Access Assessment

Commissioning Guidance

May 2012

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The West Midlands Clinical Working Group (Gate Keeping)

The Royal College of Psychiatrist's Quality Network for Forensic Mental Health Services

The National Secure Services Commissioning Group

The National Specialised Mental Health & Secure Services Advisory Group

The many providers and clinicians who have contributed to early drafts of this guidance

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Introduction

This document is designed to offer commissioners of secure mental health services guidance on how best to ensure high quality outcomes for the assessment of need; this is the assessment that determines if a referred patient requires care under conditions of security and if so at what level. The same assessment is also often used to inform decisions about moving existing patients up or down levels of security. This process has often been referred to as a "Gate Keeping" assessment. Its function is to appropriately manage access to high cost secure mental health services and to ensure that service users are placed in the least restrictive care environment appropriate to their identified risk whilst ensuring public protection. This assessment is not necessarily an assessment for admission to a specific hospital although on occasions an admission assessment may be conducted at the same time by the same team. However for clarity this guidance only relates to the assessment completed to inform the decision as to whether a person should receive their care under conditions of security.

Context

Secure mental health services are specialist services providing treatment for adults with mental disorders including personality disorders that mean that they are at significant risk of harming themselves or others. Patients are detained under the Mental Health Act 1983 and many, but not all will be convicted offenders. As specialised services they are commissioned by specialised commissioning groups and with the passage of the Health and Social Care Bill will into the future be commissioned by the National Health Service Commissioning Board.

As with other specialised services they represent low volume but high cost services. Commissioners often describe an increase in demand for these services and often at a rate that exceeds the rate at which patients are progressing through the system (being discharged to non secure services or back to the criminal justice system). Without the effective management of access to these services the upward trend in activity would increase making the funding of such services unsustainable.

To effectively manage access it is essential that only patients who have been assessed as requiring secure mental health services have access to these specialised services. As a result commissioners agreed in 1999 that this could be best achieved by the development of a "Gate Keeping" role whereby the responsibility of the assessment of need for admission to secure mental health services in either NHS or Independent sector provision lay with the local NHS providers.

Case for Change

In 2007 the Department of Health published “Best Practice Guidance: Specification for Adult Medium Secure Services”. This very clearly sets out quality principles for use by all secure commissioners to assist them in designating services and providing guidance on key domains such as safety, governance and clinical and cost effectiveness. This guidance included the access process into secure services stating that “patients should receive services as promptly as possible and have a choice in the treatments they access, and should not experience unnecessary delay at any stage of service delivery or the care pathway” (DoH 2007).

Secure Services commissioners suspected that there was some variation to how the access assessment process was managed. This had implications for different outcomes in terms of quality and efficiency between units resulting in differences in patient outcome and experience of the service. The need for an effective and consistent process has heightened following the publication of the Bradley Review (Review of people with mental health problems or learning disabilities in the criminal justice system Lord Bradley 2009) with improved identification of prisoners with a mental health problem and particularly those with a learning disability. At the time that commissioners were having these debates a National QIPP (Quality, Innovation, Productivity and Prevention) programme for secure mental health services was being developed by National Commissioners in 2010. This programme was being developed with the aim of sharing best practice and developing a new commissioning outcomes framework in the areas of assessment, referral and admission, secure care pathways, discharge and patient experience. The programme can be summarised by the following three overall objectives,

- Reducing cost by improving effectiveness and consistency in the processes and decision to admit, treat and discharge people from secure care.
- Improving quality and effectiveness by establishing clearer outcomes for patients and the community.
- Improving patient experience and making patient engagement meaningful by establishing the responsibilities people have in reaching their own personal recovery goals.

The National Secure Commissioners Group agreed that to both provide reassurance about potential variable practice and to deliver on the QIPP programme a review of Gate Keeping arrangements was required and, based on this review, the development of commissioner guidance in order to ensure a consistent and efficient process across England.

Review of Gate Keeping

The Royal College of Psychiatrist's Quality Network for Forensic Mental Health Services were commissioned to conduct a full and formal review of the process by which people are identified, referred, assessed and admitted to medium secure care.

The process involved consulting medium secure units (and some low secure units associated with MSU's), specialised commissioners and other stakeholders on their experiences of referral, assessment and admission into secure mental health units. The consultation had two parts, a questionnaire and interviews with stakeholders including service users.

The questionnaire was sent out to all medium secure units across the Quality Networks membership in December 2010. The questionnaire covered the following topics,

- The local referral, assessment and admission process
- The assessment tools used to determine risk and how the level of security required is assessed
- The blocks or difficulties in the current system and how these influence the effectiveness of service and patient experience
- What works well in the local service
- How the referral, assessment and admission process could be improved through redesign
- The current admission/exclusion criteria for their medium secure unit

The consultation interviews were held one to one and asked about their role in the process and asked about their experience within it. They were also asked how they believed the process could be improved. Service users were interviewed as part of this process.

Response to the process was very good with a total of 42 questionnaires returned from a total of 67 units canvassed.

Outcome of Review

The Report of the Review of Gate Keeping Process (Dr P Gilluley & Dr P Murphy 2011) provides a very comprehensive review of the process. Below is a short summary of the main findings.

The term "gate keeping" was clearly not understood by service users or indeed other stakeholders. Several service users found the term pejorative. Secure service providers argued that the process was much more complex than opening or closing a door and did not describe the process well.

Generally there was a lack of consensus on the assessment process which is consistent with the available literature on the subject. The responses suggested variation in the process.

Service users reported that they felt uninformed about the process and did not feel engaged. Some service users reported that they had no idea why people were visiting them and were not aware of the outcome of the visit.

A particular concern from the Independent Sector was that they were not involved in the assessment process and were only contacted to assess for admission once the decision had been made that the individual required secure care. In the main their involvement was requested as the local NHS providers did not have capacity to admit or lacked the specialist services required. The Independent Sector argued that this laid the processes open to the challenge that NHS providers could "cherry pick" their patients for admission. They further suggested that the access assessment should be an independent function to service provision although many argued that in doing so you would lose the local knowledge of secure and non secure provision as well as local Criminal justice provision.

Some respondents argued that the decision making regarding the need, and level, of secure care should be based on more formalised assessment tools rather than what was described as clinical judgment.

One of the major identified "blocks" in the system appeared to be the lack of information received in the referral to secure services. Often insufficient information meant that further information had to be requested before an assessment visit could be made building delays and inefficiencies into the system.

Respondents reported that in some cases junior members of staff were sent to carry out the assessment and did not feel qualified enough to make a decision. They then had to take the case back to the unit for discussion with senior colleagues before a decision could be made.

Respondents were asked what currently works well and gave a range of answers including,

- A single point of access to co-ordinate the referrals and associated paperwork
- Multi-disciplinary involvement in the access assessment. Respondents also noted the value of multi-disciplinary membership of referral meetings.
- Although only occurring in a few services the use of a standardised assessment process was thought to be helpful. Those services that did not have it referred to this as a weakness.
- Commissioner/case manager involvement at referral meetings was valued.
- A quick response to referrals where assessments and potential admission can happen in a timely manner.

A "clinical Working group" was established in the West Midlands (made up of local clinicians and commissioners) to review the output from the above review and begin to

form guidance around a more consistent process ensuring a better service user experience. The output from the West Midland group was considered by the National Secure Commissioners Group who have further developed and refined the guidance below.

Guidance

Definition

An Access Assessment is the clinical assessment of the mental health and risk-management needs of an individual. This assessment will determine the most appropriate placement for the individual in terms of need and level of security, with consideration of the whole care pathway.

In some cases, where it likely the assessing team will admit to their service, the service conducting the Access Assessment may also conduct an admission assessment at the same time.

In which case the service will undertake an assessment of the patient's suitability for care and treatment within their secure service prior to making a decision on the appropriateness of the facilities for the patient. Following such assessment, if the patient is suitable for treatment in the secure service the service plans to admit within an agreed timeframe (usually 12 weeks). The service will provide an assessment report to the referrer stating the reasons for the decision and a copy of the report to the appropriate commissioner by nhs.net email address or by secure designated safe haven fax (to be agreed between the Provider and the Commissioner).

The assessment report, as detailed above shall contain as a minimum details relating to;

- Patient demographics (Responsible Commissioner)
- Current clinical presentation
- Current risk issues
- Identified care and treatment needs
- Clear recommendation of the least restrictive care environment
- Proposed care and treatment plan
- Timescale for admission (if applicable)

Expected Outcome

The purpose of the "Access Assessment" will be understood and consistently applied by all services.

Referral

The source of the referral can vary but the majority will be from one of the following,

- Service users being transferred from one level of security to another as part of a planned care pathway e.g. High to Medium or Medium to Low
- Service users being transferred from one level of security to another where deterioration has occurred with a subsequent increase in risk e.g. Medium to High or Low to Medium
- Prisoners requiring transfer to a secure hospital
- Service users in Adult Mental Health services e.g. PICU who require admission to secure care
- Individuals subject to Ministry of Justice/Community Treatment Order re-calls

It is the responsibility of the referring agent to ensure that all relevant documentation is completed and accompanies the referral. Timescales for a response to referrals will not start until sufficient information is available to the assessing team.

A referral should include the following,

- Name including any aliases
- Date of birth
- NHS number
- GP
- Last address
- Local care coordinator
- PCT/GP consortia contact
- Current placement
- Diagnosis
- MHA section or other detention order
- Reason for referral/ presenting problem
- Relevant history
- Timescales of note e.g. EDR (expected date of release)
- Offending history
- MAPPA level
- Risk issues
- If available attach documentation; risk assessments, CPA reviews or reports, social work reports, MHRT reports etc.
- Any other relevant information

Expected Outcome

Referral documentation will include sufficient information to allow services to make informed decisions regarding the Access Assessment process.

Timescales

It is important to note that each referral is unique and the receiving clinical team should determine the urgency of the referral on receipt. Discussions between referrer, assessing clinicians and case managers may be required.

- For urgent referrals
    - initial verbal response regarding appropriateness of referral should be made within 24 hours of receipt
    - an assessment should be made within 7 days,
    - the outcome should be verbally notified within 24 hours of the assessment
    - a formal written assessment should follow within 7 working days.
- For routine referrals
    - Initial response on whether a multidisciplinary assessment appropriate within 14 working days
    - Assessment within 1 month
    - Decision within 2 weeks
    - Bed offered within 6 weeks

Notwithstanding the above timescales, in the case of prisoners requiring transfer to a secure mental hospital then the guidance within “Good Practice Procedure Guide the transfer and remission of adult prisoners under s47 and 248 of the Mental Health Act” should be followed. This guidance requires a transfer within 14 days after the first doctors’ assessment identifies that the criteria for detention under the Mental Health Act is met.

Expected Outcome

Access Assessments will be completed in a timely way prioritising those most in need.

Identification of service to complete access assessment

In many areas there are existing referral flows from local adult services to local secure service providers. In some circumstances these referrals are passed to specialised services commissioners to identify a service to conduct the access assessment. In any event, based on the information available within the referral, the most appropriate service possible should be identified to complete the access assessment. For example an individual referred who has significant hearing loss would be best assessed by a service specialising in secure mental health services for the deaf. Some access assessments would best be conducted by clinicians with specialised expertise for example ASD/High Functioning Autistic/AS high risk offender patient populations. The decision to “refer on” to an alternative team should be taken by the service accepting the initial referral in consultation with specialised services commissioners.

The decision regarding the most appropriate clinical team to undertake the assessment will be made by the service receiving the original referral. This decision will be informed by input from secure services case managers who will be aware of both local and national services.

Expected Outcome

Access Assessments will be completed by the most appropriate clinical team based on information available at referral.

Assessment Process

In some cases where there is overwhelming evidence, within the referral and associated documents, that the individual requires admission under conditions of security there may be no need for a face to face assessment. The access assessment may be possible as a “table top” exercise using the available clinical information. Acknowledging that they will require a face to face assessment for admission, by the admitting service, this would reduce the number of assessments experienced by the service user.

There are two aspects to the access assessment,

1. Carrying out an adequate mental health needs assessment, in order to,
2. Answer 4 key questions

Mental health assessment

The access assessment does not necessarily need to be a comprehensive assessment of mental health needs.

- There is a trade off with urgency – a very urgent case might need to be admitted immediately even with very sparse information about their more general needs
- Some issues are best left until after admission or can only be assessed after admission/partial recovery so we shouldn't *require* them to be part of the access assessment process
- Patients from prison, for example, are likely to have very many psychosocial needs. Whether these are appropriate targets for psychiatric intervention will very much depend on the post-admission assessment and the care pathway that is identified. So their assessment may well best be left until a later stage.

This assessment would be likely to cover the standard sections of a psychiatric history

1. Presenting problems & reason for referral
2. Current mental state
3. Current medication
4. Current risk to self and others
5. Personal history (childhood & home life, education, social, employment, relationships)
6. Family history
7. Past medical history
8. Past psychiatric history
9. Criminal history
10. Drug and alcohol use

The 4 Key Questions

1. Should the person be admitted to hospital?
    a. Is the person detainable under the Mental Health Act?
    b. What are the (provisional) diagnoses
    c. Can these disorders be treated effectively and safely in the current setting?
    d. Is there more effective treatment available in a hospital setting?
    e. Is that treatment likely to be effective for this particular patient and are they likely to engage?
    f. Will there be any potential increase in risks to the individual associated with admission to a secure hospital?

2. What level of security is required?
    a. Recent risk behaviours
        i. Violence
            1. Seriousness
                a. Risk of serious harm
                b. use of weapons
                c. evidence of planning/premeditation/revenge
                d. evidence of excessive violence/sadism/torture
            2. imminence, including
                a. whether mental state & situation now are the same as at the time of previous violence
        ii. fire setting
            1. seriousness
            2. imminence
        iii. sexually inappropriate behaviour
            1. contact/non-contact
            2. relationship to mental health
        iv. self harm
            1. seriousness
            2. imminence
    b. past risk behaviours
        i. violence
        ii. Sexual violence
        iii. subversive behaviour
        iv. absconding/escaping
        v. drug use
        vi. fire setting
        vii. self harm
        viii. self-neglect
        ix. coercive behaviour

        Consider the frequency of each behaviour, relationship to mental health, and the setting in which each have occurred, especially noting previous periods of hospitalisation at a specified security level
    c. victim issues
        i. note any individuals at risk, or types of individuals at risk
        ii. what is the immediacy of risk to these individuals (in the event of escape for example)
    d. publicity/public confidence issues
        i. media profile of individual or nature of (alleged) offence
    e. legal status
        i. remand or sentenced? Prospective release date
        ii. Current mental health Act Status
        iii. current charge or offence

3. How urgent is the admission?
    a. Severity of current mental disorder
    b. Stability of current mental disorder
    c. Degree of treatability in current setting

d. Immediacy of risk of suicide or serious self-mutilation
e. Risk of absconsions or escape from current placement
f. Current physical health, including dietary intake
g. Legal requirements (release date approaching, court order already in place)

4. What are the initial assessment/treatment needs?
    a. Overall initial objective of admission, immediate needs and initial treatment pathway plan.
    b. Initial pharmacological treatment needs
    c. Initial nursing observations and supervision needs
    d. Other specific initial risk management measures
    e. Security needs
    f. Adult protection/vulnerable adult issues
    g. Child protection issues
    h. Initial visitors to be approved (or specifically excluded). Consider necessary restrictions on telephone use
    i. Communication needs
    j. Cultural/ Faith/ Diversity needs. Dietary needs
    k. Physical health needs
    l. Service user choice about the geographical location of hospital e.g. close to home
    m. Potential discharge routes

Expected Outcome

The Access Assessment process will be applied consistently by all providers and will identify the least restrictive care environment that will appropriately and safely meet the assessed needs.

Use of structured assessment tools

Clinical teams will find the use of structured tools useful in completing the above assessment. Some of the available tools that may assist include,

The Security Needs Assessment Profile S.N.A.P. Manual Version 4.1 Collins M, Davies Dr. S & Ashwell C (2007).

Dangerousness Understanding, Recovery and Urgency Manual (The DUNDRUM QUARTET) V1.0.21 Kennedy H, O'Neill C, Flynn G & Gill P (2010)

HCR20 HCRv3

EPS

SVR-20

RSVP

Expected Outcome

There will be a structured approach to the assessment of risk.

Clinical Teams

Best practice would suggest that face to face access assessments are completed by a multi-disciplinary team. The actual make up of the team will depend on urgency, available resources, initial clinical picture based on referral and the service model of the provider. The clinical team should be empowered to make a decision regarding need for admission and level of security required. It is acknowledged that Access Assessments represent a valuable training opportunity and as such more junior members of the service may form part of the assessing team.

Expected Outcome

The assessing team will have the clinical skills/experience and the authority to make a decision.

Service User Involvement

Within the principles of “nothing about me without me” the process should put the service user at the centre of their care. The service user should be made aware by their current care team that an assessment has been requested. Assessing teams should endeavor to give service users notice of their assessment visit including the purpose of the assessment.

Once complete the assessing team should communicate the outcome to the service user or inform them when the decision will be made and how that decision will be communicated to them.

The admitting service should provide the service user with details of the service, including location, and a timeframe for admission. On admission they should be given further information on the unit to which they will be admitted in line with the first stage of "My Shared Pathway".

Expected Outcome

Service users will have the opportunity to be fully engaged in the assessment process the outcome of which will be communicated to them.

Transition from Adolescent Services to Adult Secure Services

Transition between adolescent and adult secure services needs to be managed in a seamless fashion. Maintaining the needs of the service user and balancing the most appropriate service to meet their needs, whist maintaining an effective care pathway. This may require individual solutions and agreements around the pathways management.

The medico legal complications of moving from adolescence to adulthood require a sensitive approach to avoid prejudging the life outcomes of individuals who have not yet reached full maturity. With this in mind and in preparation for effective secure care pathways all individuals who have a clear requirements for secure care post 18th Birthday should be notified to the local secure service for joint working and care pathway advice after their 16th Birthday, or if admitted to services after their 16th birthday from that time onwards.

Expected Outcome

There is a managed pathway between adolescent mental health services and adult secure services.

Appeals Process

There will be rare occasions when the assessing team does not agree with the referring team on suitability for access to low, medium or High secure services.

This appeals process should be followed to ensure that consideration has been given to the needs of all, but local and inter-team resolution should be tried first in all cases:

- The assessing team should provide a detailed assessment and treatment options.
- The referring team should discuss such assessment and options with the assessing team
- Any difference at this stage should be managed by case review and inter team discussion on care and treatment issues.
- The use of formal processes should be imbedded in this process as required (CPA, MARC, MAPPA etc.)
- If agreement for admission to secure services is made then case progresses as usual.
- Forensic Case Manager will be the responsible for the High Secure Cases in terms of ensuring a consistent service wide approach and detailed inter-team working.
- This should be enough to contain most disputes *If not the Appeals Process will be the next stage*
- If after a full review of all assessment and treatment options there is still disagreement then the assessing team should formally offer the appeals process.

Appeals

- If the assessing team offers the appeals process the team should notify the Forensic Case Manager in writing with copies of all reports.
- The Forensic Case Manager is then responsible for co-ordinating the appeals process and should invite *another assessing team* to provide an assessment (with or without treatment advice).
- This assessment will be discussed between all involved, usually at a Case Conference. If agreement is given for admission to secure services then the case will progress as normal.
- If the second assessment team also do not agree with the need for secure care that will be the end of the process. There will then be a joint meeting held to ensure that lessons can be learnt in terms of developing better process control, the Forensic Case Manager will co-ordinate this meeting and invite the Secure Services Clinical Director, from the assessing service, to attend.

If the referring team remains concerned:

The Forensic Case Manager should inform Specialist Commissioners and a review over the whole process will occur. In exceptional circumstances (Judicial Review or similar etc.) another NHS Medium Secure Service may be commissioned to provide an assessment of suitability.

Expected Outcome

That any disputes are resolved as informally as possible.

References

Best Practice Guidance specification for adult medium – secure services

Health Offender Partnerships / Department of Health 2007

Good Practice Procedure Guide The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act

Department of Health2011

Lord Bradley's Review of People with Mental health Problems or Learning Disabilities in the Criminal Justice System

House of Lords 2009

Report of the Review of Gate Keeping Process: National QIPP Programme for Adult Medium Secure Psychiatric Services

Dr Paul Gilluley & Dr Paula Murphy (Eds) 2011