Lancashire Care NHS
NHS Foundation Trust

Mental Health Liaison Team (MHLT) Standard Operating Procedure

Procedure Author:	Mental Health Liaison Team Practice Development Group
Procedure Reference Number:	MH006
Date Ratified:	April 2019
Expiry Date:	May 2022

Procedure Statement/Key Objective:

This SOP is to ensure best practice principles for LCFT staff to promote effective liaison between Acute Trusts and LCFT Mental Health Liaison Teams whilst maintaining the values of respect, compassion, excellence, accountability, integrity and teamwork

Supporting Health and Wellbeing

Summary

Title of Procedure:	Mental Health Hospital Liaison Standard Operating Procedure
Applicable to:	Mental Health Liaison Teams
Governance group responsible for approving and monitoring implementation *This group is responsible for approving that the document is fit for purpose and for monitoring adherence to the policy and for keeping an eye on the review date.*	☒Safety and Quality Governance Group ☐Drugs and Therapeutics Committee ☐Medication Safety Group ☐Safeguarding Group ☐Promoting Health, Preventing Harm Group ☐Infection, Prevention and Control Group ☐Mental Health Law Group ☐People and Leadership Group ☐Other: _____
Linked Sub-Committee	☒Quality and Safety Subcommittee ☐People sub-committee ☐Mental Health Law Subcommittee ☐Other: _____
People / Groups Consulted:	Mental Health Liaison Teams CGM for Localities Service Manager for Localities Deputy Head of Operations
To be read in conjunction with:	• Clinical Record Keeping procedure CL027 • Care Programme Approach Policy and Procedure - CL012 • Care Planning Standards • LCFT Values and Code of Conduct • Supervision Policy – COR031 • Safeguarding and Protecting Children Adults Policy (SG007) • MHA and Code of Practice • Mental Capacity Act 2005 • Deprivation of Liberty Safeguards 2007 • Procedure for the assessment and management of clinical risk in mental health services CL028a • Clinical Risk Assessment and Management in Mental Health Services Policy (CL028).

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MCA COMPLIANCE FORM

Please complete the questions below:	Yes/No/ Unsure	Notes
Does the procedure relate to Clinical practice?	☒ Yes ☐ No	*If 'Yes', the procedure must be compliant with the MCA. Please complete the questions below.*
Does the procedure refer all users to the MCA policy?	☒ Yes ☐ No	*If 'No' refer back to author – all clinical procedures should be read in conjunction with the MCA policy.*
Does the procedure refer to any form of consent to treatment?	☐ Yes ☒ No	*If 'Yes' is this MCA compliant?*
Does the procedure stipulate a specific method of consent is required?	☐ Yes ☒ No	*If 'Yes' is this MCA compliant?*
Does the procedure exclude service users unable to consent?	☒ Yes ☐ No	*If 'Yes' procedure is not MCA compliant – refer back to author*
Does the procedure require staff to use any form of restraint / restrictive practice?	☐ Yes ☒ No	*If 'Yes' refer procedure to MCA lead who should review it (name)*

Policy for Implementing the Mental Capacity Act and Obtaining Authorisation for Deprivation of Liberty CL048

1.0 Introduction

1.1 Liaison psychiatry / Mental health liaison is a specialty concerned with the assessment and care of people with both physical and mental illness. However, this does include individuals presenting to an ED with primarily mental health disorders.

1.2 Physical and mental health are a key component of a person's "health". Poor physical health increases the rates of poor mental health; poor mental health can cause or worsen physical health. This improves worse outcomes of physical health disorders compared to someone without mental disorder. This has significant financial impacts for the NHS and wider economy in increased costs and reduced productivity; not to mention the significant adverse impact on quality of life.

1.3 A functioning liaison mental health service can improve patient outcomes and deliver cost-savings for acute hospitals through reduced length of stay and reduced readmissions. In acute hospitals, the prevalence of co-morbid mental health problems is extremely high; many of these problems go undiagnosed and untreated. Improvements in recognition, management and treatment of mental health conditions in hospital can significantly reduce the scale and cost of these problems.

1.4 In younger inpatients the prevalence of mental disorders may be around half the rate of older people, implying an overall prevalence of physical/mental health co-morbidities in the inpatient population of nearly 50%. This high prevalence comes about due to a number of factors pre-existing mental illness contributing to the development of physical illness; psychological reactions to physical illness; organic effects of physical illness on mental function, e.g. delirium; the effects of medically prescribed drugs on mental functions and behaviour; medically unexplained physical symptoms that mask underlying mental illness; and alcohol and drug misuse (Lloyd, 2012). Many cases of mental illness among hospital patients go undetected by acute clinical staff with at least 50% unrecognised, and may be even lower for some conditions such as delirium (Fossey *et al*, 2012).

1.5 Therefore, liaison psychiatry is a critical service that should be integral to all acute hospitals (Joint Commissioning Panel for Mental Health, 2012; NHS Confederation, 2012). Good liaison mental health care is needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a small proportion currently (2018) of 24 hour EDs have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am.

1.6 The NHS Five Year Forward View mandates that no acute hospital should be without an all-age mental health liaison service by 2020/21; at least 50% of acute hospitals should have a minimum Core24 level of service (Mental Health Taskforce, 2016). In addition it includes Recommendation 21 that states "*NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care".*

1.7 Mental health liaison is able to provide a detailed biopsychosocial assessment and employs this model in the assessment and treatment of all individuals assessed. Mental health liaison services usually operate separately (but in collaboration with) community and inpatient mental health services. Liaison services are multidisciplinary and include a consultant psychiatrist with special interest or expertise in liaison psychiatry. Liaison psychiatry services have enhanced/expert knowledge on the safe operation of the Mental Health Act and Mental Capacity Act in general hospital settings.

2.0 Scope

2.1 This document applies to all the staff employed by LCFT working within Mental Health Liaison Teams settings or contracted to provide services for the Trust on either an agency or locum basis. This policy supports the MHLT SOP on a page.

2.2 This policy will be subject to regular review and amendments to reflect any changes or improvements in the current clinical practice as directed by the clinical policies within Lancashire Care Foundation Trust.

3.0 Definitions

ACE-III	ACE III – Addenbrookes Cognitive Examination III
AUDIT-C	AUDIT-C (AUDIT alcohol consumption questions)
CCG	CCG – Clinical Commissioning Group
CGI-I	Clinical Global Impression – Improvement Scale
CHC	Continuing Health Care
CROM	Clinician Rated Outcome Measure
eCPA	Electronic Care Programme Approach
ECR	Electronic Care Records
ED	Emergency Department
EDMS	Electronic Document Management System
EMIS	Egton Medical Information Systems
EPR	Electronic Patient Record
ePDR	Electronic Performance Development Review
FFT	Friends & Family Test
FBC	Full Blood Count
GDS	Geriatric Depression Scale
GP	General Practitioner
ICD-11	International Statistical Classification of Diseases and Related Health Problems 11th Revision
IRAC	Identify the aim / rate achievement of the aim
QOF	Quality and Outcomes Framework
LCFT	Lancashire Care NHS Foundation Trust
M-ACE	Mini-Addenbrookes Cognitive Examination
MAS	Memory Assessment Service
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MH	Mental Health
MHDU	Mental Health Decisions Unit
MHLT	Mental Health Liaison Team
NICE	National Institute for Health & Care Excellence
NCRS	NHS Care Records Service
NMP	Non-medical prescriber
OA	Older Adult
PHQ2	Patient Health Questionnaire (2 item version)
PHQ9	Patient Health Questionnaire (9 item version)
PREM	Patient Reported Experience Measure
SPoA	Single Point of Access
U&Es	Urea and Electrolyte
UCC	Urgent Care Centre

4.0 Duties

4.1 Operational Leads

Have responsibility to ensure this policy is promoted and implemented within their area of responsibility.

4.2 Operational / Service Managers

Have responsibility for ensuring that this policy is effectively implemented in their areas of responsibility.

4.3 Team Leaders / Managers

All managers are responsible for ensuring that this policy is effectively implemented in the area that they manage, including the monitoring and supervision activities in accordance with section 8 (monitoring) of this policy.

4.4 All LCFT clinical staff and other integrated staff groups will ensure that the procedure is followed and that they act in line with their professional standards of conduct, performance and ethics.

5.0 The Procedure

5.1 The Service

In line with our Standard Operating Procedure, we will provide *flexible, needs-led support, interventions and planning in partnership with patients, carers and colleagues* in each locality.

5.2 Mental Capacity Act (2005)

MHLT staff working should understand legislation relevant to capacity, consent and information sharing as outlined in the Mental Capacity Act (HMSO, 2005) and Mental Capacity Act Code of Practice. Mental health professionals should pay particular attention to sections 1 to 6 of the Mental Capacity Act in order to understand legal duties and limitations.

Guidelines on capacity and information sharing should always be followed and considered at all times throughout the pathway.

5.3 Referral Criteria

The Mental Health Liaison Team will offer mental health assessments and care planning to people aged 16 years or above presenting with acute mental health needs on acute trust hospital sites; this includes inpatient wards, Urgent Care centres, and Emergency Departments (ED).

Inclusions*:*
A person has an apparent mental health need which the acute trust care team want assessed before their discharge from care, particularly for cases involving complexity or where risks are identified. Complexity can refer to decisions where there are differences of opinion with regards to capacity, or where mental health needs are significantly impacting on recovery or treatment of mental health needs.

Where a specialist mental health assessment is required as a part of a holistic and comprehensive approach to care.

Where there is a suspicion of a mental health disorder, but specialist assessment is required to identify or exclude such a disorder.

Exclusions
Patients without a primary psychiatric condition or comorbidity, this includes patients diagnosed with a primary neurological condition without comorbidity (even where they are requiring a CHC assessment).

Patients with a very low level of mental health / psychological support needs not impacting on management of their physical disorder or delaying discharge. These patients can be signposted back to their GP or to other support options.

It is likely that a patient can only be excluded by an initial brief assessment or where a request for telephone advice is made and a shared outcome is agreed.

5.4 Pre-assessment information to be included with referral

- Full patient details including DOB, gender, NHS Number, and GP.
- Referrers name and contact details.
- The primary reason for referral and associated risks.
- The reason for their current admission and ongoing management plan.
- Indication of the urgency of the referral in line with the NICE Response Time Standards (Section 6.6) – remember that all ED referrals are treated as emergency referrals.
- An indication of whether the patient has consented and is agreeable to the referral, or where lacking capacity it is in their best interests.

5.5 Emergency Department Referrals

- Referrals from the emergency department will usually be via telephone or bleep.
- Any patient with mental illness should undergo a risk assessment at triage (RCEM, 2017). This basic review should be conducted by ED triage staff or appropriate staff on the ward and undertaken with compassion and understanding.

- It should include (NICE, 2017):
  - A physical assessment; a decision as to whether they need emergency physical care should be taken as a priority.
  - A personalised risk assessment, including a decision as to the appropriate action needed should the person leave the ED while waiting for review by the liaison MH team.
  - Observations on behaviour and mental state.
- In some cases the triage process will identify patients without physical illness who may be appropriate for a "fast track" referral directly to MH liaison (RCEM, 2017).
- ED nursing staff should have access to regular training in MH so that they are able to assess risk and contribute in a positive way to the patient's condition (RCEM,2017).

5.6 Response Time Standards

NICE have outlined a series of standards that are recommended as part of the Evidence Based Treatment Pathway (EBTP). These rely on definitions of acuity.

Emergency Referrals – within 1 hour: An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response. This includes ALL ED and Urgent Care Centre (UCC) referrals.

Urgent referrals – within 24 hours (but aim for same day): An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening.

Within 1 hour there should be a response to the referrer (telephone or face-face) to a referral graded as an emergency or urgent from a general hospital ward. This is to ascertain its urgency, the type of assessment needed and resources required for the assessment. (All ED/UCC referrals should receive a face-face response within 1 hour as above) (NICE, 2016).

Emergency Department: within four hours of arriving in an ED or being referred from a ward it is recommended that the person should (NICE, 2016):

- have received a full biopsychosocial assessment, have an urgent and emergency mental health care plan in place, and at a minimum, be en route to their next location if geographically different; or,
- have been accepted and scheduled for follow-up care by a responding service; or,
- have been discharged because the crisis has resolved; or,
- have started a Mental Health Act assessment.

Within 24 hours of presenting with a suspected **urgent** mental health problem on a general hospital ward it is recommended that a person should:

- have received a full biopsychosocial assessment, and
- have an urgent and emergency mental health care plan in place, and
- at a minimum, be en route to their next location if geographically different, or
- have been accepted and scheduled for a follow-up appointment by the responding service, or
- have been provided with advice or signposted, where appropriate.

Routine referrals – within 48 hours. This time frame does not exclude earlier triage and appropriate gathering of information.

The MHLT will provide a response to all ward referrals at the earliest opportunity, ideally this should be a telephone response within 1 hour (unless urgent or emergency where this should be undertaken immediately) to confirm receipt of referral and our estimated response time.

5.7 Where a hospital has a 24/7 Emergency Department (ED), then it should have a core 24 service level as a minimum to ensure 24/7 mental health cover excluding MHLT Central (NICE,2017). This will include access to a consultant psychiatrist (on-call out of hours), the ability to provide a response to mental emergencies in EDs and inpatient wards within 1 hour and to all urgent ward referrals within 24 hours.

5.8 Assessment Pathways

The MHLT will operate an integrated all-age (adult), needs-led service in line with the Five Year Forward View for Mental Health (MH Taskforce, 2016).

The MHLT will identify the most appropriate practitioner within the team to undertake the initial assessment. A patient's age alone will not be used to differentiate who undertakes this assessment. Within LCFT we have developed *Advanced Care* Criteria which identify if a patient has "advanced care" needs. This will enable the team to identify a practitioner with specific older adult skills where appropriate.

At the point of referral, an initial discussion with the referrer may take place to clarify whether a patient is fit for assessment and as to the urgency of the referral.

In some cases it may be identified that a person is too unwell or unfit for assessment; in these cases there should be a joint agreement with the referrer whether the assessment can be delayed or whether the patient should be re-referred at a point where they are fit for assessment. This will particularly be the case if someone is under care on an intensive care unit.

In cases of self-harm where they are undergoing active treatment as a result of self-harm and full assessment is not possible, then an initial brief assessment should be conducted and the referral kept open until further assessment and management can take place.

Only after attendance and review of the clinical presentation can an option for discussion can be made as to whether a routine or enhanced assessment is required and whether this can take place in **parallel** alongside ongoing physical health care treatment where deemed appropriate.

If after this initial face to face review it is felt that the person is not able to engage in a MH assessment then as much information as possible will be documented on the electronic care record and arrangements made to complete the assessment at an appropriate time.

Responsibility of care for the individual sits within the acute trust, but we also have a duty to provide a timely response, and to support them in managing risk.

Medical responsibility will remain with the relevant consultant of the acute trust.

A ***Routine Assessment*** describes the standard assessment that takes place and can be used to quickly identify if an Enhanced Assessment is required. A routine assessment only, is appropriate when the presenting problem is at a level appropriate for management in primary care or signposting to third sector services. These presentations would not be associated with any active or ongoing indicators of risk to self or others, and/or with no indicators of immediate vulnerability.

A routine assessment can be recorded within a daily contact/face-face contact entry and is not expected to require completion of an enhanced risk assessment or health & social needs document.

An ***Enhanced Assessment*** is more appropriate where additional needs or risks are identified following an initial routine assessment (i.e. to include referral information, 5P formulation and plan). This will include patients presenting with symptoms of psychosis, thoughts of self-harm or self-harm behaviours, and a severity of mental illness that would require referral to secondary care services.

An enhanced assessment will require a detailed risk formulation and management plan. This includes an assessment based on an individual's strengths & needs, completion of an Enhanced Risk Assessment incorporating a 5Ps formulation and an agreed plan.

Any patients being admitted or referred on to secondary mental health services require the assessments indicated above an enhanced assessment as well as a completed health & social needs assessment. In some areas (where applicable) a risk assessment and H&SN assessment may also be required for patients being transferred to the MHDU.

5.9 Assessment tool / form

It is appropriate for a paper based tool/pro-forma to be used for recording of information and/or as an aide-memoire for practitioners to ensure that all appropriate information is gathered at an assessment.

These assessment tools are not to be regarded as indicators of risk in themselves. No risk assessment tool has been shown to have sufficient ability to predict risk.

Best practice as advocated by the DoH (2007) involves making decisions based on knowledge of the research evidence on risk, knowledge of the individual service user (their social context and own experiences) and clinical judgement. Practitioners will therefore use a structured professional judgment approach to the assessment of risk.

It is essential where any assessment tool/form is used for assessment and where the practitioner relies on that for prompting risk indicators, it covers the following essential elements where applicable to the presenting complaint (DOH, 2007):

Risk factors for suicide:

- Demographic factors: male, Increasing age, Low socioeconomic status, relationships status (unmarried, separated, widowed), living alone, unemployed.
- Background history: deliberate self-harm (especially with high suicide intent), childhood adversity (e.g. sexual abuse), family history of suicide, family history of mental illness.
- Clinical history: mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia), personality disorder diagnosis (e.g. borderline personality disorder), physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes), recent contact with psychiatric services, recent discharge from psychiatric in-patient facility.
- Psychological and psychosocial factors: hopelessness, impulsiveness, low self-esteem, life event, and relationship instability. Lack of social support
- Current ‘context’: suicidal ideation, suicide plans, availability of means, lethality of means.

When you have identified suicidal thoughts/feelings or assessment follows an act of self-harm, you should always explore this further. This includes asking about the frequency of the thoughts they have, how long they have been present and whether they have worsened recently. Equally it is important to check if they have considered specific methods, and/or have a plan, and whether they have access to means. Check what factors increase the risk and what factors make the risk less likely this will need to include ways of mitigating any risk.

Risk Factors for Violence:

- Demographic factors: male, young age, socially disadvantaged neighbourhoods, lack of social support, employment problems, criminal peer group.
- Background history: childhood maltreatment, history of violence, first violent at young age, history of childhood conduct disorder, history of non-violent criminality.
- Clinical history: psychopathy, substance abuse, personality disorder, schizophrenia, executive dysfunction, non-compliance with treatment. Patients with dementia may also be at increased risk for violence and often have difficulties communicating their needs/feelings which can lead to frustration or lack of social awareness.
- Psychological and psychosocial factors: anger, impulsivity, suspiciousness, morbid jealousy, criminal/violent attitudes, command hallucinations, lack of insight.

Perinatal: Any patient who has given birth (or been pregnant) within the last 12 months should be screened for symptoms of depression, anxiety (including obsessional thoughts), and insomnia. They should be asked about any thoughts or acts of self-harm, worries about their ability to care for their child/children, or feeling detached/estranged from the baby/infant. It should be clarified whether there have been any significant changes in mental state or new symptoms.

Professional judgement should be used to decide what is a normal aspect of parenthood (e.g. isolated tiredness), versus something pathological, e.g. constant feelings of inadequacy or persistent low mood.

Carry out a risk assessment in conjunction with the woman and, if she agrees, her partner, family or carer. Focus on areas that are likely to present possible risk such as self-neglect, self-harm, suicidal thoughts and intent, risks to others (including the baby), smoking, drug or alcohol misuse and domestic violence and abuse (see Domestic Abuse Policy/Procedure – SG006/SG006a).

The above risk indicators should not be regarded as an exhaustive list.

5.10 MDT Working

MH patients presenting in acute trusts (especially EDs) have a high rate of co-morbidities with alcohol, substance misuse or other vulnerabilities. Close links with safeguarding (see Safeguarding and Protecting Children and Adults Policy – SG008) also promote good holistic care.

There needs to be a MDT that can deliver joint assessments in a timely fashion. LCFT does not hold responsibility for dealing with patients with primary substance misuse difficulties (unless otherwise contracted). It is therefore important that timely access to other services is also available.

5.11 Risk Assessment

Risk management is a fundamental requirement of the delivery of safe, effective and high quality mental health services.

All staff who assess individuals presenting to Mental Health Services within LCFT are required to assess the likelihood of harm to self or others as part of an overall assessment of need.

Clinical risk assessment is the process by which risk is assessed. Best practice as advocated by the DoH (2007) involves making decisions based on knowledge of the research evidence on risk, knowledge of the individual service user (their social context and own experiences) and clinical judgement. Practitioners will therefore use a structured professional judgment approach to the assessment of risk.

All staff involved in risk management should receive relevant training, which should be updated at least every three years (DOH, 2007).

LCFT has developed an Enhanced Risk Tool and a Standard Risk Tool which sits in the electronic patient record and should be used to record risk assessments. For routine assessments in MHLTs not requiring an enhanced assessment or care plan from the MHLT, or where no MH need is identified, completion of the Standard Risk Tool is appropriate although any relevant information can be incorporated within a structured daily contact entry.

An Enhanced Risk Tool should be completed for every assessment where a more detailed or “Enhanced Assessment” (as defined by the SOP CL028a) is undertaken, or where there are identified risks of harm to self, to others, and risks associated with vulnerability or all forms of exploitation.

The risk assessment tools should always be finalised and not left in draft other than in situations whereby a practitioner has been called away in an urgent situation.

All clinically trained staff are required to attend a one-day essential training which will support staff in using the 5P's risk assessment and formulation model.

Staff are expected to be able to use the 5P's 'headings' when completing an Enhanced Risk Assessment.

See the LCFT Procedure in relation to assessment and management or risk for further information related to risk assessment and recording of risk assessment (CL028A).

5.12 Managing patients who leave / or may leave:

If a Mental Health Act assessment has been arranged and the need for urgent and emergency mental health care is still in place, then the EBTP clock does not stop if the person leaves the ED or ward and is reported to the police as a 'missing person' (NICE, 2016).

If there are concerns that the person is likely to leave before an assessment and there are concerns regarding immediate harm, all efforts should be made to support the person. The following should also be considered:

Whether there is reason to suspect the person lacks mental capacity and powers to hold under the Mental Capacity Act can be used.

Whether it is appropriate to contact the police to consider the use of Mental Health Act section 136 (can be used in any location other than a private dwelling or the private garden or buildings associated with that (this does not apply to communal buildings. (Section 136(a)), or

Whether Mental Health Act holding powers should be used:

- If a person is already receiving physical health treatment, the doctor in charge of their care can apply section 5(2) holding powers.
- If no urgent and emergency mental health care is required and the person leaves the general hospital of their own accord, the EBTP CLOCK STOPS and the conditions under which they left should be recorded. The MHLT should then consider whether further referral and/or follow up is necessary.

5.13 Patients who refuse assessment

Where a patient that has been referred refuses assessment then a capacity assessment should be undertaken. If this demonstrates a lack of capacity, then a best interests judgement will need to be made (probably in consultation with the referred) to establish whether to continue with assessment.

Where it is identified that a person lacks capacity then assessment will need to take place as far as possible to ascertain their needs and associated risks. In circumstances where they present with a mental disorder and a risk to their own health, safety or that of others, a Mental Health Act assessment may be indicated.

Likewise even if someone does not appear to lack capacity, but there are clearly identified risks in the presence of a suspected or known mental disorder, a Mental Health Act assessment may be indicated. It is however, rare, that a truly capacitous person will refuse assessment. Consideration needs to be given to the circumstances in which that person has presented and the likely impact that has on their mental state.

5.14 Proxy Decision Makers

Where a patient lacks capacity to make specific decisions for themselves, every effort should be made to ensure that there is not an existing Lasting Power of Attorney, Court Appointed Deputy, or Advanced Decision To Refuse Treatment (ADRT) in place.

Where a person lacks capacity to make a specific decision, then the person holding deputyship/LPA should be treated as the decision maker.

It should always be checked whether someone holds a relevant authority (e.g. LPA) to make decisions on a patient's behalf. This may be by asking them to provide a copy of the LPA certified by the Office of the Public Guardian (OPG). An alternative course of action is to make a request via the OPG for a search of the Public Guardian Registers (known as an OPG100). This form can be found online.

An Advanced Decision does not have to be written down except in cases whereby it relates to life sustaining; in such cases it must explicitly relate to the identified circumstances and state that the decision applies even if their life is at risk / they are likely to die. In such cases the advance decision needs to be written, signed by the person themselves and a witness.

An Advanced Statement is NOT the same as an ADRT. An advance statement is a written statement that sets down your preferences, wishes, beliefs and values regarding your future care. It is designed to support those if need to make best interest decisions in relation to your care. It does not have to be adhered to but anyone making decisions MUST take it into account. An advanced statement is written by someone who has mental capacity to make those statements.

An Advanced Decision is legally binding if it complies with the MCA, is valid and applies to the specific decision. An ADRT is valid if:

- The person is aged 18 or over and had capacity to make the specific decision.
- It specifies clearly the treatments being refused.
- The person has not demonstrated they are likely to have changed their mind.
- A valid ADRT takes precedence over others making decisions under the best interest principles of the MCA.

For decisions around treatment in someone who lacks capacity please consult the MCA Code of Practice for specific guidance.

5.15 MHA Section 136

These are powers under the MHA which are available to police officers. *'If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons (a) remove that person to a place of safety…or (b) if … already at a place of safety …keep the person at that place or remove the person to another place of safety.*'(RCPsych, 2018).

Section 136 can now be used in any place other than a private dwelling or the private garden or buildings associated with that place (s.136 1A).

Police must consult a registered medical practitioner, a registered nurse or an approved mental health professional or other persons specified in the Act or its regulations, if practicable, before using s.136 (s.136(1C)). The regulations specify that an occupational therapist or a paramedic may also be consulted (Statutory Instrument, 2017).

Where police officers have removed someone to a place of safety under s.136 MHA, the person remains in the custody of the detaining officers until such a time that another organisation agrees to take over the legal detention. The chief constable would be liable for negligence for any claim if the police withdrew from a situation where someone was still subject to legal detention, without ensuring a safe handover of care.

The maximum period of detention under S136 (MHA) is 24 hours; it can be extended by a further 12 hours, but only if the registered medical practitioner decides it is necessary because it has not been possible to complete the assessment within the first 24 hours directly as a result of their condition. The "clock" starts as soon as a person arrives at the place of safety.

Where extension is required in a health-based place of safety (HPOS), this should be a decision made by a doctor who is approved under Section 12 (MHA). Unavailability of a MH bed is not a valid reason for an extension to Section 136.

HPOS should be secure enough and sufficiently staffed to manage the vast majority of patients on s.136 without requiring the assistance of the police. In some circumstances, a person may be assessed as being too aggressive to safely manage the person in the HPOS at that time. In such circumstances police officers should be asked to remain in the place of safety until there is sufficient staff/further assessment to allow a safe handover of care to take place (RCPsych, 2018).

Police officers frequently come across situations where there is no immediate need for care or control and where further information about the person such as background information, risk history or crisis plan may help their decision making. In the absence of an immediate need for care or control it may be appropriate, if safe to do so, for mental health services to offer an alternative response to the mental health crisis. This may include an emergency assessment by the mental health team if the person is able to give consent to the assessment or arrange further community support/review if the person is well known to the service and such a response is clinically indicated (RCPsych, 2018).

Use of ED as a place of safety:
Assessment at an A&E/ED may be required where there are concerns about a person's physical health.

The needs of individual persons held under S136 patient must be paramount and healthcare professionals and the police need to work in partnership to ensure a safe and timely assessment of both physical and mental health needs.

Every patient admitted to the HPOS should have the following physical observations: pulse rate, blood pressure, respiratory rate, temperature, urine drug screen and urine 'dipstick' (protein, white cells, urea, and ketones), plasma glucose and Glasgow Coma Scale assessment or other simplified measure of consciousness. These should be completed by the accepting nurse. Early warning systems e.g. Modified Early Warning System (MEWS) are useful tools to track physiological observations during detention under s.135/136 (RCPsych, 2018)

Detention under S136 ends as soon as the assessment has been completed and necessary arrangements have been made. (Code of Practice 16.50). Such arrangements might include detention under the MHA, informal admission or arrangements made for community treatment or social arrangements necessary for a safe discharge.

The s.136 cannot be discharged without the AMHP making any necessary arrangements for the person's treatment or care except where the registered medical practitioner concludes that the person is **not** suffering from mental disorder (as defined in the MHA). A doctor must discharge the person from detention under s.136 if there is **no** evidence of mental disorder.

The doctor undertaking the examination, or at least one doctor if two doctors are involved, should ensure documentation of the assessment and plan in the patient's records on the system available to the HPOS.

5.16 "Positive risk taking"

The use of this phrase and its implementation should be done carefully. It refers to risk taking where there has been a serious consideration about the issues which have been discussed with the patient. It is about deciding on a plan of actions that has recognised associated risks, but when the potential benefits outweigh the potential negative consequences of the plan (Hart, 2014).

It primarily relates to where a risk can't be completely eliminated but an approach taken is more beneficial than another course of action (such as admission under the MHA).This approach allows a patient to maintain a degree of manageable responsibility for their safety, improves engagement, and takes advantage of their participation in risk management.

Positive risk taking must only take place following a robust risk assessment and management plan. It requires a shared understanding of potential risks to the patient of their own behaviours, and the drivers of these behaviours, were they carried out. The positive benefits of the use of agreed, adaptive coping mechanisms to combat their behaviours. This will involve a focus on, and understanding of, the patient and their support network.

A positive risk approach should be something that is regularly discussed in individual and team/peer supervision to ensure appropriate and safe decision making. Clinical decisions should always be defensible rather than defensive, in the best interests of the patient (Hart, 2014) and in accordance with the principles of the Mental Capacity Act (2005).

A suggested checklist for guidance in positive risk management (O'Brien and Hart, 2013) is shown in table 1.

Table 1: Good practice considerations in undertaking a "positive" approach to risk management.

1. Are you clear about the patient's experiences and understanding of risk?
2. Are you clear about the carer experiences and understanding of risks (including any responsibilities they may be placed upon them)?
3. Have you clearly defined potential risks and their context?
4. Has there been a clearly defined identification of strengths and coping mechanisms?
5. Is everyone clear about the planned stages for risk taking?
6. Has there been an estimate of potential pitfalls and estimated likelihood?
7. What potential safety nets are in place, including identification of early warning signs linked to a crisis and contingency plan?
8. Have you and the patient explored the "what if" scenarios?
9. What was the outcome of previous attempt(s) at this course of action?
10. How was it managed, and what will now be done differently?
11. What needs to, and can, change?
12. How will progress be monitored?
13. Who agrees to the approach (and who disagrees)?
14. When will it be reviewed?

5.17 Medication Management

It is appropriate for the care team of the acute trust to request support or advice in regard to a patient's mental health medication.

5.18 Consultation & Advice

Some referrals may only require brief consultation and advice this can be in the form of signposting.

The most appropriately skilled member of the MHLT should be the one to deal with these requests.

5.19 Discussion treatment plan / care plan

All assessment information and care plan recommendations should be recorded within the patients' EPR.

Key information & recommendations around risks, follow up and management should be documented clearly within the patient record for the acute trust following every contact or assessment.

The care team should have the ability to contact the MHLT for advice or clarification as required including knowledge of their phone or bleep number.

It is recommended that each MHLT makes use of a care plan which can be attached to, or included within, the patient's notes. This will identify the key information around assessment, risks, and management (including recommendations for the acute staff around observations and actions should a patient leave). It can also enable a record of when assessments take place and a management plan is changed.

As well as assessment outcomes being recorded in notes they should also be discussed directly with a member of the referring team.

5.20 Responsible Clinician Duties

In cases where a patient is detained under the MHA (1983) whilst under the care of the acute trust, or where awaiting a MH inpatient admission, then there should be an arrangement in place between the acute trust and local MH trust as to identification of a responsible clinician.

The responsible clinician is the approved clinician who will have overall responsibility for the patient's mental health care.

Hospital managers should have local protocols in place for allocating responsible clinicians to patients (DH, 2015).

5.21 Outcome measures

Demonstrating the quality and effectiveness of liaison mental health services should be embedded within the service.

We will collect data that allows us to populate a Balanced Scorecard for internal quality control and also report against external stakeholder (e.g. Commissioner) mandated standards.

Outcome measures can measure process (e.g. time to assessment; referral numbers), clinical outcomes (i.e. Clinical Reported Outcome Measures or CROMs), and patient rated/reported outcomes (Patient Recorded Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS).

The Liaison Psychiatry Faculty at the Royal College of Psychiatrists has developed a Framework for Routine Collection of Outcome Measurement in Liaison Psychiatry (FROM-LP).

Suggested patient and clinical outcome measures are highlighted in table 2.

From April 2017 (NICE, 2016), liaison mental health services are expected to record specific data:

- the time of the referral received by the liaison mental health team
- the time of the initial response by the liaison mental health team
- that a full biopsychosocial assessment has taken place
- that an urgent and emergency mental health care plan has been agreed and is in place
- the time that the person is either en route to their next location if geographically different, or has been accepted and scheduled for follow-up care by a responding service, or has been discharged because the crisis has resolved
- the time that a Mental Health Act assessment started.

Table 2. Suggested Clinical and Patient Reported Outcome Measures (based on FROM-LP 2015; NICE, 2016)

Outcome Measure	Single Contacts	Multiple Contacts
Patient Experience	Friends & Family Test	Friends & Family Test
Outcomes – clinician rated	Clinical Global Impression – Improvement Scale (CGI-I)	CGI-I (at baseline and final assessment)
Outcomes - patient rated		Generic - CORE10 At beginning and end of series of contacts **Condition specific:** • Dementia / Cognitive: m-ACE; MOCA; MOCA-Blind • Delirium: S-CAM or 4AT • Depressive disorder: PHQ2; PHQ9; GDS • PND: Edinburgh Postnatal Depression Scale • Anxiety disorders: GAD-7 • Psychosis: HoNOS • Alchohol: AUDIT-C • MUS: EQ-5D-5L
Process Measures	Response time (routine/urgent/emergency - avoidance of breaches) IRAC (Identify the aim / rate achievement of the aim)	
Referrer Satisfaction	Referrer satisfaction scale (case by case or as regular survey)	

5.22 Decision to admit from Emergency Department

Following a decision to admit to a mental health unit, there is a national standard around the maximum waiting time in an ED. Any breaches of this 12 hour standard are considered serious and should result in a report by the CCG to NHSE's Lancashire Area Team (see *12 Hour Breach Standard Operating Procedure for Lancashire 2018*).

"The waiting time for an emergency admission via A&E is measured from the time when the decision is made to admit, or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted (leaves the department) or is transferred to another Trust (this now includes Mental Health Trusts)".

5.23 Discharge

A patient may be discharged from the MHLT when their specific input is no longer required or the patient is discharged from hospital.

The MHLT has an important role to play in referral and transfer of care to other mental health services. A number of options are available for patients who have been assessed by the MHLT.

If not MH need is identified then a patient may be discharged or signposted/referred to another service if additional needs are identified (e.g. substance misuse).

Patients with low level MH conditions may be discharge direct back to GP care and/or self-referral to services that provide psychological therapies at primary care level (e.g. *MindsMatter),* or relevant 3rd sector agencies.

For patients who have undergone an Enhanced Assessment, then a number of outcomes are available (in addition to those above):

- Admission to the Mental Health Decisions Unit to allow a period of further assessment before a final plan is formulated,
- The Acute Therapy Service (ATS); ATS is available as an alternative to being admitted to hospital or to reduce time spent in hospital by way of early discharge. It helps people to focus on problem solving and use of skills to manage situations independently..
- Crisis Houses which offer short-term placements in addition to crisis interventions,
- Other MH Crisis Accommodation (including those providing support for people with substance misuse),
- Social Care,
- Direct referral to other MH services such as Crisis, CMHTs, or Early Intervention.

If no alternatives to admission are available then admission to hospital may be indicated. If an individual lacks capacity then a MHA assessment will need to be undertaken before the person can be admitted to hospital for treatment of mental disorder.

5.24 Role of Consultant Psychiatrist

Mental health liaison teams within LCFT are nurse led. However, consultants within the team can provide senior clinical leadership, clinical input and advice, and provide a specific role in relation to the MHA.

The hospital consultant liaison psychiatrist provides mental health assessment, advice and shared management of people with both physical and mental health symptoms under the care of hospital teams, including in the emergency department, medical and surgical admissions, and the wards (RCPsych, 2014).

Hospital consultant liaison psychiatrists can offer expertise to inform hospital security and safety policies. They are often uniquely positioned to identify issues concerning human behaviour and how these might affect the safe delivery of services.

In addition, the hospital consultant liaison psychiatrist will support mental capacity assessments and the use of the mental health legislation.

To attend weekly complex case meetings. Generally, a psychiatrist should be involved in the care of any patient who has a mental disorder, or possibility of a mental disorder, and when one or more of the following factors are in place (RCPsych, 2014):

- Uncertainty about diagnosis and formulation.
- The nature of the mental disorder requires psychiatric care, including all cases of psychosis, complex disorders, severe disorders and disorders that are not resolving.
- Risk to self or others.
- Poor engagement with service or abnormal illness behaviour.
- A need to respond authoritatively to another agency.
- Complex psychopharmacology is required or being prescribed.
- Patients who have mixed diagnoses, for example mental disorder and substance misuse, mental and physical health problems or mental illness in the context of personality disorder.

The consultant within the MHL team will work within their own specialist field (e.g. working age adult or older adult/advanced care).

Older Adult Psychiatrists have a key role in assessing older adults presenting with complex or atypical problems, integrating psychological, cognitive, physical and social components of the presentation. This does not necessarily exclude them providing wider advice to the team or other colleagues. It is expected that like all members of the liaison service within LCFT, they will function within the framework of the *Advanced Care* model which ensures patients at the interface between working age and "older adult" received input that is most appropriate to their needs.

If a service user is referred to the team and does not attend his/her initial appointment, or is not available when a community assessment is attempted, advice will be sought when needed from the clinical lead or the manager (via MDT meetings) and a plan of action agreed taking into account known information and levels of risk. Feedback will always be given to the referrer and GP of the non-attendance, where clinically indicated.

5.25 Role of a specialty doctor:

The specialty doctor (SD) is embedded within the team and is expected to work across the adult age range (including older adults). This will include supporting patients requiring assessment in other clinical settings such as physical health wards and MHDUs.

All SDs will have at least one designated consultant supervisor. SDs are expected to work within the clinical competence and seek appropriate advice/supervision for cases in which senior clinical input would be beneficial.

The specialty doctor will is embedded within and will support the wider MDT by providing specialist knowledge around assessment & diagnosis of mental disorder, use of pharmacology, and use of the MHA / MCA.

5.26 Medical Cover within a Team:

Consultant cover should be provided by a reciprocal arrangement with another locality consultant. When consultant input is not available from within the team, there should be an arrangement that ensures cover during working hours. This may be through provision of a daytime "on-call" rota or other specific arrangements.

Routine clinical work can be covered by another grade of doctor, such as specialty doctor, however the team should always have access to a consultant psychiatrist when required.

Cover for specialty doctors will often have to be from within the team (e.g. consultant) unless other medical staff are available that agree to provide cover for annual leave etc.

5.27 Education & Training of Acute Hospital Staff

Where possible, providing informal and formal education/training to acute hospital staff is a core function of a liaison mental health service. Training improves the ability of hospital staff to identify mental health conditions.

Better identification of mental health conditions is likely to improve the quality and timeliness of referrals to the MHLT. This is important in achieving cost-effectiveness, as delays in the engagement of a liaison psychiatry service are strongly associated with increased lengths of inpatient stay (Kishi et al., 2004).

Training improves the quality of care provided by acute hospital staff. When mental health problems are detected, treatment is often sub-optimal by hospital staff and training can help to remedy this deficiency (Parsonage *et al,* 2012).

Training increases the overall capacity of the hospital to manage patients with co-morbid physical and mental health problems. The number of such patients is large, and therefore some rationing or targeting of liaison psychiatry services is unavoidable. The availability of trained general hospital staff allows the liaison psychiatry team to concentrate on the more severe and complex cases.

6.0 Assessment Environments

The Royal College of Emergency Medicine (2017) recommends that:

- Any assessment area needs to be safe for staff, and conducive to valid mental health assessment.
- The assessment room must be safe for both the patient and staff. There should be no ligature points, and nothing that can be used as a weapon. The room should have an alarm system and 2 doors (that open both ways). It is not acceptable to use a room that doubles as an office.

7.0 Training

Regularly team meetings (including monthly team business meeting) will take place to ensure appropriate peer supervision and ongoing training.

All Liaison clinicians will have access to relevant training to ensure competence in practice, utilising up-to-date research and evidence based learning.

All Liaison clinicians will engage in supervision in line with LCFT Supervision Policy COR031.

All Liaison clinicians will engage with LCFT ePDR process or alternative profession specific framework.

Liaison clinicians will need protected time for learning and reflection and professional development.

8.0 Key competencies

It is essential that the liaison workforce has the right skills to deliver care in line with NICE guidance. The necessary competencies for a liaison mental health service to deliver urgent and emergency mental health care are described below for each professional group (where applicable; further information is provided within the Psychiatric Liaison Accreditation Network (PLAN) Standards (RCPsych, 2011):

8.1 *Generic competencies*

- Up-to-date knowledge of relevant legal frameworks (Mental Health Act and Mental Capacity Act).
- Ability to complete personalised risk assessments, including for self-harm and suicide prevention.
- Up-to-date knowledge of the general hospital system.
- Knowledge and skills around the care and treatment of older adults, people with drug or alcohol use problems, people with learning disabilities and people with physical health problems.
- Skills in providing training and support to general hospital staff around mental health problems.
- Knowledge of local services for people who use drugs or alcohol, including social care and voluntary sector services.

8.2 *Medical competencies*

- Expertise in pharmacological treatments
- High level of competence in biopsychosocial assessment
- High level of leadership
- Specialist training in working with older adults.

8.3 *Nursing competencies*

- High degree of clinical leadership, providing clinical expertise and supervision
- Specialist training in working with older adults and people who use drugs or alcohol
- Ability to work autonomously and complete biopsychosocial
- Assessments
- See also the competence framework for liaison mental health nursing (London Liaison Mental Health Nurses' Special Interest Group; 2014).

8.4 *Occupational Therapy competencies*

The Occupational Therapy interventions that will be offered as part of Inpatient services, based on NICE guidance recommendations, PBR clustering and Royal College of Occupational Therapy (RCOT) guidelines. The assessments and interventions may be delivered as part of a 1:1 or group intervention. The principles of all the interventions are based on enabling people to make choices, personalised care and Models of Occupational Therapy they will be delivered within a philosophy of Recovery and Wellbeing. To define specific OT intervention type they have been grouped accordingly:

- Occupation as Therapy
- Self-management through Occupational Therapy
- Occupational Therapy to enable social and community inclusion
- Occupational therapy :consultancy, Education ,Liaison

Occupational therapy therapeutic interventions will be included in the care plan and documented under title Occupational Therapy.

9.0 Shared governance arrangements

It is important that there are strong links with the acute trust and provider of liaison MH services. There should be regular meetings between the acute trust/ED (in each locality) and LCFT to increase cooperation and understanding.

Shared governance structures may be appropriate in regard to MHLTs. It is important that the acute trust and LCFT share learning from any serious incidents involving a patient under shared care.

10.0 Monitoring

Standard	Time frame/ format	How	Whom
Contractual – Activity Data (No. referrals A&E, no. referrals wards, No. seen, No. not seen, average wait)	Monthly	Reporting generated manually by MHLT team and validated by Performance team as part of the working day model.	MHLT Admin
Contractual – Activity Data (No. of 4 hour breach and 12 hour breaches)	Monthly	Reporting generated manually by MHLT team and validated by Performance team as part of the working day model.	MHLT Admin

11.0 Key Related National Guidance

- Alcohol-use Disorders: Diagnosis and Management (NICE quality standard 11)
- Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192] (NICE, 2014).
- Borderline Personality Disorder: Recognition and Management (NICE clinical guideline 78)
- Dementia: Support in Health and Social Care (NICE quality standard 1)
- Identifying and assessing mental health problems in pregnancy and the postnatal period (NICE Pathways, 2018).
- Personality Disorders: Borderline and Antisocial (NICE quality standard 88)
- Self-harm (NICE quality standard 34)
- Self-harm in over 8s: short-term management and prevention of recurrence. Clinical guideline [CG16] (NICE, 2004).
- Service User Experience in Adult Mental Health Services (NICE quality standard 14)
- Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services (NICE clinical guideline 136)
- Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings (NICE guideline 10).

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