GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

Regional Audit of Assessments for Admission under the Mental Health (Northern Ireland) Order 1986

March 2016

Contents

Executive Summary

Background and rationale

The need for a regional audit of assessments under the Mental Health (Northern Ireland) Order 1986 was identified following a Serious Adverse Incident. The purpose of this audit is to examine routine practice, identify any issues and so inform consideration of how practice may be developed.

Aim

The main specific aim of the audit is to identify and examine any possible sources of delay in the process of assessment for compulsory admission under the Mental Health (Northern Ireland) Order 1986.

Methodology

The audit was designed by an inter-agency, multi-disciplinary advisory group and audit team. Data was collected for a sample of 189 assessments which were conducted between August and October 2015. The sample was weighted to ensure all Trust areas and settings were appropriately represented.

Key Findings

These assessments involve high levels of need, risk and complexity. They also require the coordination of different professionals and agencies. There were no issues or concerns identified in the majority of assessments considered in the audit. There were delays identified, mainly due to the difficulties in coordinating professionals and in securing a bed, but in only 3/189 (2%) of the assessments delay was identified as contributing to increased distress and risk. Although these are very small numbers, the potential outcomes of delay that may increase risk still makes this concerning.

Recommendations

The recommendations include the further development of regional and Trust inter-agency interface groups, to build on existing protocols and guidance, to develop and coordinate inter-agency training resources. The use of beds outside of the service user's Trust area also needs to be considered. There is an opportunity to address the complexities of these processes in the new Code/s of Practice for the Mental Capacity Bill.

Audit Report

The purpose of this regional audit is to examine how the process of assessments including the conveyance to hospital under the Mental Health (Northern Ireland) Order 1986 are working in routine practice. It is intended to inform how practice may be further developed in the future.

Background and Rationale

Following a Serious Adverse Incident in the Northern Health and Social Care Trust in 2013 a Review team was set up under regionally agreed procedures to carry out a systematic review of the incident. The Review Team subsequently made a number of recommendations in 2014 including that a prospective audit of all admissions under the Mental Health (Northern Ireland) Order 1986 be undertaken. The specific purpose of the audit was to identify and examine any possible sources of delay and to drive improvements where necessary in order to eliminate all unnecessary delay and help ensure that each person is admitted to hospital in a safe and timely manner. In discussion with the Health and Social Care Board (HSC), it was agreed that this audit should be undertaken regionally with the NHSCT as the lead Trust.

Compulsory admission to hospital under the Mental Health (Northern Ireland Order) 1986 can be a complex process that may involve: a person with some form of mental disorder; their nearest relative and other family and friends; an Approved Social Worker (ASW); a General Practitioner (GP) or other medical profession; the Police Service of Northern Ireland (PSNI), the Northern Ireland Ambulance Service (NIAS), and other mental health professionals. The need for such an assessment in relation to compulsory admission to hospital may arise at any time and in any setting. The criteria for an application for compulsory admission to hospital, as set out in Article 4(2) (a) and (b) are that:

> “(a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment); and
>
> (b) failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons.”

This is a priority area for audit, as identified in the Serious Adverse Incident review, as it involves: the coordination of a range of professionals and agencies; complex assessments and processes; and potentially very serious implications for an individual's health, wellbeing and human rights. There has been limited previous examination of this area of health and social care in Northern Ireland. In 1992, Quinn examined 'Social Worker: GP Liaison in Compulsory Admissions for Assessment'. In 1999, Britton et al. reported on 'Approved Social Work in Northern Ireland' which involved consideration of a wide range of training and practice issues. As part of the Bamford Review of Mental Health and Learning Disability a comprehensive review of the current legal framework was conducted (Bamford Review, 2007). More recently Davidson and Campbell (2010) conducted an audit of assessment and reporting by approved social workers and did find that there were sometimes delays in the process of assessment which impacted on the quality of care. There has been some comparison of law and practice in Northern Ireland with other areas (O'Hare et al., 2013) and there is also international literature which provides important context but there is a clear need for a multidisciplinary audit of how these processes are working routinely in Northern Ireland.

This audit provides an overview of the routine practice involved in the process of assessments under the Mental Health (Northern Ireland) Order 1986. While the specific impetus comes from the recommendations of the review of a Serious Adverse Incident in the NHSCT, and the focus is to identify and explore any delays in the process of assessment, the function of the audit will extend beyond this very specific focus to providing a regional audit of these important and complex processes. The overall purpose of this regional audit is therefore to examine how these processes are working in the Northern Ireland context, compared with legal and policy requirements which are brought together in the Guidelines and Audit Implementation network (GAIN) Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986. This will then inform how practice may be further developed in the future.

Aim

The main aim of the audit is to identify and examine any possible sources of delay in the process of assessment for compulsory admission under the Mental Health (Northern Ireland) Order 1986.

Objectives

- To review the available literature on assessment processes under mental health law.
- To identify the arrangements for assessment under the Mental Health (Northern Ireland) order 1986 in each Trust area.
- To describe and analyse the processes involved from the point of referral to admission to hospital.
- To analyse key data about the referrals, including descriptive statistics, reasons for referral and demographic variables.
- The central objective of the audit will be identify and assess any delays in the process, compare these to the current Guidelines and explore the factors involved.
- To inform the future development of practice under the Mental Health (Northern Ireland) order 1986.

Standards/Guidance

The main source of standards and guidance for the Mental Health (Northern Ireland) Order 1986 are the law itself and, the associated Guide (Department of Health and Social Services (DHSS), 1986) and Code of Practice (DHSS, 1992). These documents, further guidance and related resources have been very helpfully brought together into a central online resource, the GAIN Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986, accessible at http://www.gain-ni.org/flowcharts/.

For the purposes of audit it is important to acknowledge the strength of evidence on which these standards are based. The standards relevant to this audit, as listed below, are based on the Mental Health (Northern Ireland) Order 1986, the associated Guide and the Code of Practice which were developed based on Expert

Committee and Clinical and Social Care experience. There is also a growing research evidence base relevant to the use of mental health law, which is reviewed in this report, but that has largely developed since these standards were introduced.

	"Standard" Criteria	Target (%)	Exceptions	Source & Strength of Evidence	Where to find criteria
1	Article 4 (3) of the Order sets out the formal procedures that must be followed before a person may be admitted to hospital for assessment against their will. Admission requires the making of a Medical Recommendation followed by an Application "founded" on this recommendation. The medical practitioner and applicant must have seen the person not more than 2 days before the date the application is made. Although there is no specific criterion for the length of time this process should take this audit will collect that in order to explore the issue of possible delays.	100	None. There are emergency holding powers (for police, doctors and nurses) but these are to be used to facilitate the assessment process not as an alternative.	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 http://www.gain-ni.org/flowcharts/

2	If the Applicant is an ASW they must consult with the person, if any, appearing to be the nearest relative unless it appears to the ASW that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay.	100	As specified in the Order the ASW must consult unless not reasonably practicable or would involve unreasonable delay so the audit can explore the circumstances in which the nearest relative is not consulted.	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 http://www.gain-ni.org/flowcharts/

3	If the person has initially been held using police powers and taken to a place of safety, the assessment by the doctor and Approved Social Worker (ASW) should begin as soon as possible after the arrival of the individual at a place of safety.	100	The current Guidelines allow that where specific issues exist, for example the detained person is believed to have consumed alcohol and/or drugs the mental health assessment may be delayed until they are deemed fit to be assessed.	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 http://www.gain-ni.org/flowcharts/

4	Local protocols should specify that an ASW or a GP should only request police presence at an application for assessment where they have carried out a risk assessment, and the result of that assessment is that the presence of the police is both proportionate and necessary. Only in exceptional circumstances, it may be considered proportionate and necessary to provide a police escort during transportation. Such circumstances are cases where there is information to indicate that intervention by the public or other parties may occur, and that this intervention may present: • A significant danger to the public or Trust staff and/or • Risk of escape	100	Police involvement should be based on a risk assessment and be necessary and proportionate.	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 http://www.gain-ni.org/flowcharts/

5	The Code states that it will often be best to convey the person by ambulance. The Code also states that the ASW has responsibility for ensuring that the person, whose detention is sought, is safely conveyed to hospital. The ASW must ensure that the most humane and least threatening mode of transport consistent with the safety of the person and others is chosen. Code 2.40 - 2.44.	100	The person should be conveyed in the most humane and least threatening mode of transport consistent with safety.	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986	C	GAIN Guidelines On The Use Of The Mental Health (Northern Ireland) Order 1986 http://www.gain-ni.org/flowcharts/

Literature review and evidence base

A review of the literature on assessment processes under mental health law provides an important context and international comparison for the law, policy and practice in Northern Ireland. There are perhaps three main aspects of the literature which are particularly relevant to this audit. The first is how often these powers are used; this may be influenced by a wide range of factors including the detail of the relevant law, the available of services, wider societal factors and how practice develops. Hoyer (2008) makes the important point that we need to be careful about interpreting too much from the available data, "We still have insufficient knowledge about the use of involuntary hospitalization. Given the varying quality of the data, it is problematic to draw any firm conclusions about the extent, time trends and variations in the use of civil commitment. Comparison of civil commitment rates between countries should for this reason be interpreted with caution." (p. 281). Nonetheless it is still important to compare rates between countries to at least reinforce that how, and how often, these powers are used is not fixed. The second area is around the factors that may influence the assessment process and how it is experienced. In addition to the societal, legal and practice context, the literature explores how these assessments are conducted using the useful concept of procedural justice. Finally, there is also important, relevant literature on the impact and outcomes of these assessments. The research from other jurisdictions is reviewed in Appendix Two and the focus in the next section is on Northern Ireland.

Northern Ireland research

Data in relation to mental health and learning disability services is routinely collected and reported by the DHSSPS. The data available for 2015 provides the immediate context for this audit.

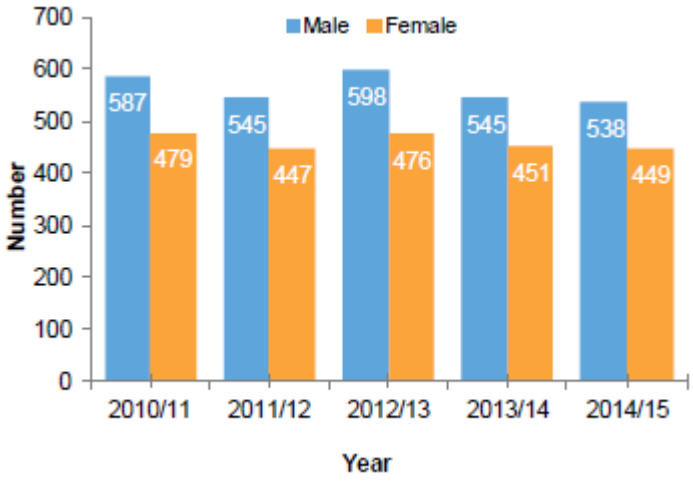
For the mental health Programme of Care (POC):

- "Over the last five years, the total number of admissions to hospital under the mental health POC has decreased by 13.3% (745), from 5,620 in 2010/11 to 4,875 in 2014/15. [In the DHSSPS report activity has been grouped into POCs on the basis of the main specialty of the consultant in charge of the patient.]

- Since 2010/11, the total number of inpatient admissions under the mental health POC has decreased by 12.1% (637), from 5,268 to 4,631 in 2014/15, whilst the number of admissions for day case treatment has decreased by almost a third (30.7%), from 352 to 244 in the same period. [Admissions for day case treatment are when a patient is admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled.]
- Across Health and Social Care (HSC) Trusts, the highest average number of available beds within the mental health POC was reported in the Belfast HSC Trust (194.1, 33.1%) whilst the Southern HSC Trust reported the lowest (78.0, 13.3%).
- Between 2010/11 and 2014/15, the average length of stay within the mental health POC in hospitals decreased by 8.4 days, from 50.8 days to 42.4 days.
- [For learning disability services there has also been a reduction in admissions] The number of admissions to hospital under the learning disability POC has decreased year on year from 503 in 2010/11 to 261 in 2014/15, a reduction of 48.1% (242)" (pp.3-4)

Data on compulsory admissions is also routinely collected and presented:

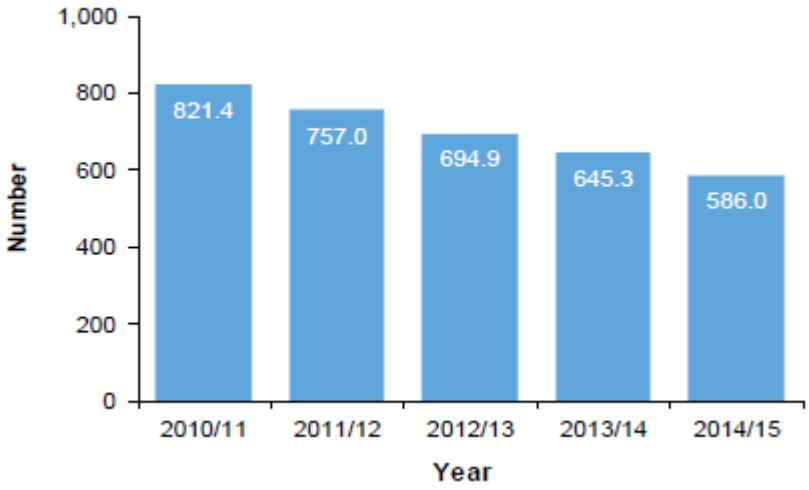
Compulsory Admissions within the Mental Health POC (2010/11-2014/15) (DHSSPS, 2015, p. 21)



Sex	2010/11		2011/12		2012/13		2013/14		2014/15		Change 2010/11 to 2014/15	
Male	587	*55.1%*	545	*54.9%*	598	*55.7%*	545	*54.7%*	538	*54.5%*	-49	*-8.3%*
Female	479	*44.9%*	447	*45.1%*	476	*44.3%*	451	*45.3%*	449	*45.5%*	-30	*-6.3%*
Total	**1,066**	***100.0%***	**992**	***100.0%***	**1,074**	***100.0%***	**996**	***100.0%***	**987**	***100.0%***	**-79**	***-7.4%***

During this period, the availability of mental health in-patient beds has also decreased:

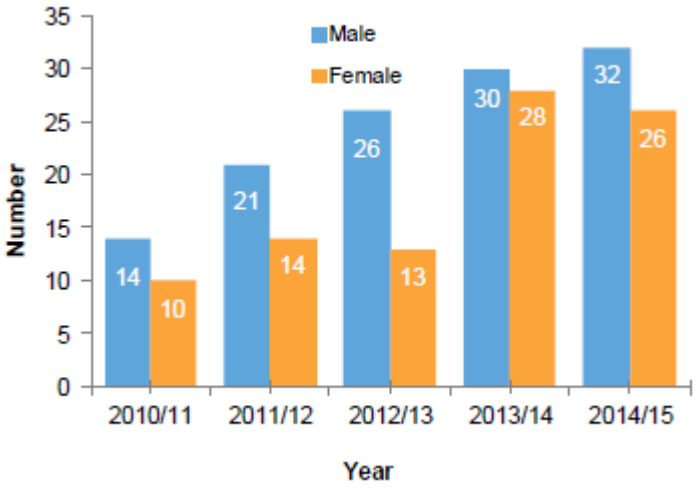
Average Available Beds within the Mental Health POC (2010/11 - 2014/15) (DHSSPS, 2015, p. 16)



So, there has been a greater decrease in overall admissions (13.3%) and available beds (28.7%) than in compulsory admissions (7.4%). Part of the overall decrease may be explained directly by the reduction and so availability of beds but during this period crisis and home treatment services have also continued to develop alternatives to admission. It would seem reasonable to assume that they would have a bigger impact on overall admissions than compulsory admissions.

For the learning disability POC, despite the overall decrease in admissions from 503 in 2010/11 to 261 in 2014/15 (48.1%), there is a very different pattern for compulsory admissions which have increased from 24 in 2010/11 to 58 in 2014/15 (133%):

Compulsory Admissions within the Learning Disability POC (2010/11-2014/15) (DHSSPS, 2015, p. 28)



Sex	2010/11		2011/12		2012/13		2013/14		2014/15		Change 2010/11 to 2014/15	
Male	14	*58.3%*	21	*60.0%*	26	*66.7%*	30	*51.7%*	32	*55.2%*	18	*128.6%*
Female	10	*41.7%*	14	*40.0%*	13	*33.3%*	28	*48.3%*	26	*44.8%*	16	*160.0%*
Total	**24**	***100.0%***	**35**	***100.0%***	**39**	***100.0%***	**58**	***100.0%***	**58**	***100.0%***	**34**	***141.7%***

There have been a number of previous studies of assessments under the Mental Health (Northern Ireland) Order 1986. An early small-scale study focused on the liaison between ASWs and GPs and highlights some difficulties with communication (Quinn, 1992). There was also a very comprehensive review of the ASW role in the late 90s which identified variation in systems (Campbell et al., 2001 and Manktelow et al., 2002). A later audit of assessment and reporting by ASWs (Davidson and Campbell, 2010) reported a number of findings that are directly relevant to this audit:

- "In fifty-one out of eighty (64 per cent) assessments, the ASW spoke with the GP; where verbal communication had not taken place, it was usually because the GP had already signed their form and left it to be collected by the ASW.
- Thirty-nine (49 per cent) were joint assessments and ASWs tended to comment positively about these; for example, one ASW reported that 'the doctor was very supportive and helpful throughout the entire process' and another said it was an 'excellent joint interview—GP knew patient very well'.

- In fourteen (18 per cent) of the assessments, the ASW identified problems in communication, including the fact that the GP was not available for joint assessment or consultation and had often left directly after a medical recommendation had been made. One ASW stated that the doctor tried to pressure them to sign by saying ‘On your head be it’.
- The police were directly involved in thirty-five (44 per cent) of the assessments, the majority of which were completed in the person’s own home. Respondents identified a number of issues associated with police involvement. These included views from some ASWs that police involvement would have created more problems; for example, one said that the use of the ‘PSNI would be more stressful for the client who was not in any way a risk to others—I agreed to family members taking her to hospital’. Others thought that delays in arrival or excessive use of coercion by the police were impediments to the process. Another ASW recalled an ‘overuse of force until [I] intervened. They wanted to handcuff very elderly man who was no threat to them’.
- The ambulance service was involved in thirty-four out of eighty (43 per cent) assessments. They were obviously not needed in those situations in which patients were already resident in psychiatric hospital settings. The ambulance service provided most of the transportation; others included the police, family and, in two cases, the ASW. There were problematic issues identified, with the involvement of the ambulance service reported in seven (9 per cent) assessments. These mostly involved delays, but, in one case, the ASW was critical of a member of ambulance staff making ‘disparaging’ remarks about the person being detained.
- The local Crisis Response Team were involved in thirteen (16 per cent) of the assessments. At times, ASWs reported problems in their relationship with the team. These usually involved demarcation or boundary disputes that led to refusals by the Crisis Team to be involved in the assessment. For example, in one case, the ASW reported that the Crisis Team ‘wouldn’t get involved because there were issues of drug/alcohol’.
- Location of ASW assessment and bed availability - The location at which assessments take place, one assumes, may impact upon how ASWs and

> other professionals carry out their functions. Similarly, the availability of hospital beds may have consequences for the way in which assessments are processed. This issue was relevant in seventy-four of the eighty assessments (when the person was detained or agreed to voluntary admission). A bed was immediately available in sixty-nine out of seventy-four (93 per cent) cases. There were issues with bed availability in six (8 per cent) cases. These were either that the available bed was a considerable distance from the person's home (in one case) or that there were delays in finding an available bed (in five cases), which caused stress for patients and professionals. In two of these cases, it was suggested by the ASW that the delay meant that a voluntary admission then became a detention. The following more detailed quotation describes the knock-on effect of such systems failure: '[I] Was advised by the Crisis Team that no beds were available. [Client] was initially prepared to go to hospital on a voluntary basis. However given nil availability of beds for non detained patients it became necessary to negotiate with Principal Officer re acquiring a bed. Given long delay [client's] mental state deteriorated and a detained admission became necessary. Bed secured only with aid of Principal Officer." (pp. 1617-1619)

There has been less research, in the Northern Ireland context, focused on the impact and outcomes of compulsory admission. One study (Beattie et al., 2009), however, has examined possible associations between psychosis, admission and symptoms of Post-Traumatic Stress Disorder (PTSD). It reported that, although there wasn't a specific association between PTSD symptoms and legal status, people did tend to report their first admission as the most distressing (with 14% severe; 31% moderate to severe PTSD symptoms).

Legal and policy context

As mentioned in the background, the legal framework for these assessments in Northern Ireland is provided by the Mental Health (Northern Ireland) Order 1986, the associated Guide (DHSS), 1986) and Code of Practice (DHSS, 1992). As mentioned previously (see Background and Rationale), the criteria for an application for compulsory admission to hospital, as set out in Article 4(2) (a) and (b) are that:

> "(a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by medical treatment); and
> (b) failure to so detain him would create a substantial likelihood of serious physical harm to himself or to other persons."

These criteria suggest that, by definition, there is a relatively high level of risk involved in these assessment processes. The Code specifies that "It is good practice for the professionals involved in the application for admission to be present at the same time (although it may be advantageous for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. They should also, where there is a risk of the patient causing serious physical harm, consider calling for police assistance and should know how to use that assistance to minimise the risk of violence." (para 2.5)

The process requires a medical recommendation and an application to be completed. The medical recommendation must be completed by a doctor and the Code specifies that they "should, if at all possible, be someone who already knows the patient, and normally the patients' own GP would be the first choice" (para 2.21). The application can be completed by the person's Nearest Relative, as defined in the Order, or an ASW. If the Nearest Relative acts as applicant then a Social Circumstances Report must be completed and if the ASW acts as applicant then they must attempt to identify and consult the Nearest Relative. The proportion of applications completed by the Nearest Relative has been decreasing. From the introduction of the current Order until 1996-1997 more applications were completed by Nearest Relatives than ASWs and the decrease in Nearest Relative applicants has continued to decrease from 488/1599 (31%) of applications in 2000/1 (Mental Health Commission, 2009) to 109/1259 (9%) in 2010/11(Regulation and Quality Improvement Authority, 2012). In 14/15 61/1045 (6%) of all applications (51/61 in the mental health POC) were completed by Nearest Relatives (Health and Social Care Board, 2016).

In terms of organising a bed the Code states "If an application for assessment is to be made the doctor should contact medical staff in the hospital to which the patient is

to be admitted, to discuss any possible difficulties or uncertainties about admission, ensure that a bed will be available and advise of the anticipated time of arrival of the patient at the hospital." (para 2.25)

The Code also provides some specific guidance about conveyance. It specifies that "the ASW has a professional responsibility for ensuring that all the necessary arrangements are made for the patient's conveyance to hospital and that the patient is properly admitted to hospital" (para 2.40). It also details that "Where the decision is that the patient should be conveyed to hospital by ambulance the doctor will normally make the necessary arrangements" (para 2.40).

In Scotland, England and Wales there have been recent policy developments which are also of relevance. In Scotland since the introduction of the 2003 Act in 2005 Health Board areas have been required to prepare Psychiatric Emergency Plans which are multi-agency authored and address similar areas. These are meant to be updated annually.

In England, in March 2014, the *Mental Health Crisis Care Concordat* (HM Government, 2014) signed by a wide range of agencies was launched. It "is a joint statement, written and agreed by its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs. It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. All the bodies and organisations that have signed up to the Concordat agree that improvements need to be made and sustained." (p. 10). It specifically recommends that the agencies in each local area should agree and deliver their own Mental Health Crisis Declaration. The scope is wider than assessments under mental health law but these are an important component of it. It also specifies that every area should have a local protocol for when a police officer uses powers under mental health law.

The Welsh Government and Partners (2015) have also published a similar *Mental Health Crisis Care Concordat: Improving the care and support for people*

experiencing or at risk of mental health crisis and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983. It outlines a number of areas of collective commitment which include:

- "To work to reduce the use of powers of detention under section 135 [warrant to search for and remove patients, the equivalent of Article 129] or 136 [Mentally disordered persons found in public places, the equivalent of Article 130] of the Mental Health Act 1983 ("the MHA") generally and to cease to use police custody suites as a place of safety, except in exceptional circumstances such as significant violence; and never for a child/young person under the age of 18.
- Police vehicles will rarely be used to convey people in crisis save for the most violent of individuals and only exceptionally to transport people between NHS facilities.
- NHS Transport or other health vehicles (not necessarily an ambulance) should be commissioned to convey people to hospital who are in mental health crisis…
- Partners should agree where assessment of intoxicated individuals can safely take place in health based settings and their needs appropriately met…
- Partners and the third sector should be supported to widen their ambition in developing 'new' places of safety and providing alternatives to in-patient care at all stages e.g. sanctuary houses, drug and alcohol support." (p. 5)

Under the Code of Practice it is also the role of the responsible Board, in cooperation with all the other agencies involved, to prepare joint guidance on the policy and procedures for conveyance (para. 2.50). In October 2015 a Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986 was introduced by the Health and Social Care Board (see Appendix Five for the Risk Matrix and Joint Risk Assessment). This was during the audit period but the Advisory Group clarified that the Protocol was intended to reflect and reinforce ongoing good practice rather than making significant changes.

Recent relevant reports

A recent report, relevant to this audit, was conducted by the Health and Social Care Board in 2013 and focused on the use of Article 130 of the Mental Health (Northern Ireland) Order 1986 which is the police power to remove a mentally disordered person found in a public place to a place of safety, usually an Accident and Emergency Department. The report provided a “review of 11 case examples provided by PSNI of occasions between March and July 2013 when police involvement lasted between 13 and 22 hours. The purpose of the review is to identify the reasons why the protracted timescales occurred, with a view to addressing any blocks in the HSC process to reduce the length of time officers are involved in mental health cases.” (p. 1). It found that there were a range of reasons that contributed to prolonged police involvement. The most common factors in this sample were that the person was intoxicated making assessment difficult; required medical treatment/admission; was refusing help, in one case violently; there was a delay in requesting a mental health assessment; and/or there was a delay in the GP being able to attend. These factors were each present in 5/11 of the cases. In two cases involving a foreign national and a “looked after child” who presented outside her own Trust area of residence there was what was referred to as “a lack of clarity about jurisdiction”. Other possible factors contributing to delay which each were only identified in one case were: an ASW not resolving different views about jurisdiction; a delay in response from the relevant mental health team; a delay in a police escort for an ambulance transfer between hospitals. The recommendations of this particular review were mainly to the implementation of a Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986 with the purpose of reinforcing what is good practice.

In February 2016 the Royal College of Psychiatrists published the report of the independent Commission to review the provision of acute inpatient psychiatric care for adults which covered both England and Northern Ireland. Its scope was therefore broader than, but included, compulsory admissions. In general it found "an acute mental health system under pressure, with difficulties in access to care compounded by - in some instances - poor quality of care, inadequate staffing and low morale. Too often inadequate data and information are available but it is clear that the whole

system has suffered from a steady attrition in funding from both NHS and local government sources in recent years." (p. 7)

It made a number of recommendations for how both inpatient care and alternatives to admission should be developed. It also specifically recommended that "the practice of sending acutely ill patients long distances for non-specialist treatment is phased out by October 2017." (p. 7)

Methodology

Audit design

The approach, as recommended by the Northern Health and Social Care Trust's Serious Adverse Incident Review Team, was a prospective audit of all admissions under the Mental Health (Northern Ireland) Order 1986.

The Audit Project Team and Project Advisory Group (see Appendix One) were made up of representatives of the relevant Trusts, PSNI. NIAS, service users, carers and the main professional groups who are involved in the process. All of the members of the Project Team were also on the larger Advisory Group. The Project began on 1st April 2015 and ended nine months later on the 31st December 2015. The Project Team met four times during the process and with the Advisory Group a further six times.

The Project Team and Advisory Group developed the Audit Tool (see Appendix Three) which identified the relevant data which needed to be collected from the routinely gathered information about assessments under the Mental Health (Northern Ireland) Order 1986. It was agreed that the most appropriate source of this routinely gathered information about these assessments is the report of the Approved Social Worker involved (see Appendix Four). Any information which wasn't contained in the ASW Report could then be collected from the relevant professionals involved. The Audit Tool was piloted using anonymised Approved Social Worker reports and further refined based on that process.

Sample

The audit period was from the 1st August 2015 until the 31st October 2015.
Based on the Hospital Statistics: Mental Health and Learning Disability (2012/13; 2013/14 and 2014/15) (DHSSPS, 2013, 2014, 2015) it was estimated that the maximum number of assessments (including those that did not result in compulsory admission) in that period would be approximately 370. Using the Raosoft sample size calculator with a confidence level of 95% (see: www.raosoft.com/samplesize.html) it was calculated that a sample of 189

assessments would therefore be needed to provide a representative sample of the total number of assessments in that period.

It was agreed with the Project Team and Advisory Group that, as it was more likely that difficulties in the assessment process could arise in community settings, no more than a third (63) of the assessments included in the audit would have been conducted in hospital settings (with people who had already been admitted voluntarily). In the actual sample there were 43/189 (23%) hospital assessments and 146/189 (77%) community assessments.

It was also agreed that the sample should reflect, to some extent, the anticipated proportion of assessments being carried out in each Trust area. The number of compulsory admissions in each Trust area in the previous year was used to provide an estimate of the proportion anticipated in each Trust. These estimates were not used to provide definite numbers for each Trust but just to provide some estimate to ensure there wasn't a dramatic over or under representation of any one Trust area.

Trust	**Compulsory admissions in mental health programme of care in 2014-15**	**% of total 987**	**Estimate for sample**	**Actual number in sample**
BHSCT	203	21	40	50
NHSCT	283	28	53	56
SEHSCT	198	20	38	28
SHSCT	202	21	40	35
WHSCT	101	10	19	20
Total	987	100	189	189

The WHSCT Delegated Statutory Functions (DSF) records for 14-15 suggest there were 163 compulsory admissions in that period which differs from the figures from the DHSSPS in the table above.

It was also important to ensure that assessments that were conducted both in and out of hours were also represented. In 2012/2013 approximately 25% were

conducted by the Regional Emergency Social Work Service (RESW) and in this audit 51/189 (27%) of the included assessments were completed by RESW.

Based on the numbers for 14/15, if the same proportion (51/987, 5%) of applications were completed by the Nearest Relative then we would expect 9/198 (5%) in the audit period.

Approval and Access

The process of designing the audit and agreeing access to the relevant data was supported and facilitated by: Ruth McDonald, Assistant Trust Clinical & Social Care Governance Manager in the Lead Trust (NHSCT); Robert Mercer, Regional Clinical Audit Facilitator in GAIN; the relevant Governance staff in each Trust; and the Project Advisory Group. All the necessary data access and confidentiality agreements were in place before data collection began. The main theme was to ensure that no information that could directly identify an individual person was collected.

Data collection

The data was collected from the Approved Social Workers' reports by the Auditor on the relevant Trust site. It was not possible to predict exactly how many reports would be available for each arranged visit and so the numbers do not exactly match the estimate based on the previous year. The Lead ASW in each Trust facilitated this process. Additional information, where necessary, was also collected from the PSNI and the NIAS. If data wasn't recorded or clarification was necessary the Auditor sought this information from the relevant professional.

Data analysis

The data were inputted by the Auditor to Microsoft Excel which enabled both the descriptive statistics and qualitative analysis to be conducted. The main aspects of analysis were descriptive statistics, some crosstabs to explore possible patterns, and thematic analysis of the qualitative data. The analysis was conducted by both the Auditor and the Project Lead.

Limitations

There are a number of key limitations of the audit that are important to highlight and acknowledge.

The intention was to include all assessments under the Mental Health (Northern Ireland) Order 1986 including those that did not result in compulsory admission to hospital and including those in which the nearest relative acted as applicant. A report should be completed regardless of outcome and when the applicant is the Nearest Relative a report (called a Social Circumstances Report) must be completed and sent to the ASW Lead. However, it is possible that relying on the reports that were sent through to the ASW Leads may not have identified all of the relevant assessments.

It is also possible that the audit period and the sample included are not representative of all assessments over time. This is a potential limitation of all samples and the discussion considers a range of other factors which may impact on how these assessments are conducted in the future.

Perhaps the most important limitation of the audit design was that the main source of data was from the ASWs' reports. It would have provided a much more complete overview to have also been able to consider the perspectives of everyone involved, including the service users and carers.

Findings

It should be noted that the findings are from a sample of the assessments during the audit period rather than from all of the assessments conducted in that three month period.

Assessments under the Mental Health Order NI

Data was collected for 189 assessments, although ten of them referred to the same five service users. Of the 189, 11% were gathered in the Western HSC Trust, 30% in the Northern HSC Trust, 19% in the Southern HSC Trust, 26% in the Belfast HSC Trust, and 15% in the South Eastern. Less than a quarter of all the assessments was conducted in a psychiatric hospital (n=43; 23%), and the majority were conducted in the community (n=146; 77%). Over a quarter (n=51; 27%) were out of hours assessments.

Table 1: Location of assessment by HSC Trust

HSC Trust	Hospital	Community	Out of hours	Total
Belfast	11	39	18	50
Northern	9	47	16	56
South Eastern	3	25	8	28
Southern	10	25	7	35
Western	10	10	2	20

Most assessments resulted in compulsory admissions (n=155; 82%), but there were also a few voluntary admissions (n=13; 7%) and alternative care plans (n=21; 11%).

Table 2: Assessment outcome by HSC Trust

HSC Trust	Detention	Voluntary admission	Alternative plan
Belfast	36	6	8
Northern	45	4	7
South Eastern	26	0	2
Southern	31	2	2
Western	17	1	2

Service users

The assessments were completed with 96 men (51%) and 93 women (49%). While in the Western, Northern and Southern HSC Trusts, a slightly larger percentage of assessments was carried out in relation to women, in the Belfast and South Eastern Trusts, a marginally bigger percentage were regarding men. Service users were aged between 16 and 93 years old, with a mean age of 47. Over half were aged between 35 and 64 (n=96), while approximately one in seven was under 25 years (n=25). The South Eastern HSC Trust held the highest proportion of young service users (under 35) (51% within that Trust; n=14), while the Northern HSC Trust held the highest percentage of older service users (55 and over) (39%; n=22). For one service user in the Northern HSC Trust, the date of birth was not specified.

Table 3: Sex and age by Trust (%)

	Belfast (%)	Northern (%)	South Eastern (%)	Southern (%)	Western (%)	Total (%)
Male	62	43	54	49	45	51
Female	38	57	46	51	55	49
16-17	4	2	4	3	5	3
18-24	**6**	11	**18**	**6**	15	10
25-34	22	13	**29**	**9**	15	17
35-44	16	14	**7**	**31**	15	17
45-54	26	20	**11**	**34**	25	23
55-64	10	16	4	6	15	11
65 & over	16	23	**29**	11	**10**	19

Ethnicity was recorded as white (n=178), including one person from the Travelling Community. Eight were recorded as either being Asian (n=2), Polish (n=2), Romanian (n=2), Russian (n=1) or Lithuanian (n=1) and for three service users their ethnicity was not recorded. In terms of living arrangements, the majority either lived with one or more family members (n=77; 41%) or lived alone (n=66; 35%), while 16 lived in supported living accommodation and hostels, seven were in nursing

care/home, five in residential care, two in hospital, three were living with others (non-family members), and eight were homeless. For five, their living arrangements had not been specified.

In terms of area where the service users lived, 80% lived in urban areas (n=145) and only 20% lived in rural areas (n=37) (as defined by Northern Ireland Statistics and Research Agency). There were a further seven service users for whom it was not possible to accurately identify the nature of the area, this was mainly due to the postcode not being available. Of those seven, four were recorded as homeless and for three their living arrangements were not recorded. In the Southern and Western HSC Trusts, there was a higher percentage of service users living in rural areas (38% and 35% respectively) than in the other HSC Trusts, with the Belfast and South Eastern HSC Trusts having the highest proportion living in urban areas (98% and 89% respectively). For seven service users, their address was unknown.

The Northern Ireland Multiple Deprivation Measure (NIMDM) 2010 provides information on seven types of deprivation and an overall measure of multiple deprivation for small areas. Super Output Areas (SOA) are ordered from most deprived to least deprived on each type of deprivation and then assigned a rank. The most deprived SOA is ranked 1 and as there are 890 SOAs, the least deprived SOA has a rank of 890. The mean rank of this sample was 346.2.The ranks were divided into quartiles (1st: ranks 1-222; 2nd: 223-444; 3rd: 445-666; and 4th: 667-890), with the first quartile as the most deprived and the fourth quartile as the least deprived. Most service users lived in either the first or second rank quartiles.

Table 4: Multiple Deprivation by Trust

HSC Trust	Mean MDM	1st	2nd	3rd	4th
Belfast	318.6	52	11	15	22
Northern	366	28	46	17	9
South Eastern	476.6	18	29	25	29
Southern	294.6	44	41	15	0
Western	261.2	45	30	25	0
Total	**346.2**	**37**	**32**	**18**	**13**

The majority were not employed (n=113; 60%), only one in 12 were employed part-time or full-time (n=16), and 18% were retired (n=34). There were also six students. For 20 service users (11%), their employment status was not specified. For most of the service users in the sample, one or more physical health problems had been identified. Some of these were: diabetes, asthma, epilepsy, chronic pain, and heart problems. For 45%, no physical health problems or disabilities were known or had been reported. One in six (n=31) had dependants (i.e. children under 18 living with them or who they had contact with).

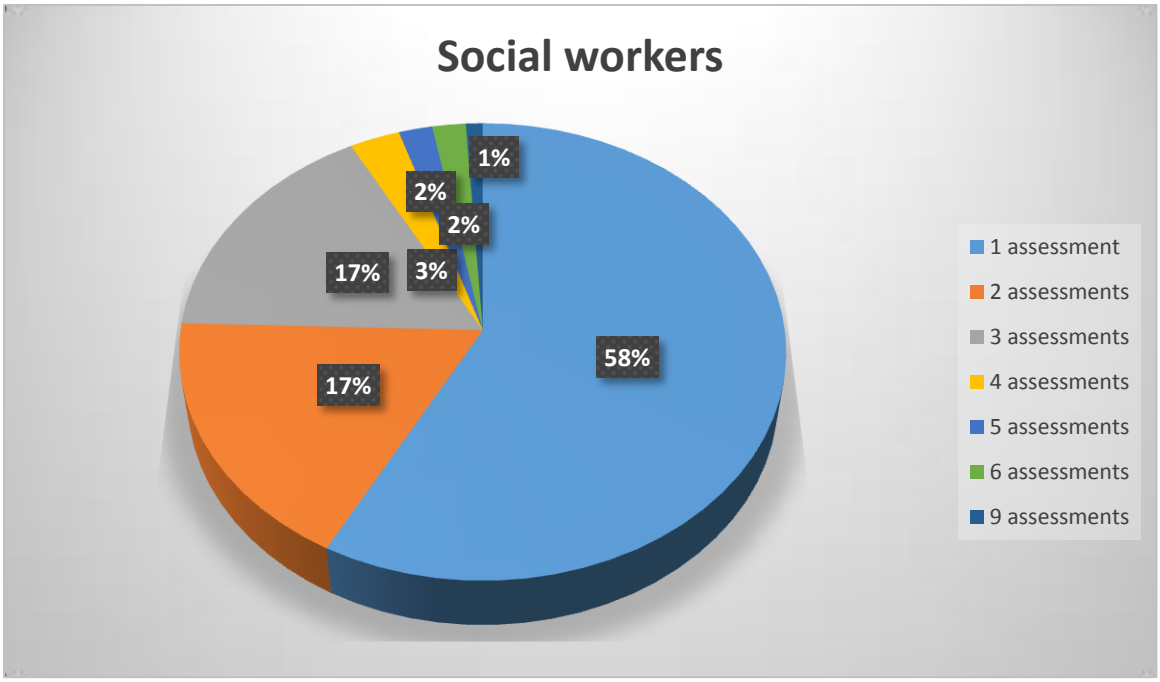
The majority of services users were currently in receipt of services, such as Community Mental Health Teams (CMHT) (n=105; 56%), Psychiatrists (n=117; 62%), Home Treatment Team (HTT) (n=23; 12%), domiciliary (n=6; 3%), or other statutory services (e.g. psychologists, 16+Team, Gateway services, Community Addictions, etc.) (n=41; 22%). The majority also were known (or had in the past been known) by mental health services (n=157; 83%).

Approved Social Workers

The assessments were conducted by a total of 102 different approved social workers (ASWs): 59 of them conducted one of the assessments included, 18 carried out two and 17 did three. However, out of 51 out-of-hours assessments, one of the ASWs from the Regional Emergency Social Work Service (RESWS) carried out as many as nine assessments included in this audit within the three-month period. In fact, a significant proportion of RESWS social workers had more than one assessment included in the audit, with three having two, four having three, one having four, two having five, one having six and the one with nine. It is also significant to note that:

- One ASWs in the Western HSC Trust carried out six of the 18 assessments included in the audit from this particular HSC Trust (excluding out of hours) (33%);
- 29% of the assessments included from the Southern HSC Trust (excluding out of hours) were conducted by ASWs that carried out more than one (out of 28, four ASWs had conducted two; three did three and one did four)

- 28% of the assessments included from the Belfast HSC Trust (excluding out of hours) were conducted by ASWs that carried more than one assessment (out of 32, five did two and three did four);
- 25% of those included from the Northern HSC Trusts (excluding out of hours) were conducted by ASWs that carried more than one assessment (out of 40, four did two, five did three, and one did four).



Although Social Circumstances reports, required under Article 5(6) of the Order, in situations where the nearest relative has made the application for admission for assessment, were identified as part of the data collection process none were made available. This may have been an issue of communication. However during data analysis Trusts were asked to check if there were any issues raised relevant to the audit in the Social Circumstances Reports. No further issues were identified.

Assessment process

Most assessments were joint assessments with the ASW and GP (n=162; 86%) present at the same time, as recommended in the Code of Practice 2.5. When this did not happen, ASWs were usually able to consult with GPs (n=24; 13%), mostly on the phone, but also face-to-face in some cases. For the three cases where ASWs did not consult with GP, these were the reasons given:

- GP had assessed the patient the night before, and completed Form 3.
- The GP attended the A&E department immediately following their surgery and made no contact with the ASW. The GP completed Form 3 and left the Department before the ASW arrived leaving no contact number.
- Hospital staff had contacted GP directly from the Ward as per Trust arrangement. The GP attended and completed their assessment and left. Neither the ward staff nor ASW were subsequently able to contact the GP.

The GP conducting the assessment was the service user's own GP only in 39% of the cases (n=74), and only in three cases for the 51 out-of-hours assessments.

The nearest relative was consulted in 85% (n=161) of assessments, as required under Article 5. While it was recorded that this consultation took place it was sometimes not specified whether it was face to face or by phone. Some of the reasons recorded for not consulting with nearest relative given were:

- Nearest relative had been admitted to hospital and was not available for consultation.
- Repeated attempts were made to contact the nearest relative on their home telephone and mobile without success.
- Repeated attempts to contact by phone, contact made with other family members but the nearest relative could not be contacted.
- The service user became unsettled and violent while the ASW was attempting to contact the nearest relative so it was urgently necessary to complete the assessment. Nearest relative was contacted later and advised of the outcome.
- Phone messages left for the nearest relative and the ASW also visited their home address and left their details. Further attempts to contact by phone but was unable to do so.

Regarding the assessment duration (from initial request for MHO assessment and completion of assessment process), for the 152 assessments (where this information had been established), the average time spent was 5.6 hours (SD 3.6), with a

maximum of 27 hours and a minimum of 1.75. The longest assessments were those where the initial request had occurred the previous day and it had been agreed to postpone the assessment in order to facilitate a joint assessment with the GP on the following day. The assessments involving a shorter duration, from request to completion, were usually those where conveyance was not necessary, including when the outcome was not a detention, or when the service user was already a patient in the psychiatric hospital. Although there were no statistically significant differences between HSC Trusts, the averages for the South Eastern and the Northern HSC Trusts were higher – 6.8 hours (SD 5), and 6 hours (SD 4.6) respectively – than the averages for the other HSC Trusts, especially for the Southern and the Western HSC Trusts – 4.7 hours (SD 2.2) and 4.9 hours (SD 2) respectively.

Table 5: Joint assessment and Own GP by Trust

HSC Trust	Joint (n)	Joint (%)	Own GP (n)	Own GP (%)
Belfast	42	84	28	56
Northern	52	93	18	32
South Eastern	27	96	15	54
Southern	27	77	9	26
Western	14	70	4	20
Total	**162**	**86**	**74**	**39**

When applications were made, none of the nearest relatives that were consulted objected, except for one case, where the partner of the service user, while acknowledging that she needed to be admitted to hospital, did not want her to be detained. In that case, a second ASW was involved, and Forms 2 and 3 were signed, as voluntary admission had been offered but declined by patient. In nearly all of the cases, ASWs mentioned a range of people that had been consulted, varying from family members and friends of the service user to a range of professionals and records/information systems.

Referral stage

Referrals originated mainly from GPs, Medical Records, Forensic Medical Practitioners, care homes, liaison/staff nurses in mental health hospitals, Home Treatment Teams, Psychiatrists, Support and Recovery Teams, social workers/key workers, Rapid Assessment, Interface and Discharge (RAID) doctors, and Community Psychiatric Nurses.

The reasons for referral were wide-ranging, and related mostly to concerns about severe mental health problems (e.g. psychosis, depression, bipolar) (n=174). In a smaller number of cases there was concern about deterioration in the mental health of people with dementia (n=12) and people with learning disabilities (n=3). In nearly one third (n=58) of cases the person had attempted suicide prior to referral or were presenting with suicidal ideation and/or self-harm.

There were 46 Forms 5s (the hospital doctors' holding power under the Order) completed, and Article 129 or 130 (the police powers under the Order) were used 18 times. Issues at referral stage were mentioned in 61/189 (32%). Many of the issues identified related to concerns about the service user and the practicalities of arranging the assessments. The usual process involved relevant professionals arranging a time to meet. However in some cases there were issues raised about:

- Delays in being able to contact and arrange a suitable time mainly with GPs 8/189 (4%);
- Delay due to ASW availability 2/189 (1%) [this may be an underestimate as based on the information in the ASW reports]; and
- Initial disagreements between ASWs and GPs 2/189 (1%), or between ASWs and other professionals 2/189 (1%).

Some examples are offered below:

- GP had been available in the morning, but strategy required armed PSNI assistance, and it wasn't possible to coordinate everyone and facilitate access until later that afternoon.

- GP had completed Form 3 earlier that day but had made a mistake on the form and provided limited information. Contacted GP who was unable to return but agreed to amend form.
- GP contacted ASW via phone to ask for assessment under Mental Health Order. Stated service user was from another country but said an interpreter would not be needed as service user's friend could act as an interpreter. ASW suggested that, in line with Trust policies and procedures, it would be better practice for an interpreter to be present. GP stated that this could be organised but would hold up the process and they did not feel it was necessary.
- Request for MHO assessment made following home visit by CPN and Support Worker. GP requested assessment, arranged for the next day.
- Email received advising that a service user had been due for assessment under the MHO that day but this had to be postponed as PSNI could not be in attendance due to a security alert. Arrangements confirmed to meet two days later, nearest relative to be there to facilitate access.

Interview process

Interviews were mostly conducted in the service users' own homes (including nursing homes, supported living accommodation, and children's residential homes) (n=95; 50%) and in hospitals (including mental health hospitals, general medicine hospitals, A&E, etc.) (n=78; 41%). Other locations for the interviews were: GP surgery (n=6), relatives' home (n=5), police station (n=3), and other community settings (n=2). Interpreters were involved in just five cases. Service users were intoxicated in five cases (including two in which the service users had taken an overdose of paracetamol). Medical assessment and treatment was required in 14 cases.

Police assistance was requested in 77 cases (41%). Reasons provided for these requests included: concerns for the physical safety of the patient and/or others during the assessment and conveyance process, for example based on a previous incidents of aggression or current aggressive; threatening and hostile behaviour; concerns that the patient would abscond; was missing (n=4); or was unwilling to go

to hospital. In a small number of occasions, service users had been arrested and were in police custody (e.g. for criminal damage, threatening others/police officers, etc.) (n=8). Police involvement at different stages of the assessment was recorded. This included:

- During the assessment interview with ASW and/or GP, and for conveyance (24 cases). In some of these assessments, the service user had either been missing or been arrested.
- Involvement just for conveyance (25 cases).
- Involved before and during the assessment interview (12 cases).
- During the assessment interview and for conveyance (6 cases).
- In the remaining cases, police were involved just during the assessment interview (n=3), after the assessment interview had taken place but no conveyance (n=2), and before assessment interview took place (n=2).

According to police records, police were requested either by the ASW (n=16) or by a doctor (usually the GP) (n=16) or both (n=1). Police were also requested by witnesses in 17 assessments, by family in three cases, and by ambulance staff in two cases. Other health and social care professionals requested police assistance in in 9 cases. In ten cases the origin of the request for police assistance was not specified. The average length of time between request for police assistance and arrival was one hour and 12 minutes (SD 1:18), with a minimum of four minutes and a maximum of five hours and 46 minutes (n=51). The average length of time between police arrival and incident closed was three hours and three minutes (SD 2:42), with a maximum of 12 hours and two minutes. This information was provided through police resources. Data supplied by social workers confirmed these records though was mostly absent from the ASW report.

There was evidence, when the data was analysed, of differences in the response time of police to requests for assistance. In rural areas the average length of time between the police being requested and their arrival, across 10 cases, was two hours and four minutes whereas in urban areas, for the 39 cases, the average was 59 minutes.

Issues with police involvement emerged in a small number of cases, most of them concerning delay (n=8):

- In one case, although the PSNI had initially agreed to attend, it still was not possible for them to do so after two and a half hours due to other demands on their services. The assessment was referred to the out of hours service because of this delay.

Other issues concerned disagreements between ASW and police on how to manage the assessment and conveyance process (n=2). It should be noted that these findings are based on the ASW report and there may be different perspectives on these events.

In one case, although the level of risk during assessment was very high, the police were not in attendance as they had been given the wrong address.

Outcomes

In terms of identifying risks, in most assessments (n=95; 50%), ASWs identified risks to the service user and to others, while in a significant proportion of cases, risks were only identified to the service user (n=79; 42%). In a few cases, there were no identified risks (n=9; 5%), or the ASWs only identified risks to others (n=6; 3%). The ASW reports include a specific section on the human rights issues which have been considered. It appeared from reviewing the ASW reports that some ASWs seemed to be using a generalised formula to record these considerations rather than taking an individualised approach. Most mentioned Articles 2, 5, 6 and 8 of the European Convention on Human Rights which are part of UK law under the Human Rights Act 1998.

Conveyance

Ambulances were involved in 42% of all 189 cases (n=80), and in eight cases reviewed, the ambulance was cancelled usually because of long waiting times, and alternative arrangements for conveyance were made. The Northern Ireland Ambulance Service (NIAS) provides most, but not all, ambulances in Northern

Ireland. According to NIAS' records (and ASW forms in a few cases where no ambulance records available), ambulances were requested:

- by a doctor (including GP and hospital doctors) in 49 assessments,
- by an ASW in 12 cases,
- by both an ASW and a doctor in 3 cases, and
- by other professionals (e.g. staff nurses, etc.) in 8 cases.
- (for 14 cases, this information was not reported)

According to NIAS' records, the average length of time between the timescale agreed and that achieved was 30 minutes (SD 0:46), with a minimum of zero minutes and a maximum of three hours and nine minutes. The timescale agreed with the ambulance was achieved for 43% of the assessments where this information is provided (26 out of 61). For 44% of cases (n=27), the ambulance arrived over 15 minutes later than what it had been agreed. For 21% (n=13), the ambulance arrived over one hour later than had been planned.

The average length of time of ambulance involvement was one hour and 15 minutes (SD 0:49), with a minimum of 15 minutes and a maximum of three hours and 50 minutes.

In 35% of the 125 assessments reviewed where conveyance was required, service users were conveyed by ambulance only. In 28% of cases police and ambulance were involved.

Table 6: conveyance by HSC Trust (%)

HSC Trust	Ambulance only	Police only	Ambulance & police	ASW &/or family	Others
Belfast	28	19	25	22	3
Northern	38	10	26	23	3
South Eastern	43	9	26	17	4
Southern	34	17	39	4	4
Western	12	25	25	25	13
Out of Hours	21	23	38	18	0
Total	**35**	**14**	**28**	**19**	**4**

In 31 cases (25%), a range of issues were identified regarding conveyance. These included: delays with ambulance/police service arrival/assistance; difficulties coordinating all the necessary services to be present at the same time; and difficulties in getting service users into vehicles. In 2/125 (2%) cases, delay appeared to have contributed to service users becoming more agitated, anxious or irritable and increased the risks involved:

- ASW tried to avoid the use of ambulance but family were unable to facilitate transportation, so ambulance was used. The ambulance service was contacted, it was agreed that the ambulance would arrive within one hour, but did not arrive until over three hours after the request. The service user became increasingly distressed during this time.
- In one case, it was reported that during the delay in the ambulance arriving the person became very threatening and the police eventually, after attempting to gain the service user's cooperation, had to force entry.

Delays were not always negative. In one case, there was considerable delay but this was due to efforts to persuade the service user to leave their house:

- It took three hours of persuasion by family and professionals for service user to leave. She was then escorted with minimal physical contact by paramedics with police following behind. The ambulance had been reversed directly towards her front door which provided ease of access and also protected her

privacy and dignity. One PSNI officer and one paramedic remained in the back of the ambulance during the journey to hospital.

Other examples were mainly to do with coordination and communication:

- In one case, there were delays due to difficulties coordinating ambulance and police. Considerable efforts were made by the police to persuade the person to get into the ambulance but eventually, after careful consideration and planning, it was necessary to restrain the service user and to use a stretcher to safely move them.
- In another case, an ambulance was requested and agreed but unable to attend, so after two hours in which the service user became more distressed, the ASW agreed to transport the service user accompanied by a family member.
- Another delay appeared to be due to failure to communicate that the service user was a wheelchair user.
- In one case there had been earlier concerns about risks during conveyance and these had been conveyed to NIAS personnel. However, following a period of sleep the service user settled to some extent so it was felt by GP, ASW and police that police assistance was not required. However the ambulance crew continued to be concerned regarding the risk involved. A decision not to involve police in the conveyance of the service user to hospital was eventually agreed through ambulance control.

Identifying beds

Beds were accessed outside the service user's Trust area of residence in 15 cases (12%). Figures indicate that the Belfast HSC Trust used the highest proportion of beds identified outside the Trust. For over half of the relevant assessments (n=70), there is no information recorded in the ASW report regarding who identified the bed. Where this information was specified, most of the beds were identified by the GP (n=28; 21%), although ASW identified them in 23 occasions (18%), while other professionals did in 10 other cases (8%).

Table 7: Beds by HSC Trust area (%)

HSC Trust	Outside Trust	Identified by GP	By ASW	By others	Not specified
Belfast	27	30	17	13	40
Northern	8	15	33	8	45
Sth Eastern	4	35	9	4	52
Southern	7	10	3	0	87
Western	13	25	25	25	25
Total	**11**	**21**	**18**	**8**	**53**

Significant delay in identifying a bed was recorded in 13 of the assessments reviewed (10% of community assessments) (seven in the Belfast Trust, five in the Northern and one in the South Eastern). Some specific examples included:

- The ASW was advised that the bed should be available within an hour as another service user was being discharged. After several hours, the ASW contacted the Ward, and was informed that the bed was no longer available as the patient was not being discharged. ASW then requested another bed which was identified in another Trust. This required the ASW to contact the GP to return to amend Form 3.
- The ASW had been unable to secure a bed in the Trust area by the time both ambulance and police had arrived to assist in the conveyance of the patient to hospital. Further protracted negotiation was required to secure a bed in another Trust area. This included consultation between the service user's Consultant Psychiatrist and his/her counterpart in the receiving hospital.
- The ASW initially requested a bed and was advised that until the service user was deemed medically fit, a bed would not be allocated. The ASW contacted the Directorate of Legal Services for advice and was advised that regardless of service user's physical health, a bed had to be allocated. Following further negotiation the service user agreed to attend the local Health Centre, the GP completed a medical assessment and advised that patient was medically fit. However when the ASW conveyed this information to the receiving hospital before conveying the service user to that hospital they were advised that the bed was no longer available. This resulted in further delay as the service user had to be conveyed to a hospital in another Trust.

Discussion

It is important to state that, despite the level of need and risk involved, and the complexity of coordinating all the professionals involved, there were no issues or concerns identified in the majority of assessments considered in the audit. Although there were delays identified due to the difficulties in coordinating professionals and in securing a bed, in only 3/189 (2%) of the cases delay was identified as contributing to increased distress and risk. Nonetheless, although these are very small numbers, the potential outcomes of delay that may increase risk still makes this concerning.

Although it is not possible to directly compare the findings of this audit with the previous audit (Davidson and Campbell, 2010), which looked at all assessments in a period rather than a sample which over-sampled community assessments, there are still some interesting differences. In the previous audit, the ASW did not speak with the GP in 36% of assessments. In this audit, this had reduced to 3/189 (2%) and there were reasons provided for each case. The level of joint assessments also increased from 49% to 86%. The level of police and ambulance involvement remained approximately the same, 44% vs 41% for police involvement and 43% vs 42% for ambulance involvement.

Although there were no issues regarding delay or increased risk identified in the audit period with assessments in which the nearest relative acted as applicant, it is still concerning that in 2014/15, 61 applications were completed by nearest relatives. The problems associated with the nearest relative making the application have been fully explored as part of the Bamford Review and the need to formally end this role accepted.

There seems to be greater variation though in who requests ambulance involvement and identifies a bed if needed. Variation in itself is not an issue but if there are differences in these processes across Trusts then, with 15/125 (12%) of community assessments requiring a bed outside of the Trust area, then additional complexities may arise. The Regional Bed Management Protocol currently being developed should address some of the complexities in identifying beds across Trusts, and its introduction may be an excellent opportunity for training on these processes.

In addition to the Regional Bed Management Protocol, there are already developments to further promote inter-agency working in this area. In the Northern Trust, a PSNI, NIAS, Primary Care and Mental Health Services Interface Group has been established (see Appendix Six for its Terms of Reference), and this could provide a model for all Trusts.

There are also a range of existing guidance and protocol documents which also relate to these processes: the Regional Interagency Protocol on the Operation of Place of Safety & Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986, Making Best Use of the Northern Ireland Ambulance Service and the Regional Mental Health Care Pathway. Inter-agency training that facilitates inter-agency discussion and brings all these protocols and guidance together may be difficult to coordinate but could be beneficial.

Recommendations

- A regional interface group could build on existing protocols and guidance to develop and coordinate inter-agency training resources.
- Specific issues in relation to the identification of beds outside of the service user's own Trust area should be addressed as a matter of urgency as part of the Regional Bed Management Protocol.
- Trust specific multi-agency interface groups could also support the development of working relationships and provide a forum in which any issues raised could be considered. The Northern Trust's Terms of Reference (see Appendix Six) provide a possible template.
- There were some changes and additions to the ASW's applicant report developed as part of the data collection process which could be considered useful for ongoing practice. It is also important to ensure this format is consistently used across Trusts regardless of the individual Trust's IT system/s.
- Guidance should assert that the nearest relative should only be considered to act as applicant as a last resort.
- The complexities of these processes should be addressed in the new Code/s of Practice for the Mental Capacity Bill.

Acknowledgements

This audit was funded by the Guidelines and Audit Implementation Network (GAIN). It was supported by Ruth McDonald, Assistant Trust Clinical & Social Care Governance Manager in the Lead Trust (NHSCT) and by Robert Mercer, Regional Clinical Audit Facilitator in GAIN. Thanks to all of the Audit Project Team, especially Dr Montserrat Fargas Malet, and all of the Project Advisory Group (listed in Appendix One).

References

Bamford Review (2007) A Comprehensive Legislative Framework. Belfast: Bamford Review of Mental Health and Learning Disability.

Belfast Health and Social Care Trust (2015) *ASW Audit of Compliance of Quality Standards of Approved Social Workers for the period 1st January 2014 to 31st December 2014*. Belfast: BHSCT.

Bowers, L., Clark, N. and Callaghan, P. (2003) Multidisciplinary reflections on assessment for compulsory admission: The views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. *British Journal of Social Work*, 33(7), pp. 961–8.

Britton, F., Campbell, J., Hamilton, B., Hughes, P., Manktelow, R. and Wilson, G. (1999) *A Study of Approved Social Work in Northern Ireland*. Belfast: DHSS.

Campbell, J., Brittan, F., Hamilton, B., Hughes, P., Manktelow, R. and Wilson, G. (2001) The management and supervision of ASWs: Aspects of law, policy and practice. *Journal of Social Welfare and Family Law*, 23(2), pp. 155–72.

Commission to review the provision of acute inpatient psychiatric care for adults (2016) *Old problems, new solutions: Improving acute psychiatric are for adults in England*. London: Royal College of Psychiatrists.

Davidson, G. (2016) *Levels of impaired decision making ability in Northern Ireland: estimates from the literature*. Belfast: Law Centre (NI).

Davidson, G., & Campbell, J. (2010) An audit of assessment and reporting by Approved Social Workers (ASWs). *British Journal of Social Work*, 40(5), 1609-1627.

Department of Health and Social Services (1986) Mental Health (NI) Order 1986: A Guide. Belfast: DHSS.

Department of Health and Social Services (1992) Mental Health (NI) Order 1986: Code of Practice. Belfast: HMSO

Department of Health, Social Service and Public Safety (2013) Hospital Statistics: Mental Health and Learning Disability (2012/13). Belfast: DHSSPS.

Department of Health, Social Service and Public Safety (2014) Hospital Statistics: Mental Health and Learning Disability (2013/14). Belfast: DHSSPS.

Department of Health, Social Service and Public Safety (2015) Hospital Statistics: Mental Health and Learning Disability (2014/15). Belfast: DHSSPS.

Furminger, E. and Webber, M. (2009) The effect of crisis resolution and home treatment on assessments under the 1983 Mental Health Act: An increased workload for Approved Social Workers? *British Journal of Social Work*, 39(5), 901-917.

Galon, P. A. and Wineman, N. M. (2010). Coercion and procedural justice in psychiatric care: State of the science and implications for nursing. *Archives of Psychiatric Nursing*, 24(5), 307-316.

Hatfield, B. (2008) Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An analysis of patterns and trends under the 1983 Mental Health Act in six local authorities. *British Journal of Social Work*, 38(8), 1553-1571.

Health and Social Care Board (2013) Report on PSNI Delay Cases: March-July 2013. Belfast: HSCB.

Health and Social Care Board (2015) Regional Interagency Protocol on the Operation of Place of Safety & Conveyance to Hospital under the Mental Health (Northern Ireland) Order 1986. Belfast: HSCB.

Health and Social Care Board (2016) Personal correspondence received on 11/02/16 to confirm the relative proportion of applications by Nearest Relatives and Approved Social Workers under the Mental Health (Northern Ireland) Order 1986.

Health and Social Care Information Centre (2014) HSCIC Fast Facts: Mental Health. Leeds: HSCIC.

HM Government (2014) *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. London: HM Government.

Hooff, S. and Goossensen, A. (2014). How to increase quality of care during coercive admission? A review of literature. *Scandinavian Journal of Caring Sciences*, 28(3), 425-434.

Høyer, G. (2008) Involuntary hospitalization in contemporary mental health care. Some (still) unanswered questions. *Journal of Mental Health*, 17(3), 281-292.

Hughes, R., Hayward, M. and Finlay, W. M. L. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health*, 18(2), 152-160.

Katsakou, C. and Priebe, S. (2006). Outcomes of involuntary hospital admission–a review. *Acta Psychiatrica Scandinavica*, 114(4), 232-241.

Katsakou, C. and Priebe, S. (2007). Patient's experiences of involuntary hospital admission and treatment: A review of qualitative studies. *Epidemiologia e psichiatria sociale*, 16(02), 172-178.

Kelly, B. D., Emechebe, A., Anamdi, C., Duffy, R., Murphy, N., & Rock, C. (2015). Custody, care and country of origin: demographic and diagnostic admission statistics at an inner-city adult psychiatry unit. *International Journal of Law and Psychiatry*, 38, 1-7.

Killick and Taylor (2014) *Professional decision making on involuntary psychiatric admission: Review of factors.* [Poster presentation] SEHSCT and University of Ulster.

Manktelow, R., Hughes, P., Britton, F., Campbell, J., Hamilton, B. and Wilson, G. (2002) The experience and practice of Approved Social Workers in Northern Ireland. *British Journal of Social Work*, 32(4), pp. 43–61.

McKenna, B. G., Simpson, A. I., Coverdale, J. H. and Laidlaw, T. M. (2001). An analysis of procedural justice during psychiatric hospital admission*. International Journal of Law and Psychiatry*, 24(6), 573-581.

Mental Health Commission for Northern Ireland (2009) *Annual Report and Accounts 2008–2009*. Belfast: Mental Health Commission.

National Institute for Clinical Excellence (2002). Principles for Best Practice in Clinical Audit. Abingdon: Radcliffe Medical Press.

O'Hare, P., Davidson, G., Campbell, J., and Maas-Lowit, M. (2013). Implementing mental health law: a comparison of social work practice across three jurisdictions. *Journal of Mental Health Training, Education and Practice*, 8(4), 196-207.

Oliver Loft, N. and Lavender, T. (2015): Exploring compulsory admission experiences of adults with psychosis in the UK using Grounded Theory, *Journal of Mental Health*, DOI: 10.3109/09638237.2015.1101415.

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F., Turner, T. and Wiersma, D. (2005). Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. *BMJ*, 330(7483), 123-126.

Quinn, B. (1992) *Social Worker: GP Liaison in Compulsory Admissions for Assessment*. Belfast, DHSS.

Regulation and Quality Improvement Authority (2012) Personal correspondence received on 03/05/12 to confirm the relative proportion of applications by Nearest Relatives and Approved Social Workers under the Mental Health (Northern Ireland) Order 1986.

Salize, H. J. and Dressing, H. (2004). Epidemiology of involuntary placement of mentally ill people across the European Union. *British Journal of Psychiatry*, 184(2), 163-168.

Welsh Government and Partners (2015) *Mental Health Crisis Care Concordat: Improving the care and support for people experiencing or at risk of mental health crisis and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983*. Cardiff: Welsh Government.

Zinkler, M., & Priebe, S. (2002). Detention of the mentally ill in Europe–a review. *Acta Psychiatrica Scandinavica*, 106(1), 3-8.

Appendix One

Project Lead

Name: Dr Gavin Davidson	Position/Job Title: Senior Lecturer
Specialty: Social Work	Email: g.davidson@qub.ac.uk
Address: School of Sociology, Social Policy and Social Work, Queen's University Belfast. Postcode: BT7 1NN	Telephone: 028 9097 3151 Mobile: 075 9019 1538

Deputy Project Lead

Name: Bernadette Hamilton	Position/Job Title: ASW Programme Co-ordinator
Specialty: Social Work	Email: bernadette.hamilton@belfasttrust.hscni.net
Address: ASW Programme, Belfast Health and Social Care Trust, Springvale Community Learning Centre, 400 Springfield Road, Belfast. Postcode: BT12 7DU	Telephone: 028 9090 0016

Project Team

Name	Job Title/Specialty	Trust	Role within Project (data collection, Supervisor etc)
Dr Gavin Davidson	Senior Lecturer	QUB	Project Lead
Bernadette Hamilton	ASW Programme Co-ordinator	BHSCT	Deputy Project Lead and Expertise on GAIN Guidelines on the use of the MHO
Dr Montserrat Fargas	Auditor	QUB	Data collection and analysis
Dr Gerry Lynch	Consultant Psychiatrist	NHSCT	Lead Trust representative
Dr Katie Connaughty	Specialist	SEHSCT	SEHSCT rep and expertise on

	Registrar		psychiatry and research
Delia McCartan	Lead ASW	SHSCT	SHSCT rep and expertise on Approved Social Work practice
John McCosker	SW Lead with responsibility for ASWs	WHSCT	WHSCT rep and expertise on Social Work and Approved Social Work practice
Jackie Scott	Lead ASW	BHSCT	BHSCT rep and expertise on Approved Social Work practice
Karen Harvey	Lead ASW	NHSCT	NHSCT rep and expertise on Approved Social Work practice

Project Advisory Group

Name	Job Title/Specialty	Organisation
Jackie McIlroy	Mental Health and Disability Officer	DHSSPS
Phil Hughes	Assistant Director Mental Health Services	NHSCT
Dr Donagh MacDonagh	GP, Dunluce Health Centre	GPs
Dr Nigel Ruddell,	Assistant Medical Director	NI Ambulance Service
Moira Harper	Cause	Carers
Martin Daly	Service User Consultant	Service users
Eithne Darragh	Social Care Commissioning Lead - Mental Health	Health and Social Care Board
Bob Blemmings	Detective Inspector	PSNI
Pat Fitzpatrick	Regional Emergency Social Work Service Manager	BHSCT

Appendix Two – International, GB and Ireland research

International research

Zinkler and Priebe (2002) provided a useful baseline for comparing detention rates under mental health law across different areas across Europe. They focused on Austria, England, Finland, Germany and Italy and reported that "Nearly 20-fold variations in detention rates were found in different parts of Europe. Criteria for detention of the mentally ill are broadly similar when it comes to patients at risk to themselves or others. However different rules apply for involuntary treatment in the interest of the patient's health." (p. 3). Rates ranged from 10.92 per 100,000 in the Trieste, Gorizia, Pordenone area of Italy to 182.2 per 100,000 in Finland. Based on their comparison across Europe they suggest that the use of these powers seems to be influenced by the relevant mental health professionals' beliefs, values and practice rather than being determined by the specific legal requirements. They also report that how service users experience these processes is not determined by whether they are detained or not, so people admitted as voluntary patients can also feel coerced. A voluntary admission may be preferred for reasons of stigma and other implications but it is still important to highlight that it is not only the outcome of the assessment that is the important issue. They conclude that "Variations in detention rates across Europe appear to be influenced by professionals' ethics and attitudes, sociodemographic variables, the public's preoccupation about risk arising from mental illness and the respective legal framework." (p. 3)

Salize and Dressing (2004) also examined detention rates across Europe and provided a more comprehensive overview of detention rates across European Union countries. Their findings are presented in the table below.

Rates of Involuntary admission for mental disorder in European Union countries

Country	Year	Involuntary admissions		
		n	% of all admissions	Per 100,000 population
Austria	1999	14,122	18	175
Belgium	1998	4,799	5.8	47

Denmark	2000	1,792	4.6	34
Finland	2000	11,270	21.6	218
France	1999	61,063	12.5	11
Germany	2000	163,551	17.7	175
Greece		Not available	Not available	Not available
Ireland	1999	2,279	10.9	74
Italy		Not available	12.1	Not available
Luxembourg	2000	396	Not available	93
Netherlands	1999	7000	13.2	44
Portugal	2000	618	3.2	6
Spain		Not available	Not available	Not available
Sweden	1998	10,104	30	114
United Kingdom	1998	46,300	Not available	93

They also found a very wide range (from 6 per 100,000 in Portugal to 218 per 100,000 in Finland) and suggested these figures "strongly hint at differences in definitions, legal backgrounds, or procedures." (p. 166)

These early reviews had acknowledged the importance of changes over time in laws, attitudes, practices and services. Priebe et al. (2005) provide data on these issues by reviewing change over time and presenting changes in service provision as well as the use of compulsory powers. Their findings are summarised in the table below.

Number of forensic beds, involuntary hospital admissions, places in residential care or supported housing, psychiatric hospital beds, and prison population in six countries in 1990-1 and 2002-3 (per 100,000)

Service provision:	**England**	**Germany**	**Italy**	**Netherlands**	**Spain**	**Sweden**
Forensic beds						
1990	1.3 (1991)	4.6	2.0	4.7 (1991)	1.2 (1991)	9.8 (1993)
2002	1.8 (2001)	7.8	2.2 (2001)	11.4 (2001)	1.5	14.3 (2001)
Change (%)	+38	+70	+10	+143	+25	+46

Involuntary admissions						
1990	40.5 (1991)	114.4 (1992)	20.51	16.4	33.8	39.0 (1992)
2001	50.3	190.5	18.14	19.1	31.8	32.4
Change (%)	+24	+67	-12	+16	-6	-17
Places in supported housing						
1990	15.9 (1997)	8.9	8.8 (1992)	24.8 (1992)	5.1 (1994)	76.0 (1997)
2002	22.3	17.9 (1996)	31.6 (2000)	43.8 (2001)	12.7	88.1
Change (%)	+40	+101	+259	+77	+149	+15
Psychiatric hospital beds						
1990	131.8	141.7	4.5 (1992)	159.2	59.5 (1991)	168.6
2001	62.8	128.2 (2000)	5.3 (2000)	135.5	43.0 (1999)	58.3
Change (%)	-52	-10	+18	-15	-28	-65
Prison population						
1992	90	71	81	49	90	63
2002	141 (2003)	98 (2003)	100	100	136 (2003)	73
Change (%)	+57	+38	+23	+1-4	+51	+16

They conclude that “Reinstitutionalisation is taking place in European countries with different traditions of health care, although with significant variation between the six countries studied. The precise reasons for the phenomenon remain unclear. General attitudes to risk containment in a society, as indicated by the size of the prison population, may be more important than changing morbidity and new methods of mental health care delivery.” (p. 123)

Zinkler and Priebe (2002) had also mentioned that they were also variations within countries and offered some possible explanations from the literature at that time, “Riecher-Rössler and Rössler [1992] explained urban–rural differences found by Spengler and Böhme [1989] by ‘special sociostructural conditions’. The detention rate in London is twice as high as in other parts of England [Department of Health, 1999].” (p.4). Hoyer (2008) commented on these within country findings further, “As differences in recording procedures usually can be ruled out within countries (they are at least affected by the same errors), it is difficult not to attribute such variations to the structure and capacity of the services…local traditions and/or attitudes towards the use of coercion, even if the latter remain to be empirically established.” (p. 283)

Consideration of how often these powers are used inevitably involves consideration of the factors that may influence the assessment process. Related to the professional complexities of conducting these assessments are the factors associated with how they are experienced by the service user. One of the main concepts relevant to this is procedural justice which McKenna at al. (2001) explain “developed from research involving participants in court proceedings to include three distinct components. The components are a perception by participants that the decision-making processes are fair and just, that they are actively included in the processes, and that professionals or authorities involved exhibit personal qualities that are congruent with the intent of the processes.” (p. 573). Galon and Wiseman (2010) reviewed some of the research on this concept in mental health services. They reported that the MacArthur Network on Mental Health and the Law conducted a series of qualitative studies on coercion in hospital admissions and later in community settings. “These seminal studies revealed that clients' responses to coercion are contextual and are positively influenced by using persuasion versus threats and by giving voice to the clients' perspectives versus the use of pure authority or force…This body of research documented that the perception of coercion is not solely a function of legal status and that voluntary patients can also feel coerced…“The amount of coercion is strongly related to the belief about the justice of the process by which the person was admitted…the belief that clinical staff acted out of genuine concern, treated the client respectfully and in good faith

(truthfulness), and afforded the client the opportunity to tell their side of the story" (The MacArthur Research Network on Mental Health and the Law, 2001)." (Galon and Wineman, 2010, p. 3)

Hooff and Goossensen (2013) have tried to distil the key messages from the literature about how to increase the quality of care during the process of a compulsory admission. They report that "Findings show that most experiences of patients can be traced back to one core experience: not being listened to or listened to. When patients experience being listened to genuinely, they feel more respected as a human being. The challenge for the professional carer seems to explicitly pay attention and stay in touch with the patients' emotional struggles while making the necessarily decision to admit the patient to prevent harm. Quality of care during coercive admission improves when professionals are able to do justice to both inside and outside perspectives simultaneously." (p. 1)

Killick and Taylor (2014) conducted a review of the literature on factors that professionals may use when making judgements about compulsory admission. They looked at six papers across countries and concluded that "Professional decisions tend to relate closely to legal mandate (symptoms and risk as defined in statute). There is some evidence of variance between professionals. Patient factors (eg. Diagnosis, age and gender) may influence decisions but their impact was not clearly shown. The main factors (usually considered by social workers) in determining ability to maintain the person in the community were identified as self-care, social supports and adherence to care plans." (p. 1)

The final area of international research which provides the context for the audit is on the impact and outcomes of these assessments. Katsakou and Priebe (2006, 2007) reviewed the literature on the quantitative and qualitative studies on the outcomes of compulsory admission. From the 18 quantitative studies they included they reported that "Most involuntarily admitted patients show substantial clinical improvement over time. Retrospectively, between 33% and 81% of patients regard the admission as justified and/or the treatment as beneficial. Data on predictors of outcomes is limited and inconsistent. Patients with more marked clinical improvement tend to have more positive retrospective judgements…A substantial number of involuntary patients do

retrospectively not feel that their admission was justified and beneficial. At least for this group, new approaches might have to be considered." (Katsakou and Priebe, 2006, p. 232). From their review of five qualitative studies they found that "The main areas that appear to be of importance are: patients' perceived autonomy and participation in decisions for themselves, their feeling of whether or not they are being cared for and their sense of identity. In these areas both negative and positive consequences from involuntary admission were mentioned." (Katsakou and Priebe, 2007, p. 172)

GB and Ireland research

The Health and Social Care Information Centre (2014, pp. 1-2) provide a summary of statistics on the numbers of people using mental health services in England during 2012/13, including the number of people subject to compulsory intervention:

- "There were nearly 50,500 cases of people being detained under the Act in either an NHS or independent hospital in 2012/13 – a four per cent rise on the previous year.
- Over 4,500 Community Treatment Orders were made in 2012/13 – a ten per cent rise on the previous year.
- An estimated 22,000 Place of Safety Orders were made during 2012/13. New information from police forces suggests that for over 30% of these orders, the place of safety was a police station, rather than a hospital.

Under other legislation:

- 12,400 applications were completed for Deprivation of Liberty Safeguards [DoLS] in 2013/14 - a ten per cent rise on the previous year. DoLS give a legal framework for a hospital or care home to deprive someone of their liberty when there is no other way to care for them or safely provide treatment and where they are unable to give informed consent regarding their care.
- There were 290 new Guardianship cases in 2013/14 – representing a four per cent fall from the previous year."

These figures were recently considered further in a report for the Law Centre (Davidson, 2016, p. 37) "In England in 2012/13 there was a national rate of 53.8 detained inpatient admissions in NHS hospitals per 100,000 population and the rate

ranged from 24.2 in the South East to 83.9 in London (Health and Social Care Information Centre (HSCIC), 2013) (this is the equivalent of an admission for assessment). If applied to the adult population of Northern Ireland the national rate in England would suggest 779 per year and the range, 350 to 1214. However, if the total number of detentions in hospital (which includes all types of detention and hospitals), 50,408, is used with the 53,500,000 population of England this suggests a rate of 94.2 per 100,000 which transposes to 1363 [total number] for Northern Ireland."

Hatfield (2008) also considered the patterns of compulsory admissions over time (1996-2004) in six metropolitan local authorities with a population of approximately 1.5 million so not dissimilar to Northern Ireland. She "identified key features in the social situations of individuals that may be associated with mental health need. Specific aspects of gender and life-stage vulnerability are suggested, as are poor material resources, isolation and lifestyle issues such as drug and alcohol misuse. The close association of psychiatric severity and social disadvantage is evident, presenting assessing ASWs with challenging and complex assessments." (p. 1569)

The Law Centre report also considered Scotland where "the number of new episodes of civil compulsory treatment in 2013/14 was 4530 of which only 116 were direct to CTO but there were 1173 new CTOs (Mental Welfare Commission for Scotland, 2014). If we use the mid-year estimate of population of Scotland for 2013 of 5,327,700 then this suggests a rate of 86 episodes of civil compulsory treatment per 100,000 and 22 new CTOs per 100,000. These rates would translate to 1245 episodes and 318 CTOs in Northern Ireland." (p. 39)

In the Republic of Ireland it was found that "the rate of involuntary admissions per 100,000 in 2013 was 46.67, the equivalent of 675 for Northern Ireland. This does not seem to have varied greatly over the past five years as the figures show "a decrease of 4% from 2009 to 2010, an increase of 5% from 2010 to 2011, an increase of 4% from 2011 to 2012 and no change from 2012 to 2013." (Mental Health Commission, 2014, p. 39). It is also interesting to note that under the Mental Health Act 2001 the role of applicant is not restricted to an appropriately trained professional and in 2013

over half (57%) of applications for compulsory admission were completed by the person's spouse, civil partner or family." (Davidson, 2016, p. 40)

Kelly et al. (2015, p.1) have recently highlighted some other aspects of these figures to consider. Their focus was on inner-city Dublin and they "previously reported an involuntary admission rate of 67.7 per 100,000 population per year in inner-city Dublin (January 2008–December 2010), which was higher than Ireland's national rate (38.5). We also found that the proportion of admissions that was involuntary was higher among individuals born outside Ireland (33.9%) compared to those from Ireland (12.0%), apparently owing to increased diagnoses of schizophrenia in the former group. In the present study (January 2011–June 2013) we again found that the proportion of admissions that was involuntary was higher among individuals from outside Ireland (32.5%) compared to individuals from Ireland (9.9%) ($p<0.001$), but this is primarily attributable to a lower rate of voluntary admission among individuals born outside Ireland (206.1 voluntary admissions per 100,000 population per year; deprivation-adjusted rate: 158.5) compared to individuals from Ireland (775.1; deprivation-adjusted rate: 596.2). Overall, admission rates in our deprived, inner-city catchment area remain higher than national rates and this may be attributable to differential effects of Ireland's recent economic problems on different areas within Ireland. The relatively low rate of voluntary admission among individuals born outside Ireland may be attributable to different patterns of help-seeking which mental health services in Ireland need to take into account in future service-planning."

In terms of the complexities of inter-agency working, Bowers et al. (2003) sought the views of Approved Social Workers, General Practitioners, Ambulance Crews, Police, Community Psychiatric Nurses and Psychiatrists in England. They found that "All groups of professionals spoke about the difficulty of getting the requested personnel to the right place at the right time. For police and ambulance services, this was particularly acute if the request was urgent, rather than planned, and occurred at a busy time of the day (afternoons and evenings). Due to set surgery times, family physicians were seen as having difficulty attending." (p. 963)

The stress and complexity of the decision making processes involved in these assessments has also been identified in the research literature. The is partly due to the nature of the issues being considered, decisions about a person's liberty should be complex and stressful but there are also aspects of how services are organised and resourced which may contribute to that. In the English context Furminger and Webber (2009) found that after the introduction of crisis teams, designed to prevent the need for admission, there had been an increase in compulsory admissions and that the role of the ASW was not well understood in these new structures and communication between crisis teams and ASWs could be disjointed.

Oliver Loft and Lavender (2015) also found, based on interviews with eight service users and nine psychiatrists, that the arrangements around compulsory admission could be complicated, "the current compulsory admission process also appears fragmented in its care provision, with different psychiatrists and staff members responsible for service user's care at different stages of the process. There needs to be greater continuity so that better staff – service user relationships can be fostered and maintained through periods of heightened psychological distress. This may facilitate the attainment of better clinical outcomes." (p. 5)

Hughes et al. (2009) interviewed 12 people about their experiences of compulsory admission to hospital. They found, in keeping with the research around procedural justice that "Participants' perceptions of self while receiving involuntary inpatient treatment were related to how they experienced the quality and nature of their relationships with staff. Participants who experienced staff as caring, supportive, or even indifferent, were more likely to see themselves as unchanged by this experience. However, participants who experienced many of their interactions with staff as coercive and punitive interpreted this as evidence supporting negative self-concepts and loss of identity. This supports the connection between negative social interactions and increased distress found in previous studies." (p. 158)

Appendix Three – Audit Tool

Question	Answer
Demographics	
Unique identifier	ID Code
Address	Urban or rural
	Deprivation index
DoB	Age
	If under 18 legal status/looked after?
Gender	Male/Female/Other (please specify)
Ethnic Origin	1. White 2. Irish Traveller 3. Mixed ethnic group 4. Asian 5. Black 6. Other ethnic group (please specify) 7. Not known
Assessment details	
Medical practitioner the person's own GP?	Yes/No
Was the assessment conducted jointly with the medical practitioner?	Yes/No
If no, was there discussion between ASW and Medical practitioner?	Face to Face/Telephone/No If no please specify why not
If no, did the ASW conduct the assessment without any other staff present?	
Was the nearest relative consulted?	Face to Face/Telephone/No If no please specify why not

Did the nearest relative object?	Yes/No If yes state reason
If yes, was a 2nd ASW involved	Yes/No
Was anyone else consulted?	Yes/No If Yes please specify
Referral – please detail any issues and/or delays	
Initial source of referral (family, professional, location)	
Date of request for GP assessment	
Time of request for GP assessment	
Date of request for ASW assessment	
Time of request for ASW assessment	
Approximate time from initial request for MHO assessment to the completion of the assessment process	
Reason for referral	
What risks were identified in the referral	
Form 5 completed?	Yes/No
Article 129 or 130?	
If Art 129/130 where was the person taken as the place of safety?	
Any issues highlighted at referral stage?	

Personal details	
Living arrangements	
Employment status	
Physical health problems and sensory disabilities	
Dependents	
Family and Child Care involvement	
Currently in receipt of services?	
Prior to the request for assessment (background)	
Was the person known to mental health services?	
Was there a pattern of increasing contact with GP or with mental health services (or with other services such as Lifeline) in the period before the referral for assessment?	
Had there been an alert put in place to OOH services?	
Any relevant issues and/or delays prior to the request for assessment?	
Process of assessment – please detail any issues and/or delays	
Location of the assessment	
Was an interpreter involved?	
Was the person intoxicated at the time of assessment?	

Was substance misuse identified as a factor?	
Did the person require medical assessment and/or treatment?	If yes please specify why
Were crisis response/home treatment involved at the time of assessment?	
Were the police involved at the time of assessment?	
Reason for police involvement?	
Any issues with police involvement?	
Any other issues with the assessment process?	
Risk identified in assessment	
Human rights considerations	
Was mental capacity/decision making ability mentioned in the assessment?	
Outcome of assessment	
What was the outcome of the assessment – application made or not?	Application made/Not made If not specify reasons
If not was an alternative plan devised?	
If application completed what were the reasons given?	
Who identified the bed? Any issues?	
Was the bed outside the Trust area?	
Was the Ambulance Service involved?	
Reason for Ambulance Service involvement?	

Any issues with ambulance involvement?	
How was the person conveyed? Any issues?	By the Ambulance Service By the Ambulance Service with PSNI support By the PSNI By the ASW Other, please specify
Assessment at hospital	
Who conducted the assessment at the hospital?	
Did the ASW speak with the person conducting the assessment?	
What was the outcome?	
Any issues at this stage of the process?	

Appendix Four – Approved Social Worker Report

MHO/B form – amended on 31 July 15 to support audit process By Phil Hughes and Karen Harvey, NHSCT

Restricted Information

APPROVED SOCIAL WORKER RISK ASSESSMENT REPORT

MENTAL HEALTH (NI) ORDER 1986

Date of Assessment: **Day Time Rota:** ☐
Out of Hours:

Approximate time from initial request for MHO assessment and completion of assessment process _____

Section 1	
Name of Patient:	
Address:	
Telephone No:	
Date of Birth:	
Legal Status (if under 18):	
Ethnic Origin	1. White 2. Irish Traveller 3. Mixed ethnic group 4. Asian 5. Black 6. Other ethnic group 7. Not known
Section 2	
Name of ASW:	
Address:	

Telephone No:			
Date and time of request for ASW ASSESSMENT			
Section 3			
Name of Patient's GP:			
Address:			
Telephone No:			
Name of Medical Practitioner, involved in considering medical recommendation for assessment (if different from above)			
Date of request for GP assessment			
Time of request for GP ASSESSMENT			
Address:			
Telephone No:			
Was this a Joint Assessment with the Medical Practitioner?	Yes		
If not, did you consult?	Yes	**Was this face to face?**	Yes
		By Telephone?	Yes
Section 4			
Name of Nearest Relative: (As defined in Article 32 of the Order)			
Address:			
Telephone No:			

Relationship with Patient:	
Did you consult with Nearest relative?	Yes
If No, state reason	
If application was made did the Nearest Relative object?	Yes
If Yes, state reason	
If yes, Give name and address of 2nd ASW (Second ASW's Report must be attached)	
Section 5	
Details of others consulted:	
Section 6	
Reason and Source of Referral	

Was Form 5 completed?	
Were Art 129 /130 used? If so was person taken to place of safety?	

Section 7

Details of Referral:	

Section 8

Personal Details:

Patient's present living arrangements:		**Occupation:**	
Lives alone	☐	Is the clie t employed at present?	☐
Lives with other/s (give details)	☐	Full time	☐
Lives in Hostel	☐	Part time	☐
Homeless	☐	Work placement	☐
Residential Care	☐	Unemployed	☐
Nursing Care	☐	Voluntary	☐
Other (please specify)		Retired	☐
		Student	☐
Any Other Details:		Any Other Details:	

Physical health problems and Sensory Disabilities (if relevant):

In situations where the patient is involved with children as a parent/carer/residing in same accommodation with children, the following details should be recorded:

1) Name and age of child/children and nature of relationship with patient;
2) Name and contact details of person/s with parental responsibility for these children.

Name	Age	Relationship with Patient	Name and contact details of Person/s with parental responsibility

Family and Child Care involvement? Details (if applicable):	
Other Dependants:	

Is the patient currently in receipt of services?		Contact Details – services/relevant personnel
CMHT	☐	
Psychiatrist	☐	
Day Care	☐	
Day Hospital	☐	
Domiciliary	☐	
Other Statutory services (i.e. child care, elderly services)	☐	
Voluntary Services	☐	

Section 9

Background Information: **Was there pattern of increased contact**	

with GP – mental health services or other E.G LIFELINE? **Was an alert put out to RESW?** **Any issues re delays in request or getting assessment?**	
Section 10	
Details of Interview: **Location** **Interpretor involved** **Ontoxicated or substance misuse** **Did person require medical assessment and/or treatment** **Were CRHTT involved at time of assessment?**	
Section 11	
Current Mental Health:	
Section 12	

Situational Factors:	

Section 13

Risk Assessment:

Risks and individuals, including the patient, to whom risk/risks apply

Name	Nature of Risk

Factors, reducing risk, currently in place for the Patient and others identified as at risk?

Name	Factors reducing Risk

Alternatives Considered:	

Section 14

Human Rights Consideration:	Are there capacity issues?

Section 15	
Assessment Outcome:	
Section 16	
Alternative care Plan (To Be Completed if application not made):	
Section 17	
Conveyance and Security Involvement: **POLICE INVOLVEMENT** **REASON for**	Include COMMAND AND CONTROL NUMBER FOR PSNI _____ INCIDENT NUMBER FOR Northern Ireland Ambulance Service _____

involvement Any issues? Ambulance service involved? Reason? Any issues? **Securing a bed – who identified bed? Any issues in getting bed? Was it outside NHSCT Trust area?**	
Section 18	
Date of Application (if applicable):	
Admission Details (if applicable): **WHO CONDUCTED ASSESSMENT AT HOSPTIAL?** **Did ASW speak with admitting nurse and doctor?** **What was the outcome and what were the issues?**	
Date:	
Section 19	

Rights Information provided to:	**(1) Patient:** **(2) Nearest Relative:**	**Date:** **Date:**

Section 20		
Any other Information and Follow-up:		
Section 21		
Signed:	**Approved Social Worker**	
Date:	_____	
Read and Signed by:	**R.M.O.**	
Date:	_____	
Check List **Copy Forwarded To**	**G.P.**	☐
	Community Mental Health Team	☐

	Learning Disability Team	☐
	Family & Child Care Team	☐
	Child and Adolescent Team	☐
	R.M.O in admitting hospital	☐
	RMO in relevant Community team	☐

Appendix Five – Interagency Protocol Risk Matrix and Joint Risk Assessment

RISK ASSESSMENT MATRIX (HSCB, 2015)

Previous History of Person	Current Circumstances	Police Support
Low Risk		
Person has a history of • violence; • active self-harm; • absconding; • other risk behaviour indicators currently present (other than very mild substance use). ***History is*** • ***Infrequent AND historic*** ***OR*** • ***Irrelevant due to circumstances.***	Person presenting is ***NOT*** • violent • actively self-harming; • stated intention to abscond; • other risk behaviour indicators ***currently present*** (other than very mild substance use).	Police assistance ***will not be*** required.
Medium Risk		
More than infrequent history of violence or more than AOABH, involving weapons, sexual violence, violence towards HSC staff or vulnerable person. **OR** ***LOW RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged.	• Person currently presenting ***some*** behavioural indicators (including substance use). **OR** • Some recent criminal / medical indicators that the individual may be violent OR poses an escape risk OR is a threat to their own or anyone else's safety.	Police assistance ***may be*** required.
High Risk		
Significant history of any of the medium risk indicators. ***MEDIUM RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	Person currently presenting ***significant*** • behavioural indicators (including substance use) • recent criminal / medical indicators that the individual may be violent OR is a threat to anyone's safety	Police assistance ***will be*** required.

In cases of dispute the joint risk assessment will be completed in respect of the person

JOINT RISK ASSESSMENT TO DETERMINE THE NEED FOR ONGOING POLICE INVOLVEMENT

Patient …….. ……. **DOB** ……

Location …… ……**Date** ……/……/……

……

(Department and name of hospital / home address etc.)

		N	**Y**	**UK**
1	Is the person intoxicated?			
2	Does the person need active restraint to prevent harm to self/others?			
3	Does history or person's behaviour suggest a risk of absconding?			
4	Has the person already harmed themselves on this occasion?			
5	Has the person any history of assault on Police or caring staff?			
6	Has the person recently assaulted anyone?			
7	Has the person threatened physical/psychological harm to others?			
8	Has the person expressed but not demonstrated aggressive behaviour?			
9	Is person suspected to have consumed non-prescribed drugs?			
10	Is there evidence/reports of sexually inappropriate behaviour?			

11	Has the person been compliant since their detention/removal by Police to a Place of Safety?			
12	Does the person detained/removed agree with the action(s) taken?			
13	Does the Police Officer believe their continued presence is required at this time?			
14	Has the person required handcuffs or limb restraints? Details ……..			
15	Does the clinician feel the client cannot be managed safely without Police presence?			
16	Please give reasons not covered above why the Police are believed to be required to remain in attendance In the event of a disagreement between staff : Has the above been discussed with the supervising Police Officer? (Please state the name of the supervising officer) What is the outcome at this time?			

Signature of Assessing Practitioner: ……

Signature of Police Officer: ……...

Where there is a dispute within this framework, HSC professionals will have the right to request Police support where they believe they require it – Police supervisors will have the right to direct on what that support should be. Each agency will accommodate the other, through this compromise.

Appendix Six: Terms of Reference for the Northern Trust's: Police Service of Northern Ireland, Northern Ireland Ambulance Service, Primary Care and Mental Health Services Interface Group

Terms of Reference

PSNI, NIAS, Primary Care and Mental Health Services Interface Group

Reviewed and updated 10.02.16

The key purpose of this group is to support effective working arrangements between the 4 agencies which work together to meet the needs of service users who have mental health problems and may need assessments under the Mental Health Order with the view to receiving treatment as an inpatient.

Frequency of Meeting – Quarterly

Meetings will have an agenda and a record of discussion/actions which will be circulated to all members within 7 days of the meetings.

Agenda items will be collated prior to each meeting by a reminder being send to members via mental health admin support and agendas agreed and circulated at least 4 working days prior to meeting.

Principles Underpinning the Groups Interactions

- We will actively demonstrate dignity and respect for all parties and agencies.
- We will work to establish open, transparent and effective working relationships.
- We will present conflict issues/concerns in a constructive way to enable effective and pragmatic resolution.
- We will share positive experiences
- We will work to enhance both our own and each other's understanding of each agency's issues.
- We will plan joint training events at least yearly
- We will review incidents and complaints to inform service improvements
- We will develop guidance for both agencies to support implementation of regional policy
- We will comment on local and regional polices and service developments as appropriate
- We will review the outcomes and effectiveness of the interface group annually
- Terms of reference will be reviewed annually

Membership

Each agency will aim to ensure at least one representative is available to participate in the quarterly meeting.

A copy of this Audit is available for download and print via

www.gain-ni.org

GAIN Office

9th Floor

Riverside Tower

5 Lanyon Place

Belfast BT1 3BT