Witness Name: Dr Milind Karale

Statement No.: 1

Dated: 25 March 2025

Rule 9 reference: EPUT Rule 9(10) and EPUT Rule 9 (10a)

**LAMPARD INQUIRY**

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**FIRST WITNESS STATEMENT OF Dr MILIND KARALE**

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I, Dr Milind Karale, will say as follows:

## Introduction

1. I am the Executive Medical Director within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since 2012. My portfolio includes medical leadership and managing medical directorate, Caldicott Guardian and Research. I am the Responsible Officer for the purposes of revalidation of doctors with prescribed connection to EPUT.

2. I have been in employment with EPUT and predecessor organisations in SEPT since 2007.

3. I report directly to the Chief Executive Officer ('CEO'), Paul Scott.

4. I am a Consultant Psychiatrist (FRCPsych, MSc Forensic Psych, DNB, DPM, MBBS).

5. I would like to offer my sincere and personal condolences to anyone who has lost loved ones while receiving care from mental health services in Essex. This statement aims to address questions from the Lampard Inquiry about safety at EPUT. No part of this statement is intended to diminish the impact that the tragic loss of life would have had on families, loved ones and the EPUT staff that cared for them.

## Approach to the Inquiry Rule 9 (10) Request

6. This statement is made in response to the requests by the Inquiry to EPUT Rule 9(10) of the Inquiry Rules 2006. Under Rule 9(10) dated 20 January 2025, EPUT was asked to respond to a series of questions related to forms of non-inpatient mental health assessments that patients received prior to admission over the Relevant Period, and an understanding of the guidance and policies or other documents which applied to those assessments. On 18 March 2025, with reference to 'EPUT Rule 9(10a)' as a follow up to the information provided in my draft statement dated 20 February 2025, EPUT was asked to clarify some of the information made in my draft statement and provide a finalised signed version.

7. This statement is to be read in conjunction with the Trust's response under Rule 9(6a) as this details the profiles of the service types detailed hereon.

8. The request is broad in scope and goes beyond matters, which are within my own personal knowledge. The statement also supplies information regarding the former Trusts (North Essex Partnership University NHS Foundation Trust or "'NEP", and South Essex University Partnership NHS Foundation Trust or "SEPT"). This information is sourced directly from the electronic information or documents held by EPUT, as described further below, and I have relied on the accuracy of that information, together with the searches described below. Accordingly, this statement has been prepared following consultation with several senior individuals in the organisation. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

9. My statement will be set out using the following structure:

Part 1: Clinical Overview of Assessments

Part 2: The Evolution of Assessments

Part 3: The Assessment Process

Part 4: Types of Assessments

Part 4a: Initial Assessments

Part 4b: Clinical Risk Assessments

Part 4c: Specialist Assessments

Part 5: Monitoring and Evaluation

## Part 1: Clinical Overview of Assessments

10. The assessment of a patient is a dynamic process and occurs at every contact with a health care professional, including a planned, unplanned, formal or informal contact. Mental health assessments are therefore a skilled and often very complex process. In addition to identifying symptoms and signs of mental disorders, it includes identifying any predisposing factors (such as family history of the illness), precipitating factors (for example a stressful life event) and perpetuating factors. It involves identifying social and

psychological factors contributing or leading to the presentation, as the professional tries to understand how each of these elements influences the person's mental wellbeing.

11. Individual personality traits influence how people perceive and cope with stress, affecting mental health outcomes. Personality is complex and shaped by both inherent and learned factors, all of which influence a person's reaction to stress and life events. The emotional resilience, optimism, and self-efficacy vary from person to person, and has a bearing on their ability to cope with stress.

12. These factors can trigger or impact on a person's mental health; notwithstanding the biological factors. An assessment during any patient contact aims to understand the role these factors play and the impact this has on the individual. A person's presentation can vary significantly from one occasion to another, even within the same day or across weeks or months due to the influence of various dynamic factors. Mental health is, therefore, shaped by a complex interaction between subjective pathology, social factors, stressors, and personality traits. Mental health exists on a spectrum, and symptoms can fluctuate over time.

13. Social factors and circumstances play a crucial role in shaping someone's mental health and wellbeing. People's social supports, relationships, emotional support, financial situation, employment, discrimination, stigma are all variables in their life. Stressful life events and chronic stress can significantly impact on mental health. Major life events such as bereavement, divorce, job loss, or illness can trigger anxiety, depression, or other mental health conditions. Exposure to trauma, neglect or abuse during childhood can increase vulnerability to mental health issues in adulthood. An interplay of the above, with genetic predisposition to some of the illnesses, can lead to emergence of a psychiatric illness.

14. The process of an assessment becomes more formal at the point of a referral being made to a service. A referral can be made to a professional or a team, and can be for various reasons such as establishing a diagnosis, treatment, accessing a specialist service, inpatient admission or for a specialist opinion.

## Part 2: The Evolution of Assessments

### Requirements for Assessment

15. Assessment documents are used to seek and document the clinical understanding of a patient's presenting problem, clinical history and trigger(s), family history, personal history, past psychiatric, medical history, substance misuse history, medication, social situation, forensic history, mental state examination and risk assessment. As part of the assessment process, the clinician will consider the patient's mental capacity to make informed decisions of the outcome and pathways to follow the assessment. To inform the assessment, additional tools may be used which are dependent upon the patient's presenting concern and needs. These are utilised in addition to the Trust's requirement of a risk assessment document approved for use within the Trust records systems. Regarding risk assessment, a comprehensive history, eliciting various risk and mitigating factors, along with a detailed mental state examination is key in understanding the risks and formulating a risk management plan.

16. The requirements for an assessment has evolved over the relevant period; an overview of how this has changed in policy is provided hereon. Although there have been reviews of policy in between the dates noted below, only those where relevant changes have been made to the requirements for assessment are detailed in this section.

17. I provide a general overview of the requirements for assessments and what an assessment covers. A generic psychiatric assessment undertaken by Psychiatrists (including trainee and senior psychiatrists) has followed the same structure over the years, as guided by the Royal College of Psychiatrists and the College examinations. Specific and specialist assessments (such as assessment of an eating disorder, forensic assessment, memory assessment, assessment of neurodiversity) may vary and I have covered this in my statement.

**SEPT**

18. SEPT's first located Clinical Risk Assessment and Management Policy is dated January 2003; however it is evidence there were other versions in place prior to this date **[MK-001: SEPT Clinical Risk Assessment and Management Policy 2003].** Within the Policy, it states that all patients will be assessed for risk and a standard psychiatric assessment was completed to include the following:

    a. History;

b. Previous violence or suicide behaviour;

c. Evidence of transitory behaviour or social restlessness, such as few relationships, frequent changes or address and/or employment;

d. Evidence of poor compliance to treatment and disengagement from psychiatric aftercare;

e. Evidence of actual potential substance abuse/misuse;

f. Identification of any precipitants and any changes in mental state or behaviour that occurred prior to violence or relapse;

g. Evidence of recent severe stress, loss events or threat of loss, such as death in the family;

h. Evidence of recent discontinuation of medication, a change in medication or noncompliance;

i. Evidence of physical health risks, eg, refusing to eat, allergies, frailty, and mobility;

j. Mental State;

k. Evidence of threatening behaviour and delusions/hallucinations of a persecutory nature;

l. Emotions related to violence for example irritability, anger, hostility, and suspiciousness;

m. Specific threats made by patients;

n. Evidence of suicidal ideation, tendencies or plans need to be discussed fully with the Team, decisions taken on the care and treatment of the patient in light of these factors documented in the care plans and reviewed on a daily basis;

o. Evidence that a patient is considered to be an absconding risk in an in-patient area or a risk of moving out of the catchment area without informing the necessary agencies such as Health, Social Services, Housing or Probation.

p. In addition, relevant factors related to the patient's home circumstances and the ward environment were to be considered.

19. SEPT's first located version of the CPA Handbook is dated July 2003 **[MK-002: SEPT CPA Handbook 2003].** Within this, the Handbook notes that the purpose for undertaking an initial assessment / screening of a service user was to determine whether intervention from mental health services was appropriate. An assessment was undertaken to determine:

    a. Areas of need / difficulties and level of risk;

    b. Strengths and abilities of the patient;

    c. Identify the service users CPA level of need;

    d. Identify the need for specialist assessments.

20. In its update to the Clinical Risk Assessment and Management Policy in September 2006 **[MK-003: SEPT Policy Regarding Clinical Risk Assessment and Management, September 2006]**, the definition of clinical risk was incorporated in the as any risk which may impact on the effective, safe delivery and quality of the care and treatment given to our patients.

21. In September 2006, the CPA Policy was reviewed **[MK-004: SEPT CPA Policy 2006].** All persons assessed by the Clinical Assessment Service would receive a Core Assessment (initial assessment) which explored a person's:

    a. Mental health;

    b. Physical health;

    c. Medication;

    d. Substance misuse;

    e. Learning disabilities;

    f. Forensic history;

    g. Cultural and spiritual needs;

    h. Relationships;

    i. Carers needs;

    j. Housing;

k. Finance;

l. Employment;

m. Education;

n. Networks.

22. Risk assessment was integrated into the assessment processes at all stages.

23. SEPT's Procedure for the Assessment and Management of Clinical Risk were also reviewed in September 2006 **[MK-005: Procedure for the Assessment and Management of Clinical Risk, September 2006].**

24. In 2009, the assessment tool used by CAS was extended to Duty Team, A&E Liaison and Primary Care Mental Health Services. The patient's initial assessment included an overview of their mental health, medication, substance misuse, safeguarding, employment, housing and physical health needs **[MK-006: SEPT Non-CPA Procedural and Professional Handbook for Practitioners May 2009; MK-007 SEPT Non-CPA Procedural and Professional Handbook for Practitioners September 2009].**

25. An assessment of needs should address the following:

a. Capacity;

b. Psychological, psychiatric, and social needs;

c. Physical health needs;

d. Medication and side effect monitoring;

e. Family roles, including parenting and other caring roles;

f. Self care and domestic functioning;

g. Employment, education, and training needs;

h. Housing / Resettlement needs;

i. Financial needs, debts and benefits;

j. Cultural, racial, gender, religious, spiritual and access needs;

k. Communication needs, language and literacy;

l. Substance misuse;

m. Safeguarding children and/or adults;

n. Statements of wishes or advance decisions.

**NEP**

26. NEP's CPA Policy was updated in March 2007 **[MK-008: NEP CPA Policy 2007];** where it was identified that assessments must identify service users' strengths, skills and abilities and must identify what is required to promote recovery. The assessment should take into account service users' own beliefs and opinions about their mental health issues. Assessments of needs should identify all aspects where specific support and further assessments are required, including:

    a. Psychological/psychiatric;

    b. Physical and medical;

    c. Social functioning;

    d. Self-care and domestic functioning;

    e. Employment (vocation) and leisure;

    f. Housing/resettlement;

    g. Finance/benefits;

    h. Cultural/racial;

    i. Religious/spiritual;

    j. Substance misuse;

    k. The needs of children and/or vulnerable adults.

27. The CPA Policy and Procedure was reviewed in June 2009 **[MK-009: NEP CPA Policy and Procedure, June 2009].** Further details of the CPA Assessment were included; all mental health service users received a comprehensive holistic assessment of their mental health and social care needs; which must always include an assessment of risk.

28. A full assessment of need covered the following aspects to identify where specific support and further specialist assessments were required:

    a. Psychiatric functioning;

b. Psychological functioning;

c. Physical health needs, including dietary requirements taking into account the impact of mental ill health on physical health and vice versa;

d. Co-morbidity and co-existing problems, such as substance misuse or learning disabilities;

e. Social functioning, social needs and social circumstances;

f. Personal circumstances (including family or other carers), family and welfare circumstances including activities of daily living;

g. Child care issues, child protection (being aware that children and families services may have relevant information that should be included in the assessment/risk assessment;

h. Impact of mental ill health on parenting or carer functions;

i. Health and wellbeing needs of any children for whom the service user has parental responsibility;

j. Risk to the individual or others (including previous violence and criminal record);

k. Occupational status, vocational aspirations and employment needs, training, education and leisure;

l. Housing status and needs;

m. Financial status;

n. Need for medication management;

o. Experience of violence, abuse and sexual abuse;

p. Communication, cultural, gender and access needs;

q. Advocacy and legal advice;

r. Religious and spiritual needs;

s. Interpretation/translation needs;

t. Carer's involvement;

u. Needs of vulnerable adults;

v. Level of support and intervention required;

w. Informal support network;

x. Ability to self-manage their mental health problems;

y. Service user's own caring responsibilities.

29. The CPA Policy and Procedure documents were reviewed in 2012 **[MK-010: NEP CPA Policy and Procedure 2012].** The following amendments to the above assessment requirements were noted:

a. The addition of forensic history;

b. The addition of employment status and benefits;

c. Child and adult protection were updated to use the term safeguarding.

**EPUT**

30. Following the merge of SEPT and NEP, the CPA Policy documents were reviewed and harmonised **[MK-011: EPUT CPA Policy 2017; MK-012 EPUT CPA Procedure 2017].**

31. An assessment was defined as being the starting point of patient care. Patients who were accepted for assessment would receive a comprehensive, holistic assessment of their mental, physical and social care needs, which must also include an assessment of risk. Assessments would be undertaken by qualified clinicians, and on occasions through joint assessments. Details were provided in the Procedure of the factors to be included in the full assessment, including prompts for each of the overarching factors in tabular form as displayed in Table 1:

Table 1: EPUT 2017 Factors for inclusion in assessment

| **Psychiatric and psychological functioning** | **Personal circumstances** |
|---|---|
| - Reason for referral<br>- Presentation<br>- Impact on daily life<br>- Recent life event<br>- Precipitating factors<br>- Psychiatric history<br>- Forensic history<br>- Pre-morbid personality<br>- Significant life events<br>- Team/specific assessment<br>- Experience of violence and abuse<br>- Family history<br>- Risks to individual or others<br>- Learning disability | - Patient's views of strengths and aims<br>- Personal circumstances<br>- Family, including genogram<br>- Caring responsibilities<br>- Childcare issues<br>- Relationship status<br>- Religious and spiritual needs<br>- Gender, sexuality, sexual orientation<br>- Advance decision<br>- Statement of wishes<br>- Lasting Power of Attorney<br>- Veteran<br>- Personalised budget<br>- Consent to seek or share information with other agencies |
| **Social functioning** | **Physical health needs** |
| - Support network<br>- Housing status and needs<br>- Financial status and needs<br>- Carer and family involvement<br>- Involvement with other agencies<br>- Advocacy needs<br>- Employment<br>- Training and education<br>- Leisure<br>- Social functioning and social needs<br>- Communication and cultural needs | - Physical health needs<br>- Medical history<br>- Allergies<br>- Accidents<br>- Hospitalisation<br>- Weight, height, BMI<br>- Smoking status<br>- Current medications<br>- Disabilities |

32. In the Policy and Procedure review in 2023, the above was updated to combine psychiatric, psychological and social functioning together. Physical health and personal circumstances were also combined **[MK-013: EPUT CPA Policy 2023; MK-014: EPUT CPA Procedure 2023].**

**Assessment Tools**

33. In addition to the Trust assessment documents described, clinicians also use a range of tools which inform the overall assessment. These are completed within the specific services where a particular element of a patient's presentation or risk requires an assessment. The tools available have changed over the years due to national recommendations, with new available research and copyrights for the tools.

34. The Trust's current Clinical Assessment and Safety Management Policy **[MK-015: EPUT Clinical Risk Assessment and Safety Management Policy]** outlines that risk assessment tools should not be used on their own but as part of a comprehensive assessment at points of key decision making. They are not diagnostic and their utility remains founded on good clinical practice. Practitioners with responsibility for risk assessment may also use one of the recognised and agreed, validated risk assessment tools with acknowledgement that some of the tools require specialist knowledge and training to implement and interpret correctly. For example, HCR 20 (Historical, Clinical, and Risk Management-20) is a universally accepted, standardised and structured risk assessment and management tool for risk of violence. It requires specialist training to apply this tool which is used mainly in forensic settings. To the best of my knowledge, there is no single universally accepted standardised tool to assess suicide risk.

35. The tools included are as follows:

*Inpatient*

a. Malnutrition Universal Scoring Tool (MUST)

b. Waterlow Tool

c. Falls Risk Assessment Tool

d. Manual Handling Risk Assessment and Care Plan

e. Infection risk on admission / transfer

f. VTE risk assessment

g. The Trust Handover tool

h. The assessment forms on Mobius, as detailed in Part 2

*Secure services*

a. Secure Services risk assessment on Mobius, as detailed in Part 2

b. Risk of Sexual Violence Protocol (RSVP)

c. Stalking Assessment Manual (SAM)

d. Historical & Clinical Risk (HCR-20)

*Learning Disabilities Services*

a. Specific Task Risk Assessment Tool

b. Initial Risk Assessment Checklist

c. Learning Disability Therapists Referring Screening Tool

d. CPA documents as defined throughout

*Community Mental Health Teams and Crisis Resolution & Home Treatment*

a. ECPA Assessment forms on Mobius as described throughout

b. Trust Needs and Risk Assessment Tools on Mobius as described throughout

c. Health of the Nation Outcome Scales Payment by Result (HoNOS, PbR.)

d. Cardio Metabolic Proforma

e. Geriatric Depression Scale

f. Montreal Cognitive Assessment

g. The Domestic Abuse Stalking, Harassment & Honour Based Violence Risk Assessment (DASH)

*Early Intervention services*

a. EI suicide risk assessment tool, which is used occasionally

b. Sad Personas (Sex, Age, Depression, Previous Attempt, Excess Alcohol or Substance Use, Rational thinking, Social support, Organised plan, No Spouse, Sickness)

c. Positive and Negative Syndrome Scale (PANSS)

d. Comprehensive Assessment of at risk mental state (CAARMS)

e. Process of Recovery Questionnaire (QPR) required by Access and Waiting Time (AWT) standards

f. Dialogue – required by AWT standards

g. Safety plans used where there is concern

*Psychology Department*

a. Risk Assessment and Management Psychology Services (RAMPS)

**Types of Trust Assessments**

36. The Trust have identified circa 1500 types of assessments across the systems which have been in place over the relevant period. The Trust have not completed a review of all of the assessments which have been in place due to the length of time this will take to complete and the narrow scope in which the Inquiry has requested the Trust to focus.

37. Within my statement, I provide details of the requirements for the documentation of Trust initial and risk assessment based on the tools in which they were completed on within in line with the CPA Policy and Procedures; details of which are identified in Table 2 and inclusive of evolutionary changes prior to the formation of EPUT on 1 April 2017 **[MK-011: EPUT CPA Policy 2017, MK-012: EPUT CPA Procedure 2017].**

Table 2: Pre-merger CPA Assessment document chronology

| Year | Trust | Document used and key changes | Additional Key notes |
|---|---|---|---|
| 2003 | SEPT | Initial Screening Assessment;<br>Health and Social Care Assessment;<br>Risk Profile;<br>Key Events | The **Initial Screening Assessment** and the **Health and Social Care Assessment** were noted as documents to be completed by the referrer at the time of admission to mental health ward (gatekeeping)<br>**Key Events** contained brief details of key historical episodes without the need to read through copious volumes of case notes to enable current and future professional staff with the management of a service user's assessment and management of risk<br>**[MK-016: SEPT CPA Policy 2003]** |
| 2005 | NEP | CPA Assessment Form;<br>Risk Management Tool | Recorded in CareBase.<br>The **CPA Assessment Form** was used for all assessments.<br>The **Risk Management Tool** was introduced which appears to have superseded the former separate key events sheet used in NEP.<br>**[MK-017: NEP CPA Policy 2005]** |
| 2006 | SEPT | Core Assessment;<br>Comprehensive Assessment of Need;<br>Risk Profile | The **Core Assessment** was used by the Clinical Assessment Service for initial assessments.<br>The **Comprehensive Assessment of Need** was completed when the patient was accepted in to secondary care services.<br>The **Risk Profile** was a risk assessment document.<br>All persons referred for a medical opinion or psychology services were assessed in accordance with their specialist practice.<br>**[MK-004: SEPT CPA Policy 2006]** |

| | | | |
|---|---|---|---|
| 2007 | SEPT | Core Assessment;<br>Comprehensive Assessment;<br>Risk Profile;<br>Key Events chart | The **Core Assessment** was used by the Clinical Assessment Service for initial assessments.<br>The **Comprehensive Assessment** was completed when the patient was accepted in to secondary care services to capture their presenting mental health issues, social care and physical health needs, and risk assessment to assist with care planning.<br>**[MK-018: SEPT CPA Handbook 2007]** |
| 2009 | SEPT | | All patients assessed by the CAS, Duty Team, A&E Liaison and Primary Care Mental Health Services would receive an initial assessment which included an overview the person's mental health, medication, substance misuse, safeguarding, employment, housing and physical health needs.<br>**[MK-006: SEPT non-CPA Procedural and Professional Handbook for Practitioners May 2009; MK-007 SEPT non-CPA Procedural and Professional Handbook for Practitioners September 2009]** |
| 2013 | NEP | Assessment | An updated CPA and Non-CPA Policy and Procedure was published and the title of the Assessment was amended to incorporate Non-CPA principles<br>**[MK-019: NEP CPA and Non-CPA Policy and Procedure, November 2013]** |
| 2015 | NEP | N/A | Details of CareBase were no longer included, with reference made to the use of electronic patient records systems<br>**[MK-020: NEP CPA and Non-CPA Policy and Procedure 2015]** |

38. Since the formation of EPUT, Paris and Mobius continue to be used in the Trust with key documents designated for the use of initial assessment and risk assessment.

**Trust systems**

39. Prior to the use of electronic patient records systems, the Trusts utilised paper records to document contacts and assessments.

40. In July 2013, SEPT introduced the electronic patient record system, Mobius. A number of the electronic documents were based on the former paper-based record. NEP saw the introduction of electronic records system in November 2013; they use Paris. After the merger of SEPT and NEP in 2017, the Trust embarked on a paperlite exercise for the former NEP. More electronic documents were created which enabled staff to update Paris. Any paper-based records which were used were scanned on to the relevant system. An example of how the Trust keep their document tools up to date within Paris has been supplied in Appendix 1.

41. The Trust utilise Health Information Exchange (HIE) which acts as central bridging between Paris and Mobius. This enables clinicians in the North who have primary use of Paris to see key information from Mobius used in the South, and vice versa.

42. Teams utilise specified templated assessment documents within Mobius or Paris and since the introduction of electronic patient records, they are primarily typed within the clinical records system. Within both Paris and Mobius systems, historic information can be automatically included in a new assessment template and updated within; this is known as “trending”.

43. In 2019, with the introduction of mental health integrated primary care services, as part of the delivery of the NHS Long Term Plan **[MK-021: NHS Long Term Plan, 2019]**, a new tier of electronic records were set up on SystemOne, and access has been rolled out thereafter. A number of teams were set up on SystemOne for this to be used as their primary records system. These records synchronise with GP systems as these services are closely aligned to other providers.

44. In relation to MHA assessment, the Local Authorities are responsible for the documentation of an assessment under the Act. The assessment is documented on the ‘Mental Health Act 1983 assessment’ template, which is managed by the Local Authority. This template is a formal AMHP report, of which all sections must be completed; and includes demographic information; assessment arrangements;

background information and reason for the referral detailing the preparation taken prior to meeting with the individual; mental state examination; risk assessment; consultation with the Nearest Relative; decision and rationale; aftercare recommendations; and signatures. The assessment is typed and uploaded to the Local Authority records system and included within EPUT's clinical records systems.

## Part 3: The Assessment Process

45. The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 to provide a framework for effective mental health care. As an overview, it provides a process which describes the approach used in mental health services to assess, develop a personalised care plan, manage risk, review, and coordinate care and support in order to address the needs of people requiring the expertise of a secondary mental health services.

### Referral

### SEPT application of referrals under CPA

46. For the relevant period, the Trust have located CPA policy documents for SEPT dating back to 2003.

47. SEPT's 2003 CPA Policy outlined that people are referred to specialist mental health services from a number of sources and at referral stage it is important to establish that they are eligible for assessment by the mental health team / practitioner receiving the referral. This decision should be inclusive rather than exclusive and should take into account the person's whole situation. A screening assessment should be carried out and the outcome of this assessment should determine whether further CPA assessment is required **[MK-022: SEPT CPA Policy, 2003]**.

48. In February 2007, the CPA Procedural and Professional Handbook for Practitioners was published **[MK-023: SEPT CPA Procedural and Professional Handbook for Practitioners 2007]** which detailed that the Clinical Assessment Service (CAS) was the gateway to all care pathways. Its purpose was to provide a clear pathway for GPs and other referrers to access a non-urgent assessment within secondary mental health services. It outlined the purpose of an initial assessment, as a first assessment of a service user's circumstances, is to determine whether intervention from secondary mental health services is appropriate.

49. In 2009, the assessment tool used by CAS was extended to Duty Team, A&E Liaison and Primary Care Mental Health Services. All referrals were assessed to determine if the person had a mental illness, what the illness was, type of support/treatment needed, and how the person should be managed by secondary mental health services **[MK-006: SEPT Non-CPA Procedural and Professional Handbook for Practitioners May 2009; MK-007 SEPT Non-CPA Procedural and Professional Handbook for Practitioners September 2009]**.

**NEP application of referrals under CPA**

50. For NEP, the Trust have located CPA policy documents dating back to 2005.

51. Since this date the policy documents outlined that when a referral was received, the receiving team acted as the point of access to services and entered the details on to Carebase, the clinical IT system. Once it was determined that a service user required an assessment, a comprehensive assessment of their mental health and social care needs was carried out by a professionally qualified member of the mental health team **[MK-017: NEP CPA Policy 2005]**.

52. With the introduction of the electronic patient records system in 2013, the use of CareBase was phased out and Paris was used to log referrals. The concept of the referral being made to a single point remained.

**EPUT application of referrals under CPA**

53. Version 1 of the EPUT CPA Policy **[MK-011: EPUT CPA Policy 2017],** acknowledges how referrals are received from varied sources; including from the voluntary sector and self-referrals.

54. As referrals are considered against service criteria to maximise the availability of the service, screening of the referral will take place to determine an outcome. Over the relevant period, referrals have been received in a number of methods which include in-person, telephone, fax, emails and system notifications. Referrals include the patient identification and contact details, clinical presentation and the reason for the referral. Some referrals also include grading for the response required by the receiving team, such as urgent or routine referral. Teams will have outlined urgency definitions; and these will differ dependent upon on the nature of the service. Some services also have Key Performance Indicators (KPIs), defined locally and nationally as a target and expectation for the timeframe in which a patient referral should be actioned with, as

shown in Table 3. Action taken following referral incorporates KPIs and service agreements.

Table 3: KPIs for referrals which outline time targets

| Team | Referral time |
|---|---|
| Crisis Response Services (NHS111, option 2) | The Trust monitor the number of calls which are answered within 60 seconds. |
| Hospital Liaison Services | The Trust aims to triage a referral from the general ward in acute hospital within one hour of receipt. |
| Dementia Intensive Support Services | Initial contact following an urgent referral is made by the Dementia Intensive Support Teams within 24 hours |
| Dementia Intensive Support Services | Initial contact following a routine referral is made by the Dementia Intensive Support Teams within 72 hours |
| Eating Disorders | Patients between 18 and 25 years of age who are referred in are contacted by a FREED Champion within 48 hours of referral. The FREED Champion provides the initial rapid contact with the patient to provide support and organise the assessment. |

55. As an overview, once a referral is received, this is reviewed by a designated member of the team. On initial review, the receiving team member screens the referral.

56. The screener reviews the referral details alongside the clinical records available to build an understanding of the patient, the clinical history and the risks. The screening of the referral is not a full assessment of a patient's needs, but a necessary component to determine the requirement for an assessment.

57. Services are designed to meet the needs of their patient group, and although there are similarities between the services, there are also key differences. These may include the location in which the service provides care; the age group or the nature of presentation/diagnosis of the patient, and the needs and risk of the patient.

58. Where further information is required to inform decision and next steps, the screener can request additional information from the referrer using the communication methods outlined below. The choice of the method will depend on the referral pathway, reason

for referral and identified risks. For instance, if a patient is referred to a community mental health team for a routine assessment with no risk identified, the team may request further information in writing from the GP. In contrast, a more immediate and direct form of communication may be used for more urgent assessments with known risks.

59. Following review of the information available, the screener will make contact with the patient to communicate the next steps of the referral process. The referrer is also informed of the outcome of the screening. The method of communication with the patient varies depending on the team and takes into account the details of the referral. For instance, Crisis Resolution & Home Treatment Teams (CRHTs) are required to contact patients within four hours of referral. As such, they typically initiate contact by phone or in person. The clinician will determine the patient's mental state, triggers, level of risk and suitability for home treatment as an alternative to hospital admission. If a full assessment is deemed necessary, it will be arranged with the patient. If not, the clinician will provide psychoeducation and explore onward referrals, where necessary. The patient is involved in the discussion and planning, and is informed of the outcome of the screening on the phone. The referrer is informed of the outcome of the screening. In comparison, a non-urgent referral to the community mental health team where the screener has identified the need for a routine assessment, the information will be communicated to the patient by letter.

60. The screener reviewing the initial referral will review the available information against the criteria of the service to which the referral has been made. Screeners have knowledge of other Trust services to make an informed decision on the referral outcome. An outcome of the screening can include the referral being forwarded to a more appropriate team.

61. There are occasions when upon reviewing the referral and engaging with the patient, the screener determines that the patient's primary need is physical health care. In such cases, a joint decision is made with the patient to redirect them to appropriate services to address this need first, with mental health assessment to follow thereafter. For example, upon communication with a patient, if they were to disclose a physical health concern which requires the response of an emergency service, the screener would make those arrangements as the primary presenting concern and once stabilised can be referred to the Mental Health Liaison Team in the acute hospital.

62. In addition, some referrals may not lead to an assessment because that was not the intended purpose of the referral. As an example, Hospital Liaison Services may receive a referral from the acute Trust medical team for an expert advice and guidance on treatment options, such as medication, or access to psychological support for the patient due to their physical health.

63. Prior to the formation of the current Trust urgent care pathway teams, patients in crisis were advised to attend Accident and Emergency departments in the acute hospitals and were supported in the community by primary and secondary care services.

64. If a patient declines an assessment, subsequent action would depend on the clinical presentation and risk. When a patient does not consent to a referral, or to engage in an assessment, and have the capacity to make such decision, a re-referral can be made when their decision around this changes. In circumstances where criteria for detention under the Mental Health Act are likely to be met, referrals for assessment under the Act can be made. Further details of the MHA (1983, amended 2007) are detailed in Part 4b.

**Arrangements for assessment**

65. Once the decision is made to assess the individual and the purpose is established, the assessment will be arranged in line with the screening outcome, identified risk, and the relevant service pathway, taking into account expected timelines and target KPIs for assessment delivery.

**Location**

66. An assessment can be carried out in a number of locations and environments. Although some services are commissioned to assess in particular locations, for those which are not, arrangements are made with the patient and include preferences and patient needs. This is assessed on a case by case basis, allowing for alternative arrangements when necessary - for example if the patient has needs that prevent them from attending an assessment outside of the home (such as a physical disability or symptom of their mental health) arrangements can be made to assess them at their home address. Risk factors, including consideration for both patient and staff safety, are also taken into account.

67. Many services are based at particular locations as part of their commissioning arrangements, as such assessments are carried out in these locations. For example, patients referred to Hospital Liaison Service will be assessed in acute hospital and patients referred to the Criminal Justice Liaison and Diversion Team will be assessed in

custody suites in  police cell and in Courts. Secure services also conduct assessments in other secure services and NHS inpatient services.

68. Services are often commissioned to maximise accessibility for individuals. For example the Street Triage Team, which is commissioned to reduce the unnecessary attendance at acute hospitals and reduce the need for detentions by the police under Section 136 of the Mental Health Act, will assess the patients at locations in the community. Other examples include the Homeless Service, which will assess patients as they attend and engage with other social engagements such as soup kitchens.

69. Most of the patients are assessed at Trust-sites. For example, for a routine assessment with a community mental health social workers, to determine needs and eligibility into secondary care services, or for an appointment with a Psychiatrist or Psychologist. Some patients have a preference to be seen at a Trust-site. On occasions, risks identified to the staff may lead to assessments carried out on Trust-sites.

70. There are often advantages of assessing patients in their home environment as it provides the assessor with information about their social circumstances. Certain assessments, such as assessments under the Mental Health Act would be undertaken in any of the above locations.

71. As noted, the location of assessment can be varied and may be beyond the control of the assessing clinician. However, in whichever environment the assessment takes place, the clinician will consider the privacy, dignity and respect of the person before and during the assessment.

**Time required to complete an assessment**

72. A standard assessment usually takes approximately one hour, and time is required following this to liaise with other agencies and significant others to share the outcome of the assessment and make onward referrals, where required. In addition, the clinician requires allocated time following the assessment for administrative purposes; this includes recording the assessment within the documents and tools defined by the Trust.

**Patient involvement in assessments**

73. Patient involvement in an assessment is key. The assessor will ensure that the patient is aware of the reasons for the referral, the nature of the assessment to be undertaken and the potential outcomes. The level of engagement from a patient forms part of the assessment, and is necessary in determining pathways and outcomes for the patient.

74. The assessment can provide an opportunity for psycho-education, helping to strengthen the therapeutic relationship between clinician and the patient. This provides an opportunity to explore person's reported difficulties and support their understanding of the potential biological, social and psychological factors contributing to their symptoms. Psychoeducation provides the individual with better insight into their illness, and may contribute to better engagement with the treatment. This can range from explanation of patient's symptoms, management of the difficulties they present with, and the services which can support to improve their current situation.

75. In addition, the assessment provides an opportunity to explore willingness to engage with services and their preferences for doing so. The assessment will explore the need for involvement from other teams or interventions to meet the patient's needs, some of which the patient may not have been aware of before the assessment.

**Family/carer involvement in assessments**

76. Collateral information from family/carers is important to understand the person's clinical presentation and risks, and to gather relevant background information. Some patients attend their assessment with a carer/family member and they remain present throughout the assessment, which enables a joint discussion between the assessor, patient and their family/carer. Together, information can be shared and a collaborative plan formulated. Family members may wait outside for a period of assessment when the patient may wish to share information they are uncomfortable sharing in presence of a family member.

77. Consent to share information with a person's family/carer must be obtained. Patients may give varying levels of consent. For example, a patient may consent for their family/carer to be aware that they are engaging with services but not for their diagnosis or treatment to be to be shared. Any reasons for refusal for family/carer involvement should be explored to better understand the relationship between the patient and the family/carer, the support network of the patients and the challenges faced by the carer and/or the patient. There are circumstances when information is shared without consent, such a prevention of serious harm. Clinicians have support of senior members of the team, Caldicott Guardian and Trust information governance team for advice in such situations.

**Involvement of other agencies in assessments**

78. Some assessments require collaboration with external agencies. The engagement often begins at the point of the referral, where the other team, service or agency provides relevant information to the receiving team, often to support decisions regarding admission or to explore other alternatives. Patients are often known to agencies outside of the NHS, such as a care agency or supported living, where joint assessments can be facilitated with patient's consent. This provides the patient with an opportunity to be assessed in presence of a familiar professional and also assists in the triangulation of information. The assessor is expected to review any relevant clinical records, if available, prior to assessing the person.

**Limitations to an assessment**

79. In general, there can be limitations to the completeness of a mental health examination and risk assessment.

80. The person may not engage with the assessment, and reasons for this should be explored by the assessor. Reasons for a lack of engagement or difficulties with the engagement will vary from person to person, and understanding the barriers can enable a change of approach to maximise engagement and undertake a meaningful assessment.

**Patient choice**

81. A patient may decline to engage in an assessment. If this is the case, it is important for them to receive relevant information so they can weigh up the decision to engage or not. If the patient has the capacity to make the decision to decline the assessment, they should be provided with information on how to access the service in future, should they need or wish to do so.

**Communication barriers**

82. If the assessing clinician does not speak the preferred language of the patient, the assessment may need to be delayed in order to ensure appropriate support is in place to address the language difficulties – such as arranging for a translator.

83. In addition, the patient may have additional needs due communication disorders affecting the person's ability to process information (aphasia) or deafness, where adaptations may need to be made to accommodate the assessment, or input from other

services and agencies sought to meet the patient's communication needs for the assessment to take place.

**Presentation**

84. A patient's presentation can influence the ability to complete the assessment. In some cases, this may be due to temporary factors, such as distress or agitation which impacts on their ability to engage in the assessment. In such instances, care and support should be offered to the patient to assist them in returning to their baseline level of functioning, allowing the assessment to proceed as intended. The patient's level of distress and their ability to engage with the assessor will form part of the assessment and assist in determining outcomes for the patient. For example, if a patient experiences a panic attack and responds well to grounding and breathing techniques, they may be provided with self-help resources to use outside the assessment.

85. A patient's clinical presentation influences the manner in which the assessment is undertaken. A person presenting with psychosis may not share the information due to their paranoia. Alternatively, a patient with hypochondriasis may wish to spend most of the allocated time seeking reassurance, making it challenging to complete the full assessment within the stipulated time. This forms part of the interviewing skills.

86. If the clinician deems that the lack of engagement is due to acute mental illness and adaptations cannot be made successfully, the clinician may consider making a referral for assessment under the Mental Health Act where the criteria for such is met.

**Acute intoxication or withdrawal**

87. If the patient is under the influence of alcohol, drugs, or experiencing withdrawal symptoms, their cognitive and emotional state may be temporarily alters, which may lead to an inaccurate assessment if carried out. Although under NICE guidance being intoxicated should not automatically delay assessment, the clinician may have to wait until the person is fit to be assessed. This will be a judgement made by the clinician in each case **[MK-024: NICE Coexisting Severe Mental Illness Psychosis and Substance Misuse Assessment and Management in Healthcare Settings]**.

**Physical illness**

88. Conditions such as delirium or infections, can influence cognition and behaviour, making it difficult to differentiate between organic and psychiatric functional causes for

deterioration. Nationally, it is established practice to rule out some physical causes before carrying out a psychiatric assessment e.g. in a suspected case of delirium **[MK-025: NICE Delirium in Adults CG103].**

**Neurodiversity or neurodevelopmental disorders**

89. An assessment requires an understanding of a patient's baseline functionality. When undertaking a mental state/mental health assessment, it is important that clinicians are aware of the potential impact and presentation of neurodevelopmental conditions such as autism, attention deficit hyperactivity disorder (ADHD) and intellectual disabilities. These can, at times, be misinterpreted as signs of psychiatric illness. Where individuals present with confirmed neurodevelopmental disorders, clinicians should be mindful of the potential diagnostic overshadowing. The neurodevelopmental condition can be mistaken as a primary area of concern, instead of the presenting psychiatric condition.

**Feigning or malingering**

90. If the patient is exaggerating or fabricating symptoms for secondary gain, such as seeking medication or avoiding legal consequences, the information provided may not accurately reflect their true clinical need. Detecting malingering can be difficult, even for experienced clinicians. Extended interviews that begin with open ended questions may help reveal inconsistencies or contradictions in the patient's account. Gathering collateral information and having a strong understanding of the condition the patient may be feigning, can assist in identifying symptoms that do not align with the established diagnostic criteria. Certain psychometric tests and psychological assessments designed to assist malingering are available, although they are more commonly used in medico-legal or forensic settings.

**<u>Outcomes of assessments</u>**

91. The outcome of an assessment can vary depending on the nature and the purpose of the assessment. Through the assessment, the clinician will better understand the needs of the patient. There are a number of self-help materials designed to support an individual to develop strategies to deal with their current difficulties. Patients will be provided with accessible information on available resources. Some of these resources are locality specific and the local mental health teams will have relevant information on such resources. These will be shared with the patient in the most appropriate format for them, such as a verbal discussion, websites, apps and leaflets.

92. The clinician will also consider which, if any, additional services the patient may benefit from, and where applicable will complete the referral. As with the incoming pathway, the outgoing referral pathway will need to consider the patient's need for the service or intervention alongside the criteria for the service. Some services outside of the Trust may not have a referral pathway established as they do not require a clinician to connect the person with the service. In these circumstances the patient may be signposted and/or supported during their assessment appointment to make contact with the agency if necessary. Examples of assessment outcomes which are not service specific include, but are not limited to:

    a. The person is referred back to the referring professional with advice and the outcome of the assessment. This can include a referral back to an internal Trust team, the GP or another organisation, depending on the initial referral.

    b. A new referral to a Trust team; for example a community mental health team to the Home Treatment Team with gatekeeping responsibility to consider admission or enhanced intervention as an alternative.

    c. The patient is referred to primary care.

    d. The person is referred to NHS talking therapy services. The service will assess the patient as per their criteria, the person's clinical need and their willingness to engage with therapies.

    e. Patient is referred to a specialist counselling support services for a specific identified need, such as for bereavement, or support for assaults or abuse.

    f. The patient is signposted to the voluntary sector or charity sector for specified needs based support.

    g. The patient is signposted to statutory services for support with access to social-based needs, such as housing.

    h. The patient is referred to the relevant local authority for a social care assessment or Care Act Assessment to assess eligibility for funded care.

    i. The patient details are shared with other teams or agencies for safety purposes, for example to Safeguarding, or to the police where a crime has been suspected or committed.

j. Referral to acute care pathway for either treatment at home or inpatient treatment.

**Raising concerns about the assessment**

93. The services have systems and processes in place whereby clinicians are able to discuss the outcome of an assessment with colleagues, including Consultant Psychiatrist, inside and outside of their team and with managers inside and outside of working hours.

94. For patients and their carers or significant others, if they have concerns in relation to an assessment completed by the Trust, this can be discussed with the assessing clinician, or the team manager. On-call managers are available should this be required. In addition, patients and their carers can raise concerns after the assessment with the Trust's Patient Advice and Liaison Service (PALS).

95. If other services have concerns with the assessment and/or the outcome, this can also be discussed with the assessing clinician or the assessing team or their manager.

## Part 4: Types of Assessment

96. This statement focusses on EPUT non-inpatient assessment types, clustered as follows:

- Part 4a: Initial Assessment
- Part 4b: Clinical Risk Assessment
- Part 4c: Specialist assessments including; gatekeeping, Mental Health Act assessments, diagnostic, memory, Neurodivergence, forensic, eating disorders and psychological

## Part 4a: Initial Assessment

97. As detailed above, when a patient is not open to services, an initial assessment is undertaken.

98. The Trust have in place KPIs related to the initial assessments as shown in Table 4.

Table 4: KPIs for initial assessment

| Service model | Referral time |
|---|---|
| Routine assessments | Routine referrals are to be seen within 28 days |
| Eating Disorders | Referrals to Eating Disorders (FREED) of patients aged between 18 and 25 years to be offered an assessment within two weeks of referral |

**Service specific outcomes**

99. When a patient is assessed by a service, part of the reason for the assessment is to determine the route into services and what pathways are required to meet their needs. These will be specific to the service completing the assessment and/or assist with determining the ongoing referrals required.

100. In addition to the generalised assessment outcomes as detailed in the statement above, Table 5 details the service specific outcomes which are KPIs monitored by the Trust following an initial assessment with a non-gatekeeping team.

Table 5: KPIs for non-gatekeeping teams following initial assessment

| Service model | Service specific outcomes |
|---|---|
| Early Intervention in Psychosis | - Accepted on to caseload: The Trust KPI includes individuals with first episode psychosis to be allocated to and engage with their care coordinator within two weeks of receipt of referral. |
| Eating disorders | - Accepted on to caseload: The Trust KPI includes Eating Disorders (FREED) patients aged between 18 and 25 years old to commence treatment within four weeks of referral. |

## Part 4b: Clinical Risk Assessment

### Requirements for Risk Assessments

101. Requirements for risk assessments are included within the Trust's Policy documents. These have been reviewed and this section shows significant amendments which have been made through the Relevant Period. Although there have been amendments between the dates discussed below, only those policy documents with changes to risk assessment components of CPA have been included.

### SEPT

102. SEPT's CPA Policy dated 2003 **[MK-022: SEPT CPA Policy 2003]** acknowledged that risk should be considered at every stage of the process not just when a formal risk assessment is being carried out. In the course of day-to-day contact with the client and carer/s and during more formal meetings it is important to consider:

    a. Suicide;

    b. Self-harm;

    c. Neglect;

    d. Abuse or exploitation (physical, emotional, sexual, financial, racial);

    e. Risk to children;

    f. Violence to others;

    g. Sexual offending;

    h. Absconding /withdrawal from treatment.

103. A formal risk assessment was described as essential, an ongoing part of the CPA process and must be documented and reviewed. The assessment must be thorough and comprehensive with the service user and carer at the centre, and include:

    a. Self-harm (including accidental harm at home / outside the home; alcohol, drug or substance abuse; deliberate self-harm)

    b. Suicide (including previous attempts, threats, opportunity, means)

c. Violence to others (including access to potential victims; specific threats made; history of violence to family, staff, to other service users, the general public, specific other people; degree of physical harm caused; history of sexual assault; non-accidental risk to children)

d. Other types of risk to other people (including accidental risk to children; arson; risk to staff other than violence; destruction to property)

e. Self-neglect (including inability to care for self; lack of carer support)

f. Exploitation by others / vulnerability to abuse (such as financial, sexual, physical)

104. The 2007 CPA Procedural and Professional Handbook for Practitioners **[MK-018 and MK-023 SEPT CPA Procedural and Professional Handbook for Practitioners 2007]**, included details of risk assessment requirements as follows:

a. Self-harm (including accidental harm at home / outside the home; risks associated with alcohol, drug or substance abuse, including any likely interaction between medication and substances, degree of dependence / withdrawal problems; deliberate self-harm);

b. Suicide (including previous attempts, threats, opportunity, means, thoughts of involving others i.e. children);

c. Violence to others (including access to potential victims; specific threats made; history of violence to family, staff, other service users, the general public, specific other people; degree of physical harm caused; history of sexual assault; and non-accidental risk to children & vulnerable adults);

d. Other types of risk to other people (including risk to children including incorporating them into delusional beliefs, accidental; arson; risk to staff other than violence; destruction of property);

e. Self-neglect (including inability to care for self and lack of carer support);

f. Exploitation (including by others/ vulnerability to abuse such as financial, sexual, physical, emotional, racial);

g. Substance Misuse (including how it impacts on the health and wellbeing of the person and those they care for).

105. In addressing risks, the following factors were identified as requiring consideration:

    a. Detention under the Mental Health Act;

    b. Previous admissions to hospital;

    c. Incidents involving the criminal justice system;

    d. Non-compliance with medication;

    e. Reluctance to engage with services;

    f. Failure to attend appointment;

    g. Previous risk taking behaviour;

    h. Substance misuse.

106. In the identification and management of risk, it was essential to seek information on the service users past behaviour and any previous potential triggers for dangerous behaviour and to consider the information in the context of the service users present circumstances as well as considering what previous strategies have worked. Information from the service user was supplemented where possible from other sources, such as voluntary agencies, other mental health units and teams. Where there were carers they should be consulted, involved and kept informed wherever possible. Details of the risk assessment and ongoing risk should clearly be evidenced in the case notes.

107. The Trust's Clinical Guidelines for the Assessment and Management of Clinical Risk were updated in February 2014, maintaining a consistent definition of risk while expanding the approaches to assessment and management of risk and use of other relevant he documentation tools **[MK-026: SEPT Clinical Guidelines of Assessment and Management of Clinical Risk, November 2011-February 2014].** The guideline defined risk as any issue which may impact on the effective, safe delivery and quality of the care and treatment given to our patients. Risk assessment was defined as a process of identifying and investigating factors associated with an increased probability of specified risk behaviours occurring, and the systematic collection of information to determine the degree to which the identified risk is present, or is likely to pose problems at some point in the future.

108. Risk management was viewed as the approach by which a range of actions and factors that are likely to minimise the occurrence and likelihood of identified risks, are identified

and implemented whilst systematically focusing upon methods of reducing both the severity and frequency of recognised adverse clinical risks for each individual patient. Alongside this is the requirement for the development of treatment strategies and plans designed to manage identified risks by reducing or eliminating them or reducing their frequency and severity.

109. The Policy detailed other factors which may be considered as adverse incidents, which may or may not have an impact upon clinical risk; this included service factors and contributory factors.

110. In 2015, SEPT's CPA Handbook was updated **[MK-027: SEPT CPA Handbook 2015]**. Within this version, the following amendments were made to the requirement of risk assessment:

    a. Self-harm: this version saw the removal of the location of the self-harm - self-harm should be considered, whether this be inside or outside of the home;

    b. Suicide: this version saw the removal of consideration for thoughts involving others;

    c. Violence to others: this version saw the inclusion of domestic violence and the removal of non-accidental risk to children & vulnerable adults with a more round definition of 'history of violence to other people';

    d. Other types of risk to other people: this version included a risk factor to children as being accidental; and included environmental risks; moving and handling; and infection control;

    e. Self-neglect: this version saw the inclusion of falls for this risk factor;

    f. Exploitation: this version maintained exploitation by others as being financial, sexual, physical; with emotional and racial removed and replaced with a wider span of bullying and harassment;

    g. Substance misuse: this version removed this as a separate factor and combined with self-harm.

111. In addressing risks, the following factors were newly identified and included as requiring consideration:

    a. Age;

b. Gender;

c. Social situation ie, redundancy, divorce.

**NEP**

112. The earliest located Clinical Risk Management Protocol for NEP was dated September 2004 **[MK-028: NEP Clinical Risk Management Protocol, September 2004]**. NEP defined clinical risk as the likelihood or probability of an adverse and/or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress. Risk assessment was defined as the process of gathering information about a service user's mental state, behaviour, intentions, personal psychiatric history and social situation and forming a judgement about the likelihood or probability of an adverse and/or harmful outcome based upon that information.

113. In NEP in 2005 **[MK-017: NEP CPA Policy 2005]** it was noted that risk assessments should take into account of all of the available information from the service user and others who have knowledge of the individual and included an estimation of the degree of risk presented in respect of:

a. Aggression / violence;

b. Child protection;

c. Hazards;

d. Neglect;

e. Self-harm;

f. Suicide;

g. Vulnerability (including advanced directives);

h. Adult protection.

114. NEP's Clinical Risk Management Protocol was reviewed in 2008 **[MK-029: NEP Clinical Risk Management Protocol, 2008]**. The definition of risk assessment included the addition of gathering information about a service user's physical, sexual or emotional abuse. The updated Protocol outlined the Trust's minimum requirement for risk

assessment to include the completion and recording of a screening tool; as described above.

115. The review of the Trust's Clinical Risk Management Protocol in 2013 **[MK-030: NEP Clinical Risk Management Protocol 2013]** saw a change of approach for the use of the risk assessment tools, whereby the mandatory use of the tools was removed and practitioners with responsibility for risk assessment *may* use one of the recognised tools contained in the Protocol and evidence of this was to be included within the clinical records system. The following additions were made to the Trust's approved tools:

    a. Risk of Sexual Violence (RSV)

    b. Domestic Abuse, stalking, harassment and honour based violence (DASH) 2009 Risk Model for (MARAC – multi agency risk assessment committee)

**EPUT**

116. Following the merge of NEP and SEPT, policy documents were updated and aligned where possible. The Clinical Risk Assessment and Safety Management Policy and Procedure was implemented in July 2017 **[MK-031: EPUT Clinical Risk Assessment and Safety Management Policy, July 2017].**

117. Clinical risk was defined as the likelihood or probability of an adverse and / or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress; and risk assessment was outlined as the process of gathering information about a patient's mental state, behaviour, intentions, personal psychiatric history, including any history of physical, sexual or emotional abuse, and social situation, and forming a judgement about the likelihood or probability of an adverse and / or harmful outcome based upon that information. An overview for risk management, safety planning, contingency planning and crisis management was also included.

118. In 2017, Version 1 of EPUT's CPA Policy and Procedure was published having merged the documents in place from SEPT and NEP **[MK-011: EPUT CPA Policy [2017]; MK-012: EPUT CPA Procedure [2017]**. The risk categories and indicators were incorporated into the Procedure in tabular form, as presented in Table 6:

Table 6: EPUT 2017 risk categories and indicators

| **Suicide** | **Self-harm** |
|---|---|
| - Previous attempts<br>- Threats<br>- Opportunity<br>- Means<br>- Internet (access to information and suicide promoting groups)<br>- Expressed intent<br>- Plans<br>- Chronic suffering of persistent pain<br>- Recent diagnosis of life changing/threatening illness<br>- Recent discharge from hospital<br>- Recent discharge from services<br>- Family history of successful or attempted suicide<br>- Flag alerts<br>- Rational decision<br>- Sleep disturbances | - Current / recent episodes of self-harm<br>- Deliberate self-harm<br>- History of self-harm<br>- Accidental harm<br>- Alcohol / drug / substance misuse issues<br>- Food issues<br>- Cutting<br>- Binge drinking<br>- Degree of dependence / withdrawal problems<br>- Change in method<br>- Increase in severity / frequency<br>- Deliberate promiscuous behaviour<br>- Deliberate avoidance of prescribed medication or treatment |
| **Aggression and violence** | **Vulnerability and neglect** |
| - Violence to others<br>- Domestic violence<br>- Access to potential victims<br>- Specific threats made<br>- History of sexual assault<br>- Paranoid delusion<br>- Verbal aggression<br>- Escalation of threats<br>- Response associated to withdrawal symptoms | - Inability to care for self<br>- Lack of carer support<br>- Falls<br>- Cognitive impairment / confusion<br>- Capacity issues<br>- Fire risk<br>- Social isolation<br>- Social media<br>- Recent discharge from hospital<br>- Impaired eyesight and/or hearing<br>- Physical ill health |

| | |
|---|---|
| - Aggressive behaviours whilst under the influence<br>- Predatory towards vulnerable individuals<br>- History of violence to family/staff/other people and degree of harm caused | - Recent discharge from prison or the services<br>- Lack of health education<br>- Poverty or lack of resources<br>- Recent bereavement |
| **Safeguarding** | **Hazards** |
| - Exploitation from others<br>- Vulnerability to abuse<br>- Bullying and harassment<br>- Domestic abuse<br>- Risk of being radicalised<br>- Financial abuse<br>- Institutional abuse<br>- Sexual abuse<br>- Physical abuse<br>- Female Genital Mutilation (FGM)<br>- Patient is the carer of their own relatives<br>- Patient is directly or indirectly providing support to a child<br>- Being cared for by carers with mental illness / addiction problems<br>- | - Environment<br>- Neighbourhood<br>- Unsafe buildings<br>- Hoarding<br>- Hazardous surroundings<br>- Aggressive pets<br>- Inadequate information on patient<br>- Location<br>- Bad lighting<br>- No mobile phone network<br>- Parking difficulties / issues<br>- Other members of the household have aggressive / intimidating behaviour<br>- |
| **Mental health history** | **Personal** |
| - Previous admissions to hospital<br>- Previous risk taking behaviour<br>- Detention under the Mental Health Act | - Age<br>- Gender<br>- Social situation (for example, redundancy, recently divorced)<br>- Key life events<br>- Relapse indicators<br>- Triggers |

| | |
|---|---|
| | - Anniversary date of death of a loved one (or pet)<br>- Non-compliance with medication<br>- Failure to attend appointments<br>- Incidents involving the Criminal Justice system<br>- Reluctance to engage with services<br>- Substance misuse |

119. In the CPA policy update in 2023 revisions included modification of some of the terminology of the indicators in the above risk categories **[MK-013: EPUT CPA Policy, 2023]**. The changes involved the elimination of some indicators and the expansion of the descriptions and scope.

**Part 4c: Specialist Assessments**

**Assessment with a team with gatekeeping responsibility**

120. A gatekeeping assessment, broadly can be defined as an assessment undertaken to access inpatient bed. Services with gatekeeping responsibility over the relevant period are included as a summary in Appendix 2. Prior to the introduction of some of the services detailed, the community teams arranged admissions directly with the wards. In addition the services have undergone a number of transformations through the relevant period, including changes to functionality and team names, therefore only the service model is provided as an overview. Further details are provided in the Trust's response to Rule 9(6).

121. Given the changes of services over the relevant period, arrangements for admission have remained clinically led, however the process in place has changed. With the introduction of services, community based crisis teams are designed to support patients in their home environments. Prior to the introduction of such services, community mental health teams provided increased support and when this was no longer feasible the patient was admitted to inpatient services. Through the years, aside from the service changes, the threshold for admission remains based on clinical presentation, risk assessment and acute mental health crisis where the patient requires additional monitoring and security of a ward environment.

122. The Trust's response to Rule 9(6) outlines how gatekeeping responsibilities for admissions were managed during the relevant period. As such, this section will focus specifically on the patient interaction within the assessment process.

123. A team with responsibility for gatekeeping will conduct an assessment to consider whether there is a safe alternative to admission or to authorise admission. This assessment would be undertaken with a patient who is in a mental health crisis and requires intensive support to manage the crisis. The patient will be actively involved in the decisions about their care, and with their consent family member/significant others may be included in the process.

**Referral pathways**

124. Some services have delegated gatekeeping responsibility within particular working hours and therefore outside of these gatekeeping hours, they will refer the patient to the gatekeeping team.

**Requirements for assessment**

125. As detailed, when patients are in mental health crisis or have had a relapse of their psychiatric illness, an assessment is undertaken with a more rapid response than other non-urgent assessments. The Trust currently has the following KPIs in place, outlining the target timeframes for completing the assessments, detailed in Table 7.

Table 7: KPIs for assessments which outline time targets

| Team | Referral time |
|---|---|
| Crisis Response Services (NHS111, option 2) | Callers who require a crisis response should be assessed face-to-face within four hours of the call being received. |
| Crisis Response Services (NHS111, option 2)<br>Home Treatment Teams | Individuals who require an urgent response should be assessed face-to-face within 24 hours of the referral being made. |
| Hospital Liaison Services | Individual's experiencing a mental health crisis should receive a response (for example, commence assessment) within a maximum of one hours of the service receiving the referral. |

| | |
|---|---|
| | In addition, the Trust also monitors the number of breaches over four hours in Emergency Departments attributable to Hospital Liaison Services. |
| Hospital Liaison Services | Individuals on general wards in the acute hospital to be assessed within 24 hours of the referral. |
| Health Based Place of Safety | The Trust monitors the number of patients in the suite over 24 hours. This is in line with the requirement for Mental Health Act assessments to take place within this timeframe. |

126. In addition to the above Trust KPIs, service-level timeframes for the initiation of assessments are in place.

**Inpatient specialist service gatekeeping arrangements**

127. As of April 2024, admissions to Mother and Baby Units (MBU) are organised in the East of England by the Provider Collaborative. Prior to this, the gatekeeping of MBU beds was managed by the local MBU; namely EPUT's Rainbow Unit in Chelmsford which opened in January 2010. Funded admissions to MBUs were managed by NHS organisations and referrals for a bed were made to the patient's local unit. The referral details were screened to determine the requirement for admission, and if admission was warranted and there was capacity at the local MBU the patient was admitted there. If there was no capacity, admission was arranged for the patient at other NHS MBU.

128. On occasions, where mothers require admission without the baby being admitted with them, a decision can be made for admission to acute mental health services. The pathway for gatekeeping falls under the usual provisions described previously.

129. The Trust are commissioned to provide community Eating Disorders Services and have not managed inpatient eating disorders services for the Relevant Period. As such, the Trust do not have responsibility for gatekeeping eating disorders services.

130. Admissions to CAMHS inpatient services are arranged with the Provider Collaborative from April 2021 onwards. Prior to this, since November 2015, NELFT delivered CAMHS Tier 2 and Tier 3 services for Essex patients. When NELFT made a decision that a young

person required admission to an Essex CAMHS bed they liaised directly with the CAMHS wards. Prior to November 2015, the Trust's CAMH Services were responsible for gatekeeping in the Trust.

**Service specific outcomes**

131. In addition to the generalised assessment outcomes detailed previously, Table 8 details the service specific outcomes which may result from assessments conducted by with gatekeeping responsibilities.

Table 8: Additional outcomes following assessment with a team with gatekeeping responsibility

| Service model | Service specific outcomes |
|---|---|
| Hospital Liaison | - Remain in the acute hospital due to physical health needs<br>- Admission to mental health inpatient unit (completed only when gatekeeping designation is applied) |
| Home Treatment | - Home treatment intervention<br>- Admission to mental health inpatient unit |
| Crisis Response (NHS111) | - Admission to mental health inpatient unit (completed only when gatekeeping designation is applied)<br>- Referral to the voluntary sector led Crisis Café/Sanctuary's |
| Service specific for Older Adults | North East Essex DIST<br>- Intervention for up to six weeks under the DIST<br>- Admission to mental health inpatient unit<br>Mid Essex DISS<br>- Onward referrals to meet the needs of a patient with dementia<br>- Intensive support from DISS for up to six weeks<br>- Admission to mental health inpatient unit<br>Mid and South Essex FIRST<br>- Home treatment intervention |

| | |
|---|---|
| | - Admission to mental health inpatient unit<br>West Essex IST<br>- Onward referrals to meet the needs of a patient with dementia<br>- Home treatment intervention<br>- Admission to mental health inpatient unit |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | - Home treatment intervention<br>- Admission to CAMHS unit through provider collaborative |
| Secure Services | - Recommendation for admission to secure services through provider collaborative |
| Mother and Baby Services | - Recommendation for admission to a mother and baby unit through provider collaborative<br>- Access to perinatal pathways |

**Mental Health Act assessments**

132. A Mental Health Act (MHA) assessment is a formal evaluation of a person's mental health, carried out to determine whether they need to be detained in hospital for treatment under the Mental Health Act 1983 (as amended in 2007). The MHA is the main piece of legislation involved in this type of assessment, and is the only form of assessment where the outcome could lead to a detention to a mental health ward.

133. The Local Authority has the statutory responsibility for arranging and managing the assessments under the Act. The National Health Service Act 2006 allows arrangements to be made between NHS bodies and local authorities, known as "Section 75 agreements". This created the facility to delegate authority for statutory duties from Social Care to Health Care. As such, the Local Authority passed this duty to NEP, SEPT and subsequently EPUT. This included the provision of Mental Health Act assessments, coordinated by Approved Mental Health Professionals (AMHP), which are completed Monday to Friday 0900 – 1700hours. Outside of these hours, the responsibility of assessments remains with the Local Authority Emergency Duty Team/Service.

134. EPUT services span across three local authorities; Essex County Council, Southend Borough Council, and Thurrock Council. Table 9 shows the service changes which have

occurred in relation to the provision of MHA assessments under the Section 75 agreement.

Table 9: Mental Health Act assessments (undertaken by Section 75 agreement, by Local Authority)

| Local authority | Dates of agreement |
|---|---|
| Essex County Council | 2006 – January 2019 |
| Thurrock Council | 2006 – March 2021 |
| Southend Borough Council | 2006 – November 2023 |

135. Approved Mental Health Professionals (AMHPs) make independent decisions regarding the making of applications under Part 2 of the MHA. Some AMHPs will not be substantive employees of the Local Authority, however all AMHPs operating for Local Authority are approved and formally authorised to undertake the role of the AMHP on behalf of the Local Authority. The Local Authority retains the overall legal responsibility for the governance of the AMHP service and in ensuring that the training needs, professional development, and approval arrangements for AMHPs are appropriately delivered.

136. An Approved Mental Health Professional (AMHP) is often a social worker, but can be a nurse, psychologist, or occupational therapist. In order to undertake the AMHP role, at least two years experience in their respective profession is needed. The AMHP qualification is a Masters level university course and is completed over a period of four months. In addition to this, the trainee is also expected to undertake a pre-AMHP course before being considered to undertake the AMHP training. The AMHP is autonomous and responsible for making decisions, but has a management support infrastructure in place for seeking advice.

**Referral Pathways**

137. An individual is referred for a Mental Health Act assessment where there are concerns about presence of acute mental illness, which requires immediate treatment to prevent deterioration, and where there is a significant risk of harm to themselves or others as a result of their mental health symptoms and/or deterioration. Anyone can request a Mental Health Act Assessment, including family members, a GP, emergency services, and a health or social care professional. A patient's allocated Nearest Relative has the

right to request an assessment under the Act. This can be requested in writing or by a telephone call.

138. When the referral is made by the health professional, it is made in writing to the day-time AMHP coordinator/hub, which is screened by the duty officer. They will review the reasons for referral, and ensure there has been the right support and contact to verify the accuracy of the referral details, and confirm there is reasonable cause for the referral. This includes ensuring a clinical assessment has been made to justify the referral for an assessment under the Act. Once the initial screening is complete, the information will be shared with the AMHP.

139. Alongside referrals which are made for community-based MHA assessments, there are two sections under the Act which are within the remit of gatekeeping, as follows.

**Section 135**

140. Section 135(1) provides the request for a magistrate to issue a warrant to authorise entrance to an individual's premises for the purpose of removing a mentally disordered person to a Place of Safety. Any warrant issued authorises a constable, accompanied by an AMHP and a registered medical practitioner to enter, and if need be by force, any premises specified in the warrant in which that person is believed to be. This is with a view to remove the individual from the property to a place of safety in order to assess whether an application in respect of the Mental Health Act is needed, or whether any other action for their treatment and care is required.

141. This would be used if a patient does not or will not allow the assessing team into their property to conduct the assessment and there are concerns that without obtaining entrance, the patient is at risk to themselves or others due to the deterioration of their mental state, and other routes of assessment are not feasible.

142. Having established that the grounds for an application are met, and that an application is justified, the AMHP will contact the Essex Police to forewarn about the process and to discuss any actions needed. All agencies involved will enquire into the background of the patient and exchange relevant information so that the AMHP and Essex Police can consider the risks. Entry to a person's home must therefore, in all the circumstances of the situation, be a proportionate measure within the context of this legislation.

143. Warrants are obtained via the Magistrate's Court and obtainable via telephone during working hours in order that the Clerk to the Court Services legal adviser can arrange for the application to be heard by the Magistrate, and a warrant issued. The warrant can

take up to 24 hours to acquire, depending on the availability of the local Magistrate. Where possible applications for a warrant should only be applied for within normal Court hours. Applications out of hours should only be made if it is urgent and it is intended to execute the warrant out of normal Court hours.

144. Once issued, the warrant is valid for one month. It is good practice to ensure the person is assessed as soon as is practicable. It is reasonable to assume that if no action has been taken after two weeks the Section 135(1) warrant should not be used without careful consideration. A warrant of any description can only be used once. If a premises is entered with or without force and no one is present inside, then the warrant is considered used.

145. Essex Police and the AMHP will agree a meeting location for a briefing. During which roles of each person in attendance will be agreed ahead of the warrant being executed. If the patient is present and the warrant is successfully executed, the individual will be transferred to a designated place of safety.

**Section 136**

146. A police officer may perceive a person to present with symptoms of mental disorder whilst in a public place, and under Section 136 of the Mental Health Act, they can be conveyed to a place of safety for a Mental Health Act assessment to be undertaken. It is good practice for an AMHP to respond within two hours of being notified of a person's detention under Section 136 of the Mental Health Act. However, it is recognised that it is not always possible to do so.

147. Whether the patient is detained under Section 135 or Section 136 of the MHA, the place of safety is usually the same. They are areas set aside for Mental Health Act assessments. Essex has a number of appointed suites, which have been provided to the Inquiry under Rule 9(6). In circumstances where they are not available, a designated area in an acute hospital can be used under the Act. Prior to December 2017, police stations were also used as a place of safety, however this was discontinued under the Policing and Crime Act 2017. Places of safety have also been known as Section 136 suites and more recently as Health Based Place of Safety.

148. The Health Based Places of Safety are managed by the Trust. Prior to transfer of the patient, the Police are required to inform staff at the Health Based Place of Safety. Once detained, discharge can only be facilitated following the MHA assessment. Where risk indicates the need, the Police will remain until the Nurse in Charge of the Place of Safety

and the Police are satisfied the risk has reduced. Where there is doubt or disagreement about this, the Police will consult their supervising officer for direction as to the length of time they can remain. The supervising Officer will consult with the Health Based Places of Safety staff before any decision for the Police to leave is made **[MK-032 - EPUT Health Based Place of Safety (s136) Operational Policy, 2023].**

149. The request for a MHA assessment is made at the earliest opportunity by the Nurse in the Health Based Place of Safety. The patient is monitored for the length of time they are detained. In December 2017, the length of time the individual can be detained in a Health Based Place of Safety was reviewed from 72 hours to 24 hours, with the addition of an extension of 12 hours if clinically necessary.

**Assessment**

150. On receiving a referral for an assessment under the Mental Health Act, the AMHP will commence the process of seeking background information, which may include review of clinical records, and discussions with professionals involved in the patients care. It is the responsibility of the AMHP, at the time of application of assessment under the Act, to pursue the contact with the Nearest Relative. The AMHP should take all such steps practicably possible to contact the Nearest Relative, and if this is not possible, they should contact them subsequent to the assessment.

151. Outside of the Health Based Place of Safety, a MHA assessment can be carried out anywhere appropriate in the circumstances. A Mental Health Act assessment is carried out by two Doctors and the AMHP. The AMHP will organise the attendance of the two Doctors. It is the decision of the AMHP to identify the doctors for the assessment, and often involve doctors not employed by EPUT. At least one of the Doctors must be a registered medical practitioner under Section 12(2) of the Mental Health Act, as they are approved to give one of the medical recommendations for the compulsory admission of a patient to hospital under the Act. To be approved under Section 12(2), the Doctor must be a registered medical practitioner, have completed specific training on the treatment and diagnosis of mental disorders and approved by the Secretary of State for Health. Since 2015, it is a national requirement for the Section 12 Approval Training Course to be completed.

152. Prior to a Mental Health Assessment, the AMHP will inform the bed manager of the assessment so that they can arrange a bed, if needed.

153. During the assessment process the assessors will speak to the individual in order to assess their mental state and presentation of risk, as well as gather information on any historic risks or incidents relevant to the assessment. Consideration for detention under the MHA must be given with the least restrictive practices and principles being applied.

154. The AMHP will seek the view of the individual as part of the MHA assessment. The Code of Practice for AMHP's stipulates that all assessments under the MHA are completed in a suitable manner ensuring the person is able to fully participate in the process. All reasonable steps must be taken to ensure there is a suitable environment for the assessment to take place. The person must be informed of the nature and implications of the MHA assessment and the possible outcomes of the assessment. The person should be included in all decision making to support their safety and that of others. The AMHP and Doctors are expected to consider the individual's co-morbidities, neurodiversity, developmental history, substance misuse, and other personal characteristics, and how these factors impact on their mental wellbeing. This informs the decision around most appropriate management and treatment for that presentation.

155. The aim of the assessment is to determine whether the person meets the legal criteria for detention under the Mental Health Act. The outcomes of assessment are inclusive of those detailed previously, with the addition of the potential that a patient could be admitted to hospital against their will under the Mental Health Act. This type of assessment, due to the legislation and Code of Practice which underpins the processes, makes it different to other assessments.

156. For an individual to be detained, they must have a mental disorder that requires hospital treatment, pose a significant risk to their own health, safety, or others; and be unable or unwilling to accept treatment voluntarily.

**Diagnostic assessment**

157. The assessment involves gathering information from the patient (and relatives, where possible) in a structured manner and understand their mental state, described as mental state examination.

158. Medically trained staff (mainly psychiatrists) are trained in providing a diagnosis and the diagnostic assessments are generally carried out by medical professionals using internationally recognised diagnostic classification systems, such as International Classification of Diseases (ICD-10). The assessments undertaken by members of the multidisciplinary team can assist the team psychiatrist in making a diagnosis. Certain

specialist diagnostic assessments (for example, assessments of Autism and ADHD) are undertaken by other professionals such as psychologists, who are specialists in that field. This process will start when a new referral is made to a mental health service but continues at each patient contact along the care pathway.

159. Psychiatric diagnosis can change over time. For example, diagnosis of Depressive Disorder in an individual may change to a diagnosis of Bipolar Affective Disorder (if the individual has a manic breakdown) or Schizophrenia (if schizophrenic symptoms emerge).

**Memory assessments**

160. The Memory Assessment Services are part of the Older Adult Mental Health Services in the Trust. The service is designed for people who experience memory and / or other cognitive difficulties. The focus of the service is to determine whether or not the person has dementia and the type of dementia, so a plan can be developed to meet the person's current and future needs.

161. The assessment and diagnostic process involves three main contacts:

    a. The first is an initial assessment which takes place within six weeks with a Memory Assessment Service Nurse. The assessment can take place either in the patient's home or at a Trust site. In addition, investigations such as an Echocardiogram (ECG) are completed either by an Associate Practitioner or through attendance at the local ECG drop-in clinic.

    b. The second contact is with a Doctor as part of the diagnosis pathway, which is to be completed within 12 weeks.

    c. The third is a follow up with the Memory Nurse for a post-diagnostic appointment.

162. In between the above appointments, the patient may also have contact and assessments with the occupational therapists, speech and language therapists and psychology as part of the diagnostic and support process.

163. Currently, MASS assessment tool which is based on FrEDA **[MK-033: EPUT MASS Diagnostic Assessment; MK-034: FrEDA]** is being used as a diagnostic assessment tool in Mid and South Essex. There are a range of validated assessment tools that may be used alongside this including Hospital Anxiety and Depression Scale (HADS) **[MK-035: Hospital Anxiety and Depression Scale]**, Informant Questionnaire on Cognitive

Decline (IQCODE) **[MK-036: IADL]**, Addenbrooke's Cognitive Examination (ACE-III) GDS **[MK-037: ACE111].**

164. Historically, the assessment documents and tools used were replaced when copyright changed. As an example the Trust used the Mini Mental State Examination which were replaced by ACE111 and MOCA **[MK-037: ACE111; MK-038: MoCA].**

165. To exclude other causes, inform diagnosis or sub-typing and identify suitable treatment options, further examinations may be completed and may include:

    a. CT (Computer Tomography) scan - will be undertaken for all patients referred to the clinic (this may be done prior to clinic by GP or the Memory Assessment Nurse;
    b. The review of medication in order to identify and minimise the use of drugs that may adversely affect cognitive functioning;
    c. ECG;
    d. Structural imaging such as MRI (magnetic resonance imaging) computer tomography or DAT ( dopamine transporter scan);
    e. Formal neuropsychological testing, where appropriate;
    f. Other investigations as appropriate e.g. Activities of Daily Living (ADL), AMPS (atypical movement pattern scale).

**Assessments of Neurodivergence**

166. Neurodivergence assessments incorporate Autism and ADHD. Assessments which take place within these services are to identify whether an individual has one or both of these conditions. In addition, the assessment can inform any future support needed, such as reasonable adjustments in a work setting, or help in addressing some of the potential consequential challenges, for example managing anxiety.

167. A referral may not be accepted where there is insufficient information around the signs and symptoms of Autism and / or ADHD, or where there is no developmental history of these difficulties, or where the individual is currently too unwell to participate in the assessment.

168. For a diagnostic assessment to be undertaken in either the Autism or ADHD services, there has to be enough information to indicate the possibility of a neurodivergent condition, and they are not better explained by other conditions. In the Autism and ADHD

services the referral forms contain set information requests, in addition to screening measures for each condition.

169. The waiting times for assessments in both Autism and ADHD services are considerable due to the volume of demand for these services, which is nationally recognised.

170. In the Trust's South Essex Autism Service, the team completes a triage. Following this, some patients are placed on a waiting list with the referral clinic, which has a waiting time of approximately six months. The referral clinic provides a way to gather additional information where there is a greater level of complexity. The waiting time for diagnostic assessments in the South Autism Service is currently around four years.

171. In the ADHD services and the Trust's North Autism service, an initial assessment is completed which seeks to gain additional information regarding developmental history, education and features that might indicate neurodivergent differences. The initial assessment is however, not a diagnostic assessments, which takes place at a later stage. In the Trust's ADHD services, the diagnostic assessments are around two years after the initial assessments. In the North Autism services they are around ten months to one year after the initial assessment.

172. Initial assessments take a minimum of 90 minutes to complete with an additional 30 minutes with an informant who is usually someone who has preferably known the individual since childhood but as a minimum, someone who is able to provide collateral information. Initial assessments are completed by Assistant Psychologists (APs), trainees, Clinical Associate Psychologists (CAP), nurses and qualified psychologists. The APs, trainees and CAPs take the initial assessments to discuss in supervision. A full diagnostic assessment in the Trust requires a minimum of 2-2.5 hours.

173. Regarding autism assessments, in the North Autism Service, diagnostic assessments take a minimum of 2.5-3 hours depending on the complexity; and in the South Autism Service, as initial assessments are not utilised, the diagnostic assessments are completed over 4.5-6 hours, depending on the complexity. The diagnostic assessments are completed by nurses, OTs and qualified psychologists. The nurses discuss their diagnostic assessments in supervision. The OT (in the South Autism Service) will discuss their assessment in supervision or will complete jointly with the qualified psychologist. Responsibility for the assessment remains with the qualified member of staff.

174. Medication assessments in the Trust's ADHD service are undertaken by nurse prescribers, pharmacist and psychiatrists. For new appointments these can take 90 minutes.

175. Assessments take place remotely and in person. Due to the importance of a developmental history, collateral information is essential which is often obtained from a family member. The individual is involved in the assessment and discussions related to the outcomes.

**Assessment outcomes**

176. From diagnostic assessments for either ADHD or Autism the outcomes include:
    a. Discussion and support related to the description for the differences the individual experiences;

    b. The individual also needs an assessment for the other condition identified (Autism or ADHD);

    c. The individual does not have either condition but there is a different/better explanation for the differences they experience and they will be advised signposted to support services;

    d. For Autism assessments, the individual meets a number of the features of this condition, but not the full complement (i.e. has traits of the condition but does not meet the threshold for the diagnosis);

    e. In all cases, the individual is given resources and guidance that will be helpful to them.

177. The Autism and ADHD Services offer consultation to other Trust teams around referrals as well as support for those with an existing diagnosis.

**Forensic assessments**

178. For the Trust's secure services, the inpatient Psychiatrists are responsible for conducting assessments to determine if a patient requires admission to the service. Assessments are also conducted for specialist advice.

**Referrals**

179. Referrals are made by prisons and Courts, other secure hospitals, and occasionally from community teams. At any point between an individual's arrest and sentencing, they can be referred for assessment, although it is more common to receive a referral when a patient is in prison. A referral may be made from the Courts an individual awaiting sentencing is mentally unwell.

180. A referral is made when the referring clinician or service requests a specialist forensic opinion, or consideration for transfer to the Trust's secure services. This will be due to the patient presenting with increased risk that cannot be managed in their current environment, involvement in an offence requiring a forensic opinion, medication advice, or consideration for hospital admission.

181. Since the formation of the Provider Collaborative in July 2021, referrals to the secure services are received from the Provider Collaborative. Prior to this, they were received directly by the local secure services and the commissioners were notified.

182. Once the referral is received from the Collaborative, it is discussed at the Trust's internal forensic referrals meeting to determine if an assessment is required. The referral template received contains the information the services need in order for them to make a decision. When required, further information can be requested to assist with screening. When the risk is low or another identified service can complete the assessment, the referral is not accepted. When a referral is received for a transfer from another secure service, it is made directly by the referring psychiatrist and the assessment process remains the same.

183. The non-forensic psychiatrist can seek an assessment from forensic psychiatrist as part of specialist / second opinion, particularly when a patient presents with significant risk of violence.

**Assessment**

184. Upon arrival at the assessment location (such as Courts, prisons, detention centre, other inpatient settings in the NHS or another secure hospital) review of records and discussion with staff will assist in obtaining an updated account of the patient's current presentation. The patient is present for the assessment, however their decision making may be limited due to the detention under the Mental Health Act.

185. The assessment is completed by the Psychiatrists as the responsibility for determining admission into the services is medically led. Consultant Psychiatrists have overall responsibility for the assessments; and where this is delegated to speciality doctors or

higher trainees (previously known as registrars) the assessments are reviewed by the Consultant.

186. The medical assessment is documented as a standard forensic psychiatric assessment. For individuals being considered for admission to the Trust's secure services, the same initial assessment tool used across other services is applied. The assessment primary focus is on the nature and degree of the psychiatric symptoms, mental state, and risk factors to inform decisions regarding suitability for secure admission **[MK-039: EPUT Secure Services Structured Clinical Risk Assessments Protocol, 2023].**

187. If a decision is made to admit the patient, a nursing assessment is completed in the patient's location. The timing of admission is based on the Trust's availability of beds and on Court timetables. Following a forensic assessment, the patient may be admitted to a low secure or a medium secure forensic unit, depending on the assessed risk level and the required security. A recommendation can be made for admission to a high secure unit. As the Trust do not provide high secure services, the referrer would be responsible to engage in the high secure hospital referral process. The outcome of the assessment is shared with the Provider Collaborative (formerly NHS England).

**Eating disorders assessments**

188. An eating disorder service assessment, in comparison to the general mental health assessment, has the focus on eating thoughts and behaviours **[MK-040: EPUT Eating Disorders Initial Assessment; MK-041: EPUT Eating Disorders Assessment (North Essex)].** This includes considerable detail on history of eating disorders and recent changes, current diet, any eating disorder behaviours (such as restricting, bingeing, purging, laxative use, water loading, and over-exercising), frequency of weighing and body checking.

189. The assessment includes physical health and includes accurately measuring Basal Metabolic Index (BMI) and vital signs, such as blood pressure and pulse. It enquires about physical symptoms that may be present because of an eating disorder (relating to cardiorespiratory, hydration, or gastroenterology).

190. Referral pathways include but are not limited to GPs, community mental health teams and crisis services, physical health professionals such as diabetes nurses/specialists, and mental health or physical health wards where a patient is admitted.

191. Referrals are triaged on a weekly basis by two senior clinicians (Band 7 and above). A member of the psychology team triages with either a nurse or Occupational Therapists (OT) each week. Triaging clinicians review information on the referral form provided and also access the available clinical records to inform decision making.

192. Referrals are triaged based on information provided in the referral form. They are either accepted for assessment and allocated to a clinician to assess, or a request is made for further information to be provided. A referral may also be rejected on the information that has been provided indicating that the patient would not have a primary eating disorder, or would not meet severity for the service.

**Assessment**

193. If a patient is accepted for assessment, this is typically completed within 2-4 weeks, or sooner should the risk be triaged as urgent. Typically an assessment will last up to 90 minutes, and may be longer where a joint assessment is undertaken or the presentation is complex. If needed, extended assessments over 2-4 weeks following discussion and agreement with MDT.

194. Qualified practitioners carry out initial assessments both independently and jointly as required. Trainee psychologists and therapists can conduct initial assessments under supervision. Consultation for the assessments take place with the SCOD that day, in supervision and with the MDT. Responsibility of oversight lies with the clinical supervisor, Consultant Psychiatrist and the MDT.

195. An eating disorders assessment will:

    a. assess eating disorder specific psychopathology such as presence of weight/shape concerns;

    b. distinguish eating disordered behaviours from disordered eating by establishing the drivers for said behaviours;

    c. distinguish whether a primary eating disorder is present or if eating is disordered as a result of another primary mental health difficult, for example, overeating or missed meals/lack of appetite due to depression/anxiety/OCD/health anxiety etc, or as a result of self-harm;

    d. establish if a primary eating disorder is present; whether the patient would meet moderate to severe severity in order to be accepted for treatment by the service;

196. The patient is involved in the assessment, and this includes input from them about their goals. If a family member attends the assessment with the patient, the patient will be asked if they would like the family member to be involved in the discussion.

**Assessment outcomes**

197. An outcome of the assessment may lead to accepting the patient for community based treatment, which may include psychological interventions, nurse-led care, occupational therapy and medical monitoring- either individually or in combination. The assessment may lead to inpatient care. As the Trust do not provide inpatient services, a bed referral will be made for a Specialist Eating Disorder Unit by the initial assessor and a named practitioner will be allocated to monitor the patient in the community until a bed referral is accepted **[MK-042: EPUT Draft SOP Community Adult Eating Disorder Service, 2023].**

**Psychological assessments**

198. In general, a specialist psychological assessment is holistic in nature, taking in to consideration all available factors to generate a formulation, using psychological theory. This helps explain the difficulties, distress, and mental health symptoms a patient may be experiencing. The psychological formulation can guide all treatments, but specifically will inform what psychological interventions are best suited for the patient.

199. A referral for a psychological assessment, and the assessment itself, may be the initial point of contact for some services; however in a secondary care mental health setting, a service user may have had an assessment with another member of a multidisciplinary team before being seen for a specialist psychological assessment. The specific pathways to a psychological assessment will depend on the service.

200. A psychological assessment will vary in specific focus, depth and methods depending upon the service context and therefore the specific questions being answered. It sets out to enable a psychological understanding of the service user's presenting difficulties, gathering a variety of different strands of information, linking this to psychological theory and the evidence base. This information is drawn together, informed by psychological knowledge, to develop a 'formulation' or case conceptualisation. This in turn guides treatment planning.

201. A specialist psychological assessment might take place as a part of treatment planning to inform whether a psychological intervention is indicated, and if so what type and when;

to guide or inform other interventions by the wider multidisciplinary team, or to guide other aspects of treatment planning. Specialist psychological assessments can also take place to inform more specific questions. For example, a psychological assessment may seek to answer a question(s) about a service user's cognitive functioning.

202. A specialist psychological assessment encompasses a breadth and depth of information. Typically such an assessment would cover a range of subject areas relating to the presenting difficulties:

    a. The likely factors predisposing a person to develop mental ill health and/or psychological distress;

    b. The factors precipitating the onset of difficulties;

    c. Those range of factors that may play a role in maintaining or perpetuating the difficulties;

    d. The strengths or protective factors that may support the person. This might include consideration of their personal history, family circumstances, social context, trauma history, health concerns, current psychological functioning, risk and main presenting concerns, goals and expectations. This list is indicative rather than an exhaustive one, and the level of detail and focus would vary depending on the specific service context, and question(s) to be answered.

203. The time taken to carry out a psychological assessment varies. Typically an initial assessment interview may allow an hour, but this can increase to several hours in the cases of more specialist assessments requiring the use of psychometric tests. Psychological assessments can encompass a wide range of relevant information to provide depth and breadth to the data. This includes, but is not limited to, interviews with the service user, information from their family or carer, information from multidisciplinary colleagues and from other agencies, data gathered from self-report questionnaires and specialist psychometric assessment tools. The specific range of data gathered and the time taken for the assessment will differ depending on the type of service, the question(s) to be considered and the needs of the service user.

204. A psychological assessment is, in most circumstances, undertaken by a qualified and Health and Care Professionals Council (HCPC) registered practitioner Psychologist. In the context of mental health services, this would usually be a practitioner Clinical Psychologist or a practitioner Counselling Psychologist. Where a psychological

assessment is undertaken by a Trainee Psychologist or a Clinical Associate in Psychology, this would be under the supervision of a registered Psychologist who would hold overall clinical responsibility and oversight.

## Part 5: Monitoring and Evaluation

### Monitoring

205. EPUT has the following Care Units led by the Senior Leadership Team:

    a. Community Mid and South

    b. Community North East

    c. Community West

    d. Mental Health Inpatient and Urgent Care Services

    e. Specialist Services

    f. Psychological Services.

206. Each Care Units hold monthly accountability meetings which are attended by Executive Directors, Directors of the Care Unit along with Care Unit leadership team and members of the Risk and Compliance teams.

207. EPUT introduced the Accountability Framework in September 2021 as a new tool for Executive oversight of delivery linked to the new target operating model and through the new Care Units. The Accountability Framework monitors performance, which includes Trust KPIs. Some KPI's are set by Commissioners and others are agreed by the Trust for internal monitoring. Monitoring of referrals and the capacity of the assessing teams, along with waiting times are monitored in the Accountability meetings. Performance information is drawn from electronic patient records and is reported into Power BI web-based system, which is accessible to all managers.

208. In addition, Trust community mental health teams use the digital Monitoring and Supervision Tool (MaST). MaST helps for the community teams to prioritise their patient's care and it flags any issues which are in urgent need. Using an algorithm which takes into account a number of factors which might influence a patient's needs, such as housing, medications, disabilities and other health conditions, the Tool highlights when a patient may need additional support and may be at increased risk of crisis. The

dashboard also flags patients who have not had contact with services recently or require a follow-up appointment.

209. Whilst MaST is not designed to replace clinical expertise and judgement in managing community caseloads, it brings a range or relevant information into one place which enables clinicians to make informed evidence-based decisions.

**Evaluation**

210. The Trust has a Clinical Audit Programme which is reviewed annually. The Programme consists of all relevant National Clinical Audits that EPUT are required to participate in, as outlined by the Healthcare Quality and Improvement Partnership (HQIP). HQIP release the NHS England Quality Account which comprises national audits, clinical outcome review programmes and other quality improvement projects that NHS England advises Trusts to prioritise for participation. The Trust will identify the audits relevant to its services, prioritise the audits and share with the Care Units and Executive Team for information.

211. A project lead is nominated for all clinical audits and support is provided by the Clinical Audit Department.

212. Additional clinical audits can be proposed by Care Units, Teams, and individuals as the need arises over the course of the year. EPUT also include clinical audit projects carried out by junior doctors, who complete these as part of their training.

213. Reports on the progress of all clinical audits, and those completed, are provided to the relevant Quality & Safety meetings on a monthly basis. Clinical audits are also presented to relevant organisational steering groups and educational/peer related sessions across the Trust. A quarterly progress report regarding the Clinical Audit Programme is also presented to the Effectiveness of Care Committee and Quality Committee. An annual report is also provided to the Audit Committee.

**Statement of Truth**

The content of this statement is true to the best of my knowledge and belief.

Signed: [I/S]

Dated: 25 March 2025

**Appendix 1: Example within Paris of Trust amendments to the initial assessment document**

| Assessment version | Date of use (from) | Date of use (to) | Version amendments |
|---|---|---|---|
| Initial assessment | 08.02.2013 | 03.09.2015 | |
| Initial assessment (V1) | 04.09.2015 | 02.05.2016 | This version saw the introduction of:<br>- Document details<br>- Care Act in line with compliance of legislation<br>- Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS ) Likert-scale questions related to the person's symptoms over the two weeks prior to assessment |
| Initial assessment (V2) | 02.05.2016 | 24.08.2016 | This version saw the introduction of more questions related to Mental State Assessment, including:<br>- Appearance / behaviour<br>- Speech<br>- Mood<br>- Mood rating (1 being the lowest and 10 being the highest)<br>- Thought content<br>- Abnormal beliefs<br>- Abnormal perceptions<br>- Cognition<br>- Insight/judgement<br>- Pre-morbid personality |
| Initial assessment (V3) | 24.08.2016 | 17.10.2022 | This version saw the introduction of:<br>- Carer Assessment to fulfil contract with Essex County Council and enable data collection<br>- Version 2 of Care Act questions<br>- Crisis Plan (including early warning signs and relapse indicators; and risks when in crisis)<br>- Specific section for History (including views of others, personal history, family history, mental health history, detention history, and history of abuse)<br>- Specific section for Housing/Accommodation<br>- High Intensity Users (a high intensity user at A&E and in Trust services) as requested by operational services for monitoring<br>- Export to HIE |

| | | | |
|---|---|---|---|
| Initial assessment (V4) | 18.10.2022 | 27.02.2024 | This version saw the introduction of:<br>- Version 3 of Care Act questions<br>- Specific section Employment, Education and Vocation to improve quality of data reporting requirements |

**Appendix 2: Summary of service models with gatekeeping responsibility, by area of the Trust**

| Service model | Gatekeeping operation (by year) |
|---|---|
| **North East Essex** | |
| Home Treatment | 2000 – present date |
| Hospital Liaison | Early 2000s – present date |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | 2007 – 2015 |
| Service specific for Older Adults | 2014 – present |
| Crisis Response (NHS111) | April 2020 – present date |
| **Mid Essex** | |
| Home Treatment | 2001 – present date |
| Hospital Liaison | 2001 – present date |
| Service specific for Older Adults | 2001 – present |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | 2007 – 2015 |
| Crisis Response (NHS111) | April 2020 – present date |
| Mental Health Urgent Care Department | March 2023 – present date |
| **West Essex** | |
| Hospital Liaison | Early 2000s – present date |
| Home Treatment | 2002 – present date |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | 2007 – 2015 |
| Service specific for Older Adults | 2015 – present |
| Crisis Response (NHS111) | April 2020 – present date |
| **South East Essex** | |
| Hospital Liaison | Early 2000s – present date |
| Home Treatment | 2002 – present date |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | 2009 – 2015 |
| Crisis Response (NHS111) | April 2020 – present date |
| Mental Health Urgent Care Department | March 2023 – present date |
| Service specific for Older Adults | July 2023 – present date |
| **South West Essex** | |

| | |
|---|---|
| Hospital Liaison | Early 2000s – present date |
| Home Treatment | 2004 – present date |
| Child and Adolescent Mental Health Services (CAMHS) Crisis | 2009 – 2015 |
| Crisis Response (NHS111) | April 2020 – present date |
| Mental Health Urgent Care Department | March 2023 – present date |
| Service specific for Older Adults | July 2023 – present date |