

SECTION 2

CARE

INTERVENTIONS

Care Interventions

The purpose of care interventions is to improve the way that vulnerable people with mental health needs in the community receive services. It aims to be client-centred, to identify individuals' needs and to develop individual care plans.

Care interventions should result in care that is both well planned and well co-ordinated and ensure that the needs of individuals are not neglected between services. A designated individual (the care manager) is responsible for co-ordinating an individual's care and acting as the link between the individual, his/ her family and the various caring agencies involved. The quality and efficacy of the care provided is monitored on a regular basis.

There are three different levels of care intervention depending on the needs of the individual.

LEVEL 1	Care Management
LEVEL 2	Care Programme Approach

The eligibility criteria for each level is described below.

Level 1 - Care Management

This is appropriate for individuals who require a co-ordinated multi-agency approach to meeting their needs.

People are considered to need a designated care manager if they have mental health needs, use a variety of services and:

- are at risk of a breakdown in their health/social care arrangements;
- or
- are at risk of physical, sexual or financial abuse;
- or

- their family situation is at risk of breakdown because of carers' stress;
- or
- the way they respond to services puts them at risk.

Care Management Procedure

Providing the right type and level of services to people as their needs change requires a great capacity for listening, careful and experienced judgement, good systems for keeping track of people and situations and smooth co-ordination between different agencies.

These activities come together under the heading of 'care management'. Care management is an essential part of any service system. It is the process of organising care and support around an individual. Care management is the key to good multi-agency working.

As with the actual provision of services, care management needs a light touch. People should only get as much care management as they need.

Most people who have mental health problems can identify and describe their own needs very clearly. They are able to navigate their way through the system on their own or with the help of friends and family. They can make decisions about what services to use and when to stop using them. They can keep the various professionals they see informed about what is happening.

Other people are in more complex situations or have greater difficulty in managing the services they use. They may find it difficult to plan and organise, or to keep other people informed. They may put themselves or others at serious risk or under great strain. They may get 'stuck' in the system if no-one is helping them to become less dependent or to explore alternatives. In these situations, more active and intensive care management is needed.

A care manager may be appointed for someone either during their stay in hospital or while they are living in the community. Once a care manager is appointed, s/he will continue to keep in touch with the person through any subsequent admissions to hospital.

The mechanism for appointing a care manager is through the Multi Agency Planning meeting. This group considers with the person concerned and on the basis of the assessment if the situation calls for a designated care manager. At a subsequent review, it may be agreed that care manager is no longer required.

Hospital

If the named nurse undertaking the assessment considers that the situation meets the criteria for care management following admission to hospital, s/he calls a multi-agency planning meeting. The care manager will be appointed at this meeting. The care manager will then work alongside the ward's named nurse in discharge planning.

Community

If the situation looks as if it is or will soon become complex enough to meet the criteria for care management the worker undertaking the assessment will call a multi-agency meeting.

Whether the person is in hospital or in a community setting, the person undertaking the assessment will collate the information on the joint community care assessment form (mental health) (see Section 6 page 56). In doing this, the assessor will usually consult other professionals and family members with the patient/client's consent, to develop a full picture of the situation. The assessor's task is to bring these perspectives together into a single document, noting where necessary significant differences of opinion.

In completing the assessment form, the assessor constantly checks back to the patient or client to agree what can be written down on the form and shared with other professionals. Only in exceptional circumstances would an assessor decide to record information on the form or pass on information to other professionals without the person's consent

The multi-agency planning meeting

1. The person who has called the meeting chairs the meeting and explains the purpose and ground rules (for example, confidentiality)
2. The summary part of the assessment form (page 4) is circulated and discussed
3. The overall aims of the care plan see (Section 6 page 58) are agreed with the person concerned
4. When the person is in hospital, discharge arrangements are discussed.
5. The details of the care plan are discussed as much as required (some of the detail can be sorted out subsequently by the person and the care manager)

6. The criteria for care management are discussed. If the situation calls for it, a care manager is appointed. This person will then be responsible for putting the care plan into writing and distributing it as appropriate (the client always gets a copy).
7. Arrangements are agreed for monitoring and review

If the person is unwilling to be part of this process (for example, s/he does not want a designated care manager) the risks involved must be considered and recorded. The agencies concerned would only overrule the client's wishes and insist on a formal involvement if there were significant and immediate risks to the person or to other people which would be reduced by this course of action.

Multi-agency review

Where someone has a designated care manager a review meeting will be held at least once every six months (reviews may be more frequent, if required). Between reviews the care manager can make minor adjustments to the care plan, in consultation with the person and relevant others.

The purpose of the review is to assess the effectiveness of the care plan and to determine whether any changes to it are required.

A review meeting begins with the care manager asking everyone involved in the care plan what progress is being made and what, if any, difficulties are being experienced.

Review meetings also check that the patient's current medication has been reviewed by their GP within the last twelve months.

The care manager then feeds back the results of his/her continuous monitoring of care. The meeting considers the care management criteria to decide if a designated care manager is still needed, and if the person needs to be considered for referral to the CPA core group.

Any changes necessary to the care plan are agreed. The care manager will update the care plan (see Section 6 page 60) which will include a summary of the discussion and circulate it. He/she will agree another review date with the others involved.

The role of the Local Assessor

A care manager is a named individual who is responsible for co-ordinating the assessment of care needs and formulating an individual plan. The care manager will;

- plan the provision of services;
- act as the link between the individual, his/her family and the agencies involved;
- monitor care inputs;
- review and update the individual care plan on a regular basis.

The care manager will be either a Social Worker or a Community Psychiatric Nurse (CPN), or a Community Learning Disability Nurse but may not be the person most involved in the individual's day-to-day support. As far as possible, the choice of care manager should be guided by who would be most effective and who the individual would prefer.

Where the care manager does not have regular contact with the individual, he/she may delegate the day to day monitoring to an identified 'key worker'.

If the individual meets the criteria for CPA the care manager will also liaise with the CPA core group.

Level 2 - Care Programme Approach (CPA)

CPA is appropriate for individuals with serious long-term mental illness and complex health and social needs who are at risk unless their situation is carefully and actively monitored. CPA is intended for only a minority of people who use mental health services.

1. People must be considered for CPA if they are subject to certain statutory order in the following legislation:

Mental Health (Care and Treatment) (Scotland) Act 2003

Adults with Incapacity (Scotland) Act 2000

Criminal Procedures (Scotland) Act 1995

or if they fall outwith the above but have a history of dangerous or violent behaviour.

2. Others who should be considered for CPA will have a current diagnosis of severe and enduring mental illness, characterised by one or more of the following conditions:

- psychosis;
- severe neurosis;
- dementia;
- or
- personality disorder complicated by severe and enduring mental illness. (Some enduring mental illnesses may be episodic.)

They will also be affected by one or more of the following sets of circumstances (whether actual or potential):

- a history of relapse in their condition due to a breakdown in their medical or social care in the community;
- a severe disability (e.g. learning or physical);
- a major housing problem as a consequence of their mental illness;
- complex and multiple needs necessitating multi-agency involvement and co-ordination;
- a history of serious suicide risk or self harm, severe self-neglect or violence or danger to others as a consequence of their illness;
- risk of physical, financial or emotional abuse;
- evidence of significant carer stress.

Operation of the Care Programme Approach (CPA)

The CPA is monitored by a Core Group as follows

Core Group membership

Principal Officer (Planning & Development)
Social Work Department, CNES

Consultant Psychiatrist
(Western Isles Hospital)

CPN Team Leader
Western Isles NHS

Care management co-ordinator (Administrator)

Co-opted members: Housing Officer (where relevant)

Consultation with relevant statutory and voluntary sector agencies
as identified by individual needs of user.

Care managers make a formal written referrals to the Core Group administrator when the CPA criteria are met.

This group will meet on a four weekly basis initially to consider new referrals and review existing referrals to the CPA.

An activity report will be produced for information and should include the following:

- numbers of referrals;
- complications regarding care management;
- numbers of hospital admissions and discharges;
- care gaps;
- resource implications;
- training implications.