GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

MENTAL HEALTH & LEARNING DISABILITY SERVICE GROUP

IDENTIFYING AND SUPPORTING SERVICE USERS AT RISK OF DISENGAGEMENT FROM SERVICES (INCLUDING NON-COMPLIANCE WITH TREATMENT) POLICY

Originator:	MH&LD Serious Incident Group
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1. INTRODUCTION

1.1 Users of Mental Health and Learning Disability Services may choose to discontinue contact with a proportion or all of the services provided. In the vast majority of cases this is not problematic; however, there could be occasion/s when this situation gives cause for concern.

The Swansea Bay University Health Board Mental Health & Learning Disability Service Group has a responsibility to ensure that it delivers safe and effective services and to attempt to engage service users in treatment and care.

Service users referred to Adult Community Mental Health / LD Services attend, in the main, on a voluntary basis. Exceptions to this are those that are subject to Community Treatment Orders, Treatment Orders directed by the courts and other sections of the Mental Health Act. This also includes patients who lack capacity who have been formally assessed under the Mental Capacity Act (2010).

Other such sections can include those legislated under Part 3 of the Mental Health Act, 1983 where additional restrictions and/or conditions of discharge can be directed by the Ministry of Justice. However, patients who are not subject to section under the MHA following discharge (e.g. Previously sectioned under 47/49 or 45a) could be subject to follow up by probation or PPU, who are likely to impose conditions which include engagement with mental health services.

All service users may be at risk of harm to self or others if they disengage, or are at risk of disengaging, from mental health services prior to the completion of treatment.

It is important that during the early stages of a service user entering into an episode of treatment a discussion takes place with them to both determine their individual expectations and to provide them with information as to the type and level of engagement which will be expected of them. This discussion will enable

the Health Practitioner to assess the extent to which a patient is committed to a course of treatment /therapy plan and appropriate measures/modifications to facilitate continued engagement.

Disengagement can be defined as a service user who avoids contact with services, either intentionally or unintentionally over a period of time. The period of time will be determined by the risks that the service user poses and the clinical judgement of the care team. Reasons for disengagement are varied and may include poor insight, deterioration or acuity of mental health difficulties, lack of capacity, transport difficulties, substance misuse and safeguarding concerns. For others it may simply be that they have reached a stage in their recovery where they no longer feel that they need to engage with services. However, in some cases, disengagement with services will raise significant concerns relatintg to the health, safety and wellbeing of an individual or others. In order to promote the health, safety and wellbeing of all service users and others, it is vital that disengagement from services is considered seriously and that responses from the service are commensurate and proportionate to any measured or perceived risk.

1.2 It is recognised that the nature of non-engagement with services is extremely complex and there may be a number of reasons why an individual chooses not to engage or fails to attend services. These may include:

- Lack of information relating to their referral or planned programme of care or treatment.
- Poor relationship between the service user and clinician or clinical team.
- The experience of adverse side effects to treatment.
- A lack of recognition on the part of the service user/s of the benefits that the care or treatment may offer.
- Culturally inappropriate courses of treatment or care, which do not reflect or take into account the lifestyle, beliefs and financial needs and position of the service user.
- Stigma in relation to mental health services.
- Negative symptoms related to mental health conditions.

- Adverse effects of drug and alcohol use.
- Previous experience of services

1.3 The report of the National Confidential Enquiry into Suicide and Homicide by People with a Mental Illness, "Safer Services" (1999), found that non-attendance and loss of contact with services are frequent findings in inquiries into suicide and homicide.

1.4 The report recommends that Health Boards have written policies regarding non-compliance and disengagement from services.

2. POLICY STATEMENT

2.1 This Policy sets out a pragmatic guide to assist clinicians in providing safe and appropriate care for service users at risk of disengagement from services. These procedures should apply to all those referred to or receiving services from Mental Health and Learning Disability Services in Swansea Bay University Health Board (SBUHB).

3. DEFINITIONS OF "SERVICE USERS AT RISK OF DISENGAGEMENT" AND "NON-COMPLIANT WITH TREATMENT"

3.1 The service user must already be receiving services from specialist Mental Health / Learning Disability Services and continues to meet the eligibility criteria. The reasons for monitoring and managing service users who are difficult to engage is to minimise the risk they could present to themselves and/or others.

3.2 "Difficult to Engage" – there is a history of dis-engagement from services (usually leading to hospital admission) and sufficient risk to self or others to negate the option of case closure.

3.3 "Non-compliant with Treatment" – refers to (non) receipt of proposed treatment.

4. SERVICE USERS THAT ARE RELUCTANT TO ENGAGE OR WHO HAVE DISENGAGED FROM SERVICES

4.1 Whilst every effort should be made to engage with service users when they are in need of Mental Health / Learning Disability Services, it must be recognised that any person who has capacity and whose mental illness does not warrant detention under the Mental Health Act 1983 has the right to refuse such services.

4.2 An urgent review/case review meeting should be arranged by the care coordinator to determine the reasons for disengagement and to establish whether any changes can be made to the Care & Treatment Plan (CTP) in order to re-engage the service user. However, where the situation warrants prompt intervention, an assessment under the Mental Health Act 1983 or best interest assessment should be considered.

4.3 Should these strategies prove unsuccessful, the following approaches to facilitate engagement and management of risk should be considered:

- Who is to visit/contact and how often
- Communication plan between all involved agencies and parties
- Consideration of referral to the Crisis Resolution Home Treatment Team (CRHTT)
- Consideration of referral to the Assertive Outreach Service (AOS)
- Consideration of referral to Specialist Behavioural Team (SBT) and Learning Disability Intensive Support Team (LDIST)
- Consideration of involvement of relatives and/or carers
- Consideration of involvement of police and/or other agencies
- Consideration of involvement of statutory mechanisms
- Plan review with multidisciplinary team

4.4 Where appropriate, primary care should be asked to try and engage service users, perhaps by a further assessment or by involving relatives/carers.

4.5 Service users should not be discharged back to primary care simply because they have missed a number of appointments. Consideration must be given to the degree of mental illness and the level of risk posed.

4.6 The care co-ordinator, in discussion with the Multidisciplinary Team (MDT), should consider whether the service user meets the criteria for CRHTT or however it should be noted that these services do not have emergency response criteria.

4.7 The care co-ordinator should also consider requesting either eligibility under Multi-Agency Public Protection Arrangements (MAPPA) or a Vulnerable Adult Multi-Agency Conference, whichever is the more appropriate depending on the risks identified in the CTP.

4.8 The care co-ordinator, in discussion with the MDT, may decide that the referred person presents a significant risk (e.g. of violence to others), but that this is not as a result of mental illness and so does not require follow-up within Mental Health / Learning Disability Services. This decision should be clearly documented and information should be shared with other agencies, e.g. Police, on a need-to-know basis following information sharing procedures. Consideration should be given to requesting a MAPPA conference.

4.9 If the action plan to engage the service user fails, further discussion with the MDT may conclude that the service user's needs are best met by primary care. An action plan to manage identified risks should be agreed with primary care, which will include specific indications for re-referral. If the service user does not have a GP, then straightforward arrangements should be made so he/she can self-refer back to the relevant Community Teams (CMHT/CLDT) if necessary under Part 3 Mental Health Measure (2010)

4.10 Service users with a history of significant violence when mentally unwell should not be discharged back to primary care unless there is an explicit care plan in place that has been discussed with primary care and agreed with CMHT/CLDT Managers. This should include a risk assessment (stating who may be at risk), crisis plan (including consideration of MHA and/or capacity assessment if appropriate), and specific indications for rapid re-referral.

4.11 Where the CMHT/CLDT is unable to work directly with a service user but has identified a potential for significant risk to self or others due to a mental health problem (where a Mental Health Act assessment is not indicated), the Team

should discharge the service user following the procedures set out in 4.10 above. In addition, the CMHT/CLDT should set up a crisis/relapse care plan whereby the service user can access services promptly via a named experienced care co-ordinator (under Part 3 Mental Health Measure) should they present to the Team.

5. SERVICE USERS WITH LEARNING DISABILITIES WHO ARE RELUCTANT TO ENGAGE OR WHO HAVE DISENGAGED FROM SERVICES

5.1 Where it is established that an individual with Learning Disabilities has the capacity to make decisions to engage or disengage with services then the processes described in section 4 of this documents should be utilised by the supporting CLDT.

5.2 Where an individual with learning disabilities lacks or is suspected of lacking the capacity to make the decisions to engage or disengage with services and in cases where others such as parents or carers are doing so for them, then the legal processes of mental capacity assessment and best and best interest decision making should be implemented by the CLDT and MDT professionals involved.

6. SERVICES USERS ENGAGED WITH FORENSIC COMMUNITY MENTAL HEALTH SERVICES

6.1 Average inpatient admissions within Forensic Secure Services can last for over 700 days, meaning they have likely had been able to develop effective therapeutic relationships with their MDT/Clinical Team. This includes members of the aftercare team, namely Forensic Community Mental Health Nurse and Social Work.

6.2 When it is deemed a service user no longer requires conditions of medium security, the clinical team alongside the Care Co-ordinator will identify a suitable placements following extensive risk assessments and liaison with other agencies. A comprehensive transition plan is implemented to provide a safe and achievable pathway into the community for the patient and will be developed in collaboration with the patient. It is felt that inclusion of patient's opinions,

perception of need and wishes can increase the likelihood of ongoing engagement with their aftercare team.

6.3 Those under section 37/41 can be subject to conditions of discharge such as; to abstain from illicit substances and alcohol, conditions of residency, engagement with their care and treatment along with more specific conditions dependant on the individual need. All patients under this section will be subject to social supervision which entails regular reports to the Ministry of Justice (MOJ) by the RC and Social Supervisor and is made aware of the conditions prior to discharged including the consequences should they breach and/or disengage. Such consequences can include;

- Recall to hospital should they not adhere to the specified conditions alongside an increase in the risk posed to themselves or others
- Recall due to a deterioration in their mental state to a point whereby their risk to others and/or themselves has been assessed as having increased and deemed unmanageable within a community setting,

6.4 Service Users sectioned under 47/49 or 45a whilst an inpatient will not be subject to sectioning following discharge from the hospital/unit. However, depending on the service users index offence, a likely condition will be to engage with mental health services as directed by other agencies including; MAPPA, Probation Services, WECTU and Public Protection Unit (PPU).

6.5 Where required/requested, regular updates will be provided to MAPPA / other external agencies to not only enable collaborative working with multiple agencies, but to also contribute to service user's future pathway. Whereby, management strategies can be amended to reflect the service users level of engagement with mental health community services.

7. NON-COMPLIANCE WITH TREATMENT

7.1 Generally, where a service user has not engaged in the care plan to the extent that they are considered non-compliant with treatment (see section 3 for definition), the steps outlined in Section 4 should be followed.

7.2 Where the service user has discontinued taking his/her medication, then the Responsible Clinician (RC) should consider undertaking a treatment review in order to try to agree a medication plan that is acceptable to the service user. Where such a plan cannot be agreed, then the steps outlined above (section 4) should be followed. Where the service user is not registered with a GP, then the procedure set out in 8.1 should be followed.

7.3 In relation to Forensic community service users and/or in-patient Learning Disability Services, an update should be provided to the RC who will liaise with the MOJ if risks are deemed unmanageable due to disengagement. For Forensic community based patients another option considered would be placing the patient on a civil section order to avoid lengthy inpatient admissions. For inpatient Learning Disability services best interest and mental capacity decisions will be made via MDT and RC.

8. SERVICE USERS NOT REGISTERED WITH A GP

8.1 Service users who are not registered with a GP should be encouraged to register by their care co-ordinator. If this is not possible, the care co-ordinator should assist the service user in contacting the GP practice and becoming a registered patient.

8.2 CARER CONCERNS

8.3 If a carer has expressed concern about risk to the service user and/or others, then a care co-ordination case review should be held at the earliest possible opportunity to address these concerns. If the concerns cannot be dealt with through a care co-ordination case review, then a plan must be agreed with the carer. This should include:

- Clearly stated methods for engagement and monitoring of the service user. This will include a member of the care team seeing the service user or speaking to the service user.
- Time scales that reflect the assessed urgency of engagement and monitoring.
- A contact point for the carer.
- Contingency arrangements for the carer.

8.4 The plan will be recorded and a copy passed to carers (subject to the service user's rights to confidentiality).

8.5 If there is immediate significant risk to the service user and/or others, then a Mental Health Act or Best Interest assessment should be considered.

9. A SECOND OPINION

9.1 The Team may wish to seek a second or a specialist opinion about how to engage with a service user. This practice should be facilitated, if necessary, by senior clinical and managerial staff e.g. referral to the Risk Reference Panel.

9.2 The CRHTT / CLDT, where appropriate, should be considered for assessment and/or advice and treatment of eligible service users.

REFERENCES

1. BMJ 1999; 318 doi: https://doi.org/10.1136/bmj.318.7193.1225 (Published 08 May 1999) Cite this as: BMJ 1999;318:1225.
2. https://www.legislation.gov.uk/mwa/2010/7/contents

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