plan which are produced following review – unless that carer has indicated that they do not wish to receive a copy. Again, the care co-ordinator must take into account the views of the patient before providing a copy of the plan to a carer, but may still provide a copy of the plan against the patient's wishes so long as they have given due consideration to the patient's views. The care co-ordinator may also decide to withhold a copy of the plan, or provide a copy of part of a plan, to a carer, if they believe it is in the patient's interests to do so.
- 4.25 Where it is decided that consultation or sharing copies of the care plan with carers should not take place it is good practice to record the reasons for this decision and that this should be kept under review.
- 4.26 The Carer's Strategies (Wales) Measure 2010 requires LHBs and local authorities to have in place local strategies to ensure that carers are identified (including young carers who may be caring for a parent or other relative) and provided with information and support which will assist them in their caring role – including their entitlement to an independent assessment of their needs as a carer. Care coordinators and service planners should be aware of their own service's carers' strategy requirements and ensure that these are adhered to when carer's are involved in the care and treatment planning process.

## **Outcome planning**

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- 4.27 The care coordinator must work with the patient and providers of services to agree the outcomes that the provision of mental health services for the relevant patient should be designed to achieve.

- 4.28 The care and treatment plan should list these outcomes, record the services and/or actions that are to be provided to achieve each outcome including when they will be provided and state who is responsible for providing the service. The care and treatment plan should reflect the findings of any assessment of need and risk that has been undertaken. The care coordinator should ensure that a comprehensive assessment has been conducted, in order to ensure that the agreed outcomes and the care and treatment plan appropriately reflect the needs of the individual patient.
- 4.29 The process of agreeing outcomes requires involvement and engagement with the relevant patient, the mental health service providers, and other appropriate consultees. Seeking agreement for those actions or services designed to deliver outcomes will require differences of opinion on care and treatment options to be openly discussed and any conflicts resolved.
- 4.30 The care and treatment plan should include a clear description of the outcomes agreed (where possible) with the relevant patient and the patient's mental health service providers. Outcomes are to be achieved in one or more of the following areas –
- a) finance and money;
  - b) accommodation;
  - c) personal care and physical well-being;
  - d) education and training;
  - e) work and occupation;
  - f) parenting or caring relationships;
  - g) social, cultural or spiritual;
  - h) medical and other forms of treatment including psychological interventions.

Whilst there is no requirement for a care and treatment plan to record outcomes against each of these areas, it is likely that outcomes would arise in more than one of these areas. It is also the case that Care coordinators are not limited to recording outcomes only in relation to these 8 areas. Outcomes in additional areas may be recorded where appropriate.

- 4.31 Whilst outcomes can be based on the wishes, feelings and experiences of the patient, they should be recorded in a way which is objective and quantifiable. In all cases outcome planning should be based on the principles of recovery-orientated mental health practice, where the patient is supported to take as much responsibility for developing the care and treatment plan as they are able. A whole-person approach should be used (seeing the person from a wider health and social perspective), and where each partner in the care and treatment plan - including the patient themselves - is making a commitment to achieving the stated outcomes.
- 4.32 In writing an outcomes based care and treatment plan, a clear statement of the issues to be addressed, ideally from the patient's perspective, will first be required. Following this, the care coordinator and care team, along with the patient, will work to identify, agree and describe the desired end goal (or goals)



either long term or short term which if attained would demonstrate that the issues identified had been resolved or are progressing towards resolution. To achieve a full and meaningful 'outcomes based' care and treatment plan the care coordinator, care team and patient will need to work together to identify and agree the realistic, observable and achievable milestones to be reached in order to realise each goal.

- 4.33 Ongoing monitoring and review of whether the written care and treatment plan reaches these milestones should be undertaken. This approach is consistent with good practice in care and treatment planning, and as such remains the responsibility of the care coordinator.

## **Matters to be considered in the care and treatment plan**

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### **Finance and Money**

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- 4.34 The assessment process should consider the financial aspects of the person's life, and agree any related outcomes which ought to be achieved and recorded on the patient's care and treatment plan. This will enable consideration of any support that may be required to help the person access benefits, respond to any financial anxieties or address any identified vulnerabilities of financial abuse.
- 4.35 Mental health problems may cause an individual to neglect personal finances; alternatively, for someone living with a diagnosis such as dementia, they may worry about how they and their family will cope as their illness progresses. The assessment process should therefore consider a range of issues relating to finance and money, including –
- a) if the patient's ability to work is affected and whether there may be a sudden or, possibly, dramatic reduction in their income as a result;
  - b) the impact of time away from home (for example, admission to hospital) on the patient's ability to keep abreast of financial commitments;
  - c) whether a patient's capacity to make financial decisions is affected, perhaps leading them to act recklessly or unwisely;
  - d) loss of motivation or the ability to concentrate and thus keep control of finances;
  - e) vulnerability to financial exploitation or abuse.
- 4.36 Outcomes in this area may also be related to the impact of financial problems on a patient's mental health (for example, stress and worry associated with trying to maintain control of finances could lead to feelings of inadequacy and despair, and a lack of security, or pessimism about the future). These issues can have an impact on family and carers, which will need to be considered and which may include a patient's ability to parent or meet other caring responsibilities arising from financial pressure.

- 4.37 Consideration should be given as to whether there needs to be longer term planning where the patient's capacity may fluctuate or be lost. Assessment of finance must identify whether or not a donee or deputy for the relevant patient is in place, and whether the scope of the powers includes financial matters.

## **Accommodation**

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- 4.38 The relationship between accommodation and mental health is complex. Poor housing or homelessness can contribute to mental ill health, or make an episode of mental ill health more difficult to manage. Mental ill health can make it more difficult for people to find and maintain good-quality accommodation. The assessment process will need to identify whether the patient's current accommodation has an impact upon their mental health, and agree any related outcomes which ought to be achieved and recorded on the patient's care and treatment plan.
- 4.39 An assessment needs to consider whether the patient's accommodation is warm, weatherproof, equipped with modern facilities and in a good state of repair, and is safe and secure. The security of a patient's home in their absence is of particular relevance when admission to hospital is being considered. The immediate environment of the accommodation should also be taken into account, including whether there is access to clean, safe, green spaces, access to public services and opportunities for social contact.
- 4.40 Taking into account other needs of the individual patient, agreeing outcomes may relate to the suitability of the accommodation in relation to any physical requirements, including mobility or poor sight, and whether assistance is needed with this. Additionally the assessment should consider any history of rental arrears as this can be an indicator of help required with 'money management' and can adversely affect future accommodation needs. Accruing rent arrears or other debt can also be an indication of relapse of a mental illness. The accruing of rent arrears and the risk of eviction could therefore be seen as a potential relapse indicator.
- 4.41 For patients in hospital, accommodation should be viewed on two levels – firstly their accommodation needs in hospital regarding the suitability of the ward environment, together with a consideration of their accommodation needs when they will be discharged from hospital. In relation to children and young people, section 131A of the 1983 Act places a duty on hospital managers to ensure that a child or young person that is need of admission to hospital for treatment of their mental health is accommodated suitably for their age, subject to their needs.
- 4.42 Addressing needs and setting outcomes about the availability of appropriate accommodation upon discharge is a critical part of discharge planning. This should be undertaken as early as possible during an admission to hospital.
- 4.43 In more general terms agreeing the outcomes for a child or young person will need to establish the safety and suitability of the current accommodation; if the

parents of the child are separated consideration should be given as to whether there is a residency order, and if so, the requirements of that order.

## **Personal care and physical wellbeing**

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- 4.44 Consideration of a patient's personal care needs and physical wellbeing ought to be identified regardless of their age, with any outcomes which ought to be achieved recorded on the patient's care and treatment plan. Such consideration will include the patient's ability to address their own personal care and wellbeing (such as hygiene or domestic aspects). In doing this consideration should be given to whether the patient has a GP and other relevant health professionals such as a dentist or optometrist and if so is maintaining appropriate contact with them.
- 4.45 There should be consideration of the impact of other physical and well being issues such as disability, mobility, pain management, together with lifestyle choices on the patient's mental health
- 4.46 Following assessment outcomes may be agreed regarding physical health screening or support to access health promotion or screening for long-term health conditions. Physical health assessments may be undertaken by the patient's GP or by an appropriately qualified member of the secondary mental health service.

## **Education and training**

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- 4.47 Education and training for patient's of all ages, not just those in or aspiring to full or part-time education, and agreeing any related outcomes which ought to be achieved and recorded on the patient's care and treatment plan is important. Education and training may be particularly relevant to the patient's recovery journey and personal goals, whether or not it results in a formal qualification. For some participation in education or training may provide necessary life skills or social skills.
- 4.48 Agreeing outcomes for the care and treatment plan may involve recognising that the patient's is receiving education and training and requires support to continue with this whether in specialist services or within mainstream learning environments.
- 4.49 Access to education and training for children and young people should not be denied because they are receiving care and treatment. It is important that the educational needs of a child or young person are considered and suitable arrangements for these to be met are identified when agreeing outcomes.
- 4.50 It is important that the learning needs of older people are not overlooked. Developing new skills or pursuing activities which build upon existing skills is important. This is particularly the case where patients need to adjust to life

events in later life such as retirement or bereavement. Pursuing interests including education, training and hobbies can be enormously beneficial in promoting self esteem, confidence and social connectedness all crucially important to good mental health.

- 4.51 Outcomes may relate to the education and training that a patient's requires or may benefit from in managing their own mental health or developing coping and prevention skills.

## **Work and occupation**

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- 4.52 Work is generally good for our physical and mental health. Therefore needs and wishes in relation to full or part-time employment should be carefully considered when agreeing outcomes for a patient's care and treatment plan. This may well include work-related activities such as volunteering.
- 4.53 For a patient who is not working but wishes to undertake employment, exploring outcomes around the support that may be required in identifying new job opportunities, vocational skills, contacting employment agencies, or accessing specialist mental health employment services can be beneficial. The prospect of paid employment for those who have been out of the job market for some time can be stressful and may for some people negatively impact on their mental health. Care coordinators and other members of the mental health team may need to review the additional support a patient may require in overcoming this potential barrier.
- 4.54 For children and young people who may be approaching or have attained working age, consideration should be given to goals for employment and occupation and the steps for supporting the achievement of such goals.
- 4.55 For patients who have retired from paid employment and who do not wish to seek fresh employment, consideration should be given to other meaningful activity and occupation, for example volunteering.
- 4.56 In all cases, outcomes which ought to be achieved need to be agreed and recorded on the patient's care and treatment plan.

## **Parenting or caring relationships**

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- 4.57 Agreeing any outcomes relating to a patient's parenting or caring relationships or responsibilities is important. Determining what, if any, support is required to maintain any such parenting or caring relationships should inform outcomes and consideration should be given to the effect that these relationships may have on the patient's health.
- 4.58 It is important that any risks (including neglect or acts of omission) towards children or vulnerable persons are identified and acted upon appropriately.

- 4.59 If there is a parental or caring relationship which the individual is maintaining and managing well this can be acknowledged positively along with the fact that support may not be required at this time.
- 4.60 Where the assessment identifies that the patient has a carer, the care coordinator should take steps to ensure that the carer is directed to sources of information and support – including, where appropriate, a carer's needs assessment – in line with the service provider's Carer's Strategy<sup>9</sup> and a separate carer's assessment is undertaken if appropriate.
- 4.61 A child or young person may also have parenting or caring responsibilities and it is imperative that in agreeing outcomes any such responsibilities are identified. The care and treatment plan should recognise this role and outcomes may relate to the ability that the patient has to care for other and the effects on the patient's mental health of such responsibilities or failure to meet these responsibilities adequately.

## **Social, cultural and spiritual**

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- 4.62 A patient's needs in relation to enjoying a full social life, good personal relationships with family and friends, and full engagement with community and leisure facilities are the same as any other person in the community.
- 4.63 Agreeing social, cultural; and spiritual outcomes should consider the social wellbeing of the patient, including leisure activities and aspects of social inclusion or exclusion, together with the impact that this has on the patient's mental health.
- 4.64 The process for agreeing outcomes needs to recognise and give full regard to the cultural identity of the patient; this may include recognition of the patient's own perception of their cultural status and background. Services should seek to ensure that there is provision to meet the cultural needs of the patient as appropriate.
- 4.65 Spirituality can play an important role in helping people live with or recover from mental health problems. Spirituality is often seen as a broader concept than simply religion. Outcomes can relate to those aspects of life which give a patient meaning, hope, value and purpose and can help to inform the care and treatment planning process overall.

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<sup>9</sup> The Carer's Strategy Wales Measure 2010 requires Local Authorities and Local Health Boards to put in place Carer's Strategies which ensure that carers are identified and referred on to appropriate sources of support. Guidance on developing these strategies will be published by the Welsh Government in 2012.

## **Medical and other forms of treatment, including psychological interventions**

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- 4.66 Identifying whether the patient has previously received treatment or interventions for their mental health, and whether this was successful can be a necessary step in agreeing outcomes for the care and treatment plan.
- 4.67 The agreement of outcomes will also need to involve consideration of which treatment or interventions may be required now, how these will be accessed, and the agency or organisation that will provide the service. The process will also need to ensure that any information regarding treatment options is provided and discussed.
- 4.68 For many patients treatment for mental disorder will include medication. The care coordinator should ensure that the assessment identifies potential actual side effects and contra-indications of prescribed medication. Additionally the care coordinator should liaise with the patient to monitor medication effectiveness, satisfaction and seek on-going consent with the treatment programme.

## **What should happen if a person is becoming more unwell**

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- 4.69 The regulations made under Part 2 of the Measure set out a standard format for care and treatment plans which includes sections to record the thoughts feelings or behaviours that may indicate when a patient is becoming more unwell and may require extra help or support and also the actions that ought to be taken should this happen.
- 4.70 The purpose of recording these is to try and prevent circumstances escalating into a crisis by detailing the arrangements or strategies that may have worked well in the past for the patient.
- 4.71 The actions that ought to be taken may include identifying who the patient is most responsive to, and expressing wishes about care or treatment in certain circumstances including details of the relevant people or services to contact.
- 4.72 The contact details of services including telephone numbers and the times when the services are available should be included.

## **Timeliness of care and treatment plans**

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- 4.73 In the first instance, the duty of the care coordinator to prepare and put into writing a care and treatment plan arises when they are appointed. Care and treatment plans should therefore be provided as soon as is reasonably practicable after the individual has become a relevant patient and the care

coordinator has been appointed. Care coordinators will need to balance the importance of settling the plan so that outcomes and services are agreed and services can begin to be provided, with ensuring that the plan is comprehensive, and that due consultation in its preparation has taken place.

- 4.74 Whenever a care and treatment plan has been revised, the new (i.e. revised) care and treatment plan should be copied to the patient, and relevant others (in accordance with the Part 2 Regulations, as soon as practicable after completion.
- 4.75 To ensure that these statutory duties are met in a timely manner, LHBs and Local Authorities should set standards for completion and provision of care and treatment plans, and should audit performance against these to assure themselves that timely and accurate information is provided to relevant patients, and to those involved in the provision of the patient's care and treatment.

## **Copies of the care and treatment plan**

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- 4.76 So that the relevant patient, and those involved in the patient's care and treatment, are aware of the outcomes which the provision of mental health services are designed to achieve, and of the plan for the achieving those outcomes, it is essential that the care and treatment plan is made available.
- 4.77 For this reason the Regulations made in relation to Part 2 of the Measure require that the care coordinator takes all practicable steps to ensure that where the following persons may be identified in relation to a relevant patient, they are provided with a copy of the care and treatment plan –
- a) the relevant patient, unless they do not wish to receive a copy or the provision of a copy (or part of it) is likely to cause serious harm to the physical or mental health or condition of the patient;
  - b) all persons with parental responsibility for the relevant patient, unless they do not wish to receive a copy;
  - c) all carers of the relevant patient (including adult placement carers), unless they do not wish to receive a copy;
  - d) the relevant patient's general practitioner;
  - e) the mental health service provider(s) and voluntary organisations who provide mental health services to the relevant patient;
  - f) the relevant patient's responsible clinician;
  - g) the patient's guardian and responsible local social services authority (within the meaning of the Mental Health Act 1983);
  - h) a donee or deputy the relevant patient, where the matters included in the plan fall within the scope of their decision making powers;
  - i) an independent mental capacity advocate who has been appointed for the relevant patient;
  - j) the managing authority and supervisory body where the relevant patient is subject to urgent or standard authorisations under the Deprivation of

Liberty Safeguards of the Mental Capacity Act 2005, together with and 'relevant persons representative', under those provisions.

- 4.78 A full explanation of all of these terms (and persons listed) is given in the glossary of terms at Appendix A.
- 4.79 The care coordinator may also provide a copy of the plan to any other person, in order to facilitate the achievement of the outcomes which the provision of services are designed to achieve.
- 4.80 Before providing copies of the plan to any of these persons the care coordinator must take account of the views of the relevant patient about whether or not copies should be provided. The relevant patient should be given support and information to help them understand value and purpose of sharing information in this way. The care coordinator may provide copies of plans against the wishes of a patient provided they have given due consideration to the wishes of the patient. Good practice would suggest that such decisions and evidence of due consideration being given are clearly recorded.
- 4.81 The care coordinator may also provide copies of the plan to any other person who the relevant patient wishes to receive a copy.
- 4.82 Copies of care and treatment plans should be provided to the persons mentioned in paragraph 4.77 above as soon as practicable after it is made. In cases where it is not possible for the patient to be given a copy of their care and treatment plan immediately after a planning or review meeting with their care coordinator, the patient should still be provided with a explanation of what services are being provided and the arrangements for provision, together with an understanding of what needs are not being met and why.
- 4.83 The Part 2 regulations provide specific instructions about the delivery of copies of care and treatment plans to the persons identified in 4.77 above. In order to meet the requirements for providing copies, a care plan is considered to be provided when it has been:-
- a) delivered to a person by hand or to their last known address;
  - b) sent by prepaid post to their last known address;
  - c) sent by facsimile to a number specified by a person, or;
  - d) delivered or sent by any other means agreed between the person for whom it is intended and the care co-ordinator.



## **CHAPTER 5 – COORDINATION OF THE PROVISION OF SERVICES**

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- 5.1 This chapter gives guidance to mental health service providers and care coordinators on how they should undertake their duties to coordinate and provide mental health services under Part 2 of the Measure.

### **Duty to provide services**

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- 5.2 Section 18(10) of the Measure requires that, so far as it is reasonably practicable to do so, a mental health service provider must ensure that mental health services for a relevant patient are provided in accordance with the patient's current care and treatment plan. However, the care coordinator does not have responsibility for ensuring that the services on a patient's care and treatment plan are provided.
- 5.3 The care coordinator should have oversight of the delivery of the care and treatment plan. This is achieved by monitoring the delivery of the care and treatment plan and the achievement of the recorded outcomes through the delivery of appropriate mental health services.
- 5.4 Where it is not possible to provide mental health services in accordance with the care and treatment plan, the care coordinator should inform the relevant mental health service provider. The service provider must have regard to any advice given by the care coordinator and together - where appropriate - with other relevant agencies should take the necessary steps to ensure where practicable that the services specified in the care and treatment plan are provided. If after following such steps it is still not reasonably practicable to provide such mental health services, the care and treatment plan ought to be reviewed in order to seek alternative means of delivering the desired outcomes through a revised care and treatment plan.

### **Coordination of the provision of services**

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- 5.5 Section 17 of the Measure places mental health service providers under a duty to take all reasonable steps to ensure that the mental health services that it is required to provide are delivered in a coordinated manner. The provider is also under a duty to coordinate its mental health services with those provided by other mental health service providers or not-for-profit third sector providers.
- 5.6 The mental health services which must be coordinated (if relevant for the patient) include:
- a) secondary mental health services which include certain community care services, services provided under section 117 of the Mental Health Act

1983, and certain services provided to a child under Part III of the Children Act 1989;

- b) local primary mental health support services provided under Part 1 of the Measure; and
- c) things done in the exercise of a local authority's powers in relation to guardianship under the Mental Health Act 1983.

- 5.7 The care coordinator may (at any time) give advice to the service provider(s) on how the duty to coordinate services can be achieved. Such advice could include identifying the most effective means of delivering the various components contained within the care and treatment plan.
- 5.8 Mental health service providers should aim to meet the needs of services users and provide them, where practicable, with choice. Care coordinators are expected to ensure that care plans are holistic and draw on a breadth of service provision, not just those services that their service provides locally. Where appropriate, such services may be drawn from a broad base of specialist mental health and mainstream services.
- 5.9 Where aspects of the care and treatment plan are being delivered by carers, mental health professionals should ensure that, where possible, they work in partnership with those carers to ensure that outcomes are being worked towards and, where possible, achieved.
- 5.10 Collaborative care is particularly important in cases of complex need. Co-occurring mental health and substance misuse problems are frequently cited as a particularly common and challenging cause of complexity. In such cases the service framework to meet the needs of people with a co-occurring substance misuse and mental health problem should be followed to facilitate the delivery of effective care for the purposes envisaged by Part 2 of the Measure.
- 5.11 Specific arrangements will also need to be in place to support and manage patients with mental health needs complicated by a physical health problem, sensory impairment or a physical or learning disability.
- 5.13 Patients may need to access different levels of mental health services at various stages in their care and treatment. For example, receiving support from Crisis Resolution Home Treatment type services, or medical outpatient services, or fast stream inpatient rehabilitation services. In addition patients may move from one area to another whilst still requiring secondary mental health services. Ensuring continuity in support and care for patients that may be moving between areas or receiving support from different agencies is important and can be enhanced through the co-ordination of care as required by section 17 of the Measure.
- 5.14 In order to achieve an effective transfer of care and thus ensure that services continue to be coordinated in accordance with section 17 of the Measure, careful assessment by competent clinicians should be conducted and used as the basis for planning decisions. They should also be used to establish arrangements for effective case management.

- 5.15 It is expected that any such changes would usually require a review and possible revision to the care and treatment plan.
- 5.16 Mental health service providers should have robust procedures in place to support the timely and effective transfer of care between services. Whilst the care and treatment plan may need to be reviewed and revised it is not acceptable for care to be adversely affected because of administrative or organisational barriers. Every effort should be made to avoid any negative impact on the care and treatment provided to the individual during any transfer of care from organisation or agency to another.
- 5.17 A transfer of a patient's care will not necessarily mean a change of care coordinator for the patient, but where it does, the guidance on changing care coordinators provided in Chapter 3 should be followed.
- 5.18 The care coordinator should ensure that, where possible, the implications on care and treatment arising from a transfer between services are clearly understood by the patient, their carer(s) and family.
- 5.19 It is crucial that, where possible, the patient is involved in making decisions about the need for, and the process of, transferring between services including the need to transfer information between services.

## **Coordination for Discharge from hospital**

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- 5.20 It is important that when a patient no longer requires inpatient care but still requires secondary mental health services that the coordination of those services is considered. It is good practice that discharge from hospital be planned as early as possible in the inpatient episode and consideration should be given to the need to revise the care and treatment plan as part of the process of achieving outcomes for living as independently as possible outside of the inpatient setting. It is particularly important that services which take time to secure, such as accommodation, are planned as early as is possible in the planning of discharge.
- 5.21 It is good practice that where possible, any patient discharged from hospital, but who will continue to receive secondary mental health services, is seen within five working days of discharge by a mental health professional<sup>10</sup>. This does not need to be the care coordinator.
- 5.22 Where an inpatient has discharged them self from hospital against medical advice, effort should be made to contact that patient in the community as expeditiously as possible.

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<sup>10</sup> Safety First - Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. 2001

## **Prison release**

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- 5.12 Clearly defined working arrangements should be in place to support and manage patients who have a history of offending. This is particularly important at the point of entry into, and release from, secure environments including mental health secure units, custody or prison.
- 5.23 As with hospital discharge, prison release needs to be carefully planned and coordinated. The mental health prison in-reach service should ensure that local services are notified in advance of release and at the point of release. This will ensure that where secondary mental health services are required these are available upon release from prison and that the services planned are recorded within the care and treatment plan.

## CHAPTER 6 – MONITORING AND REVIEW

- 6.1 Part 2 of the Measure, and the associated Regulations, places duties on care coordinators to review, and revise, care and treatment plans which have been developed to meet the needs of patients. The Part 2 Regulations set out when and how frequently a plan must be reviewed, and if necessary revised, as well as who may request a review.
- 6.2 This chapter provides guidance on these requirements and how they may be met.

### **The importance of monitoring and review**

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- 6.3 The degree of need and risk evident in a patient's life, and therefore the outcomes which the provision of mental health services are designed to achieve for that patient, will change over time depending upon their circumstances, including their current mental health. Monitoring and responding to such changes is fundamental to the delivery of effective care and treatment, and is also needed to ensure that reviews take place when required. In order to ensure that care and treatment provision remains optimal to the patient's recovery, regular monitoring of the plan and the delivery of services is required.
- 6.4 The process of monitoring the implementation of the care and treatment plan should therefore include –
  - a) ongoing assessment of the patient's mental health along with the nature and degree of need and risk they are currently presenting;
  - b) ensuring the delivery of the care and treatment specified in the plan; and
  - c) that the outcomes specified within the care and treatment plan continue to meet the patient's needs and minimise any risks posed.
- 6.5 The continued appropriateness of a care and treatment plan is likely to be affected by changes of circumstance in the patient's life. Changes of circumstance not only include issues such as securing employment, moving house, establishing a relationship, the loss of a carer but also issues such as poor compliance with the care and treatment plan, relapse indicators becoming apparent, improvements of mental health and social functioning, an increase in the level of risk or the potential for an identified risk to be realised.
- 6.6 The review should consider any monitoring information which has been gathered since the care and treatment plan was first established, or since its revision at a previous review. Where amendment is required consideration should be given to all aspects of care and treatment and not simply a revision of those components that were included in the initial plan. Any member of the care and treatment planning team can request a formal review.

- 6.7 Where such changes require only minor amendment of the care and treatment plan, the care coordinator may use their discretion to revise the plan in consultation with the patient, without a formal review. Where amendments are more significant, the change of circumstances should trigger a formal review through which the care and treatment plan should be amended.
- 6.8 The degree of impact on the care and treatment plan by a proposed amendment is a judgement to be made by the care coordinator, however, attention must be paid to the individual patient affected by the care plan. A seemingly minor change to a care plan may give rise to major implications for the patient. Each change to a care and treatment plan must be viewed on a patient by patient basis. Consequently, the care coordinator must be satisfied on the degree of impact of care and treatment plan changes. Where minimal impacts are perceived a full review may not be required. Minor amendments do not require a re-distribution of the care and treatment plan, but it is good practice to send a revised copy of the plan to those affected by the amendment. Further good practice would be indicated by sharing minor changes with the team at a full review.
- 6.9 In addition to ongoing monitoring, the more formal review process which is required under the Regulations is crucially important. It provides an opportunity to consider the effectiveness of the care and treatment plan in meeting goals, assessing whether outcomes set have been met, whether the care and treatment plan should be amended, whether or not the patient requires continued care and treatment within secondary mental health services and if not whether the person should be discharged for management within primary care.

## **Triggers to prompt review**

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- 6.10 The care coordinator may review the care and treatment plan for a patient at any time.
- 6.11 The Part 2 Regulations require a review to be held, as a minimum, at least once in any twelve month period. However, reviews should be needs-led, and should be held as frequently as required. For example, when the care coordinator becomes aware of any significant changes to the patient's health or social needs or identified risks.
- 6.12 A review must be held if requested by the mental health service provider.
- 6.13 A review must be held if requested by the patient or a carer (including an adult placement carer), unless the care coordinator considers that the request is frivolous or vexatious, or there has been no change in circumstances which merit the holding of a review since the last review. Guidance on 'frivolous or vexatious' is given in Chapter 8 below.

- 6.14 Reviews should be held as soon as reasonably practicable after any request is made.
- 6.15 A formal and clear record should be made of each review, including any changes to the care and treatment plan, together with any updates to assessments (including risk assessment). It is advised that, where practicable an agreed and reviewed care and treatment plan is produced within 10 working days of the review for signing by the patient (where they wish to sign their plan)
- 6.16 A review may be undertaken in a meeting involving a number of members of the care team and other interested persons. Equally such a review may only include the patient and care co-ordinator if the care coordinator considers that there is no requirement to involve other health and social care professionals involved. It is advised that where possible, the patient must be informed prior to the meeting that a review is taking place. This information sharing ought to be recorded within the notes of the care and treatment plan.

## **CHAPTER 7 – DISCHARGE FROM SECONDARY MENTAL HEALTH SERVICES**

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- 7.1 This Chapter gives guidance on the duties which are set out in the Measure and the Part 2 Regulations which may relate to discharge from secondary mental health services, and providing certain information to individuals upon their discharge from services.

### **Meaning of discharge**

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- 7.2 Discharge from secondary mental health services can be considered as an important potential outcome for patients within secondary mental health services as part of the recovery process, and in order to maximise the opportunities for good mental health and achieving a better quality of life for the individual. It is important however to understand the implications of being discharged for both the individual and mental health service providers.
- 7.3 The phrase ‘discharge from secondary mental health services’ is used to describe a situation where, for whatever reason, the individual is no longer in receipt of any secondary mental health services provided by an LHB, a Local Authority, or (exceptionally) the Welsh Ministers. The individual may well continue to be in receipt of other services provided by these bodies, for example community care services from a local authority, or mental health support from their GP.
- 7.4 Discharge from secondary mental services can be considered to be a significant achievement and outcome for the individual. However there must also be recognition that some people may find the transition from high levels of support to reduced levels, or even no further support, difficult.
- 7.5 Discharge from services should be based, where possible, on agreement that the planned outcomes have been achieved.
- 7.6 Ongoing monitoring and review of the patient’s care and treatment plan should continue until it is determined when considering outcomes to be achieved that the patient no longer requires the services provided by secondary mental health services. It is normally the case that this will take place during the formal review of the care and treatment plan where the views of all relevant members of the care plan team should form a part of this decision making process alongside those of carers, immediate family members and other significant supporters in the patient’s life.
- 7.7 For the relevant mental health service providers this means that the duties placed on them under Part 2 of the Measure for appointment of care coordinators and for care and treatment planning will cease. However the responsibilities under Part 3 of the Measure relating to assessment will come into play should a request for a reassessment for secondary care services be



made directly to such providers in their role as local mental health partners under Part 3 of the Measure.

- 7.8 The care and treatment team should not necessarily regard discharge as an end point in meeting a patient's mental health needs. Discharge from secondary mental health services may be a staging post in a longer course of recovery.

## **Provision of information on discharge**

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### **The duty to provide information**

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- 7.9 The Regulations made under Part 2 of the Measure place duties on Local Health Boards and Local Authorities to provide individuals who are being discharged from secondary mental health services with certain information.
- 7.10 When an individual is discharged from secondary mental health services the duty to provide information falls upon the LHB or local authority undertaking the discharge. However, this duty only arises where the individual is being fully discharged from all secondary mental health services. If, for example, the LHB discharges an individual from the secondary mental health services which it provides, but the individual remains in receipt of a secondary mental health service provided by the Local Authority, the duty will fall upon the Local Authority to provide the required information at such time as a full discharge from those secondary mental health services finally takes place.
- 7.11 Where a decision is made to discharge a patient from secondary mental health services provided by a Local Health Board and also from secondary mental health services provided by a local authority on the same day and it cannot be ascertained which partner made the final discharge, local policies may be developed between the partners for an area that set out which partner is to be viewed as making the later discharge for the purposes of provision of information to that patient on discharge.

### **Information to be provided**

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- 7.12 When an individual is discharged from secondary mental health services the LHB or local authority is under a duty to provide certain written information to the patient, namely –
- a) the reason for the individual's discharge from secondary mental health services; and
  - b) the action which may be taken, and by whom, if the individual considers that further support and advice in relation to his or her mental health is required following discharge.

- 7.13 To enable this to take place appropriate planning with the patient, their family/carers and any on-going support agency is likely to be necessary. A lack of comprehensive transition arrangements around discharge is known to elevate the risks of on-going support breaking down. It is likely that in doing this the care coordinator, acting on behalf of the local authority or Local Health Board, may lessen the potential risks associated with a break in the continuity and consistency of care and support following discharge.
- 7.14 When an adult is discharged from secondary mental health services, in addition to the information above, they must also be informed in writing about their entitlement to assessment under Part 3 of the Measure (see Chapter 8 of this Code).
- 7.15 When a child or young person (i.e. an individual below the age of 18) is discharged from secondary mental health services, but will become an adult (i.e. attain the age of 18) within three years of the date of their discharge, then they must also be informed in writing about their entitlement to assessment under Part 3 of the Measure when they reach the age of 18. In providing this information, a child should also be informed of the duration of their entitlement (i.e. the period of time between their 18<sup>th</sup> birthday and the end of the relevant discharge period).
- 7.16 In addition to the information required by the Measure and Regulations, the mental health service provider may also choose to give additional information to an individual (of any age) on discharge. In practice this may well be carried out by the care co-ordinator. This could include, for example, information on
- a) medication and side effects;
  - b) who to speak to for advice on benefits and entitlements;
  - c) other services available to provide ongoing support, such as voluntary support groups, drop in centres, self help groups;
  - d) where to access housing advice;
  - e) the availability and access to health and leisure activities, such as gymnasias and swimming pools.
- 7.17 The information which is provided should be in a language and format which is appropriate and easily understood by the individual. The information may be provided to the individual's carer, parent, partner or similar if it is believed that this would be appropriate and the individual is in agreement.
- 7.18 In practice, this information may be provided by the patient's care coordinator, although the responsibility for the provision of such information rests with the mental health service provider.

## **CHAPTER 8 – ASSESSMENTS OF FORMER USERS OF SECONDARY MENTAL HEALTH SERVICES**

**Please Note that if Regulations relating to Regional Provision are made which alter the constitution of local Mental Health partners then references to Local Mental Health Partners, local authority and Local Health Board in this chapter will be amended accordingly.**

- 8.1 Part 3 of the Mental Health (Wales) Measure 2010 is concerned with assessments of former users of secondary mental health services. The aim of Part 3 is to enable individuals who have previously been in receipt of secondary mental health services to refer themselves back to secondary services for assessment directly. This allows assessments to take place without individuals necessarily needing to first go to their general practitioner or elsewhere for a referral therefore improving access.
- 8.2 This chapter provides guidance on how the arrangements under Part 3 of the Measure should be managed and delivered.

### **Purpose of Assessment under Part 3 of the Measure**

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- 8.3 Whilst Part 2 of the Measure deals with care and treatment planning and care coordination for individuals in secondary mental health services, Part 3 of the Measure provides eligible individuals who have received secondary mental health services at some point in the past, but who have been discharged from those services, with an entitlement to seek reassessment again should they feel that their mental health is deteriorating.
- 8.4 An assessment under Part 3 of the Measure is an analysis of a person's mental health to identify the secondary mental health services (if any) which might improve or prevent a deterioration in the mental health of the person being assessed. The assessment must also identify whether there are any community care services (other than those which would be considered secondary mental health services), or housing or well-being services which might improve or prevent a deterioration of the person's mental health.

### **Arrangements for the assessment of former users of secondary mental health services**

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- 8.5 Section 19 of the Measure requires "local mental health partners" to take all reasonable steps to agree arrangements for responding to requests for

assessments from former users of secondary mental health services and the making of referrals following such assessments.

8.6 These arrangements must be recorded in writing. Once initial arrangements have been agreed and put into writing, they can subsequently be altered provided that the partners agree and record the alterations in writing.

8.7 The agreed arrangements may allow for:

- a) one of the partners to provide all the assessments and make all the referrals that flow from the assessments; or
- b) that different aspects of an assessment, and different referrals following assessment, may be undertaken by different partners.

This allows a level of flexibility which enables partners to make arrangements which maximise joint working, and reflect the joined-up delivery of secondary mental health services.

8.8 It is important that the arrangements which are made ensure that the processes for former users of secondary mental health services to request an assessment are simple and accessible, and do not place disproportionate burdens on the individual seeking help and support from the service.

8.9 The arrangements should also ensure that assessments are provided in a timely manner, which should be consistent with response times for requests for assessments from GPs or other referrers. Local mental health partners may include standards for response times for assessment within their written arrangements. Where such response times are included it is expected that these should, at a minimum, match the usual standards for community mental health teams – namely that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request.

8.10 Inclusion of ‘usual response times’ in written arrangements ought to enable practitioners undertaking assessments under the arrangements to use their clinical judgement to prioritise assessments to perceived clinical need or risk, and respond to requests in a way which ensures that individuals receive a timely and safe response to their request for assessment.

8.11 Arrangements should also consider the responsibilities that mental health service providers are required to provide a written report following assessment. Such reports must set out whether any services have been identified that may improve or prevent a deterioration in the person’s mental health and should include information regarding the date of the assessment and who undertook the assessment on behalf of the mental health partners.

## **Failure to agree arrangements**

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- 8.12 In exceptional circumstances, it may be the case that local mental health partners are unable to reach agreement on the arrangements for undertaking assessments and making referrals as outlined above. Where this is the case the Local Health Board are required to inform the Welsh Ministers that agreement cannot be reached. Such notifications should be sent in the first instance to:

Head of Mental Health & Vulnerable Groups Division  
Welsh Government  
Cathays Park  
Cardiff CF10 3NQ

- 8.13 Upon notification, the Welsh Ministers may determine the arrangements for the local authority area, and where they do so, the Welsh Ministers will record these arrangements in writing. Where arrangements have been made in these circumstances, the local mental health partners can subsequently amend the arrangements (provided the partners are in agreement, and the alterations are recorded in writing).
- 8.14 During any period when agreed arrangements are not in place, it is the responsibility of the Local Health Board to carry out any assessments, and to make any necessary referrals. The Local Health Board should ensure that former patients of secondary mental health services requesting assessment are able to access such assessments without any impediment, and that requests are responded to in a timely manner in accordance with the standards for responding to referrals for secondary mental health services from GPs and others.

## **Duty to carry out an assessment**

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- 8.15 The local mental health partners for a local authority area are under a duty to take all reasonable steps to agree arrangements for carrying out assessments under Part 3 of the Measure and making any referrals required as a consequence of those assessments in accordance with arrangements agreed between the partners.
- 8.16 Where agreement to arrangements has not been reached the duty to provide assessments lies with the LHB, until such time the Welsh Ministers make arrangements for that local authority area.

## **Entitlement to assessment**

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- 8.17 A former user of secondary mental health services is able to seek a further assessment of their mental health, with a view to determining whether secondary mental health services or community care and housing or well-being

services, may be required to improve or prevent a deterioration of their mental health. This entitlement arises if, at the time of making the request the person:

- is aged 18 years or above (i.e. an adult);
- is usually resident in the area where they are making the request; and
- has, at any time in the three years prior to making the request, been discharged from secondary mental health services or guardianship (within the meaning of the Mental Health Act 1983)

and the local mental health partners to whom the request is made do not consider the request to be frivolous or vexatious (see below).

- 8.18 The entitlement to make a request lies only with the person who was previously a relevant patient. No other person can make the request on behalf of the person, e.g. a carer, unless they are a donee or deputy under the Mental Capacity Act 2005.
- 8.19 If an individual has made a previous request for assessment, and an assessment was undertaken which concluded that no secondary mental health or community care services etc. were required, or the request was ruled to be frivolous or vexatious, this does not affect the individual's ability to request a further assessment within the three year qualifying period – indeed, the number of requests which an individual may make is unlimited, as long as at the time of making each request, the individual continues to meet the eligibility requirements.
- 8.20 A new period of entitlement to assessment will begin each time an individual is discharged from secondary services
- 8.21 Patients who are below the age of 18 at the time of their discharge from secondary mental health services, but will attain the age of 18 within 3 years of their discharge, will qualify for assessment under Part 3 of the Measure from the point at which they reach their 18<sup>th</sup> birthday. They will remain eligible until the remainder of the 3 year period has expired.
- 8.22 Further, the secondary mental health services which the individual received need not have been provided by, or on behalf of the LHB or local authority to whom the request for assessment is made.
- 8.23 Guidance on what is meant by 'discharge' from secondary mental health services is given in Chapter 7.

### **'Usually resident'**

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- 8.24 For the purposes of responding to requests for assessment under Part 3 of the Measure, an individual is considered to be usually resident in the local authority area where they currently live.
- 8.25 There may be occasions when it is unclear where the individual is usually resident, and in such circumstances a decision as to usual residence will be

made in accordance with Regulation 5 of the *Mental Health (Assessment of Former Users of Secondary Mental Health Services) (Wales) Regulations 2011*.

- 8.26 The regulations set out that where there is any question or uncertainty regarding an individual's current address, or where the individual who has requested an assessment does not have a current address, then it is the responsibility of the local authority to whom the individual has made the request to establish where that individual is usually resident. It is also incumbent upon that local authority to make arrangements for that assessment to take place whilst the usual residence of the individual is being determined. Requests for assessments should not be delayed unnecessarily because an individual's place of usual place of residence has not yet been established, or is disputed.
- 8.27 Where an individual has received secondary mental health services in the past, but is now detained in a state run prison in Wales, they will be considered as usually resident in the local authority area where the prison is located<sup>11</sup> An adult in a state run prison in Wales is therefore eligible to seek an assessment under Part 3 of the Measure. Local mental health partners for the local authority areas of Swansea, Cardiff and Monmouthshire, should ensure that their agreed arrangements accommodate requests from prisoners. For Parc, the privately run prison, good practice would suggest that the local mental health partners for the Bridgend local authority area, in which Parc is located, be responsible for providing assessments under Part 3 of the Measure. (The Welsh Government's draft Responsible Body Guidance<sup>12</sup> acknowledges that, with the exception of primary care, the NHS in Wales is responsible for the health and well-being of adults who are detained in Parc).
- 8.28 Further, where an individual who has received secondary mental health services whilst in prison in Wales is subsequently released and takes up or returns to usual residence in Wales, they will also be eligible to seek an assessment from secondary mental health services in the local authority area in which they are usually resident at the time they make that request.
- 8.29 Where an individual received secondary mental health services in a prison outside of Wales, their eligibility for further assessment will depend on whether those services are recognised for the purposes of Part 3 as secondary mental health services.

### **Frivolous or vexatious requests**

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- 8.30 Most individuals seeking an assessment of their mental health needs under Part 3 of the Measure will do so because their previous experience and

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<sup>11</sup> See the Directions to Cardiff Local health Board, Swansea Local Health Board and Monmouthshire Local Health Board 2006

<sup>12</sup> See the Welsh Government's draft Responsible Body Guidance  
<http://wales.gov.uk/docs/dhss/consultation/110808guidanceen.pdf>

knowledge of their own health and needs leads them to believe that they may require the help and support of secondary mental health services once more. It is recognised that there is a risk that some individuals however, may seek to exercise a right to assessment with requests that are manifestly unreasonable and which, were they to be met, would impose substantial burdens on the local mental health partners. For this reason the duties on the mental health partners to carry out assessments only arise where a request is not considered to be frivolous or vexatious. Local mental health partners can not conclude that a request is frivolous or vexatious unless there are sound grounds for such a decision, and it is expected that the individual should be notified of the grounds for any such decision.

- 8.31 The Measure does not define what is meant by ‘frivolous’ or ‘vexatious’. Frivolous requests would include those that were made without serious intention, for example mentioned in passing in a general conversation. Frivolous requests are requests that would not warrant any action at all or any action required would be disproportionate.
- 8.32 Vexatious is generally accepted to mean ‘causing annoyance or worry’, and therefore it may be reasonable to consider a request for assessment to be vexatious if it is designed to subject the LHB and/or the Local Authority to inconvenience, harassment or expense. However it would not be sufficient for a request to be treated as vexatious simply because it causes inconvenience or expense - the mental health partners should consider the effect of the request as well. Even though it may not have been the explicit intention of the applicant to cause inconvenience or expense, if a reasonable person would conclude that the main effect of the request would be disproportionate inconvenience or expense, then it will be appropriate to treat the request as being vexatious.
- 8.33 Local mental health partners should consider including within their agreed arrangements a process for identifying frivolous or vexatious requests, and identifying the delegated officers with responsibility for making such a determination.
- 8.34 At all times it must be remembered that an apparently frivolous or vexatious request may well be an indication that an individual does in fact require secondary mental health services to improve or prevent a deterioration in their mental health. Mental health service providers must carefully consider all such requests and ensure that any decision not to assess which is taken on these grounds is demonstrably fair and well-evidenced, and is recorded.

## **Actions following assessment under Part 3**

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### **Provision of a report**

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- 8.35 In all cases it is important that the assessed person is aware of the findings of their assessment, and mental health service providers are required to provide a written report following assessment which sets out whether any services have



been identified that may improve or prevent a deterioration in the person's mental health.

- 8.36 Both the assessment and the written outcome of assessment should be undertaken in a timely manner, as soon as reasonably practicable after a request is made. The Regulations made under Part 3 require that a copy of the report is provided to the person who was assessed no later than 10 working days after the conclusion of the assessment.
- 8.37 A report will be considered to have been provided when it has either been delivered by hand to the person or sent by prepaid post to the person's usual or last known address.

### **Provision of services following assessment**

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- 8.38 Where a need for secondary mental health services or other community care services have been identified as part of the assessment, which might improve or prevent deterioration in a person's mental health, and either the local authority or LHB would be responsible for providing those services, they must consider whether or not the provision of such services is called for (section 27).

### **Referrals relating to housing or well-being services**

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- 8.39 The assessment may identify that housing or well-being services are potentially required which might improve or prevent deterioration in a person's mental health. Where either the LHB or local authority would not be responsible for providing such a service, a referral to the relevant provider must be made by the assessing partner. However, as the provision of some housing and well-being services are only considered if applied for by the individual who considers they may require them, the individual should be invited to apply for such a service, and supported in doing so where appropriate.

## Appendix A – Glossary of key terms

The following terms and abbreviations have been used in this Code of Practice.

Term	Meaning
<b>The 1983 Act</b>	Mental Health Act 1983
<b>Adult placement carer</b>	adult placement carer means a person in whose home an adult is or may be accommodated and provided with personal care under an adult placement agreement entered into or proposed to be entered into by the carer;
<b>After-care</b>	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Mental Health Act 1983 following the discharge of a patient from detention or treatment under that Act
<b>Attorney</b>	Someone appointed under the Mental Capacity Act 2005 who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor?) who made the power of attorney. Also known as a 'donee of lasting power of attorney'
<b>Care coordinator</b>	The person acting on behalf of the mental health service provider who has responsibility for appointing them to act as the care coordinator. The care coordinator works with the patient and service providers to agree outcomes which the provision of services are designed to achieve, prepare a care and treatment plan for the individual, and oversee and keep under review the delivery of the services and outcomes recorded in those plans
<b>Care and treatment plan</b>	A plan prepared for the purpose of achieving the outcomes which the provision of mental health services for a relevant patient are designed to achieve
<b>Carer</b>	In relation to a relevant patient this means an individual who provides or intends to provide a substantial amount of care on a regular basis for that patient, but does not include an individual who provides (or intends to provide) that care by virtue of a contract of employment or other contract with any person, or as a volunteer for a body. In this code the term carer should also be taken to mean adult placement carer (see above).
<b>Carers Strategy</b>	The Carer's Strategy (Wales) Measure 2010 requires Local Authorities and Local Health Boards to put in place Carer's Strategies which ensure that carers are identified and referred on to appropriate sources of support. Guidance on developing these strategies will be published by the Welsh Government in 2012
<b>Child (also children)</b>	A person under the age of 18
<b>CAMHS</b>	<b>Child and adolescent mental health services</b> Specialist mental health services for children and adolescents

Term	Meaning
<b>Community care services</b>	Has the same meaning as in section 46 of the National Health Service and Community Care Act 1990, namely services which a local authority may provide or arrange to be provided under any of the following provisions— (a)Part III of the National Assistance Act 1948; (b)section 45 of the Health Services and Public Health Act 1968; (c)section 254 of, and 20 to, the National Health Service Act 2006, and section 192 of, and schedule 15 to, the National Health Service (Wales) Act 2006, and (d)section 117 of the Mental Health Act 1983;
<b>Detention/detained</b>	Unless otherwise stated, being held compulsorily in hospital under the Mental Health Act 1983 for a period of assessment or medical treatment for mental disorder. Sometimes referred to as “sectioning” or “sectioned”
<b>Deputy</b>	Someone appointed under the Mental Capacity Act 2005 by the Court of Protection with ongoing legal authority to make particular decisions on behalf of a person who lacks capacity.
<b>Donee</b>	See ‘attorney’
<b>Guardian</b>	The person named as the guardian in a guardianship application or order under the Mental Health Act 1983
<b>Guardianship</b>	The arrangements including the appointment of a guardian under the Mental Health Act 1983 to help and supervise patients in the community for their own welfare or for the protection of other people.
<b>GP</b>	A general practitioner (or ‘family doctor’)
<b>IMCA</b>	<b>Independent Mental Capacity Advocate</b> Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act 2005. It is not the same as an ordinary advocate, or an independent mental health advocate provided under the independent mental health advocacy (IMHA) service.
<b>IMHA</b>	<b>Independent Mental Health Advocate</b> An advocate independent of the team involved in the patient’s care, available to offer support to patients under arrangements which are specifically required to be made under the Mental Health Act 1983. The IMHA is not the same as an ordinary advocate or an independent mental capacity advocate (IMCA) Note: Since October 2011 the IMHA scheme in Wales differs to that in England, with more patients in Wales eligible to receive help and support from an IMHA
<b>Local authority</b>	A county council or a county borough council
<b>Local Health Board (LHB)</b>	Type of NHS body responsible for providing NHS services in a local area
<b>Local mental health partners</b>	The Local Health Board for an area which includes the local authority area, and the local authority for that area
<b>Local social services authority (LSSA)</b>	The local authority (or council) responsible for social services in a particular area of the country
<b>Managing authority</b>	The person or body with management responsibility for the hospital or care home in which a person is or may become, deprived of their liberty under the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005
<b>The Measure</b>	The Mental Health (Wales) Measure 2010, unless the context otherwise requires

Term	Meaning
<b>Mental Health (Wales) Measure 2010</b>	The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services
<b>Parental responsibility</b>	This is defined by the Children Act 1989 as being all the rights, duties, powers and responsibility which a parent of a child has in relation to the child and his or her property up to the age of 18. It includes rights and duties with regard to education, choice of religion, administration of a child's property and choice of residence.
<b>Recovery</b>	There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. Recovery is often referred to as a process, outlook, vision, conceptual framework or a set of guiding principles.
<b>Part 2 Regulations</b> <i>(also referred to as Regulations made under part 2)</i>	Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011 which are made under the Mental Health (Wales) Measure 2010 setting out detailed requirements as to how certain parts of the Measure will work in practice
<b>Part 3 Regulations</b> <i>(also referred to as Regulations made under part 3)</i>	Mental Health (Assessment of Former Users of Secondary Mental health Services) (Wales) Regulations 2011 which are made under the Mental Health (Wales) Measure 2010 setting out detailed requirements as to how certain parts of the Measure will work in practice.
<b>Relevant discharge period</b>	The period of time, following discharge from secondary mental health services, within which the former patient may request an assessment by secondary mental health services if they believe that their mental health is deteriorating to the point where such an assessment is required. This period is set in regulations made under Part 3 of the Measure at 3 years.
<b>Relevant mental health service provider</b>	The secondary mental health service provider who is identified under section 15 of the Measure, or regulation 3 of the Regulations
<b>Relevant patient</b>	Within the meaning of Part 2 of the Measure, an individual for whom a mental health service provider is responsible for providing a secondary mental health service; or one who is under guardianship of a local authority in Wales; or one for whom a mental health services provider has decided that they would provide secondary mental health services, if that individual cooperated with the provision of such services.
<b>Relevant person's representative</b>	Under the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005 this is a person who is appointed to maintain contact with a person who is being deprived of their liberty and to represent and support them in all matters relating to the safeguards.
<b>Responsible clinician</b>	Within the meaning of the Mental Health Act 1983, the approved clinician with overall responsibility for the patient's case
<b>Responsible local social services authority</b>	This is the local authority for a person who is subject to Guardianship under the Mental Health Act 1983 as set out in section 34(3) of that Act.
<b>Section 117</b>	See 'after-care'
<b>Supervised community treatment (SCT)</b>	Arrangements under which patients can be discharged from detention in hospital under the Mental Health Act 1983 but remain subject to that Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again

Term	Meaning
<b>Supervisory body</b>	The Local Health Board, Primary Care Trust or Local Authority which has issued a standard authorisation, or in the case of an urgent authorisation to whom a request for a standard authorisation has been made, within the meaning of the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005
<b>Welsh Ministers</b>	Ministers in the Welsh Government
<b>Working day</b>	Any day except a Saturday, Sunday, Christmas Day, Good Friday or bank holiday in England and Wales under the Banking and Financial Act 1971