Policy:

OPS 001 Difficult to Engage Service Users (Including Non Compliance with Treatment and Non Attendance)

(*Review Date Extended to 31/03/2020 by EDG)*

Executive or Associate Director lead	Executive Director of Operations
Policy author/ lead	Project Consultant
Feedback on implementation to	Project Consultant

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Ratified by	Executive Directors Group
Date of issue	17 November 2017
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Target audience	All Clinical Staff

Keywords	Difficult, engage, service users

Policy version and advice on document history, availability and storage

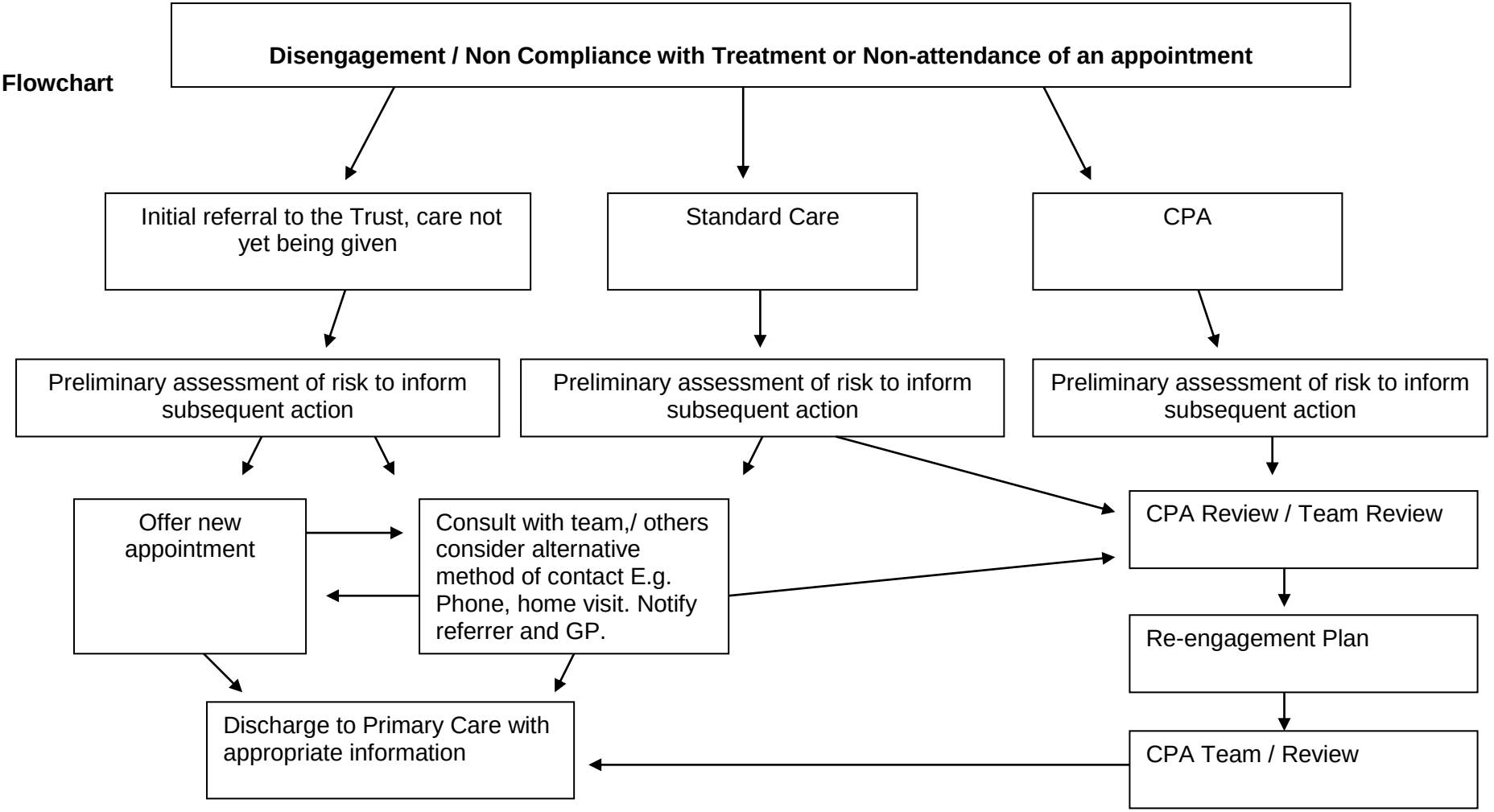
This is version 3.0 of this policy and replaces version 2 (May 2009). This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V2) should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

Flowchart



Note:

- **In all situations if assessment under the Mental Health Act is appropriate prompt action should be taken**
- **At all stages in above process consideration should be given to how helpful is the care offered and how this can be adapted (as defined in Sec 3.2), and the advice and involvement of others highlighted in Sec 3.6 of the policy.**

1. Introduction

Equality, Inclusion, and Human Rights are at the heart of the Trusts Values of Respect; Compassion; Partnership; Accountability; Fairness and Ambition. Services and practices will always be undertaken in line with these Values which have been agreed in partnership with staff, and people who use Trust services, Carers and families**.**

The 1999 report of the 'National Confidential Enquiry into Suicide and Homicide by People with Mental Illness "Safer Services" found that loss of contact with services was often a feature for people referred to or known to Mental Health Services in suicide and homicide enquiries.

This policy makes use of Care Programme Approach (CPA) processes to set a structure to ensure that all that is possible is done to engage clients referred into mental health services, especially those who are at risk.

This policy makes use of the directives within Care Programme Approach, and acknowledges the 1983 Mental Health Act including the Mental Capacity Act.

The need for such a policy is simple, which is to provide clinicians a structure within which they can maximise efforts to help vulnerable people at risk.

This policy will be included as a part of the trusts Scheduled Care Pathway within Secondary Adult Mental Health care.

This policy also has linkages to the SHSC NHS FT guidance document 'Resolving Differences of Opinion between Professionals' found on the trust intranet.

2. Scope

This policy is trust wide, and applies to all staff responsible for providing support to service users.

3. Definitions

3.1 Difficult To Engage

This refers to a client with a history of disengagement from services with known risk factors of risk of harm to self or others sufficient to negate the option to close the case.

3.2 Treatment

This covers all relevant aspects of health and social care intervention in the care plan, not just medical treatment.

3.3 Non-Compliant

The word 'non-compliance' should not obscure the fact that, unless statutory powers are in place, a client has the right to refuse treatment or services.

What constitutes 'non-compliance' will vary case by case, the significance and meaning of (for example) two missed appointments will vary greatly between one client and another and no policy eliminates the need for such assessment and judgement.

3.4 Non-attendance

This is often referred to as "Did Not Attend" (DNA) and is used in this policy to describe clients who have been referred to a Trust service and who failed to attend an agreed appointment.

The client will be classed as DNA (Non-attendance) where they have failed to attend a service in the following circumstances:

- The client does not attend for the initial assessment interview.
- The client does not attend for an outpatient or therapy session.
- The client is not at home when visited by a mental health professional when the date and time of the visit has been pre-arranged.
- The client has not attended Day or Community Services on one or more occasion. In some circumstances one failure to attend will give concern to take action.
- The client has obviously moved from their usual place of residence and has given no indication of their new address

3.5 Care Programme Approach (CPA)

The Care Programme Approach is integral to the underpinning of this policy further advice on this policy is available on the trusts intra-net sight.

The following text is quoted from the Department of Health's 2006 policy document "Reviewing the Care Programme Approach".

The Care Programme Approach (CPA) was introduced in 1990 by the Department of Health and reviewed in 1999 and 2008 the principles are to provide a framework for effective mental health care for people with severe mental health problems, the four main elements are:

- That systematic arrangements are in place for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers.
- The appointment of a key worker (care co-ordinator) to keep in close touch with the service user, and to monitor and co-ordinate care;
- Regular review and, where necessary, agreed changes to the care plan.

The importance of close working between health and other agencies is paramount, as is the need to involve service users and their careers in the assessment and planning of the care plan.

4. Purpose of this policy

To give clinicians a structure within which they can maximise the efficacy of efforts to help vulnerable people at risk who do not engage well with the service.

5. Duties

Directors are responsible for ensuring that practices within their service areas are carried out in accordance with this policy.

Directorate Clinical and Service leads must be familiar with this policy and ensure that governance related to the policy is implemented in their area of responsibility.

Service Managers must have good knowledge of the policy and ensure that the policy is applied in practice in their areas of responsibility.

Team Managers are responsible for ensuring that staff are aware of the policy and that it is applied in their areas of practice. They are also responsible for monitoring such practices.

6. Process/Specific details

In the majority of cases where clients choose not to attend, or to disengage from all or some of the service offered, it is not problematic, but there will be occasions when this gives cause for concern. See section 3 above for definitions of terms used in this section.

6.1 Reasons for non – engagement

There may be several reasons why a client may not engage with services including:

- Lack of information relating to the programme of care / treatment
- Poor relationship between the client and clinician, clinical team / care provider
- Experience of adverse side effects of treatment
- Lack of recognition of the benefits that the care / treatment may offer, due to the severity of the mental disorder or other reason.
- Inappropriate care or treatment, not adequately taking into account, for example, the lifestyle, beliefs, faith or financial position of the client.
- Lack of understanding of intended support / intervention
- Lack of appropriate communication with a client who has communication difficulties for example a client with cognitive or learning disabilities.

- Language and or cultural barriers

6.2 Action to be followed in cases of disengagement, non-compliance with treatment and Non-attendance

- Right to Refuse Care

While every effort should be made to engage with those in need of mental health services, it is recognised that a person whose mental illness does not warrant intervention under the Mental Health Act 1983 has a right to refuse services.

If the client is lacking in capacity as defined by the Mental Capacity Act of 2005, then there is a responsibility to act in their best interests in those areas where they lack capacity, this may overrule the right to refuse services. So actions can be taken, where possible, to ensure that the person receives a service as long as it is proportionate to any risk involved.

For further detail see 'Practice Implementation Guidance for the Implementation of the Mental Capacity Act', on the Trust Intranet.

- Considering reasons and the helpfulness of care offered.

The term non-compliance can appear to carry a tone of identifying the client as difficult, it is important to remember that the reason for disengagement and non-compliance may be that the care we are offering is not helpful, and to be open to discussion and negotiation with clients about this, particularly in respect of the reasons for disengagement. For example, it should be considered whether the care offered is appropriate to the person's culture, whether a language or signing interpreter is needed, that information offered may need to be written in a different language, consider the use of advocacy services, and if different approaches to engagement and intervention are required to meet the needs of client's from different cultures or those with learning disabilities or other cognitive deficiencies (see also section 3.9 concerning stopping taking of medication).

- Informing the care co-ordinator

Any person involved with the client who identifies disengagement or non-compliance with care / treatment should inform the care co-ordinator.

Non-attendance of an appointment may or may not be an indicator of such disengagement or non-compliance.

- Preliminary Consideration of Risk to Inform Subsequent Action

When disengagement, non-compliance with care/ treatment, or non-attendance of an appointment is identified, it is the responsibility of the care co-ordinator to first undertake a consideration of risk as soon as is practicable, even when a full risk assessment has been completed recently, this assessment should make use of information from other clinicians, carers or relevant people.

This consideration of the risk must be entered on Insight and should either use the 'Detailed Risk Assessment and Management (DRAM) form or if the risk issue is recorded on progress notes, then this should be entered as a 'risk note'.

In the case of DNA for an initial appointment, the ability to do a risk assessment is limited but should be undertaken as thoroughly as possible based on information from the referrer and any other sources.

- Subsequent Action

This risk assessment will inform the subsequent action below and is divided into three areas:

a) Did not attend - initial referral to the Trust - care not yet being given.
b) Standard Care
c) CPA

Did not attend, after initial referral to the Trust / care not yet being given.

Based on a consideration of the referral information and conversation with the referrer or others if possible, a decision should be made whether to offer a further appointment, or develop an alternative method of contact (e.g. make contact by phone or offer a home visit),or to refer back to Primary Care.

- Standard Care Clients

Where the levels of risk are assessed as low, the only action may be to offer a further appointment or ask the service user to make contact to discuss their care.

If the service user does not respond, or the level of risk is more substantial, the care co-ordinator should consult others involved, and use judgement on any further steps that may be required to be taken this could include unplanned or unannounced visits, or plans to monitor via a third party.

If no further action is deemed necessary the care co-ordinator should arrange discharge and inform, in writing the persons General Practioner (GP) and/ or any other initial referrer, service user, and relevant others, including carer as appropriate.

If as a result of any of the above it is felt that the client should move to enhanced CPA, then this should proceed, and a review arranged with the speed appropriate to the urgency of the situation.

(If the situation warrants and based on risk that more prompt action/intervention is considered a priority, then an assessment under the Mental Health Act may be an option considered.)

- CPA Clients

A CPA review should be arranged with an appropriate level of urgency when disengagement or non-compliance has been identified for a client on CPA. This review should be informed by the service users risk assessment. It should determine the reasons for disengagement and consider any changes that can be made to the care plan to re-engage the service user.
As an outcome of the CPA review, the following approaches to facilitate engagement and management of risk should be considered:

Who is to visit / contact and how often

Develop a communication plan between all involved agencies and parties.

Consideration of involvement of carers / relatives.

Consideration of involvement of Police and other Statutory and non-statutory Agencies

Consideration of the need for involvement of statutory mechanisms such as the mental health Act

Consider that there are in place suitable arrangements for the continued review and monitoring of the case.

- Advice / Involvement of Others

  Consideration should be given as to whether involvement by, or advice from the following teams or services would be appropriate:

  SHSC NHS FT Safeguarding Adults/Children
  Drug and Alcohol Services;
  Home Treatment Teams
  Out Of Hours Team
  Liaison Psychiatry
  Older Age Psychiatry Teams
  Specialist Mental Health Teams
  Sheffield Assertive Outreach Team (SORT)
  Community Mental Health Teams (CMHTs)
  Inpatient Services Teams
  Improving Access to Psychological Therapies (IAPT Teams)
  Sheffield Local Authorities: Safeguarding and Children's Teams
  South Yorkshire Police
  South Yorkshire Probation Service
  Other agencies specific to a person's cultural background, language or physical needs.

- Other procedures

  Consideration should be given as to the relevance of other procedures, such as in the case of violent and or sex offenders coming to the attention of Mental Health Services weather there is a need to consider a referral to call a Multi-Agency Public Protection Arrangements meeting (MAPPA)

  In cases of domestic violence and honour based crimes consideration should be given for a referral for a Multi-Agency Risk assessment Conference (MARAC).

  Local Safeguarding Children / Child Protection Procedures and action / referral must be made if appropriate, and not delayed especially if there is any immediate risk/ concerns as to the safety and wellbeing of children, and vulnerable adults.

- Primary Care and Re-referral

  Where appropriate, primary care should be asked to be involved in trying to engage service users.

  If it is concluded that the needs of a disengaged or non-compliant client are best met by primary care, an action plan should be agreed with the appropriate primary care

team, including risk assessment, crisis plan (including Mental Health Act assessment triggers) , and specific indicators for rapid re-referral.

If the client does not have a GP, efforts should be made to arrange for him or her to have one. If this is unsuccessful, arrangements should be made so that he/she can self-refer back to the CMHT direct via the respective CMHT duty desk .

- Medication

Where a service user has discontinued taking medication, the appropriate doctor should consider undertaking a medicine review in order to agree a medication plan that is acceptable to the service user. If this is not possible to agree, then the steps outlined above should be followed.

If the patient is under a Mental Health Act -Community Treatment Order (CTO) then consideration needs to be given for actions as described in the terms of the CTO.

- Informing Others

The care co-ordinator and others involved in the person's care should give consideration as to any other Agencies to be informed of disengagement / non-compliance with treatment. This should be appropriate to the level and nature of the risk's and may include for example the Police, Probation Service, and or Children and Young Persons Services

- Differences Between Professionals

In following the above procedures it is possible that different practitioners have different views as to risk and action to be taken. If is this is the case, reference should be made to the guidance "Resolving Differences of Opinion Between Practitioners", available on the trust intra-net site

6.3 Carers Concerns

If a carer has concerns about risk to the client or others, then a plan should be agreed with the carer (through the mechanism of a CPA review where appropriate).

This should include:

- Clearly stated methods for engaging and monitoring the service user.
- Clearly stated arrangements to provide support to the carer
- Timescales to reflect the assessed urgency
- Contingency arrangements for the carer.

7. Dissemination, storage and archiving;

This policy will be available on SHSC website in the same place as other policies. Dissemination will be via e-mail to staff, and also via references in CPA newsletters and CPA training and CPA manager's regular visits to teams

8. Training and other resource implications for this policy

This material will be incorporated into CPA training courses, and in presentations to teams. It does not need separate training courses, as it is consistent with CPA processes and, within this context it is fairly straightforward to understand and implement

9. Audit, monitoring and review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group / committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
All teams to embed the policy into their local standard operating procedures and performance monitor	Team Governance Peer Inspection Arrangements	Operational & Clinical Team Lead & Senior Operational Manager	quarterly	Quarterly Team Governance Meeting	Senior Operational Manager / Deputy Director At Directorate governance level	Associate Director / Associate Clinical Director At Clinical Operations governance

10. Implementation plan

This is the third version of this document, and changes are very small from the first one but take into account various changes in policy and procedure from this first date, this reduces the amount of implementation necessary, It also very much acts as a strengthening of current CPA procedures, rather than a new direction.

Lead role for implementation will be Paul Nicholson Assistant Service Director. There are no new roles or responsibilities, no new resources are required, the policy will be placed on the SHSC policies page and all staff will be e-mailed to draw attention to it.

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to Other Policies

CPA Policies and Procedures
Practice Implementation Guidance – Mental Capacity Act
Mental Health Act 1983 / 2015 National Code of Practice
Mental Capacity Act 2007 National Code of Practice
Resolving Differences of Opinion 2006

12. Contact details

Title	Name	Phone	Email
Assistant Service Director	Paul Nicholson	2718898	paul.nicholson@shsc.nhs.uk

13. References

- Practice Implementation Guidance: Mental Capacity Act (Department of Health 2015)
- Mental Health Act 1983: National Code of Practice (Department of Health 2015)
- Mental Capacity Act: National Code of Practice (Department of Health 2015)

- Five Year Forward View for mental Health; Mental Health Task Force Group (Department of Health 2016).
- Mental Health: New Ways of Working for Everyone (Department of Health 2007)
- Effective Care Co-ordination in Mental Health Services; Modernising the Care Programme Approach (Department of Health 1999)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby et al 1999)

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
3.0	Review / ratification / issue	Nov 2017	Full review completed

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
3.0	Dec 2017	Dec 17 via Communications Digest	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No	Older service users are more likely to suffer from conditions which impact on their ability to engage.	No
DISABILITY	No	Evidence that people with disabilities with communication and cognitive issues may have more difficulty with engagement	No
GENDER REASSIGNMENT	No	No	No
PREGNANCY AND MATERNITY	No	No	No
RACE	No	Evidence that language and culture may have an impact on engagement across different communities this is recognised in the policy	No
RELIGION OR BELIEF	No	No	No
SEX	No	No	No
SEXUAL ORIENTATION	No	No	No

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)	Graham Bishop Project Consultant SHSC NHS FT

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

X **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

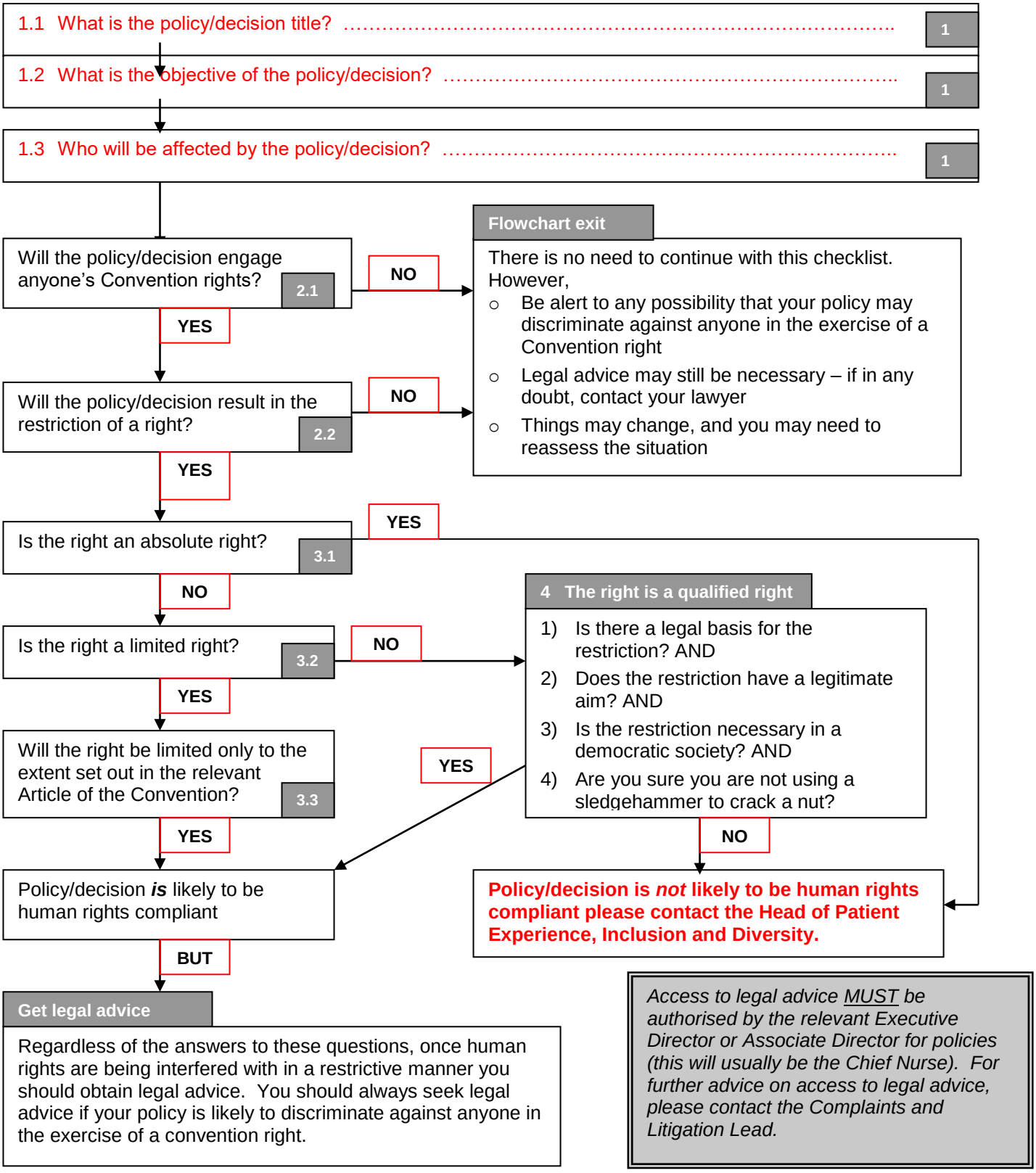
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

This policy was originally written in 2006 and then reviewed in March 2009 this is the third review completed in draft in October 2016 as part of the on-going policy development and review process.

This policy was reviewed in line with changes/advances in policy and procedures in Mental Health Services, including the Mental Health “New Ways of Working for Everyone” (Department of Health 2007) policy document and the “Five Year Forward View for Mental Health” (Department of Health 2016) document, this policy may need review at the point that local or government policy changes affect the scope of this document.

The content was reviewed and approved by the Deputy Chief Nurse and the draft was verified by the Chair of the Service Users Safety Group.

Appendix F – Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart ✓

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ✓

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓