directors of adass
adult social services

Benchmarking Network

AMHPs, Mental Health Act Assessments & the Mental Health Social Care workforce

April 2018

National Findings - England

Raising Standards through Sharing Excellence

Contents

Introduction

This joint report summarises and brings together the findings of two separate pieces of work undertaken in the autumn of 2017, looking at the work and workforce of Adult Social Care in Mental Health services, and at Approved Mental Health Professionals (AMHPs) in particular. The first piece was commissioned by NHS England and undertaken by the NHS Benchmarking Network as part of a wider stocktake of community mental health services, and the second was done on behalf of ADASS to examine the AMHP activity in depth.

Its aim is to inform local and national understanding in this vital area of practice in the context of the Five Year Forward View for Mental Health, the independent review of the Mental Health Act commissioned by the Prime Minister, and future priorities. This is particularly timely with the development of local Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), and the report strengthens the case for NHS and Local Authority mental health services to work together closely within these evolving structures to improve care and support for local communities. To support this, throughout this report are questions that local leaders can ask of their own services to inform themselves of challenges and issues experienced locally in order to co-design solutions across partnerships. In addition, where local authorities look part in the two surveys (workforce and AMHP practice), individual reports with comparisons for their area have been prepared and will be distributed to each local authority. Local authority data will also be included in the bespoke reports for STPs prepared by the NHS Benchmarking Network.

Margaret Wilcox
Chair, ADASS

Stephen Watkins
Director, NHS Benchmarking Network

Participant profile

100 councils (out of a total of 152 in England) responded to one or both of the collections that were undertaken.

Of these:

- 66 responded to both collections
- 16 only responded to the NHSBN collection (82 in total for NHSBN)
- 18 only responded to the ADASS collection (84 in total for ADASS)

The table on the following pages details the local authorities who responded to each collection.

	ADASS		NHSBN
Barking and Dagenham	■		■
Barnet	■		
Barnsley	■		■
Bath and North East Somerset	■		■
Bedford	■		
Bexley	■		■
Birmingham	■		■
Blackburn with Darwen			■
Bolton	■		■
Bournemouth	■		■
Bracknell Forest			■
Bradford	■		■
Brent			■
Brighton and Hove	■		■
Bristol			■
Bromley	■		■
Buckinghamshire			■
Bury			■
Cambridgeshire	■		■
Camden	■		■
Central Bedfordshire	■		
Cheshire West and Chester	■		■
City of Wolverhampton	■		
Cornwall	■		■
Cumbria	■		■
Darlington	■		
Derby	■		■
Derbyshire	■		■
Devon	■		■
Doncaster	■		■
Dorset	■		■

	ADASS		NHSBN
Durham	■		■
Ealing	■		■
East Riding of Yorkshire	■		■
East Sussex	■		■
Gateshead			■
Gloucestershire	■		■
Greenwich	■		■
Hackney	■		■
Halton	■		■
Hammersmith & Fulham	■		■
Haringey	■		■
Hartlepool	■		■
Havering			■
Herefordshire	■		
Hillingdon	■		■
Isle of Wight			■
Islington	■		■
Kensington and Chelsea	■		■
Kingston	■		■
Kirklees Social Services	■		■
Lambeth	■		■
Leeds	■		■
Leicester	■		
Leicestershire	■		
Lincolnshire	■		■
Luton	■		
Manchester	■		■
Middlesbrough	■		■
Milton Keynes			■
Newcastle	■		■
Newham	■		■
Norfolk	■		■

	ADASS		NHSBN
Northamptonshire			
Nottingham			
Nottinghamshire			
Oldham			
Peterborough			
Poole			
Portsmouth			
Reading			
Redbridge			
Redbridge			
Redcar & Cleveland			
Rochdale			
Rotherham			
Salford			
Sefton			
Sheffield			
Slough			
Southampton			
Southwark			
Stockport			
Sunderland			
Sutton			
Tameside			
Telford & Wrekin			
Tower Hamlets			
Trafford			

	ADASS		NHSBN
Waltham Forest			
Warrington			
Warwickshire			
West Berkshire			
Westminster			
Wigan			
Windsor and Maidenhead			
Wokingham			
Wolverhampton			
Worcestershire			

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Service models

Models of care and integration

In Adult Social Care, models of delivery have in recent years moved towards greater integration with health. In contrast, in Mental Health, AMHPs and other council resources previously seconded to provide services within Mental Health Trusts, have in some areas been brought back under direct council control. Part of the survey therefore looked at this trend, and asked questions about models of care and integration.

The data suggests most mental health services continue to be provided within services that are integrated to a greater or lesser extent with health partners.

Degree of integration between health and social care	%
Fully integrated	39%
Partially integrated	39%
Not integrated	22%

How are services set up and delivered locally?

If your local authority has brought back all services, including AMHP services, under direct line management, what has the impact been at the front line? Has it lead to more difficulties accessing trust based resources [such as section 12-approved doctors for Mental Health Act Assessments]?

Models of care and integration : further questions

Participants in the NHS Benchmarking Network's survey were asked a number of questions about their service model. The numbers below represent the number of participants who answered "yes" to each statement.

87% Have social care staff allocated to specific mental health functional teams

38% Have social care provided as part of an integrated Health and Social Care Partnership Trust

43% Of services are provided through a formal Section 75 partnership agreement

77% Have NHS and social care staff work as part of a multi-disciplinary team(s).

77% Of services have direct line management from the LA for the social work MH staff

70% Have NHS and social care staff work as part of a co-located multi-disciplinary team

Advocacy services and additional mental health support

Local Authorities have responsibilities to provide advocacy under the Care Act, and the Mental Health Act. 98% of local authorities reported that they commissioned MH Advocacy, and in addition 54% reported that they directly provided MH Advocacy.

Under the Mental Health Act 2007, anyone detained under sections that last for longer than 72 hours has a right to such support.

In addition, most councils provide (67%) and/or commission (79%) support services for people with mental health needs. Anecdotal reports from the AMHP data survey suggested that social care cuts in mental health services have largely fallen on non statutory support services (support workers, day centres etc.) with the result that some people who had previously stayed well with low levels of social support, were experiencing difficulties (debt for example) and becoming unwell.

What impact have cuts had on funding for social care support staff and services?

Is there evidence of increases in detention rates as a result of cuts?

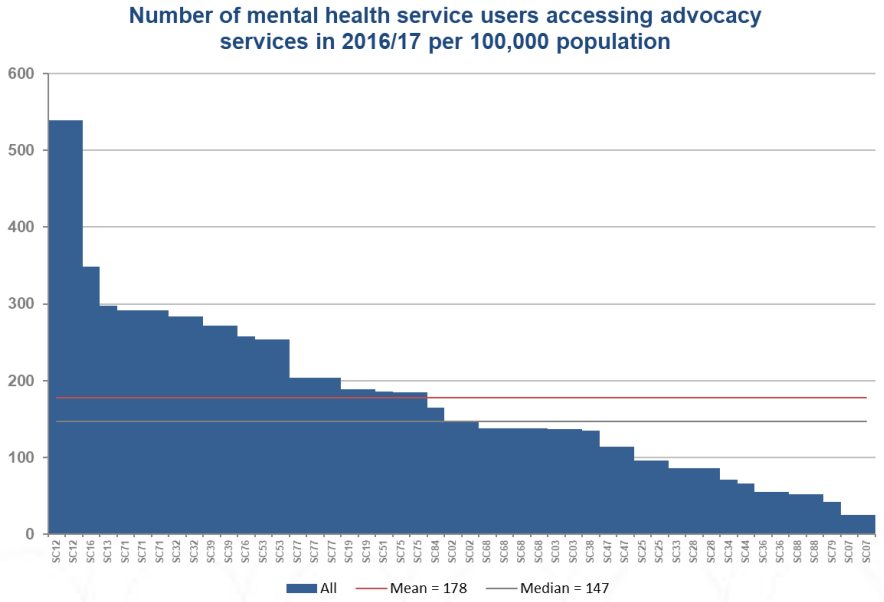
98% of Local Authorities **commission** advocacy services to mental health service users

54% of Local Authorities **provide** advocacy to mental health service users

79% of Local Authorities commission additional mental health support services

67% of Local Authorities provide additional mental health support services

On average, 178 service users per 100,000 population accessed advocacy services during 2016/17.



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Workforce

Mental Health social workers

The survey asked questions about the numbers of Mental Health Social Workers, their age, the hours they worked and ethnicity. Although questions were not asked about AMHP demographics specifically, most AMHPs are social workers (as detailed later in the report) and therefore the two workforces largely align.

Mental Health Social Workers carry out a range of other duties alongside being an AMHP including:

- Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority
- Promoting recovery and social inclusion with individuals and families
- Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity
- Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship

Department of Health (2016) Social work for better mental health - A strategic statement

What is the age profile of the Mental Health Social Workers in your areas? How many are likely to retire in the next 5-10 years?

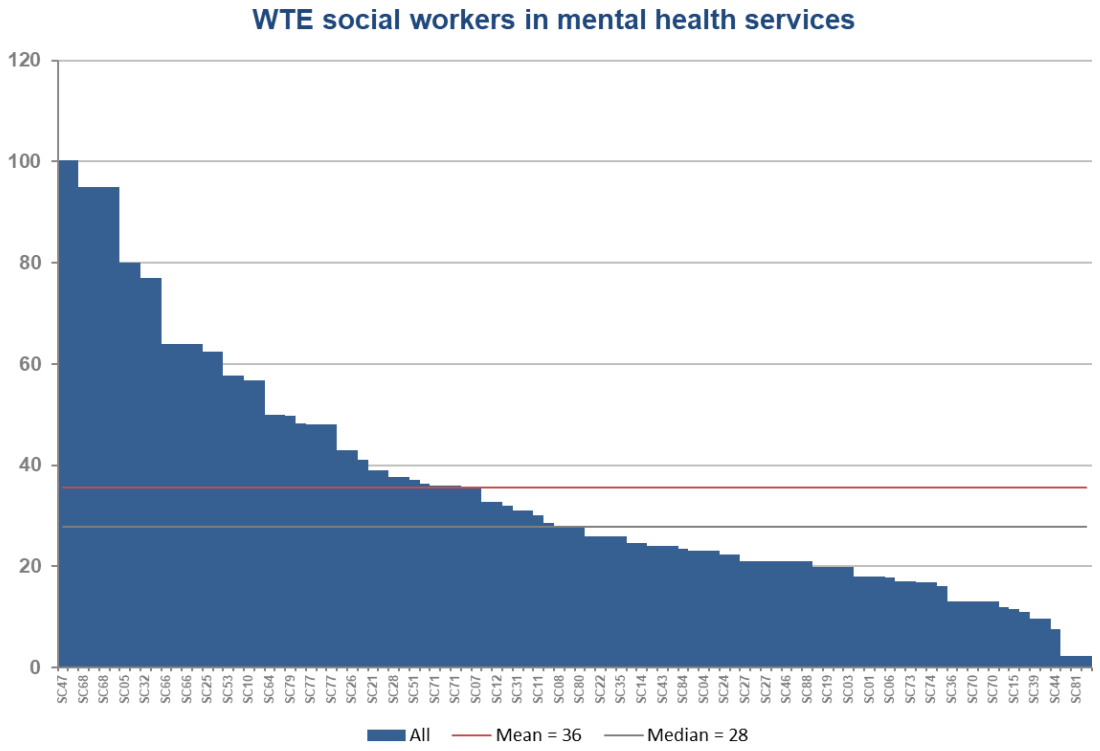
How many newly qualified AMHPs leave your authority within 5 years of approval? How many leave within 2 years?

What recruitment and retention plans do you have in place to meet the needs of your area?

Mental Health social workers – total staff

The average Local Authority social care team has 36 WTE social workers dedicated to mental health services within their team.

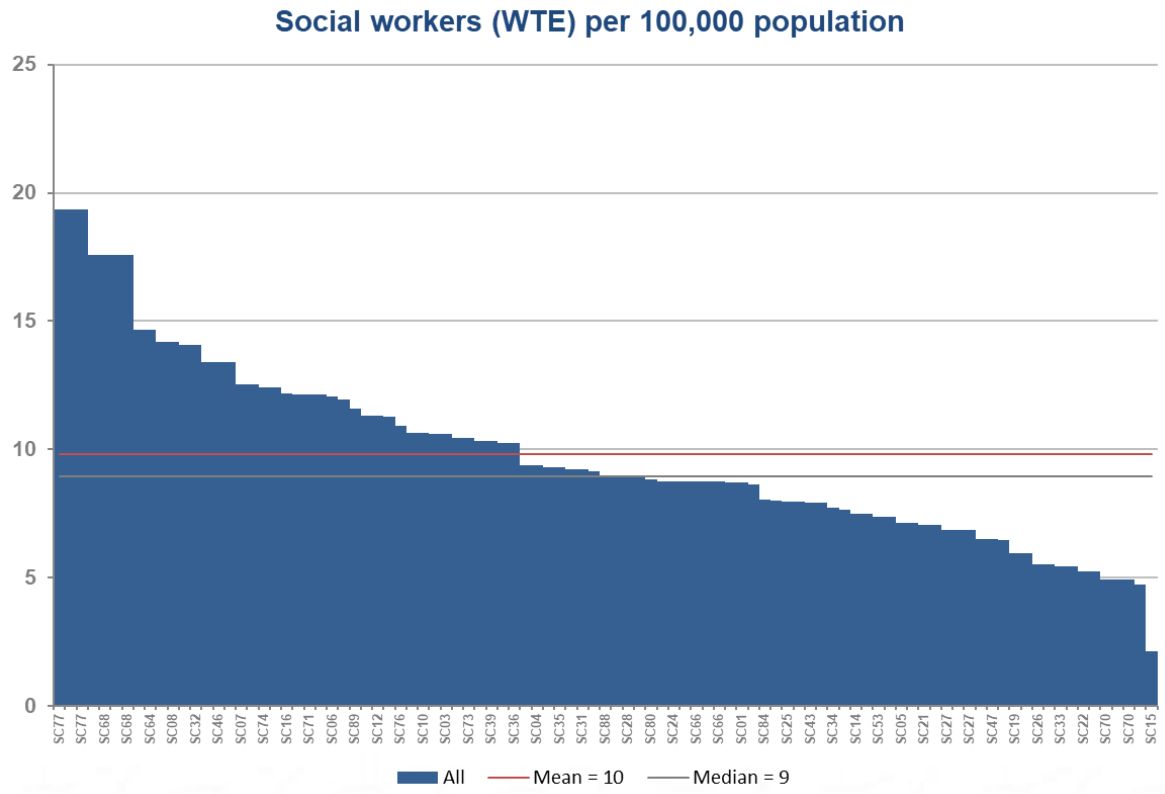
This is the unbenchmarked position and does not take into account the size of the team or population covered. The chart on the following page presents a benchmarked position by population.



Mental Health social workers (WTE) per 100,000 population

When a population benchmark is applied, Local Authorities report an average position of 10 WTE mental health social workers per 100,000 population.

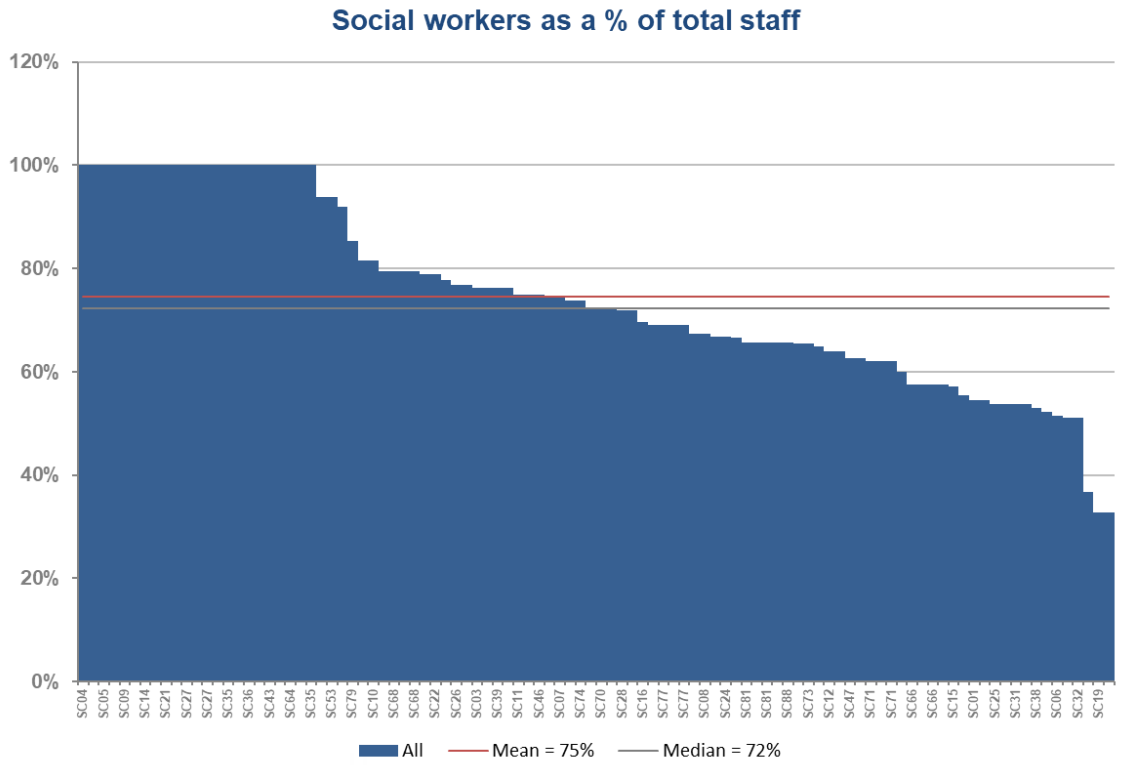
The population benchmark used in this study is the all age resident population by Local Authority area, sourced from ONS. The use of such a benchmark allows different areas to compare their services on a more even basis, accounting for geographies of different sizes.



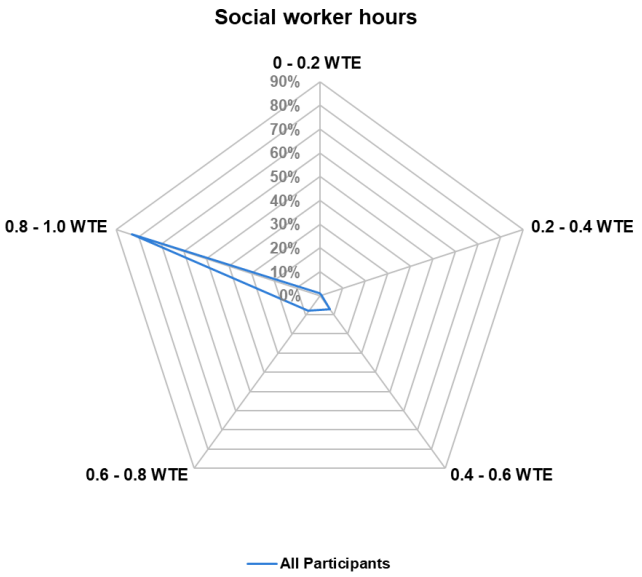
Mental health social workers – percentage of total team

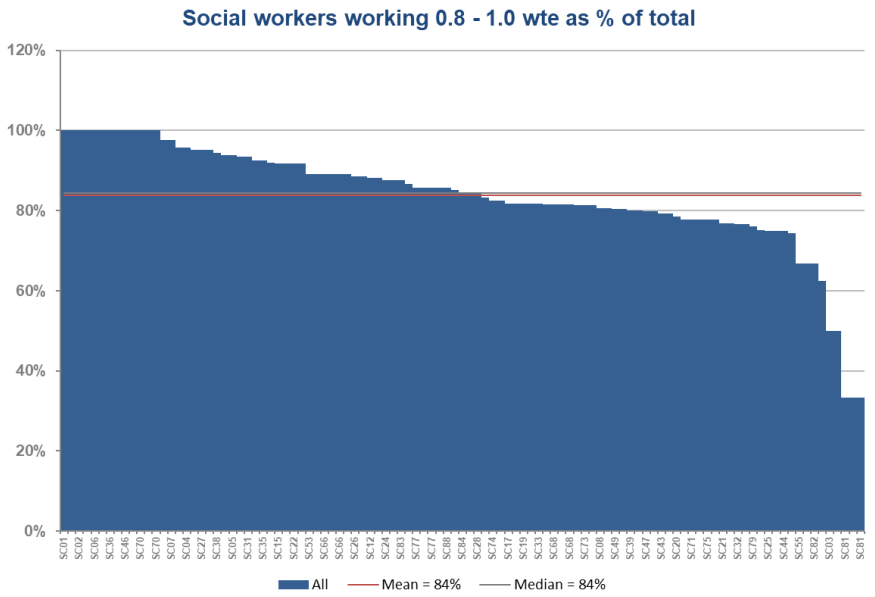
On average, social workers comprise 75% of a Local Authority's mental health workforce

This varies across Local Authorities from 32% to 100%.



Mental Health social workers - profile of staff





The majority of mental health social workers (84%) work between 0.8 and 1.0 WTE, with only 1% of social workers working less than 0.4 WTE (equivalent to two days a week).

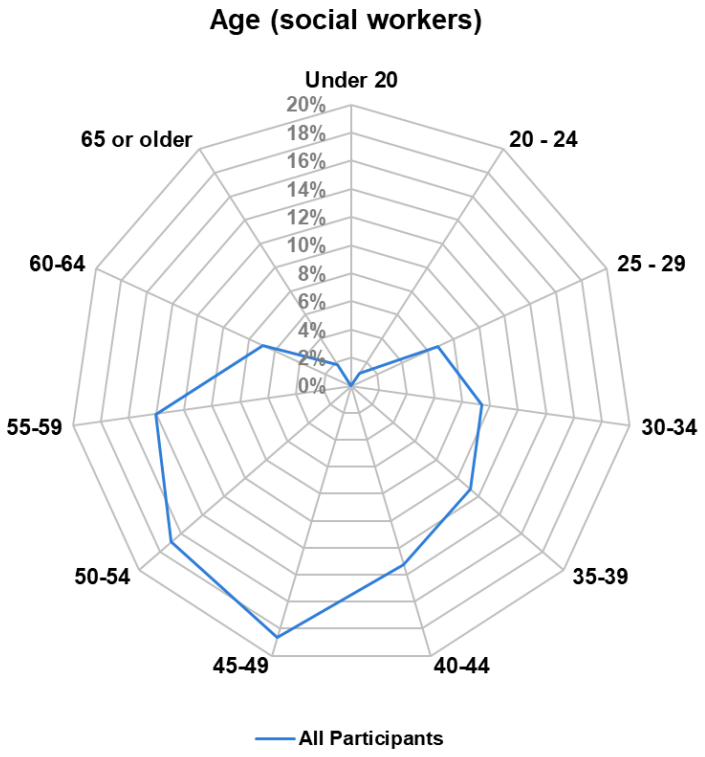
In some teams, 100% of staff work 0.8 – 1.0 WTE, though in a small number less than half the workforce are in full time positions.

Workforce age – mental health social workers

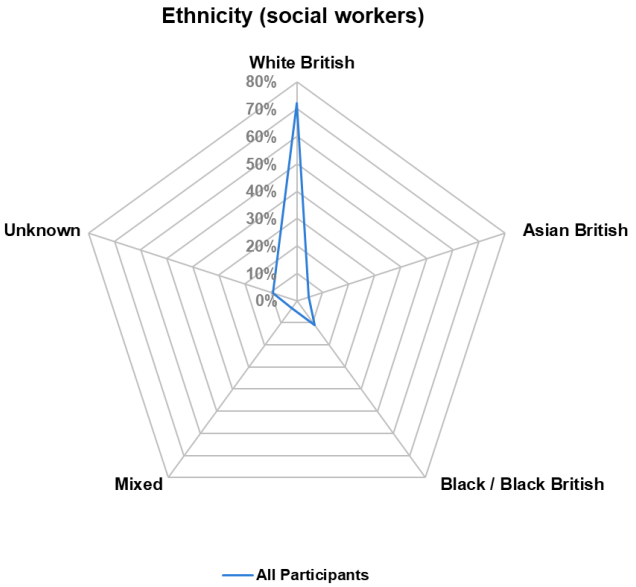
The mental health social worker workforce includes a wide age range of staff.

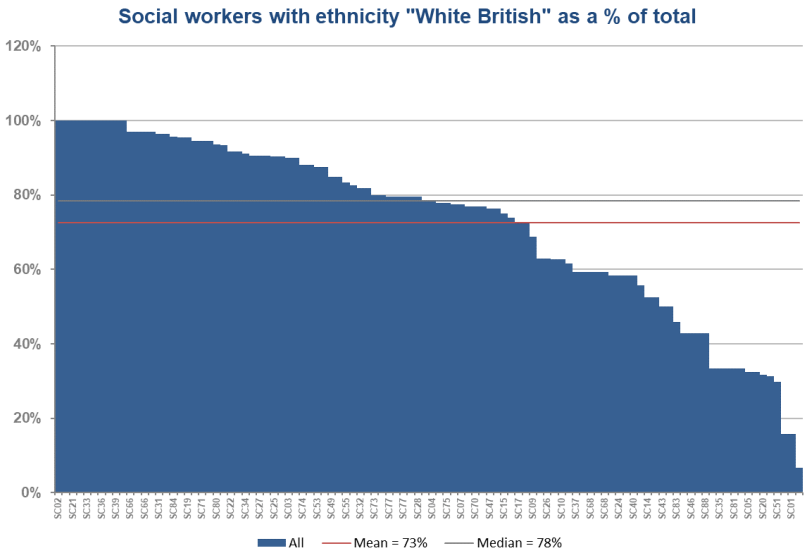
The blue line on the chart shows the England average, which suggests around 38% of the workforce are aged 50 years or older.

This is a similar proportion to that found in the ADASS DH ASW survey of 2005/6, which found 39% of Approved Social Workers (the forerunner to the AMHP) were aged over 50 years.



Workforce ethnicity – mental health social workers





The majority of mental health social workers are White British (73%). This corresponds with the report *The state of the adult social care sector and work force in England* (published September 2017), which estimates the adult social worker cohort to be 77% white.

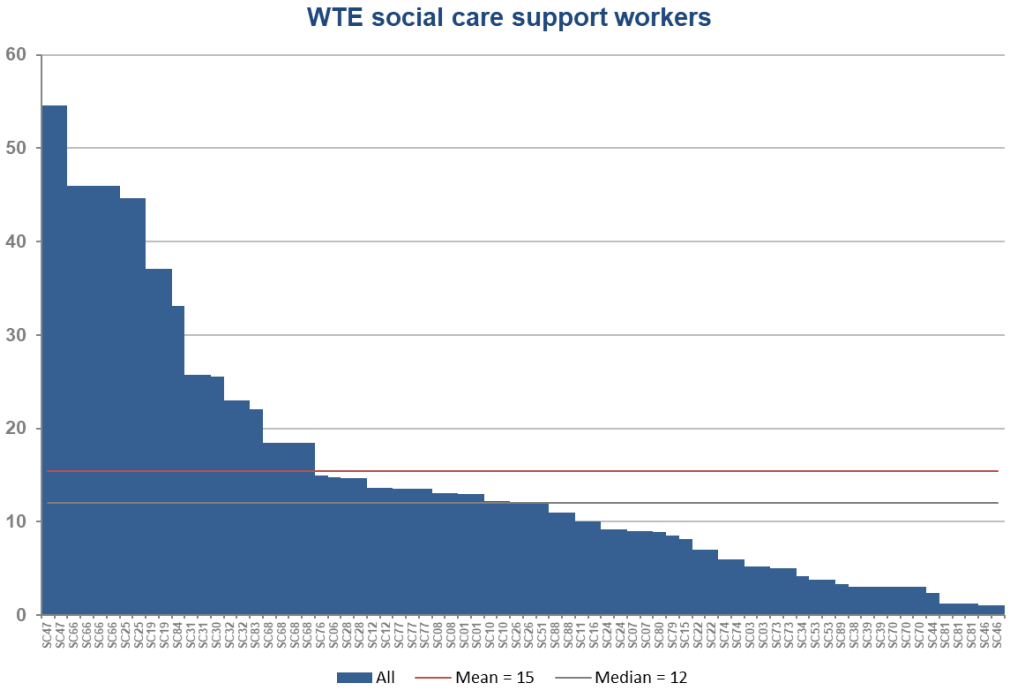
There is regional variation in this metric, and across individual teams the mental health social care workforce ranges from 7% to 100% White British.

How well does the profile of your social care workforce reflect your local community?

Mental Health social care support workforce – total staff

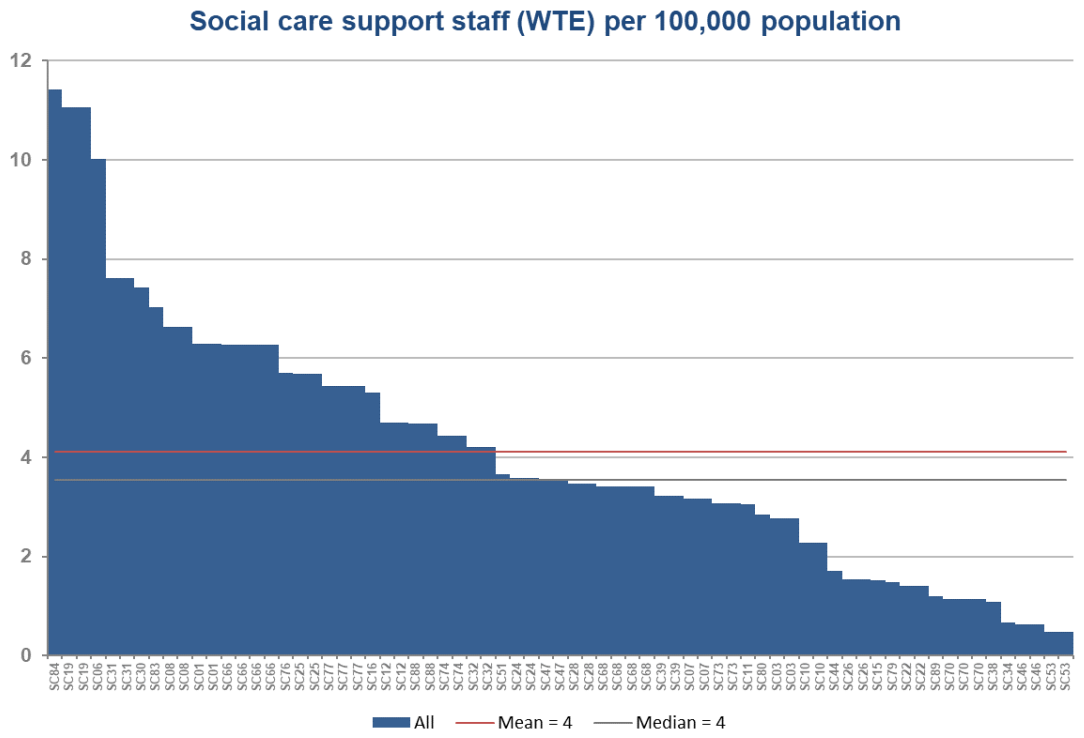
On average, Local Authorities reported 15 mental health social care support workers , though this figure varies from 1 to 55 WTE across local authorities.

This data does not take into account population, or size of the team and is the unbenchmarked position.



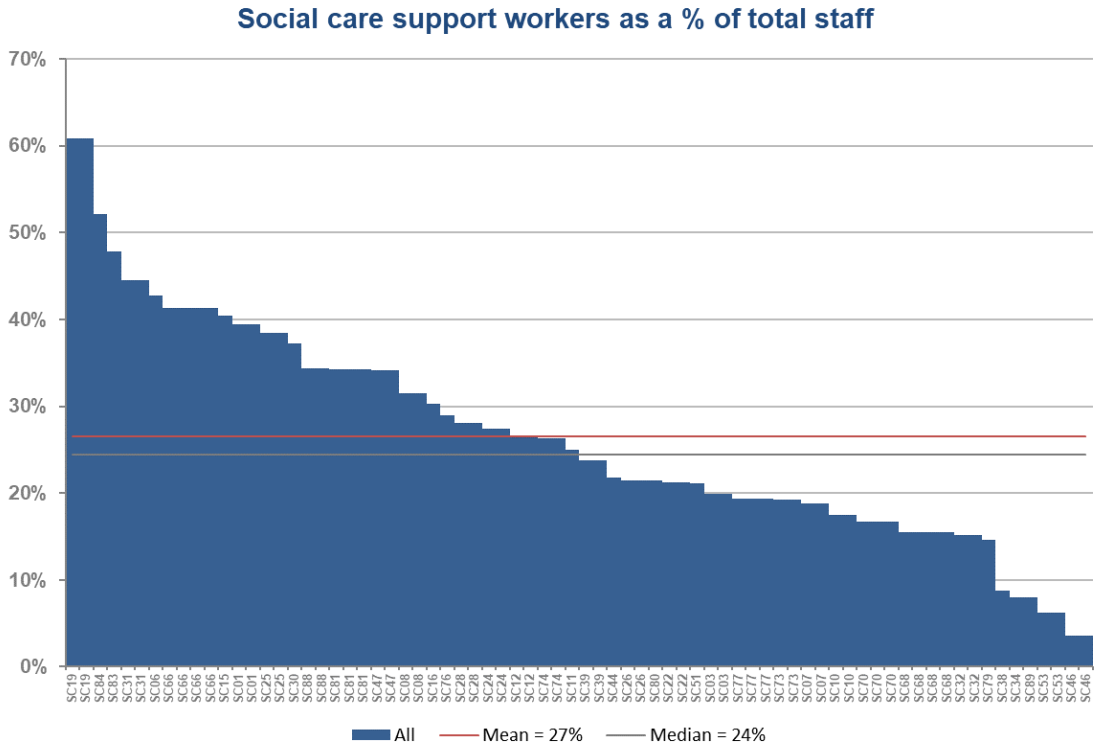
Mental Health social care support staff (WTE) per 100,000 population

When a population benchmark is applied, an average position of 4 WTE mental health social care support staff working in mental health was reported per Local Authority.

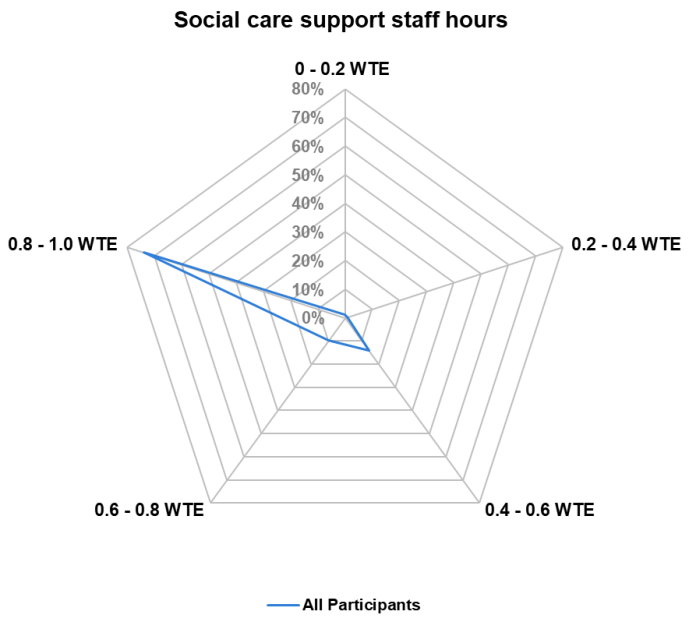


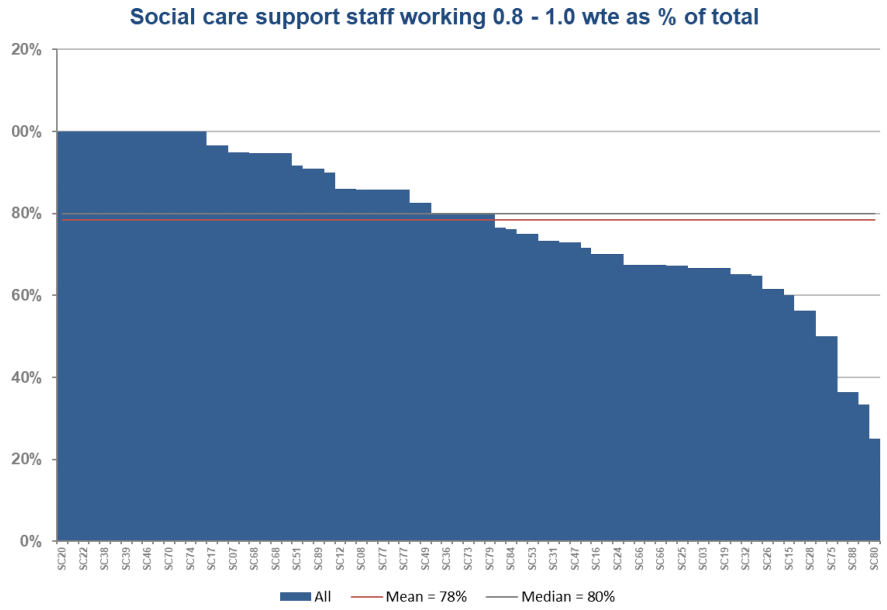
Mental Health social care support workforce – percentage of total team

On average, mental health social care support staff represent 27% of the total mental health workforce in Local Authorities.



Mental Health social care support workforce - profile of staff



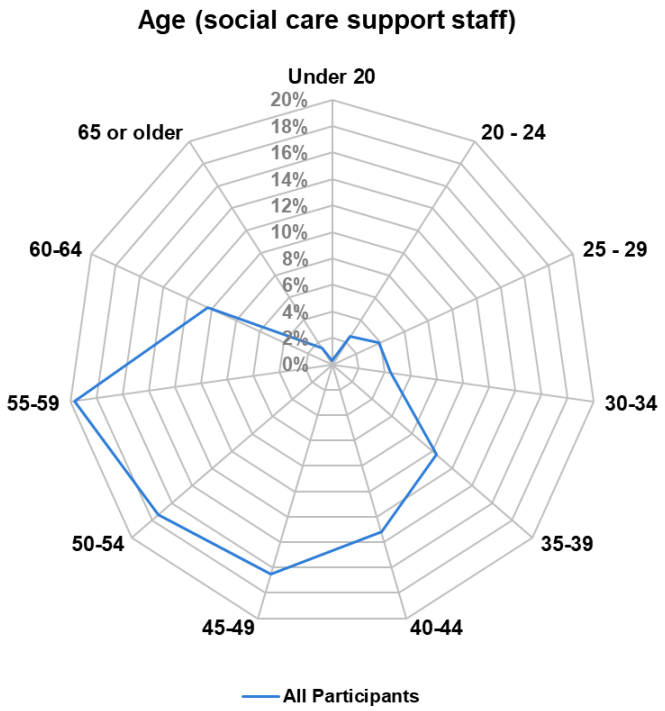


Much like mental health social workers, mental health social care support staff are most likely to be in full time positions, with 78% working 0.8 – 1 WTE.

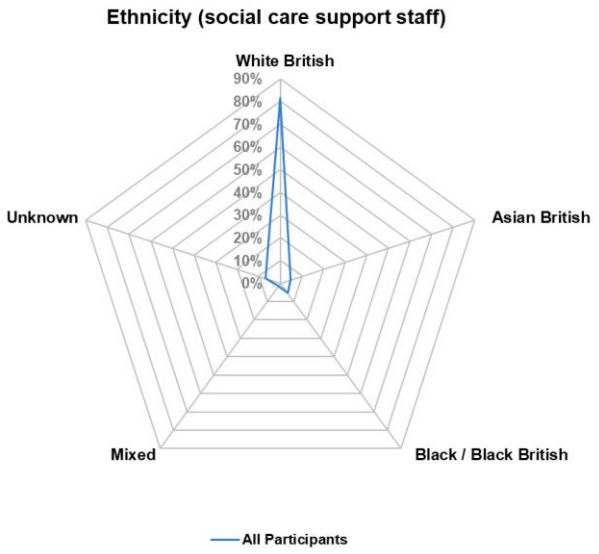
Workforce age - Mental Health social care support staff

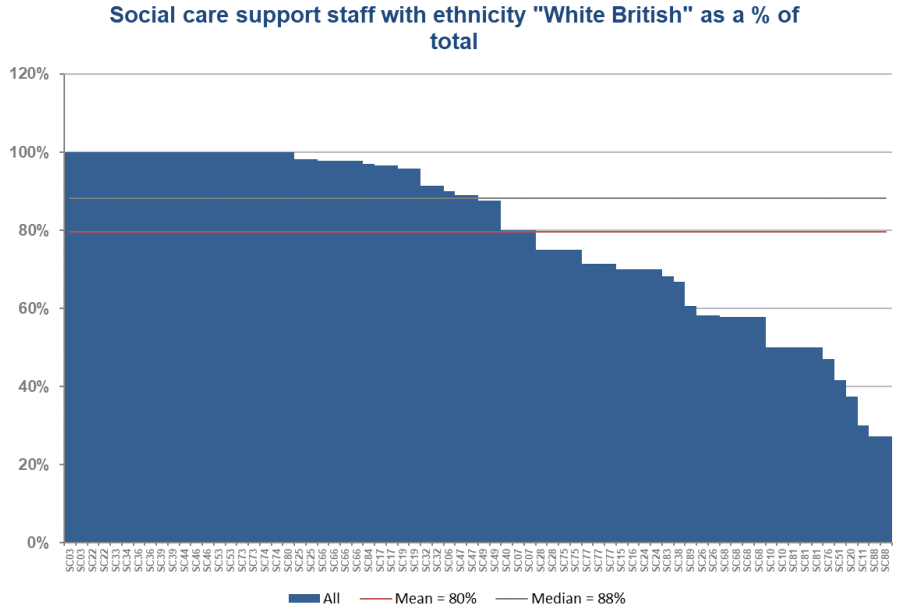
The mental health social care support staff workforce also includes individuals across a wide age range.

Just under half of staff (47%) are aged 50 or older.



Workforce ethnicity – Mental Health social care staff

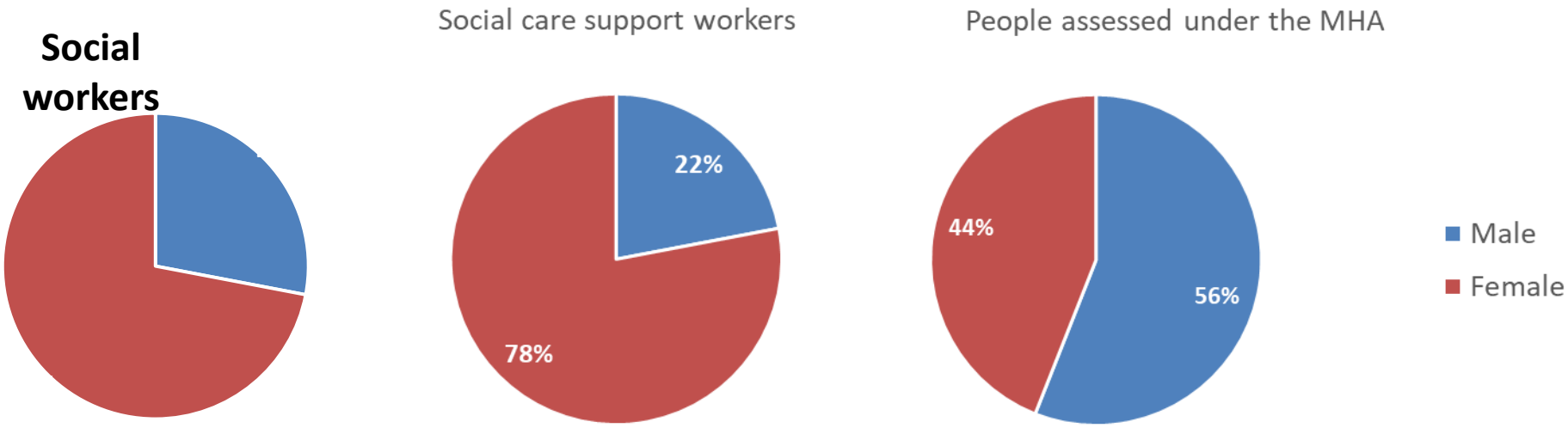




Mental health social care support workers are also typically White British (80%). Again, this reinforces the suggestion within the report *The state of the adult social care sector and workforce (September 2017)* which estimates that the social care support worker cohort is 77% white.

Across teams, variation is reported with a range from 27% to 100% of staff classified as White British.

Gender of staff compared to those being assessed

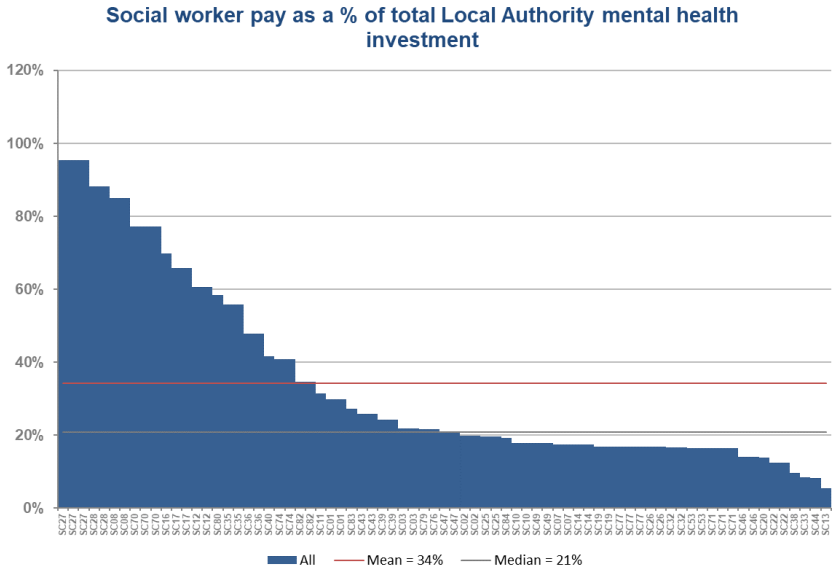


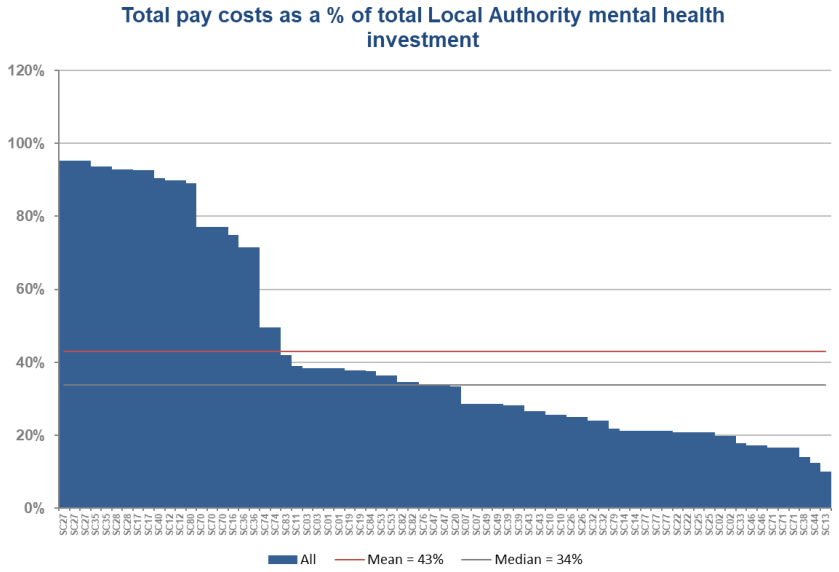
The workforce element of the data collection reported that 72% of social workers and 78% of social care support staff were female.

Within the group of people for whom mental health act assessments were undertaken during the period, the split is reversed, and 56% of those subject to assessment were male.

Although not all social work staff are in AMHP roles, this data none the less suggests that assessors are more likely to be female and those being assessed are more likely to be male.

Pay costs





Participants reported that 34% of Local Authority investment on mental health could be attributed to mental health social worker pay. In total, pay costs across all mental health social care professionals accounted for 43% of investment on mental health.

Approved Mental Health Professionals

Approved Mental Health Professionals (AMHPs) are experienced and specialist professionals, trained to undertake Mental Health Act Assessments with doctors. Since 2007, Mental Health Nurses, Occupational Therapists and Psychologists have joined Social Workers as being eligible to train as AMHPs. However, as this survey shows, social workers make up the vast majority of practicing AMHPs.

Whilst two doctors must agree that a person meets the criteria for detention under the Mental Health Act, the AMHP holds the balance of power, and needs to decide whether, in all the circumstances of the case, detention in hospital is the most appropriate way for the person to receive the care and treatment they need.

Ideally, assessments should be undertaken jointly (the AMHP plus the two doctors) as this ensures that the patient is not subject to repeated assessments, and allows for a sharing of risk and professional judgement. Unfortunately, pressures in the Mental Health system currently mean that such joint assessments are not always possible.

Local Authorities have a statutory obligation to provide enough AMHPs to deliver an accessible service 24hrs a day, 365 days per year. There have been concerns that as the numbers of Mental Health Act Assessments has increased, the numbers of AMHPs available to undertake assessments has decreased. Other reports have suggested that lack of AMHPs was a primary cause of delays in the Mental Health Act process. However, despite numerous bespoke attempts to establish an accurate figure for the number of practicing AMHPs, there are no routine data collections in place and consensus is still being sought as to the best way in which to count them. Routine data on the number of MHA assessments undertaken by AMHPs is not collected or reported nationally. Part of the purpose of this study was to examine these concerns and attempt to fill these gaps.

In 2005/6, ADASS undertook a national review of the numbers of WTE Approved Social Workers (ASWs) on behalf of the Department of Health. 77% of local authorities responded, indicating a high degree of reliability in the data obtained. At that point in time, the credible estimate was that there were 3900 WTE AMHPs available to undertake Mental Health Act Assessments in England. Although there was a concern noted about the age profile of ASWs (39% were over 50 years of age, and retirement was the top reason for an ASW moving on) local authorities also estimated a 5% increase in the numbers of AMHPs over the previous 5 years.

In 1991 the Social Care Inspectorate recommended a ratio of between 1:7600 and 1:11,800 Approved staff to population (dependent on locality). The lower ratio was expected to be in inner city areas, where more deprivation was evident, with lower levels of WTE ASWs being needed in more affluent areas. These ratios continue to be the only guides available to local authorities, and take into account the wider role of the AMHP as an experienced practitioner, with expertise in risk assessment and management, and an essential role in intervening to divert people away from detention under the Mental Health Act where possible.

The 2017 survey reported an extrapolated total of 3250 WTE AMHPs in England, or an average of 1:16,000. This represents a 17% drop in AMHPs since the previous survey.

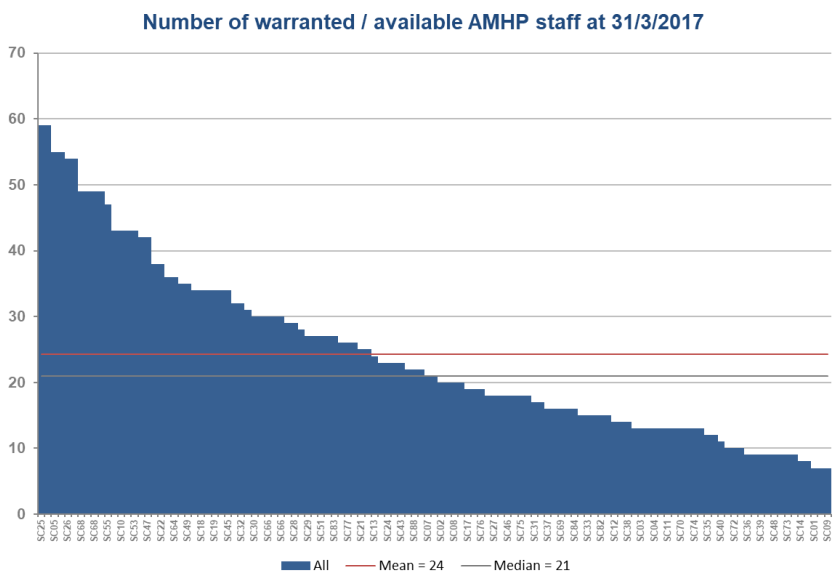
What is the ratio in your area of (practicing) AMHPs per 100,000 population?

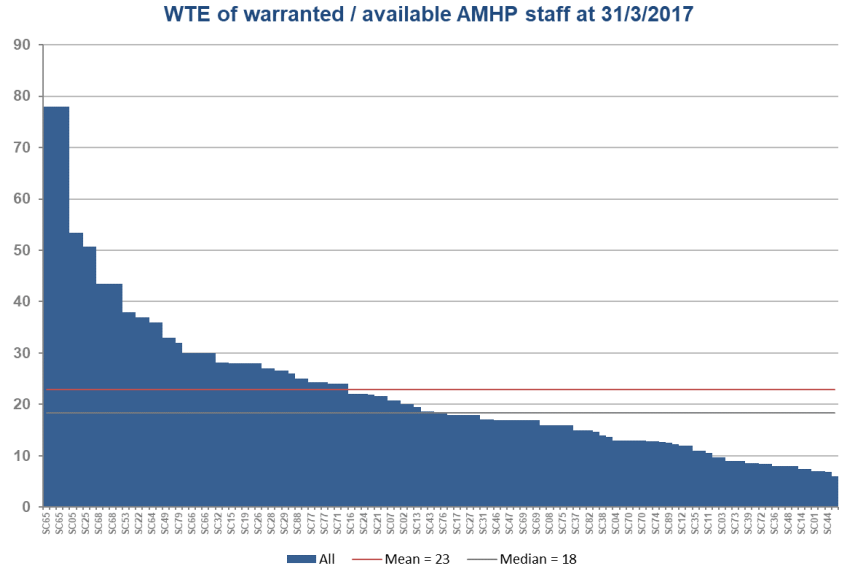
How has this changed in the last 10years?

Are there particular concerns about retention, turnover, proportion approaching retirement age etc?

Based on the recommended ratios, an inner city local authority with a population of 250,000 would need 33 WTE AMHPs and a shire county of 1.1 million population would need 100 WTE AMHPs

AMHP Workforce





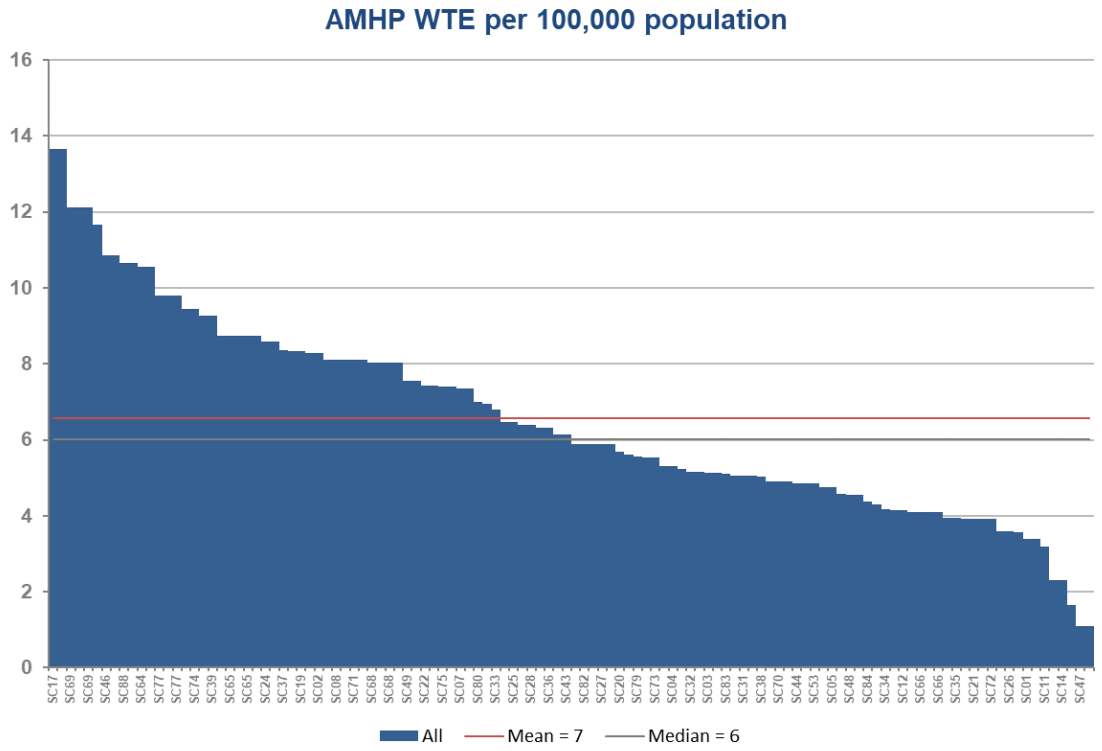
Local Authorities reported a mean average of 24 AMHP staff, working equivalent to 23 WTE. The chart on the following page applies a population denominator to this metric.

AMHP Workforce per 100,000 population

Local Authorities report an average position of 7 WTE AMHPs per 100,000 population, or 1:16,000

Again, the population benchmark used is the all age resident population for each Local Authority's footprint.

If data is extrapolated from the submissions received, this would suggest there were around 3250 WTE AMHPs in England as of 2017.



Location of AMHPS

The Code of Practice to the Mental Health Act recommends that AMHPs undertaking assessments of people with particular needs have the training and experience required to do so effectively. In particular, the following groups of patients are mentioned as having specific needs:-

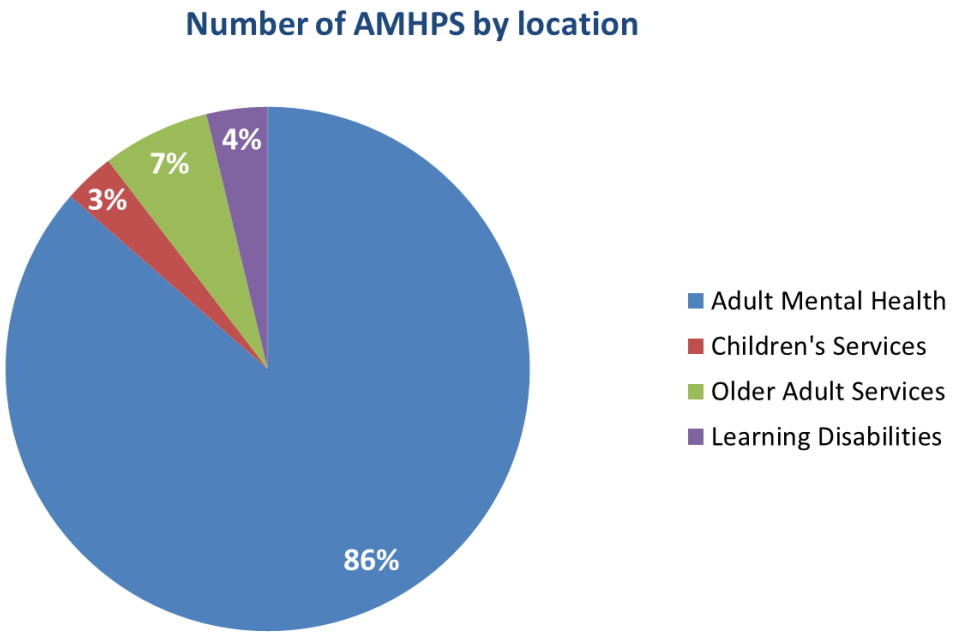
- Children and young people under 18yrs,
- people with learning disabilities
- Older people (i.e. people with dementia)
- People with personality disorders
- The deaf community

The 2017 survey asked specifically about whether AMHPs were located in:

- Adult Services
- Older Adult Services
- Children's Services
- Learning Disability Services

Across England, 86% of AMHPs were reported to work within adult mental health and 7% within older adult services. 3% of AMHPS sat within children's services, and 4% within learning disabilities.

Although 3% of AMHPs were reported to be employed by Children's Services, it is believed that most of these were employed in Emergency Duty Teams (out of hours services that remain generic, and are managed via Children's Services) and that only a handful of AMHPs worked specifically with Children & Young People.



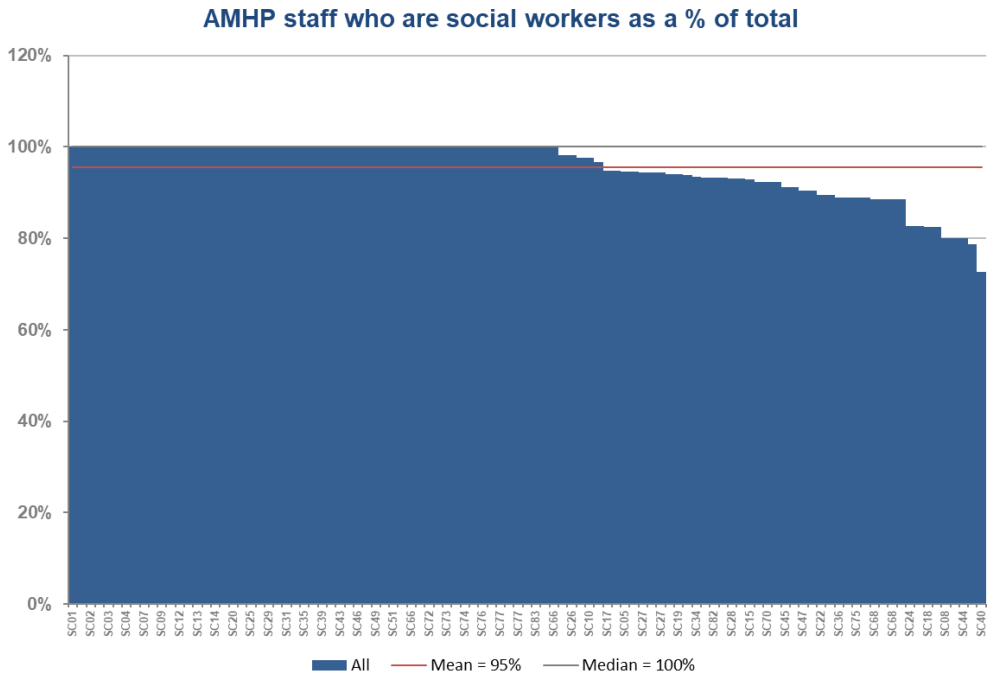
How are AMHPs distributed in your area?

In particular, how many AMHPs with specialist skills do you Approve or Authorise to in your area?

Discipline of AMHPs

The 2007 Mental Health Act enabled professionals beyond Social Workers to train and be authorized to Act as AMHPs. The Act also removed the requirement that AMHPs must be employed by a local authority (so, for example, AMHPs can be direct employees of an NHS Trust, or employed via an agency.)

Despite this change the study found only 5% of AMHPs came from different professional backgrounds.



In your area, are AMHPs from other disciplines supported or enabled to be trained? Once trained, are they released to practice? If not, why not? Have you established any creative or innovative ways to attract staff from other disciplines to train as AMHPs?

Best Interest Assessors

Where people lack capacity, but need to be cared for in a way that deprives them of their liberty, this deprivation must be authorised by a legal framework. The majority of those affected are likely to be subject to the Deprivation of Liberty Safeguards. For those who need assessment and treatment for a mental disorder, the Mental Health Act is usually a more appropriate option.

Under the Mental Health Act, if people remain in hospital over 28 days they may be placed on s3 which gives people access to free aftercare under s117. This in turn can have significant financial consequences for local authorities and CCGs.

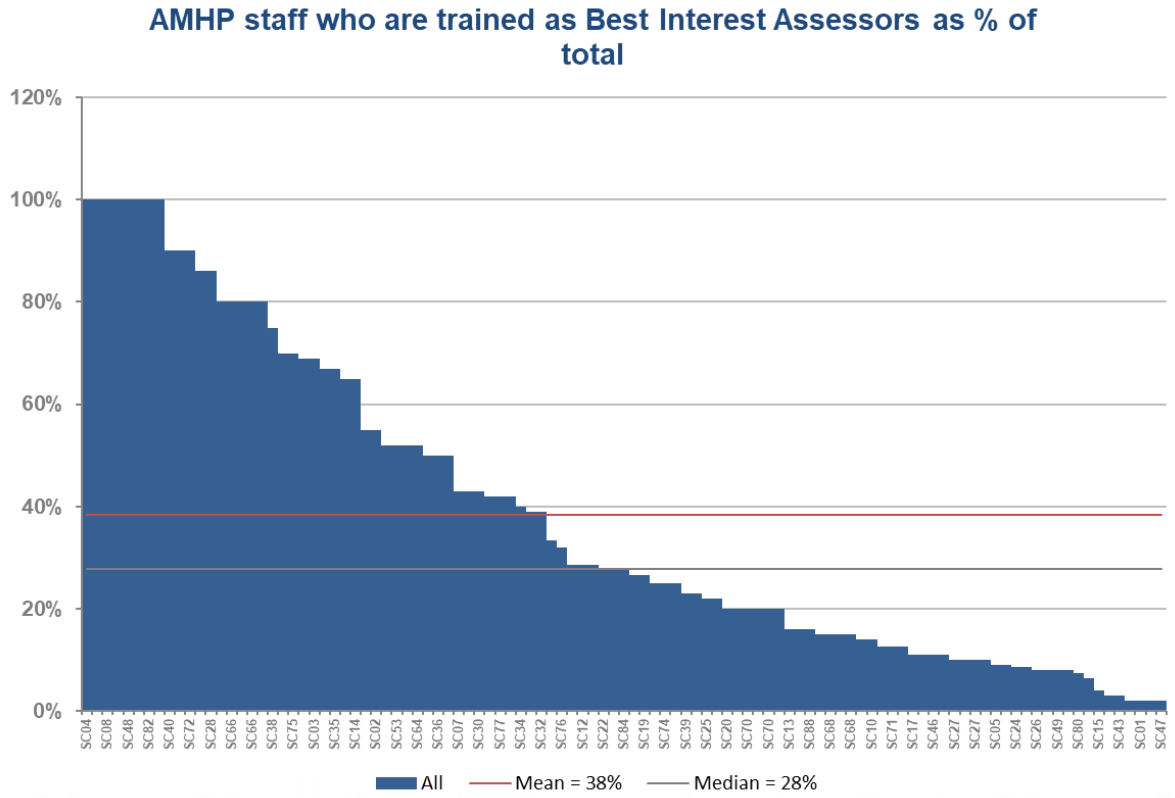
Questions were asked about whether AMHPs were also trained as BIAs. This varied around the country as the chart on the next page shows.

Best Interest Assessors

Local authorities report a mean position of 38% (28% median) of AMHP staff trained as Best Interest Assessors.

Best Interest Assessors (BIAs) have a key role in the Deprivation of Liberty Safeguards (or DoLS) processes. Where BIAs are also AMHPs, they are able to decide whether the patient's rights are best protected by the use of the Mental Health Act or the Mental Capacity Act.

However, being trained as a BIA does not guarantee those people practice in that role, many do not.



Model of AMHP provision

Areas were asked to provide data on the type of model they used to deploy AMHPs. These ranged from ‘central hub’ models (where all requests for assessment go directly to the one point, and AMHPs are only located in that place) to ‘hub and spoke’ models (where all or most requests go to a central hub, but most AMHPs are based in community teams and spend a certain number of days per month ‘on duty’) and ‘locality only’ teams (where AMHPs serve only their own community).

The advantage of the ‘central’ model is its ability to absorb assessments and cope with surges in demand (as there will always be 2 or more AMHPs on duty, so if an AMHP leaves a community team in one area, or is unwell, cover is available) whereas locality only team AMHPs are more likely to know the patient (so arguably can better judge when admission is the only safe option) but will struggle more if there is a drop in the number of AMHPs available in a team, as the pool of available AMHPs is usually smaller.

Approved Mental Health Professional (AMHP) availability

Different models for AMHP duty rota during daytime hours were reported:

	%
Central Hub only	19%
Hub and Spoke model	36%
Locality Team	16%
Other Model	29%

The model of weekly hours coverage in use is:

	%
5 days a week normal working hours	71%
5 days a week extended working hours	11%
7 days a week normal working hours	2%
7 days a week extended working hours	16%

Additionally, 38% of Local Authorities employ sessional AMHPs to cope with peaks in demand

directors of adass adult social services

Benchmarking Network

AMHP Data survey

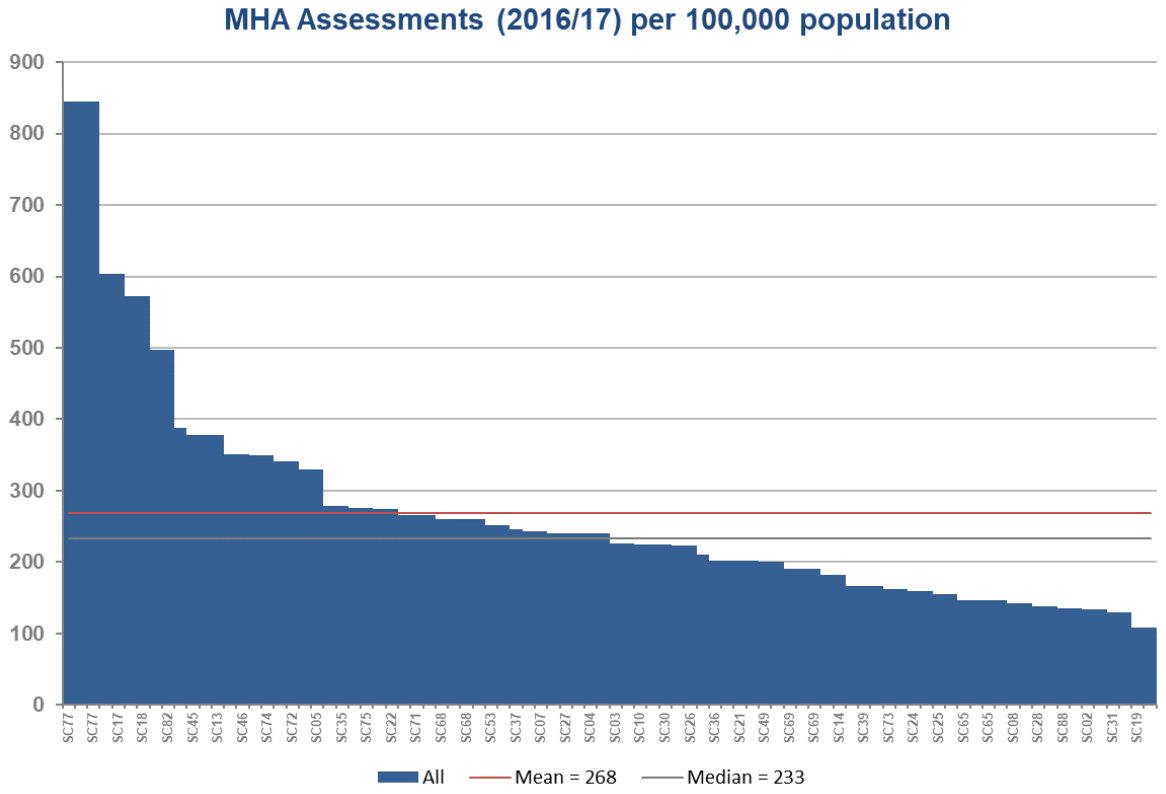
Annualised data

Number of assessments per 100,000 population

In 2016/17, on average 268 Mental Health Act assessments were carried out per 100,000 population.

If data is extrapolated from the submissions received, this would suggest 140,000 Mental Health Act assessments were undertaken in England in 2016/17.

NHS Digital data for 2015/16 reports that in England approximately 63,622 patients were detained using the Mental Health Act (http://digital.nhs.uk/catalogue/PUB22571)



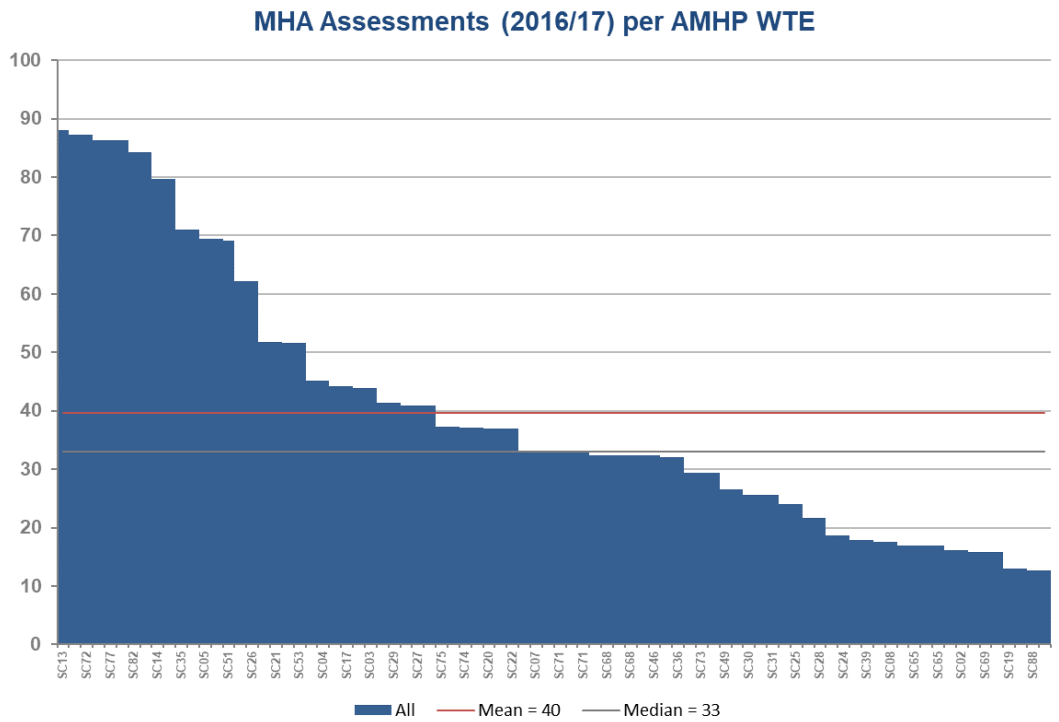
Number of assessments per AMHP (WTE)

When considered as a ratio per AMHP, on average every WTE AMHP undertook 40 assessments over the year - when leave is taken into account this would mean completing an assessment each week.

Some AMHP leads commented that the survey did not take account of what might be a considerable amount of work undertaken to prevent an referral needing to be undertaken as a Mental Health Act assessment.

In Cornwall and Bradford, AMHPs receive a reduction in caseload to compensate for the additional Mental Health Act work they do.

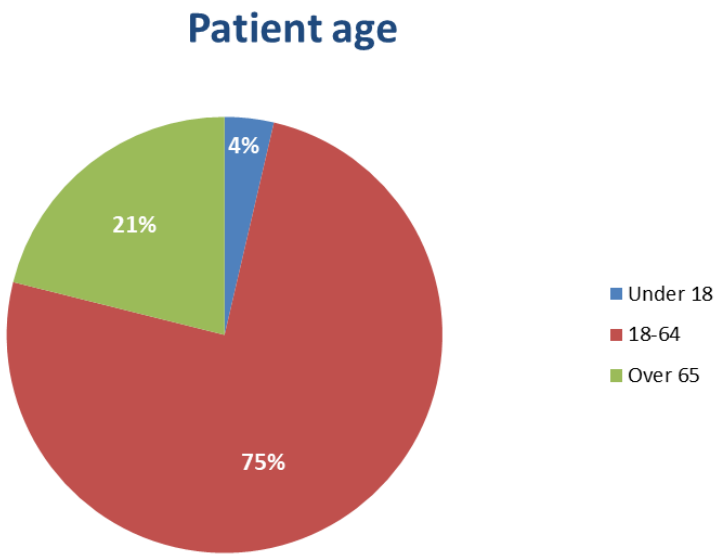
How does your area ensure AMHP workload is manageable?



Age of people being assessed

Most assessments undertaken were for adults of working age (75%). 21% were for adults over the age of 65 and 4% were for those under the age of 18. These rates reflect national data from NHS Digital's *Mental Health Act Statistics, Annual Figures 2016/17* which suggested that 3% of detentions under the Mental Health Act in 2016/17 were for those aged under 18 and 22% of detentions were for those aged over 65.

The following pages look in closer detail at the young adult and older age cohorts.



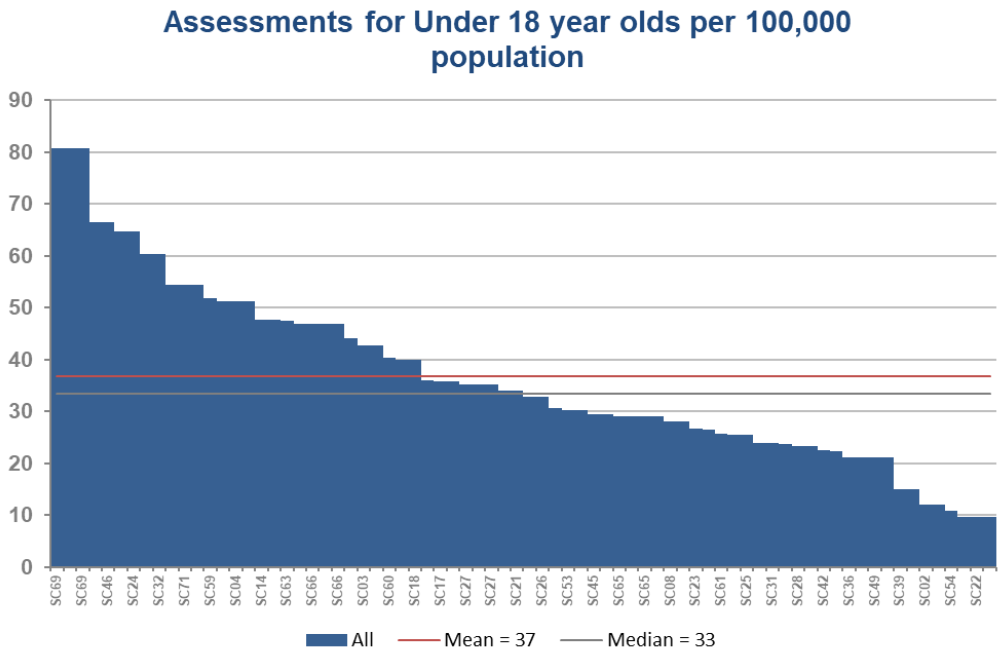
Under 18s

48% of participants reported they had seen a “small” increase in assessments for under 18s in the last 5 years. 34% reported this increase has been “significant”.

Participants reported an annual average of 37 assessments for young people per 100,000 population (age 0-17 inclusive).

This can be extrapolated to around 4100 assessments per year being undertaken for under 18 year olds. In contrast, 74 assessments were reported by participants as undertaken last year for people with a learning disability.

Has your area experienced a growth in assessments in these specialist groups? Does the allocation of your AMHP resources reflect local patterns of need?



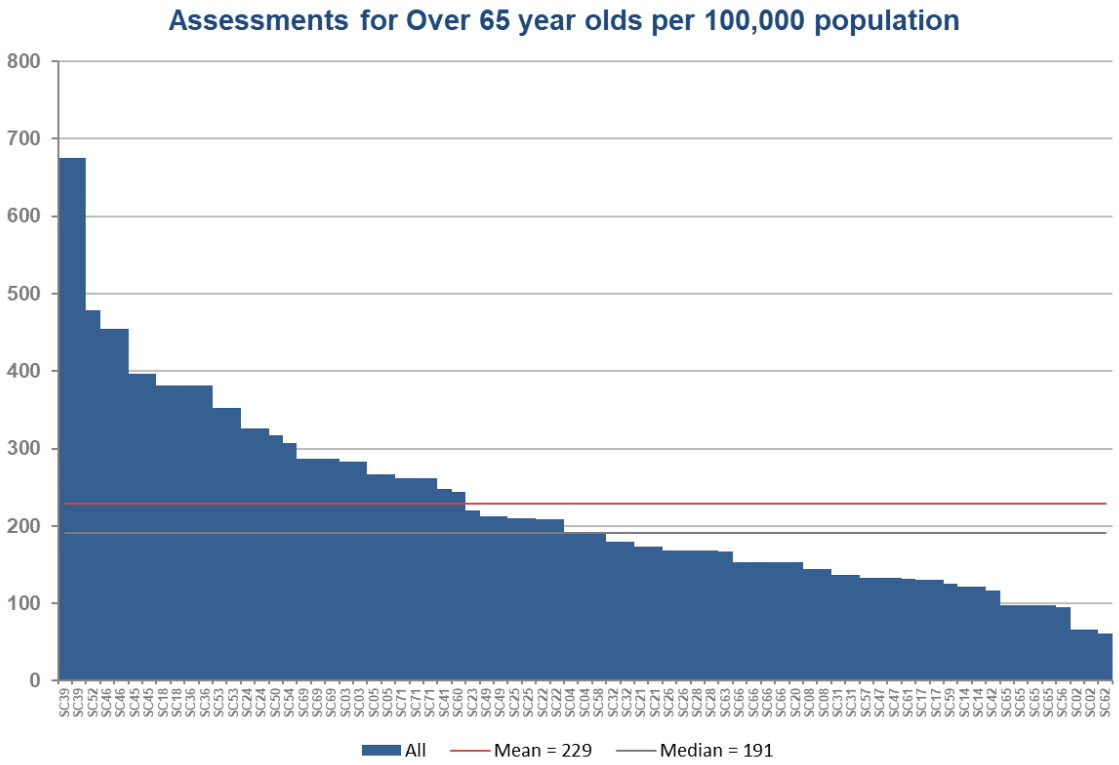
Over 65s

42% of participants reported a “small increase” and 38% a “significant” increase in assessments for older adults (age 65+).

Participants reported an annual average of 229 assessments for older people per 100,000 population (age 65 +).

This can be extrapolated to around 22,500 assessments per year being undertaken for those age 65+.

These increases are likely to relate to both the growing numbers of over 65 year olds, and an increased understanding of the legal limitations of informal admissions where people lack capacity to agree to admission



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Benchmarking Network

AMHP Data survey

‘Snapshot’ data

The ‘Snap shot’ survey

Between 9am on Monday 13th of November, and 9am on Monday 27th November 2017, ADASS asked its members to record information on all referrals made for Mental Health Act Assessments, and all assessments that were undertaken.

In addition, areas were asked to report on the numbers of Mental Health Act assessments over a 12 month period (April 2016 to March 2017).

Current NHS Digital official statistics on the use of the Mental Health Act look only at those admitted under the Act. This survey considered the number of people assessed under the Act (including those who did need admission to hospital on section). In addition, information was collected on where people were assessed, their gender and ethnicity, and the outcomes when assessments were undertaken in different places.

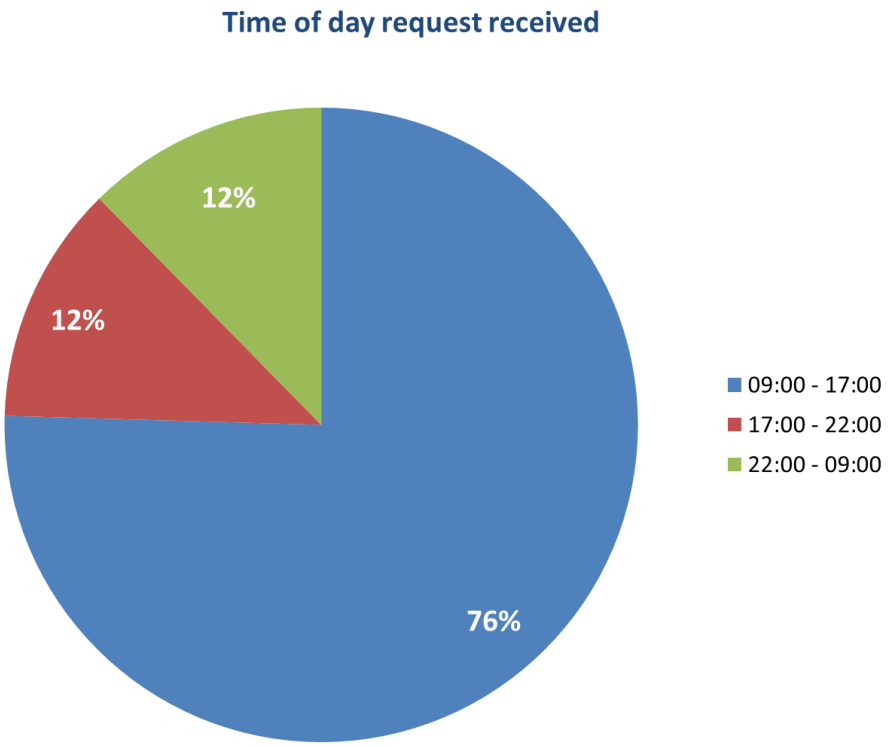
The results provide a rich source of information - and highlight areas for future inquiry. They will also inform ongoing discussions about the development of new data items and a new official social care dataset.

Timing of assessments

71% of services operate a standard 9-5 service, with a further 24% of services operating extended hours over either a 5 or 7 day period. The least popular option (at 2%) was a 7 day, 9-5 service.

One of the challenges for services is whether the distribution of AMHPs is appropriate to the need for Mental Health Act Assessments. Community assessments tend to be planned around the availability of resources (such as AMHPs, Ambulances and Police resources) but urgent and emergency assessments follow a different pattern.

During the two week 'snap shot' in November, areas were asked to record when referrals were received and when assessment started during the day finished.



When daytime assessments were completed

Of the 2783 assessments for which time was given:

- 76% (=2100) of requests for assessment were received within normal working hours (9am – 5pm),
- 12% (=339) received in the evening and a further 12% (=344) received over night.

With fewer AMHPs dedicated to out of hours working, there tends to be an expectation that assessments referred before 5pm should be finished by the daytime services - even if this means working longer hours. Equally, information on delays following assessment later in the report also indicates AMHPs working long hours.

When reporting on when assessments started during the day finished, the following was found:-

- 79% of assessments started between 9am and 5pm were completed within normal working hours,
- 15% were completed between 5 and 10pm, and 6% later than that.

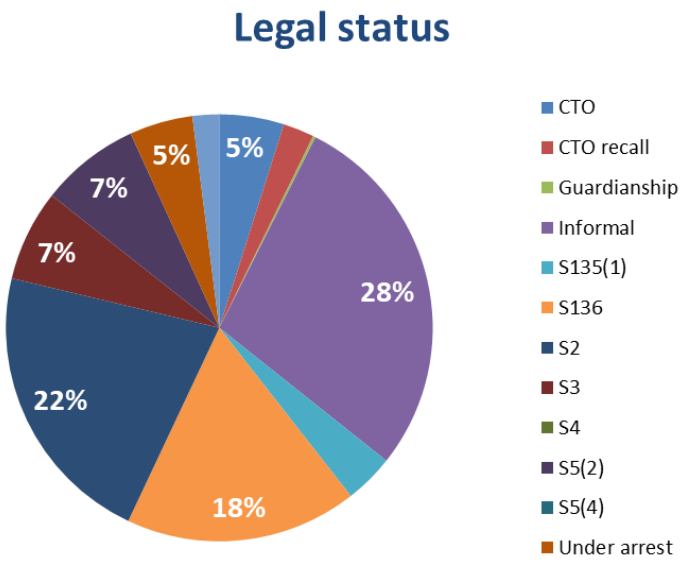
On a local level, information is needed on the referral pattern for mental health act assessments, what is influencing when assessments are being referred, and whether the availability of staff is matching the need for assessment.

Legal status at time of assessment

28% of assessments (=588) were for informal patients, not subject to the Mental Health Act at the time of assessment. A further 5% (=100) were for people who had been arrested.

Section 5(2) was used in 7% of cases (=157). This is a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged under the Mental Health Act.

Through the NHS Benchmarking Network's annual Mental Health benchmarking work, figures relating to detention following admission (for patients admitted on a voluntary basis) are collected. In 2016/17, approximately 3,150 people were admitted on a voluntary basis but subsequently subject to detention during their admission.

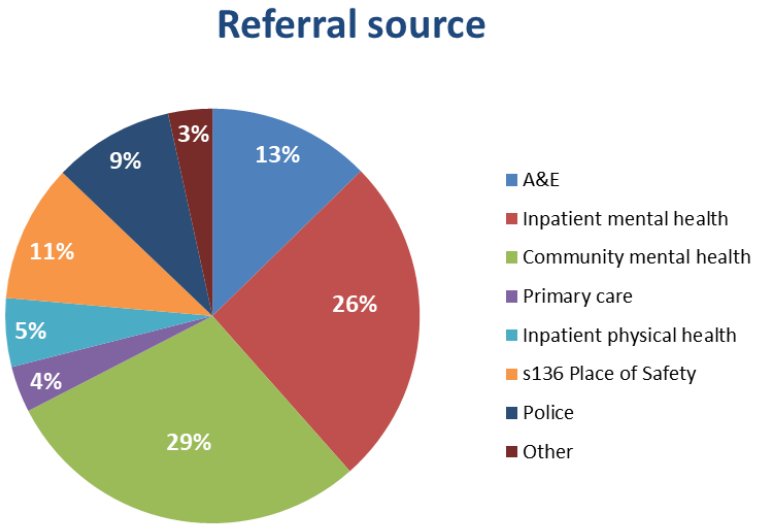


Referral source

The two most common sources of referral for Mental Health Act assessments are community mental health teams (29%) and inpatient mental health (26%). The category “other” includes a number of sources with only small numbers of referrals including the criminal justice system, voluntary sector and friends/family.

CMHT referrals are most likely to need Community Assessments, and Inpatient request would relate either to those on s5/2 (detained on a ward after being informal) or those already on s2, where s3 assessments or CTO assessments were being requested - in other words, these are assessments that can be planned in advance and the assessment carried out over a 24 to 72hr period (depending on the needs of the patient.) Community and Ward based requests for assessment accounted for 60
% of all requests.

On the other hand, requests from the police, A&E, the s136 suite would need to be responded to urgently (within 4hrs). These represent on average 33% of all referrals.



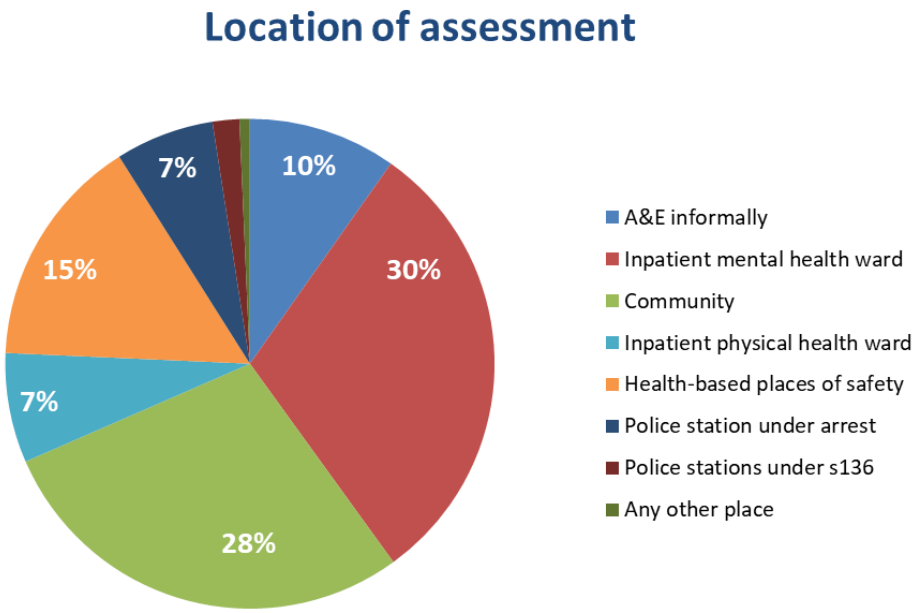
How does the referral profile in your area compare to the national averages?

For areas where the numbers of urgent/emergency assessments approach or exceed the numbers of more planned assessments, further investigation may be helpful. For example, are people presenting in an emergency because they are unable to access help in a more planned way?

Assessment location

These results very much replicate those of the referral source. 65% of assessments happened on wards or in peoples homes in the community, and as explained above allowed a level of planning.

Assessments occurring in police stations, in A&E and in the s136 suite all required an urgent response (within 4hrs). These accounted for 34% of assessments.



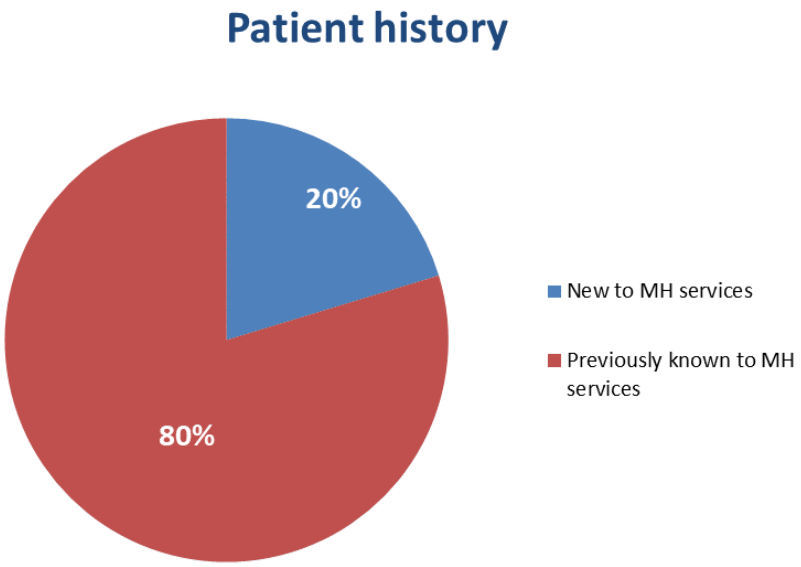
Locally, what is the ration of “urgent” to “planned” assessments? If more people are being seen in an emergency, why?

Is there data to suggest delays in community assessments are resulting in more urgent presentations?

Prior involvement with Mental Health services

80% of Mental Health Act assessments during the period were requested for patients previously known to mental health services. Only a fifth of requests were for people new to mental health services.

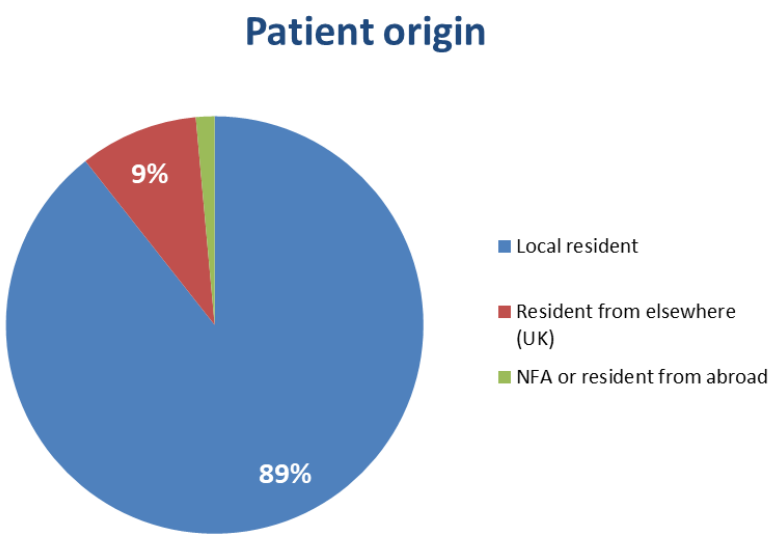
This question was intended to detail the proportion of assessments which were for people currently or previously known to secondary mental health services anywhere in England, although was open to some local interpretation.



Origin / Ordinary residence of patient

89% of assessments were carried out for people resident in the local area. A further 9% were for people resident in other parts of the UK, and 2% were for those of no fixed abode or from overseas.

Some areas saw only local residents, whereas metropolitan areas were more likely to seeing people from different areas, and different counties.



Locally, where do most people assessed originate from?

If large numbers of assessments are completed for people from neighbouring areas, this will increase the numbers of AMHPs required in the assessing area.

What local protocols are in place to ensure people are assessed by AMHPs most likely to have information about them? In other words, do AMHPs cross local authority boarders to ensure patients known to them are seen by them, or is there a reliance on neighbouring areas providing the AMHP resource?

Profile of Urgent/Emergency assessments

55% of urgent or emergency assessments undertaken during the period were for people being held under a section 136. 18% of these assessments were for people who had been arrested and were in police stations, and 27% were informal presentations in A&E.

Understandably, there has been a great deal of emphasis on the use of s136, but as these statistics illustrate, 45% of urgent and emergency assessment take place when people present informally in A&E, or in police custody following arrest. Whilst the move to develop specialist s136 suites is welcome, many people are likely to continue to present informally to A&E, and if parity of esteem means anything, it should mean that wherever people present, they should receive the same supportive and expert care and assessment.

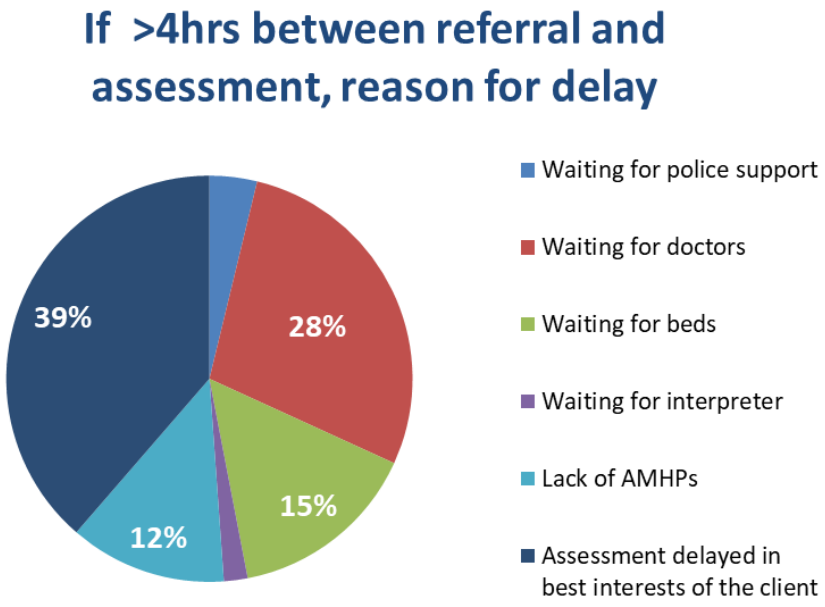
There is, however, a legal dilemma for people who present informally in A&E. Currently staff in A&E have no powers under the Mental Health Act to stop someone leaving, and can only rely on the Mental Capacity Act if they are satisfied it applies.

What is the local profile for your area for types of urgent and emergency assessments? For example, if there is a low number of people picked up on s136, but a high number of people presenting informally in A&E, further examination of this would be helpful.

Delays – urgent / emergency assessments

Respondents were asked to indicate the main reason for any delay lasting longer than 4hrs between referral and starting the assessment. This was of interest as previous reports have suggested that a lack of AMHPs was a key determinant in delays starting assessments. Data reported here only displays reasons where delays occurred. Most assessments are not subject to such delays.

Where delays occurred between the receipt of a referral and the assessment taking place, the most common causes are shown in the chart below. The most common reason (39%, 102 occasions) was that it was in the best interests of the client to delay the assessment, followed by a wait for a doctor to be available (28%, 74 occasions). Lack of beds was cited as a reason for delay in 15% of cases (40 occasions), and lack of AMHPs in 12% of cases (33 occasions).



In what circumstances does lack of AMHPs delay assessments?

What can be done to address such delays?

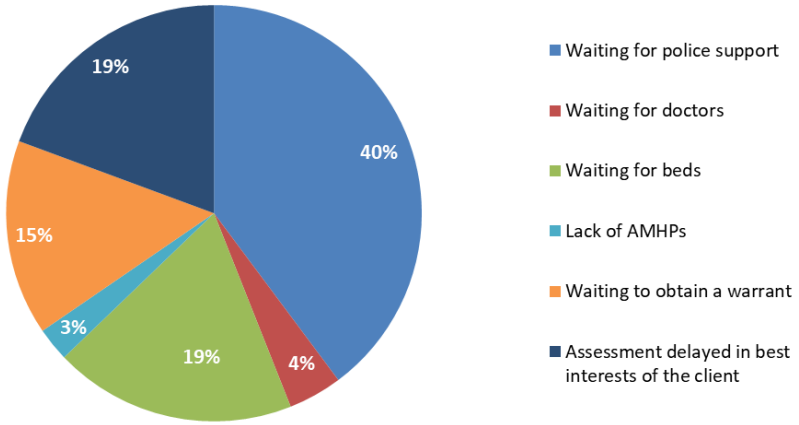
Are data on delays collected and shared routinely with local partners to prompt improvements in practice?

Delays – planned / community assessments

Information was also requested on reasons for community assessments being delayed for more than 24hrs after the AMHP felt it should ideally have happened.

For planned assessments, the following reasons were given for delays of 24 hours or more beyond the time when the AMHP felt assessment was necessary. The most common reason was waiting for police support (40%, 76 occasions) followed by a delay being in the best interests of the client (19%, 37 occasions). In a further 19% of cases (36 occasions), a delay was due to a lack of availability of beds, in the event that an admission be required following the assessment

If >24hrs between referral and assessment, reason for delay



What are the local reasons for delays in assessment?

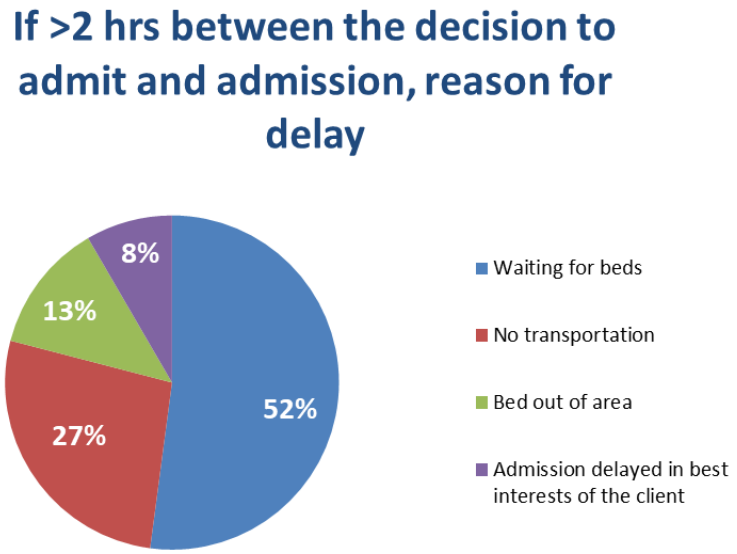
How are such delays monitored, and how are such issues shared across the health, police and social care network?

Are people waiting in your area for admission to hospital? If yes how is this monitored and shared across the local system.

Delays following assessment

Another reported area for delays was following assessment. People were asked to record the reason why it took longer than 2 hours between making a decision that admission to hospital was needed, and the person actually arriving on the admitting ward.

The most common cause of such delays was bed availability (52%, 87 occasions) though in 27% of cases (45 occasions), the required transportation was not available.



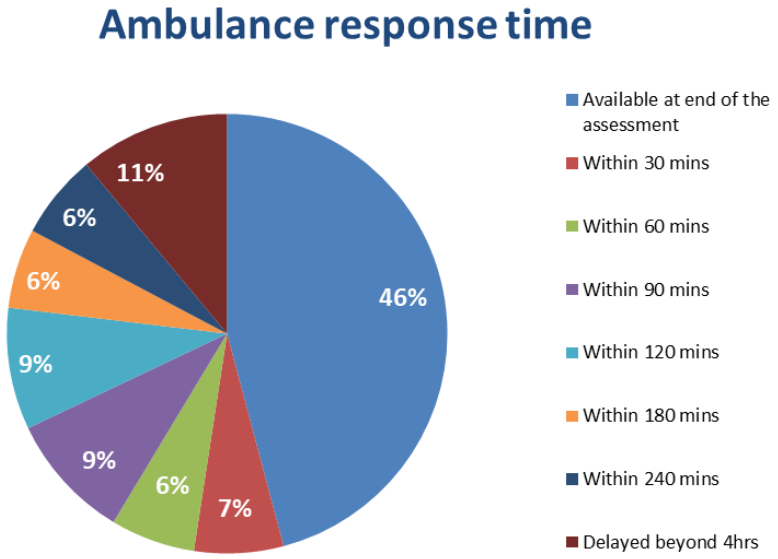
On a local basis, directors should find out more about the experiences AMHPs are facing, and why.

Directors should support AMHPs to feed back these concerns to prompt improvements in local practice.

Delays involving transport

In 46% of cases (133 occasions), an ambulance was available at the end of the assessment to transport the patient to hospital as needed. In some areas (some London boroughs, for example) police will not execute s135 warrants unless an ambulance is on site, and this may be why such a large number of assessment had such quick assessment to transport.

However, in 6% of cases the wait was 3 – 4 hours, and in 11% of cases the wait was beyond 4 hours.



What are the commissioning arrangements for conveyancing under the Act? Do transport providers work to commissioned set response times?

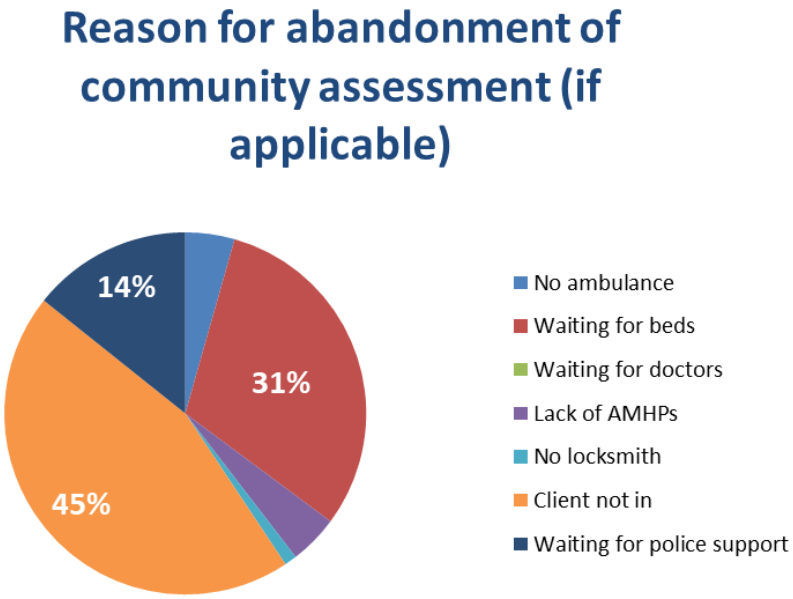
How are response times and delays captured in AMHP and transport services and is this data shared locally on a routine basis?

Directors should agree on the circumstances where such delays should be recorded as an institutional safeguarding concern.

Abandonment of community based assessments

During the period, 91 assessments were abandoned, and the reason reported. The most common cause of abandonment of an assessment was the client not being home (45%, 41 occasions). A lack of beds was the reported reason in 31% of cases, and in 14% of cases lack of police supported was the reason assessments were abandoned.

Lack of AMHPs was cited in 3% of cases. Lack of doctors was not reported as a reason for abandonment in any cases during the stocktake period.



How often are assessments abandoned in your area?

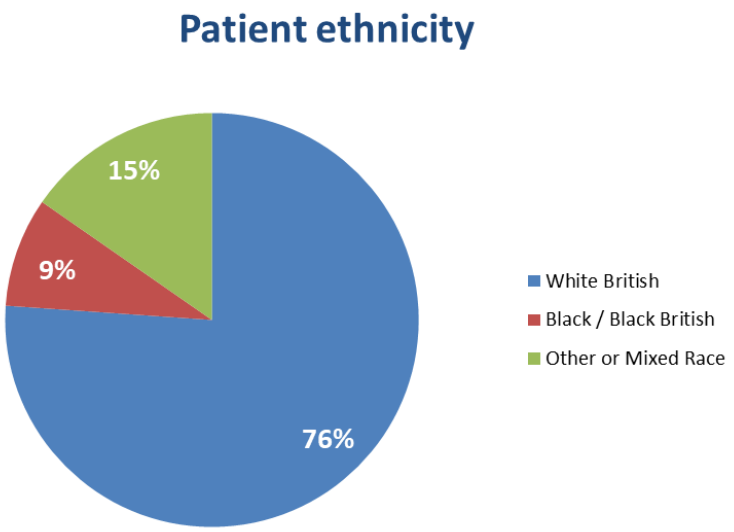
Is there a waiting list of people needing admissions from the community?

In what circumstances are such delays recorded and monitored as safeguarding alerts?

Ethnicity of patients

Of all people assessed under the Mental Health Act within the period, 76% (=3159) were from a White British background. Thus the ethnicity of people being assessed is largely similar to the ethnicity of social work staff. People from a Black or Black British background are over-represented in these figures. 9% (=355) of those who received Mental Health Act Assessments were from this background, compared to 3% of the general population.

Additionally, there are differences in ethnicity in terms of where people are assessed and what has led to this assessment, as the following pages illustrate.



What is the local profile of people assessed under the Mental Health Act?

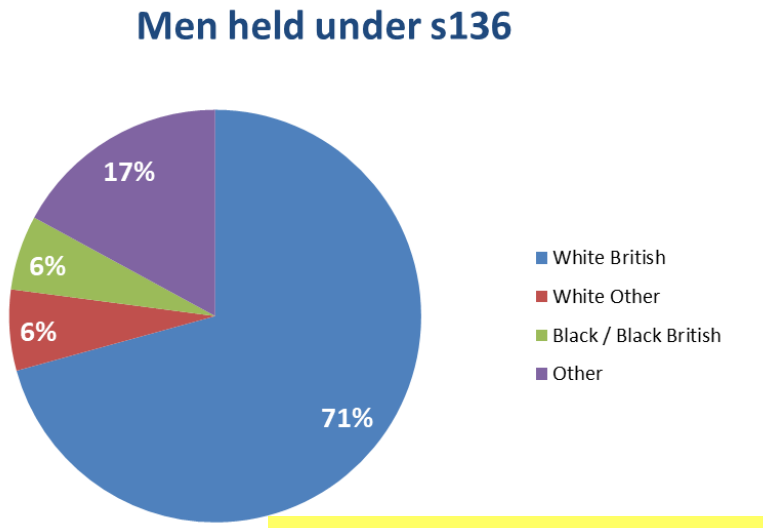
Are particular groups of people over represented as compared to your local population?

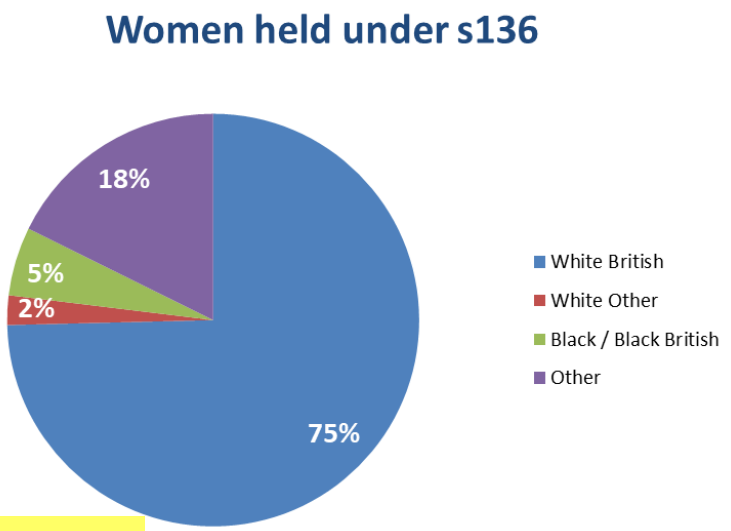
How does this compare to the ethnic profile of your local AMHP staff?

Ethnicity of people assessed while under s136

71% of men (=145) and 75% of women (=97) held under a section 136 for a Mental Health Act assessment were White British. No other single ethnicity featured prominently, with the next most prevalent being 6% of men (=13) as White other and 6% (=12) as Black or Black British. 5% of women (=7) were in this category.

In addition, there has been a 90% reduction in the use of police stations as places of safety in the last 5 years with fewer than 4% of s136 assessments taking place in police custody during that snapshot period. (https://www.england.nhs.uk/wp-content/uploads/2017/10/mental-health-letter-s135-s136-changes.pdf)





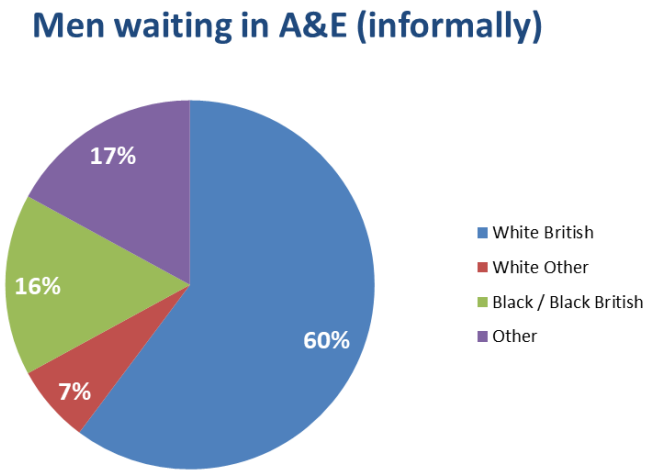
Where are local residents taken under s136?
What are the profiles locally for ethnicity and use of s136?
How does this compare to your local population?

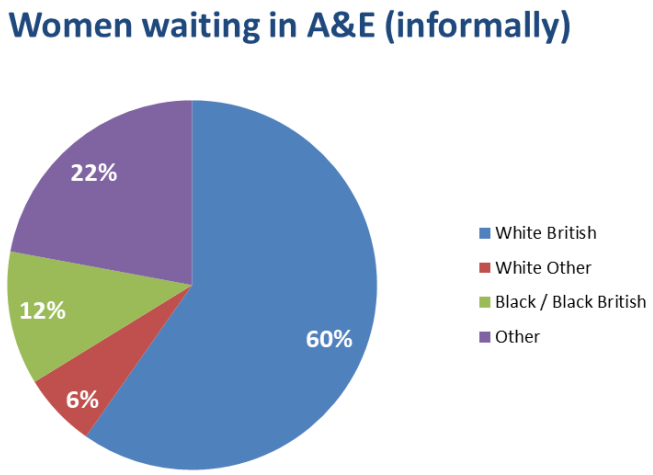
Ethnicity of those assessed in A&E

Although most of the people assessed in A&E were also White British (60%) there is more variation in other ethnic groups than was seen with people held under a s136. For men, 7% (=6) were White Other and 16% (=14) were Black or Black British. For women, 6% (=5) were from other White backgrounds and 12% (=9) were Black or Black British.

People from a black background are notably over-represented in this cohort compared to the general population. More work is needed to understand why in this cohort, more non-white people were presenting via A&E (and subsequently identified as needing a MHA Assessment) rather than being able to access support earlier and more informally.

People in this group are very likely to have been assessed either by a psychiatrist, or by experienced mental health liaison staff as needing assessment & admission under the Mental Health Act, rather than being able to be supported more informally, via crisis intervention for example.

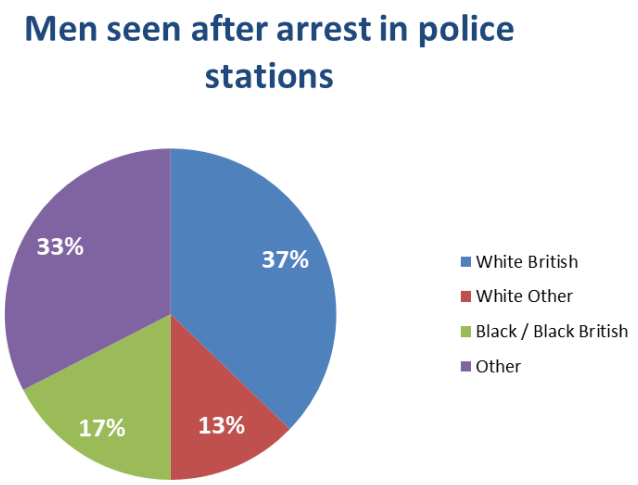


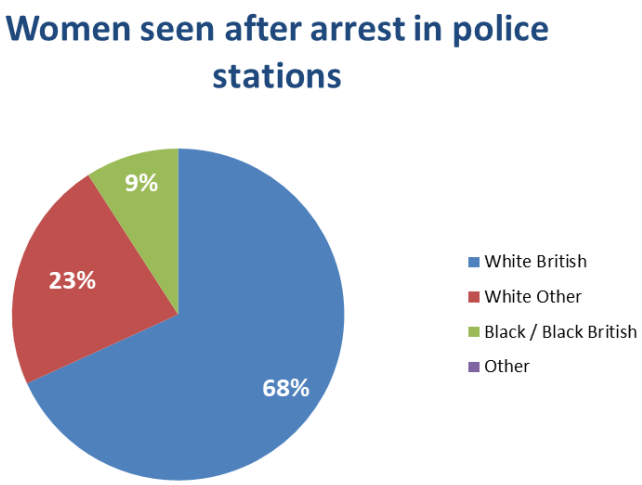


Ethnicity of those assessed after arrest

37% of men (=32) and 68% of women (=15) assessed in police stations following arrest are White British, but other ethnic groups are also strongly represented. 17% of men (=15) and 9% of women (=2) are Black or Black British. This compares to around 3% of the general population being from a Black background.

This is an area that would benefit from further investigation, in terms of how such a high proportion of non-white men (in particular) are being assessed after arrest. One hypothesis is that arrest provides police officers with a way of managing a volatile situation involving someone who appears to be unwell, but is in a private place (such as a home) where the option of using s136 is not available, and those involved cannot be persuaded to go informally to A&E. Another could be that officers are more likely to misinterpreted what they observe as criminality rather than mental distress.





Assessment outcomes

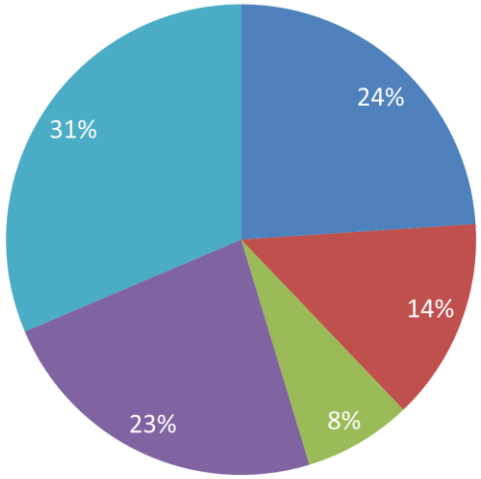
The location and legal status of the person at the time of assessment are good indicators of the eventual outcome of that assessment. The law requires than an AMHP see and assess all those detained on s136 (unless a doctor sees them first and decides the person has no mental disorder), whereas people who present informally to A&E or who are arrested, are generally screened by nurses. In A&E, those people referred for MHA assessments will have been seem by Psychiatric Liaison services and/or SHOs in Psychiatry. Of those, only people regarded as likely to need formal admission on section are referred for a Mental Health Act assessment. 24% (=74) of people held on a section 136 during the reporting period were discharged following MHAA, but only 3% (=5) of those assessed in A&E and 11% (=10) of those under arrest in police custody were discharged following their MHAA. In all instances, admission was the single most likely outcome following assessment, though this ranged from 31% (=97) of those held under s136 to 72% (=107) of those assessed after presenting informally in A&E.

Is this data reported to senior local authority figures and shared routinely with local NHS and policing partners to inform demand planning, commissioning and resource allocation?

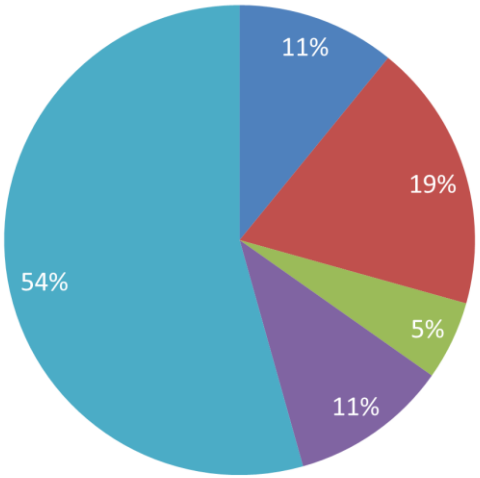
Are your local partners aware of the proportion of assessments that do not result in detention and are you able to analyse any patterns to identify particular reasons or pressure points?

Assessment outcomes

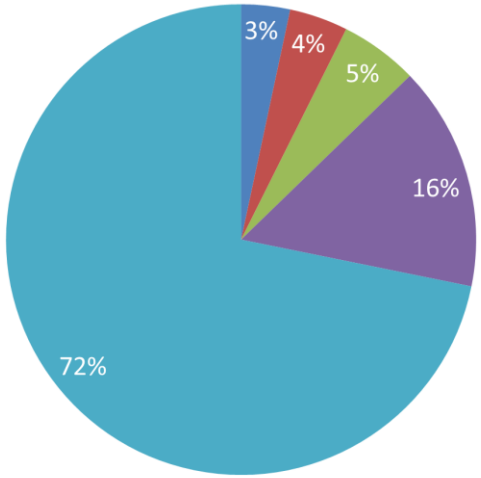
Outcomes for people on s136



Outcomes for people under arrest in police custody



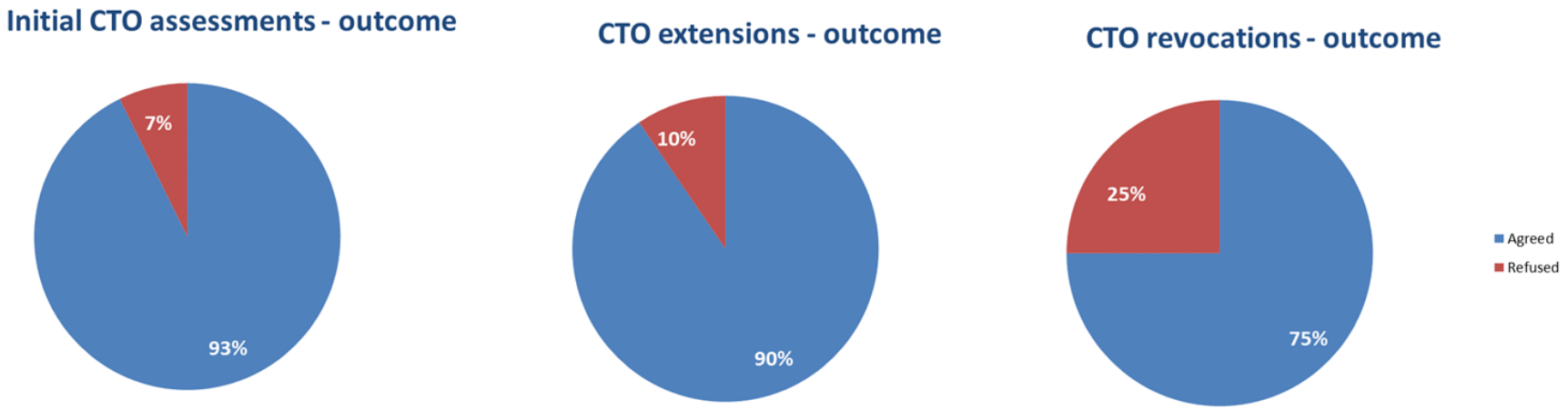
Outcomes for people in A&E (informally)



- Discharged (no mental disorder)
- Care needed already provided
- Informal or crisis house admission
- Home treatment
- Admission under section

directors of adass adult social services

AMHPs and Community Treatment Orders



Annual data on AMHP involvement in Community Treatment Orders (CTO) was less robust that other data, (it is not recorded how many requests for CTOs were diverted by AMHPs informally in discussion with Doctors) however, requests to consider whether to revoke an order were counted as urgent requests as part of the snapshot (and are therefore the most reliable of the 3 sets of statistics).

A number of different types of CTO assessments were reported.

In all types, an agreement to the request was the most likely outcome. 93% (=51) of requests for CTOs were agreed, as were 90% (=57) of requests for CTO extensions. However, only 75% (=21) of requests to revoke a CTO and recall a patient to hospital were agreed. In 25% of cases, AMHPs refused to revoke orders, meaning that people were able to return home.

This is an area where more robust data would be helpful, particularly given the current scrutiny of CTO's.

For further information

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