

The Public Services Ombudsman Act (Northern Ireland) 2016

Investigation Report

UNDER SECTION 43

The Northern Ireland Public Services Ombudsman 33 Wellington Place

Belfast BT1 6HN

Tel: 028 9023 3821

Email: nipso@nipso.org.uk Web: [www.nipso.org.uk](http://www.nipso.org.uk/) @NIPSO\_Comms

# Confidentiality

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## The Role of the Ombudsman

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The 2016 Act provides for the Ombudsman to investigate and report on complaints from a ‘person aggrieved’. The Ombudsman may investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care in consequence of the exercise of professional judgement, exercisable in connection with the provision of health and social care. In general, the purposes of an investigation are to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the 2016 Act, but is generally taken to include decisions made following improper consideration; action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgement, she must also consider whether this has resulted in an injustice. Injustice is also not defined in the 2016 Act but can include upset, inconvenience, loss of opportunity or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

Section 30 (6) of the 2016 Act states that ‘the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case’. Therefore the Ombudsman has discretion to determine the procedure for investigating a complaint.

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**Case Reference:** 202004130

**Listed Authority:** South Eastern Health and Social Care Trust

# SUMMARY

This complaint was about mental health care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the patient in 2021 and 2022. The patient’s GP first referred the patient shortly after the death of his wife in November 2020. The patient was not only grieving the loss of his wife, but also lost the support she provided to enable him to cope with the distress of surviving historical childhood sexual abuse.

The Trust first assessed the patient in January 2021. From then until 22 November 2022, the Trust’s Mental Health Assessment Centre (MHAC) conducted four mental health assessments. The patient believed the Trust’s assessments were inadequate and failed to provide him with a diagnosis when he expected to receive one of post- traumatic stress disorder (PTSD). Based on the available evidence, the investigation found the Trust conducted its assessments in accordance with guidance. It also found the Trust did not reach a diagnosis following its assessments. Furthermore, the investigation did not find any evidence to suggest the patient should have received a PTSD diagnosis.

The patient raised a further concern that the Trust failed to provide him with an appropriate care plan to meet his needs. He felt ‘*discarded*’ by the Trust’s decision to discharge him and refer him to an external body. He said the Trust left him without any treatment for more than 18 months.

The investigation did not identify a failure in the care plans developed for the patient. However, it found the Trust failed to support the patient to achieve the recommendations within the care plan. It also did not communicate its decision to discharge either to the patient himself, or his GP. I was disappointed and concerned that these failures caused the patient to experience an 18-month delay before he received treatment. This is especially given the trauma the patient experienced during his childhood, and also the impact the recent loss of his wife had on his recovery. I offer my sincere condolences to the patient for his loss.

I recommended the Trust apologises to the patient for the injustice caused. I also recommended actions for the Trust to take to prevent these failures from reoccurring. The Trust acknowledged it ought to have followed up on the patient’s fulfilment of the care plan during the re-assessments it subsequently carried out with him. However, generally, it denied responsibility for following up on recommendations for self- referrals included in care plans. It also maintained the patient was aware of being discharged.

# THE COMPLAINT

1. This complaint was about care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the patient following its receipt of mental health referrals in 2021 and 2022.

## Background

1. The patient lives with trauma caused by sexual abuse he experienced during his childhood. He received support from his wife who aided in his recovery. Sadly, the patient’s wife died in November 2020.
2. The patient’s General Practitioner (GP) sent a routine mental health referral to the Trust on 22 January 2021. The reason for the referral was ‘*depression / grief*.’ The Trust conducted four mental health assessments for the patient during 2021 and 2022.
3. The patient raised a complaint with the Trust on 15 September 2022 regarding these assessments and the subsequent treatment received. The Trust issued a final response to the patient on 26 January 2023.

## Issue of complaint

1. I accepted the following issue of complaint for investigation:

**Whether the Trust provided appropriate care and treatment to the patient regarding GP mental health referrals from January 2021.**

# INVESTIGATION METHODOLOGY

1. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust’s complaints process.

## Independent Professional Advice Sought

1. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):
	* A Consultant in Adult Psychiatry with over 30 years’ experience.

I enclose the clinical advice received at Appendix two to this report.

1. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided ‘advice’. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

## Relevant Standards and Guidance

1. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman’s Principles[1](#_bookmark0):

* + The Principles of Good Administration.
1. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

* + The National Institute for Health and Care Excellence’s Clinical Guidance on Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, Published 14 December 2011, Endorsed in Northern Ireland February 2012 (NICE CG136);
	+ NHS Mental Health, Your Rights – Mental Health Assessments, Last Reviewed 17 February 2022 (NHS MH Assessments); and
	+ UK Trauma Council’s Definition of PTSD[2](#_bookmark1) and Complex PTSD (UK

1 These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

2 Post-traumatic stress disorder.

Trauma Council on PTSD).

I enclose relevant sections of the guidance considered at Appendix three to this report.

1. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.
2. A draft copy of this report was shared with the patient and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the comments I received and, where appropriate, incorporated some of these comments into the report.

# THE INVESTIGATION

## Whether the Trust provided appropriate care and treatment to the patient regarding GP mental health referrals from January 2021.

In particular this will consider:

* The Trust’s assessments of the patient; and
* The Trust’s treatment and referral for treatment.

*Mental Health Assessments*

## Detail of Complaint

1. The patient said the Trust failed to carry out appropriate mental health assessments following referrals from his General Practitioner (GP).

*22 March and 5 December 2021*

1. The patient said the Trust’s assessments consisted of two 10-minute telephone calls which did not discuss his historical abuse or consider the impact this had on his mental health.

*22 November 2022*

1. The patient believed the Trust’s assessor was not an appropriate person to provide an accurate diagnosis. He explained ‘*trauma is not a diagnosis*.’ He

also said the Trust failed to provide a diagnosis which he requested[3](#_bookmark2).

## Evidence Considered Legislation/Policies/Guidance

1. I considered the following policies and guidance:
	* NICE CG136;
	* NHS on MH Assessments; and
	* UK Trauma Council’s diagnostic criteria.

## Trust’s response to investigation enquiries

1. The Trust explained its Mental Health Assessment Centre (MHAC)[4](#_bookmark3) is the first point of access to mental health services within the Trust area. MHAC conducted an initial assessment of the patient’s ‘*presenting needs*.’ The aim is to identify what further support a patient may require and develop a plan to best meet their needs. MHAC’s primary function is to ‘*signpost or refer*’ the patient to other services, which the Trust or external agencies deliver.

*22 March 2021*

1. The Trust stated the patient first presented to them for mental health assessment via referral from his GP. A Community Practice Nurse (CPN) initially assessed the patient by telephone. The Trust stated this was a ‘*detailed and comprehensive assessment*’ of the patient’s mental health. An initial assessment *‘generally’* takes one or two hours.

*5 December 2021*

1. The Trust stated this was a telephone re-assessment to include a review of ‘*demographics*’ and focus on a ‘*careful assessment*’ of the current presenting symptoms.’ The Trust already recorded the patient’s social history from the March assessment to which the assessor had access. A re-assessment ‘*generally*’ lasts approximately one hour.

3 This was stated in the GP urgent referral to the Trust dated 6 September 2022.

4 Provides a single point of entry to a stepped care model for the delivery of mental health services.

*26 September 2022*

1. The Trust’s Complaints Investigation Overview Report stated it triaged the GP’s urgent referral on 7 September 2022. Based on Triage Guidance, the Trust ‘*downgraded*’ the referral to routine.

*22 November 2022*

1. The Trust stated the assessor was a psychiatrist. It explained the term speciality doctor refers to their grade and not their speciality. The Trust stated it conducted a ‘*thorough assessment’*. This included a standard history, mental state examination, reading written correspondence provided by the patient’s daughter, and taking a collateral history from the patient’s friend.

## Complainant’s Response to Draft Report

1. The complainant said his mental health treatment has been *‘non-existent’* and the way the Trust treated him has been ‘*abhorrent’*. He highlighted a more recent assessment, beyond the scope of the present investigation, also failed to diagnose him with PTSD. He continued to dispute the lack of a PTSD diagnosis.

## Relevant Trust Records

1. I enclose relevant extracts of records considered at Appendix five to this report.

## Relevant Independent Professional Advice

1. A summary of the independent professional advice is enclosed at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

## Analysis and Findings

1. The patient said the Trust did not:
	* Discuss his historical abuse or consider its impact on his mental health during its assessments;
	* Provide an appropriate assessor; and
	* Provide him with a diagnosis.

I will consider each of these in turn below.

*The assessments*

1. NICE CG136 states an assessment ‘*will cover all aspects of [the patient’s] experiences and life*[*5*](#_bookmark4).’ The healthcare professional when carrying out an assessment[6](#_bookmark5) should ensure there is enough time for the patient to describe and discuss their problems.
2. I note the Trust’s records of the 2021 assessments state the calls lasted one hour. Neither the Trust nor the patient were able to provide a copy of their telephone records to establish the length of the calls. I have therefore been unable to verify this. However, the IPA considered the notes of the calls and advised they likely took between 40 and 60 minutes. He advised this suggested ‘*a comprehensive interview’* took place.
3. NICE CG136 also states that clinicians should offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed.
4. The assessment reports did not document the abuse the patient experienced. However, they did record in detail how the abuse impacted the patient’s health. The IPA advised that discussing abusive experiences can be traumatic for patients. Therefore, it is ‘*best left for therapy’*. The IPA advised the Trust’s assessments were ‘*appropriate*’ as the clinicians did not ask for details of the abuse.
5. The records also document that the Trust provided the patient with details of several community services. The IPA advised this is evidence of ‘*support given’*.
6. The IPA advised it is for these reasons that each of the Trust’s assessments ‘*met all the relevant standards*’ as set out by the NHS and NICE CG136. I

5 Section 1.3.2.

6 Section 1.3.3 relevant to the complaint.

accept this advice. I have not identified any failure in the care and treatment the Trust provided during its assessments of the patient.

*The assessor*

1. The patient believed the Trust’s assessor in November 2022 was not an appropriate person to provide an accurate diagnosis. The Trust stated the assessor was a ‘*Speciality Doctor in psychiatry…a psychiatrist.*’ The IPA advised the assessor was a *‘Specialist Psychiatric Registrar.’*
2. The NHS guidance on MH Assessments lists the healthcare professionals a patient may speak with during an assessment. The IPA advised the assessment in November 2022 fulfilled *‘all the standards’* of this guidance. I am therefore satisfied the assessor was an appropriate person to conduct the assessment. I have not identified any failure for this element of the complaint.

*Diagnosis*

1. The patient said the Trust failed to provide him with a diagnosis as he requested.
2. The IPA advised that a clinician may not reach a diagnosis following an assessment. The records evidence that for each assessment, the Trust documented and acknowledged ‘*the distress suffered’* by the patient and concluded he ‘*did not suffer from a diagnosable mental disorder*.’ The IPA further advised that during the patient’s final assessment on 22 November 2022, diagnosis was ‘*mentioned…only to say’* the patient’s symptoms ‘*did not reach the level of severity required to make a diagnosis of PTSD*.’ Therefore, the Trust made ‘*no psychiatric diagnosis’* following its assessments. The IPA advised this was ‘*reflective of good practice*.’
3. However, the patient believed he may have PTSD or complex PTSD, which the Trust did not diagnose.
4. I refer to the UK Trauma Council’s diagnostic criteria[7](#_bookmark6) for PTSD. It states that

7 The IPA advised these criteria use the diagnostic guides DSM-5 and ICD-11.

PTSD is the diagnostic label used to describe a particular profile of symptoms that people sometimes develop after experiencing or witnessing a potentially traumatic event or events. However, the difficulties experienced may not fulfil the criteria for PTSD. I enclose a copy of the criteria in Appendix three of this report.

1. In relation to a PTSD diagnosis, the IPA reviewed the patient’s history and mental state examination. He agreed with the Trust’s assessment outcome that the patient ‘*did not reach the level of severity required to make a diagnosis of PTSD*.’ Based on his advice, I have no reason to question the Trust’s decision not to diagnose the patient with PTSD. I have therefore not identified a failure in care and treatment for this element of the complaint.
2. The NICE CG136 states that if a patient is ‘*unhappy*’ about the assessment and diagnosis, the clinician should offer them the opportunity for a second opinion.[8](#_bookmark7) The Trust advised it did so and the patient received a second opinion in June 2023. I note the decision regarding the PTSD diagnosis did not change.

*The Trust’s treatment and referral for treatment*

## Detail of Complaint

1. The patient said the Trust failed to provide an appropriate care plan to meet his needs. He felt ‘*discarded*’ by the Trust’s decision to discharge him and refer him to an external body, Nexus. He said the Trust did not inform him it discharged him, and he does not understand its reasons for doing so. He said, prior to his referral, the Trust did not consider if he met the criteria to receive treatment from Nexus. The Trust left him without any treatment for more than 18 months.

## Evidence Considered Policies/Guidance

1. I considered the following policies and guidance:
	* NICE CG136;
	* Nexus website; and
	* MHACP10 Discharge Procedure.

8 Section 1.3.4.

## Trust’s response to investigation enquiries

1. The Trust stated signposting a patient to voluntary services such as Nexus was a common assessment outcome. Nexus offers specialist counselling to patients affected by sexual trauma.
2. The Trust’s practitioner on 22 March 2021 felt the patient could benefit from such therapy. The Trust did not identify a clinical need to refer the patient to a secondary care community mental health service.
3. The Trust stated on 5 December 2021 that it determined the patient continuing to await Nexus counselling was ‘*the most appropriate course of action*.’ The Trust’s assessor understood the patient would contact Nexus regarding timeframes and that the patient was agreeable to the management plan.
4. Further assessments recommended other patient support, including referral to Action Mental Health and Benefits Advocacy.
5. The Trust stated, following assessment on 22 November 2022, it referred the patient to a Clinical Psychologist. The patient continued with Nexus treatment in the interim.
6. The Trust apologised to the patient for any confusion around responsibility for contacting Nexus.

## Trust’s Response to the Draft Report

1. The Trust stated the MHAC is an initial point of contact service, generally offering a one-off, initial mental health assessment. This assessment determines if secondary mental health services are needed. If so, it makes the appropriate onward referral. If not, its case with the patient is closed. A common outcome is signposting to the community or voluntary sector.
2. The Trust stated its assessment of the patient, and its outcome, was communicated verbally to the patient, who agreed with the proposed care plan. It also stated it would have made the patient aware verbally there was no

further follow up arranged with the Trust. However, it acknowledged it did not reinforce this with written documentation. The Trust stated it is exploring the possibility of improving its digital records system (Encompass), to ensure its functionalities for recording and communicating the outcome of initial assessments are adequate.

1. The Trust stated it does not accept it was its responsibility to check the patient had self-referred to Nexus and to establish the waiting time for this service, as it was not receiving him into secondary care services after assessment. It may have been good practice to do so, but it is up to the patient to refer themselves if they wish.
2. The Trust stated monitoring self-referrals would be difficult due to staffing levels and referral rates. It is also hesitant to do so because it prefers to promote autonomy for patients. Nevertheless, the Trust stated, at each re-assessment of the patient after the initial one, when the self-referral to Nexus was recommended in the care plan, it ought to have confirmed the patient had carried this out. The Trust stated it will undertake a review of its referral and discharge processes, and this will explore actively encouraging vulnerable patients to pursue self-referrals, and seeking permission to include families or carers in the follow up process.
3. The Trust stated it intends to improve its management of patients’ expectations in terms of waiting times by seeking a quarterly update on this from the main community and voluntary agencies, which it will then communicate to patients. It will also develop a leaflet explaining the services provided by the MHAC, to help manage the expectations of patients who attend for an initial assessment.

## Complainant’s Response to Draft Report

1. The complainant said the Trust discharged him without putting him on a waiting list for treatment. Although the Trust recommended self-referral to Nexus, it is a separate organisation from the Trust and it could not be sure Nexus would ever treat him.

## Relevant Records

1. I enclose relevant extracts of records considered at Appendix five to this report.

## Relevant Independent Professional Advice

1. A summary of the independent professional advice is enclosed at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

## Analysis and Findings

*The care plans*

1. The patient said the Trust failed to provide an appropriate care plan to meet his needs. Section 1.4 of NICE CG136[9](#_bookmark8) provides guidance on care plans. It recommends discussing strategies with the patient and incorporating these into their care plan.
2. The Trust’s records evidence that it developed care plans with the patient following his assessments. Each of the care plans documented information and advice provided to the patient. The IPA advised the care plans evidence the Trust referred the patient to a wide variety of sources of support and treatment including community resources for survivors of sexual abuse, trauma and bereavement. He further advised that each of the Trust’s care plans ‘*met NHS and NICE recommendations for care plans in adult mental health services’*. I accept this advice.
3. Section 1.4 of NICE CG136 also states that bodies should ‘*Develop care plans jointly’* with the patient. I considered the Trust’s assessment documentation. Each assessment documents that the Trust ‘*discussed’* and *‘agreed’* the plan/recommendations with the patient. The 2021 assessments document the patient’s verbal agreement, which he gave either over the telephone or in person in November 2022. The patient also signed the September 2022 assessment[10](#_bookmark9). I am therefore satisfied that the patient agreed with the care plans the Trust developed.

9 Section 1.4 on Community Care.

10 As enclosed in Appendix 5C.

1. Based on the available evidence, I have not identified a failure in the Trust’s development and communication of the patient’s care plans.

*Referral to Nexus*

1. The complainant raised concern with the Trust’s decision to refer him to Nexus as part of his care plan. The Trust stated it felt the patient could benefit from therapy from Nexus who provide specialist counselling for sexual trauma.
2. The Trust recommended the patient ‘*self refer to Nexus for therapy*’ following his first assessment on 22 March 2021. The IPA advised this was a ‘*reasonable piece of advice*.’ However, he noted the second and third assessments, on 5 December 2021 and 26 September 2022, documented that Nexus had not yet contacted the patient. In fact, ‘*Nexus involvement’* was not recorded until the November 2022 assessment.
3. The IPA advised that after making the recommendation in March 2021, it was ‘*the Trust’s responsibility to check that the self-referral had been made*’ and to ‘*establish the approximate waiting time*.’ However, in response to investigation enquiries, the Trust said[11](#_bookmark10) it did not have any ‘*formal communication’* with Nexus.
4. The IPA also noted there was no evidence prior to the September 2022 assessment to suggest the patient did self-refer. He advised the patient’s ‘*literacy problems may have impacted that*.’ The IPA further advised that the Trust ‘*failed to check’* the patient had self-referred and received treatment ‘*within a reasonable time*.’
5. I also considered the Trust’s assessment forms, which included a section for entering the ‘*Expected waiting time for service/Estimated waiting time for onward referral.*’ I note this section is blank on each of the forms completed[12](#_bookmark11) for 22 March 2021, 5 December 2021 and 26 September 2022.

11 By letter dated 27 March 2024.

12 Enclosed in Appendix five.

1. NICE CG136 requires mental health staff to ‘*provide support to help [the patient] realise the plan*.’ This guidance, and the IPA’s advice, indicate it was the Trust’s responsibility to follow up on the status of the self-referral, to make sure the patient had self-referred appropriately, and to ascertain the approximate waiting time for treatment.
2. However, I note in its response to the draft report the Trust stated following up on self-referrals is beyond the function of the MHAC. It therefore disputed the relevance of NICE CG136 and disagreed with the IPA’s advice. I have taken this viewpoint into consideration, and I accept it may not be usual practice for the MHAC to follow up on the self-referrals it recommends after an initial assessment.
3. Nevertheless, in the same response, the Trust also acknowledged it ought to have followed up on the patient’s self-referral to Nexus during subsequent re- assessments on 5 December 2021 and 26 September 2022. Therefore, although the Trust did not accept it had responsibility for following up on the patient’s self-referral to Nexus after the initial assessment carried out on 22 March 2021, I am nevertheless satisfied it accepted responsibility for following up on the self-referral as part of its re-assessments of the patient, which it failed to do. This is especially pertinent given the patient’s literacy issues.
4. Therefore, due to its failure to follow up on the self-referral to Nexus during later re-assessments, I am satisfied the Trust failed to fulfil its duty to support the patient to realise the care plan it developed with him. I consider this a failure in the patient’s care and treatment.
5. I note the Trust apologised to the patient for any ‘*confusion*’ around the responsibility for contacting Nexus. While I appreciate the Trust’s decision to apologise to the patient, I do not consider it fully recognised that the failure occurred due to its own inaction. Given the patient’s difficult circumstances, which the Trust was fully aware of, it is of deep concern to me that it allowed the situation to continue for so long without checking if the patient completed

the self-referral. This is despite the Trust having clear knowledge at each re- assessment that Nexus had not yet become involved. The IPA advised that the Trust’s failings ‘*left the patient without adequate care for at least 16 months*[*13*](#_bookmark12)*.*’ Therefore, I am satisfied that the failure identified caused a vulnerable patient to sustain the injustice of a loss of opportunity to receive earlier treatment, frustration, and uncertainty.

*Discharge*

1. The patient said he felt ‘*discarded*’ by the Trust’s decision to discharge him from its mental health services, which left him without treatment for 18 months. He telephoned the Trust on 15 September 2022[14](#_bookmark13) and reported that he ‘*wasn’t told he was discharged and doesn’t understand why*.’ He stated he was ‘*supposed*’ to be getting treatment from Nexus.
2. The IPA advised it is common practice for a Trust to discharge a patient from its mental health services following a mental health assessment and the development of a care plan. This is also if the care plan ‘*does not involve the community mental health team*’. The IPA advised that as this was the case for the patient, the Trust’s decision to discharge the patient was ‘*reasonable and appropriate*.’ I accept that advice.
3. The IPA further advised the Trust should inform the patient and GP of its discharge decision. The Trust’s Discharge Procedure requires clinicians to complete ‘*Closure/Transfer Forms’* when processing a discharge. I note the Trust completed these forms following each assessment in compliance with its procedure. I also note the patient’s Closure/Transfer Form following his assessment on 5 December 2021 documented; ‘*no further MHAC role*.’
4. However, there is no evidence in the records that the Trust informed the patient of its decision to discharge him from its service. Furthermore, while the accompanying letter to the GP[15](#_bookmark14) stated it would follow up the Nexus referral, it did not confirm a cessation of the MHAC role or that the patient was being

13 Sic 18 months.

14 Enclosed in Appendix 5C.

15 Enclosed in Appendix 5B.

discharged. Therefore, there is no evidence the Trust communicated its decision to the patient or to the patient’s GP.

1. Section 1.7 of NICE CG136 requires clinicians to plan discharge ‘*carefully beforehand’* and ensure the process is ‘*structured and phased’*. I am

disappointed that for the reasons outlined, there is no evidence to suggest the Trust involved the patient in its plan to discharge him. Therefore, I do not consider the Trust acted in accordance with this NICE guidance during its discharge process.

1. The guidance also refers to collaboration with other services and requires clinicians to support patients during the referral period. Again, I do not consider the Trust acted in accordance with this guidance, as there is no evidence to suggest it informed the patient’s GP of the decision to discharge.
2. In its response to the draft report the Trust stated the patient demonstrated awareness of being discharged during a phone call ‘*following the assessment in 2022’*, in which he *‘spoke badly of being discharged’*. However, this is a misquotation of a phone call record from 14 September 2022, in which the Trust recorded the patient *‘complained about being discharged…and spoke badly of [a staff member] doing his last MHAC assessment’*. This phone call took place nine months after the patient’s last assessment with the MHAC (on 5 December 2021) and twelve days before his next one (on 26 September 2022). The patient was clearly referencing his discharge nine months prior during this phone call. It is therefore inaccurate to describe the record of this phone call as constituting evidence the patient demonstrated contemporaneous awareness of being discharged.
3. I therefore consider the Trust failed to provide appropriate care and treatment to the patient when it discharged him from his mental health service. In doing so, I am satisfied the patient sustained the injustice of uncertainty and frustration.
4. I note the Trust’s Discharge Procedure MHACP10 provides details of services a

patient may be ‘*discharged t*o’ which includes: ‘*Advised to make a self referral to the Voluntary sector e.g. Relate, Nexus*’. The procedure outlines the process for onward referral for services such as Acute Community Services[16](#_bookmark15). However, it does not provide guidance on the process to follow for a self-referral to a voluntary service such as Nexus. This lack of clear procedure, and the lack of clear communication about the scope of the MHAC’s role, may have contributed to the failings. I would ask the Trust to consider this when it next reviews its procedure.

# CONCLUSION

1. I received a complaint about the care and treatment the Trust provided to the patient following referrals for mental health assessment from his GP.
2. In respect of the mental health assessments, the investigation established these were compliant however, they did not identify or provide opportunity for delays in treatment to be monitored or addressed.
3. In respect of the patient’s treatment, the investigation established the Trust appropriately discussed and agreed the care plans with the patient as required. However, the Trust failed to provide the necessary support to ensure the treatment, it recommended, was received by the patient to meet his needs it identified. The Trust also failed to ensure the treatment would be available in reasonable time. These failures resulted in a delay to the patient receiving appropriate care and treatment.
4. I note the Trust received the referral from the patient’s GP in January 2021 which was three months after the death of his wife in November 2020. The referral documented that the patient had a history of sexual abuse as a child and by confiding in his wife he had been ‘*able to manage this over the years*.’ Due to the loss of his wife and her support, the patient sought help and communicated to the Trust on 22 March 2021 that the impact of his historical abuse was ‘*more significant’* as documented in the Trust records above. Despite the patient’s disclosures and his needs as identified by the Trust, it left

16 Etc. as documented in Appendix four.

the patient without appropriate treatment for his ‘*very distressing symptoms*[*17’*](#_bookmark16)for an 18-month period. I recognise this caused the patient to feel ‘*discarded*’ by the Trust and the failings caused the patient to sustain the injustice of a loss of opportunity to access healthcare. I further recognise this caused the patient and his family frustration and uncertainty during an already difficult time.

## Recommendations

1. In its response to the draft report the Trust outlined several steps it could take to improve its service and prevent the failures identified in this report from happening again. This included improving its digital records system, seeking regular updates from community and voluntary organisations about waiting times, and creating a leaflet to explain the role of the MHAC to patients. I welcome this learning.
2. In addition to the above learning, I recommend that within **one month** of the date of the **final report**, the Trust provides to the patient a written apology in accordance with NIPSO’s ‘Guidance on issuing an apology’ (July 2019), for the injustice caused as a result of the failures identified.
3. I further recommend for service improvement and to prevent future recurrence, that within **three months** of the date of the **final report** the Trust should:
4. Share the findings of this report with relevant staff to provide them with an opportunity to reflect on the findings identified;
5. Conduct a review of its referral/discharge process. The review should consider how staff monitor patients’ self-referrals to voluntary services, particularly when it carries out subsequent re-assessments of patients, and the support it provides to service users who transition between services. Following this review, provide training to relevant staff on any changes to the referral/discharge processes;
6. Provide training to relevant staff on the requirement to communicate discharge decisions to both patients and their staff; and

17 As described in the IPA’s conclusions.

1. Implement an action plan to incorporate these recommendations and provide me with an update. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).



**MARGARET KELLY**

**Ombudsman 31 March 2025**

**Appendix 1**

**PRINCIPLES OF GOOD ADMINISTRATION**

**Good administration by public service providers means:**

1. **Getting it right**
	* Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
	* Acting in accordance with the public body’s policy and guidance (published or internal).
	* Taking proper account of established good practice.
	* Providing effective services, using appropriately trained and competent staff.
	* Taking reasonable decisions, based on all relevant considerations.

## Being customer focused

* + Ensuring people can access services easily.
	+ Informing customers what they can expect and what the public body expects of them.
	+ Keeping to its commitments, including any published service standards.
	+ Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
	+ Responding to customers’ needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

## Being open and accountable

* + Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
	+ Stating its criteria for decision making and giving reasons for decisions
	+ Handling information properly and appropriately.
	+ Keeping proper and appropriate records.
	+ Taking responsibility for its actions.

## Acting fairly and proportionately

* + Treating people impartially, with respect and courtesy.
	+ Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
	+ Dealing with people and issues objectively and consistently.
	+ Ensuring that decisions and actions are proportionate, appropriate and fair.

## Putting things right

* + Acknowledging mistakes and apologising where appropriate.
	+ Putting mistakes right quickly and effectively.
	+ Providing clear and timely information on how and when to appeal or complain.
	+ Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

## Seeking continuous improvement

* + Reviewing policies and procedures regularly to ensure they are effective.
	+ Asking for feedback and using it to improve services and performance.
	+ Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

## Appendix 2 IPA

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| **Clinical Advice** (to be completed by Adviser) |
| **Clinical Adviser’s Name and Qualifications:**XX XX MB BS MD FRCP FRCPsych SFHEA |
| **Relevance of qualifications and/or experience to clinical aspects of this case:**I am a consultant in General adult psychiatry and Eating Disorders and I have over 30 years’ experience dealing with the conditions relevant to this advice request and all questions are in my field of expertise. |
| **Conflict of Interest (clarification of any links with Body or clinicians complained about, see conflict of interest policy):**None |
| **Documentation Reviewed:*** **Complaint Documents**
* **Trust Response to NIPSO Initial Investigation inc appendices**
* **Trust Response to NIPSO Further Investigation inc appendices**
* **GP Records**
 |
| **Background and Chronology:**The patient was a male in his 50s at the time in question who had been sexually abused as a child and this had led to long term problems with mood. He had depended on his wife for support and when she died unexpectedly he deteriorated psychologically. He was referred several times to the mental health services and they referred him to local community resources for survivors of abuse, bereavement and alcohol misuse. He was also treatment with antidepressant medication. He did not fulfil criteria for severe mental illness. However, his distress remained. He was referred to psychology for therapy in 2022 and treatment there might have an impact on his undoubtedly distressing symptoms. |
| **Questions and Responses:**For all questions, please refer to relevant **guidelines** in your response **(relevant at the time treatment was provided and relevant to Northern Ireland)**. Where there are no guidelines or standards, please provide a clear rationale for your answer and/or refer to the relevant **professional standard** (for example, the GMC Guidance). |

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| Please also use the following terminology to ensure confidentiality:1. The patient
2. The Trust
3. Please use job titles when referring to Trust staff
 |
| **Assessments** |
| **1. Please advise how a Trust should assess a patient referred to mental health services by a GP and who within a Trust should complete such an assessment.****Please refer to any relevant guidance to support your response.** |
| Following referral, the patient should be seen by one or more mental health workers within a reasonable time, and have an opportunity to discuss his or her difficulties in a comfortable environment while being treated with empathy and understanding. Following the assessment, the patient should be provided with and be able to contribute to a management (care) plan to try and address his or her difficulties. The patient should be able to bring a carer or supporter, and if appropriate, the carer should be offered an assessment for the carer role. The Trust should then communicate by letter with the referrer and offer to send a copy to the patient.These principles are described in a number of documents. The NHS document Mental Health, Social Care and Your Rights[18](#_bookmark17) advises in relation to mental health *assessment “…you might talk to a nurse, social worker, psychologist, specialist pharmacist, psychiatrist, or a combination of these and other healthcare professionals.”*NICE guidance on “Patient experience in adult mental health services”[19](#_bookmark18) advises: *“During the assessment, you should be given enough time to talk about your problems, with time at the end for you to ask questions. If you are given a* [*diagnosis*](https://www.nice.org.uk/guidance/cg136/ifp/chapter/glossary#diagnosis)*, this should be clearly explained and you should be given a booklet or leaflet about it. The healthcare professional should discuss different treatments and give you information about each. You should also be offered time to talk after the assessment, especially if any sensitive issues were discussed. If you are unhappy about the assessment and diagnosis, you should be given time to talk about this and offered a second opinion.”* Lastly, another section of the same NICE guidance[20](#_bookmark19) gives advice on developing a care plan after the assessment *“After your assessment, you may be supported by a community mental health team who will develop a care plan with you. The plan should include:**activities to increase or maintain your social contact, such as education, work, volunteering, caring for family members or leisure activities**what you can do to keep well**how to cope with and reduce any risks to yourself or others”.*In answering the rest of the questions I will refer back to these principles. |
| **Please advise how the Trust in this case assessed the patient and whether the assessments were in accordance with good practice and procedure on:**22 March 2021;On 25/1/21 the patient was referred to mental health by his GP because of depression. The assessment following this referral was done by the CPN on 22/3/21.Here are the CPN’s first and final paragraphs in her report: |

18 https://[www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-assessments/](http://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-assessments/)

19 <https://www.nice.org.uk/guidance/cg136/ifp/chapter/what-should-happen-during-an-assessment-at-mental-health-services>

20 https://[www.nice.org.uk/guidance/cg136/ifp/chapter/What-should-happen-after-I-have-been-assessed](http://www.nice.org.uk/guidance/cg136/ifp/chapter/What-should-happen-after-I-have-been-assessed)

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| “Thank you for the routine referral of the above-named patient who attended the assessment centre with low mood anxiety and TLNWL, TDSH and SI on 22 March 2021.He completed a telephone assessment with the CPN.Summary and recommendations. This is a further presentation of a 57-year-old male with low mood anxiety and TLNWL, TDSH and SI. There is a history of CSA and the patient reports this has significantly impacted his mental state over several years with deterioration in same following court cases. His wife also passed away in recent months which has impacted mood. He presents with emotional dysregulation due to CSA reduced reactivity and reduced motivation. There is a history of self harm via cutting as a coping mechanism . No active, plan or intent was specified and no active risk to self was identified.Following the assessment, I have discussed and agreed the following recommendations with the patient:Self refer to Nexus[21](#_bookmark20). Refer to SHIP.Refer to Action Mental Health.Posted, information on SHIP, Action Mental Health, Nexus, abuse, bereavement, self harm, and anxiety.Points of contact (GP, GPOOH, A and E, lifeline) explained and agreed.”Abbreviations:TLNWL: Thoughts of life not worth living TDSH: Thoughts of deliberate self-harm SI: Suicidal IdeationSHIP: Self-harm Intervention Programme GPOOH: GP Out of Hours serviceCSA: Child Sexual Abuse.I am fairly sure of the above abbreviations, but the CPN would need to confirm.Comment: The assessment conducted by the CPN met all the relevant standards set by the NHS and NICE, as quoted above. No diagnosis was made and no second opinion was offered, probably because the patient appears to have agreed verbally with the plan.**(ii). 5 December 2021**On 9/11/21 the GP made a referral to mental health services because of low mood. On 5/12/21 he was seen by the Mental Health Social Worker who made an assessment and wrote the following: “The patient reports he is still awaiting input from Nexus after being referred by ourselves last March. This will be followed up as Nexus would be the most appropriate service given his history and presentation. There are no risks to warrant any more intensive support. [The patient] did query the effectiveness of his Sertraline and I said I would mention this in our GP letter to see if this could be reviewed.” |

21 https://nexusni.org

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| Comment: Again, the assessment conducted by the Mental Health Social Worker met all the relevant standards set by the NHS and NICE, as quoted above.1. **26 September 2022**; On 7/9/22 the mental health services received an urgent referral of the patient. Subsequent discussion with the GP resulted in agreement that the referral was not urgent and he was seen on 26/9/22 by the Mental Health Social Worker.

Here is the final part of the Mental Health Social Worker’s assessment which wascommunicated to the GP:“Summary and recommendations: this is a further presentation of this 59-year-old man to mental health services reporting a deterioration in mood and increased anxiety. The patient reported history of past CSA, the sudden loss of his wife and recent situational stress in respect to allegations being made against him for benefit fraud. He reported that he has observed increased alcohol misuse reporting drinking both alcohol and Guinness daily. The patient completed the alcohol use disorder’s appendix when he scored 37 out of 40 (Referral to specialist service). On assessment, there are no psychotic symptoms observed but behaviours suggestive of emotional instability, past trauma and increased alcohol misuse. The patient denied any thoughts of deliberate self-harm, but reported chronic thoughts of life, not worth living. He denied any active, suicidal ideation citing his grandchildren as a protective factor* + Management plan discussed with team leader.
	+ Routine referral to the community addictions team and information proved on Dunlewey.
	+ Reinforced waiting for input from Nexus-patient reported that he has submitted referral
	+ Agreeable to engage in Lifeline counselling commencing 27th of September
	+ Agreeable to Matt Thompson, (Patient Advocate) to contact him re benefits advice
	+ He declined referral to AMH for personal development and support reporting too much on
	+ Information provided on recovery college, NI helplines, post-traumatic stress disorder, depression, and low mood
	+ Carers information given
	+ Information provided on CRUSE
	+ Patient was reinforced of increased risks of deliberate self harm with continued alcohol misuse
	+ Patient was agreeable to maintain his own safety: points of contact GP, OOH-GP, ED and Life reinforced.”

Comments: Again, the assessment conducted by the Mental Health Social Worker met all the relevant standards set by the NHS and NICE, as quoted above. Given that a discussion was held with the GP to determine urgency, I believe that downgrading the referral to routine was reasonable.1. **22 November 2022.**

On this occasion, the patient was referred by his GP on 1/11/22 following discharge by the Community Addictions service. He was assessed by a Specialist Psychiatric Registrar. Ireproduce extracts from the SpR’s report:“Impression: no SMI (Advisor note: this usually means severe mental illness). Ongoing trauma features, not diagnostic threshold for PTSD or complex PTSD. However, explained to patient that does not minimise the trauma/abuse experienced (CSA). No immediate |

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| risks identified. There was a six page letter written by his daughter that the patient brought to his appointment with him as she was unable to attend. This has been noted.Plan:1. Aware of crisis contacts.
2. No change in medication is recommended.
3. Consented to referral to AMH – patient was to contact MHAC to up58 in on an NOK contact details as wanted to change from his brother to his daughter. However he has not contacted the MHAC regarding this.
4. Discussed with psychology for ongoing trauma work-accepted for same.
5. Discharge from mental health assessment centre.”

Comment: This assessment fulfils all the standards quoted in the documents cited under question 1, above. It is not clear whether the patient received copies of letters sent to the GP and if so whether he was able to access their contents.**It is clear that the Trust communicated appropriately with the GP.**In addition, his treatment was discussed with psychology and he was accepted for“ongoing trauma work”. It is not clear precisely what this would entail but I believe it would have included trauma therapy and as the Trust notes in their letter to the patient dated 20/9/23 the therapy offered by psychology would have been similar if not identical to the treatment offered to someone with a diagnosis of PTSD. |
| **The patient said the Trust’s assessments in March and December 2021 consisted of two 10-minute telephone calls which did not discuss his historical abuse or consider the impact this had on his mental health. He disputes these assessments were an hour long. Patient fails to see how Trust can say conducted a ‘*thorough*’ assessment.****1a. Can advice be provided on the length of time of these calls – was it enough time?** |
| The length of the call is recorded as 1 hour. However, the content of the report suggest a comprehensive interview which would have taken between 40 and 60 minutes. |
| **1b. Did the assessments in 2021 cover all aspects of the patient’s experiences and life****including historical abuse and impact of this on his mental health?** |
| The details of the abuse were not recorded, but the various ways the CSA impacted his health were recorded in detail. It would be appropriate not to request details of the abuse at the consultation. This is best left for therapy and discussion of these details can be traumatic for patients. |
| **1c. Was support offered after these assessments?** |
| He was advised to contact a number of community services. Support given. |
| **2. Please advise at which stage a Trust carrying out a mental health assessment(s)****should be able to diagnose a patient. Please refer to any relevant guidance to support your response.** |
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| A mental health assessment may result in a patient receiving a diagnosis but this is not necessarily the case. I patient may be suffering undoubted distress, but their symptoms may not satisfy the criteria required for a specific diagnosis. The main diagnostic guides are the DSM-5 and the ICD-11. They are very large documents and cannot be reproduced here. However, as an example, the UK Trauma council has reproduced diagnostic criteria for PTSD under both DSM5 and ICD11 systems[22](#_bookmark21). It can be seen that following a traumatic event a patient may suffer distress which does not fulfil the criteria for any mental illness, or they may develop PTSD or, under ICD11, may develop Complex PTSD. We can see from the SpR’s report of 22/11/22 that although the patient suffered distress, his symptoms did not reach the level that suggested a diagnosis of PTSD or Complex PTSD. In answer to your question, after a psychiatric assessment most psychiatrists would be able to say whether a mental disorder was present or not. In complex cases, for example with personality disorder or autism, a longer assessment and a number of interviews may be required. |
| 1. **Please advise whether the Trust in this case made a diagnosis following each mental health assessment dated below and whether its diagnosis was appropriate and in accordance with good practice and procedure:**
	1. **22 March 2021;**
	2. **5 December 2021;**
	3. **26 September 2022; and**
	4. **22 November 2022.**

I can answer this question covering all these assessments. No psychiatric diagnosis was made in the first three assessments and diagnosis was not discussed. At the last assessment, on 22/11/22, the SpR mentioned diagnosis only to say that the patient’s symptoms did not reach the level of severity required to make a diagnosis of PTSD. This is in line with good practice. A paper in the British Journal of Psychiatry[23](#_bookmark22) describes the importance of diagnosis but also it’s shortcomings.According to the notes made in each of the assessments, the distress suffered bythe patient was acknowledged, and it was also believed that he did not suffer from a diagnosable mental disorder. This is reflective of good practice. |
| **The patient believed the Trust’s assessor in November 2022 was not an appropriate person to provide an accurate diagnosis. The patient said ‘*trauma is not a diagnosis*.’ He said the Trust failed to provide a diagnosis which he requested.****The Trust stated the assessor was a ‘*speciality doctor in psychiatry…a psychiatrist*.’ It****explained the term speciality doctor refers to their grade and not their speciality. 3a. Was the assessor in November 2022 appropriate?** |
| Yes, a Speciality Doctor is a trained psychiatrist under the supervision of a consultant psychiatrist. The NHS document “Employing and supporting specialty doctors: A guide to good practice”[24](#_bookmark23) states “All specialty doctors have appropriate clinical supervision”.It is not clear who, in the Trust, this doctor’s supervising consultant was, however. |
| **3b. Was patient offered a second opinion?** |

22 https://uktraumacouncil.org/trauma/ptsd-and-complex-ptsd?cn-reloaded=1

23 https://[www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/psychiatric-diagnosis-impersonal-imperfect-](http://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/psychiatric-diagnosis-impersonal-imperfect-) and-important/C29813EAC72CCC801F4F17AC96126093

24 https://[www.nhsemployers.org/system/files/2021-06/sas-supporting-spec-doctors-guide-good-practice-290408.pdf](http://www.nhsemployers.org/system/files/2021-06/sas-supporting-spec-doctors-guide-good-practice-290408.pdf)

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| Yes, in June 2023 a second opinion was given. |
| **3c. June reference to Adjustment Disorder – any comment on this assessment and any diagnosis?** |
| Adjustment Disorder is a diagnosis indicating mental symptoms as a result of a stressful event[25](#_bookmark24). It is not an unreasonable diagnosis, but it does not suggest any specific treatment. I do not think that the presence or absence of this diagnosis confers any particular benefit or harm. |
| **4. Please advise how a Trust should communicate mental health assessment outcomes with a patient. Please refer to any relevant guidance to support your response.** |
| After an assessment the assessor should discuss the results of the assessment with the patient and explain and discuss the various treatment options available. This is in accordance with NHS guidance on mental health assessment[26](#_bookmark25). |
| 1. **Please advise how the Trust in this case communicated the assessment outcomes with the patient and whether its actions were in accordance with good practice and procedure following assessments on:**
	1. **22 March 2021;**
	2. **5 December 2021;**
	3. **26 September 2022; and**
	4. **22 November 2022.**
 |
| From the reports written after each assessment, there is evidence that the assessor explained their findings and conclusions and discussed a range of options for support and intervention. This approach accords with accepted good practice. For example, following the telephone assessment on 22/3/21 the assessor wrote to the GP:“Summary and recommendations. This is a further presentation of a 57-year-old male with low mood anxiety and TLNWL, TDSH and SI. There is a history of CSA and [the patient] reports this has significantly impacted his mental state over several years with deterioration in same following court cases. His wife also passed away in recent months which has impacted mood. He presents with emotional dysregulation due to CSA reduced reactivity and reduced motivation. There is a history of self harm via cutting as a coping mechanism . No active, plan or intent was specified and no active risk to self was identified.Following the assessment, I have discussed and agreed the following recommendations with [the patient]:Self refer to Nexus. Refer to ship.Refer to action mental health. |

25 https://[www.psychdb.com/trauma-and-stressors/adjustment](http://www.psychdb.com/trauma-and-stressors/adjustment)

26 https://[www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-assessments/](http://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-assessments/)

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| Posted, information on ship, action, mental, health, Nexus, abuse, bereavement, self harm, and anxiety.Points of contact (GP, GPOOH, A and E, lifeline) explained and agreed.”This assessment and management plan reach levels of competence recommended by NICE (footnotes 2 and 3 on page 4)Equivalent assessment notes and management plans were recorded after each of the assessment interviews. |
| **Treatment** |
| **6. Please advise how a Trust should identify appropriate treatment and referral options following a mental health assessment. Please refer to any relevant guidance to support your response.** |
| Following the assessment and the initial feedback to the patient there should be a discussion covering supports the patient has used, and suggestions from the assessor on what additional support and treatment might be appropriate given the patient’s symptoms. NICE guidance which has already been cited[27](#_bookmark26) gives advice on developing a care plan after the assessment *“After your assessment, you may be supported by a community mental health team who will develop a care plan with you. The plan should include:**activities to increase or maintain your social contact, such as education, work, volunteering, caring for family members or leisure activities**what you can do to keep well**how to cope with and reduce any risks to yourself or others”.* Clearly interventions offered will vary depending on the specific symptoms and circumstances. I will refer to them in subsequent answers to questions. |
| 1. **Please advise whether the Trust in this case identified appropriate treatment and referral options for the patient and whether its actions were in accordance with good practice and procedure to meet the patient’s needs following assessments on:**
	1. **22 March 2021;**
	2. **5 December 2021;**
	3. **26 September 2022; and**
	4. **22 November 2022.**
 |
| I will answer this question in one discussion, referring to the various interventions that were suggested.After the first assessment on 22/3/21 the assessor wrote the following plan:“Following the assessment, I have discussed and agreed the following recommendationswith the patient:Self refer to Nexus. Refer to SHIP.Refer to action mental health. |

27 https://[www.nice.org.uk/guidance/cg136/ifp/chapter/What-should-happen-after-I-have-been-assessed](http://www.nice.org.uk/guidance/cg136/ifp/chapter/What-should-happen-after-I-have-been-assessed)

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| Posted, information on SHIP, action mental health, Nexus, abuse, bereavement, self harm, and anxiety.Points of contact (GP, GPOOH, A and E, lifeline) explained and agreed.” Abbreviations aregiven above (Question 1).After the second assessment on 5/12/21, the assessor wrote:“The patient reports he is still awaiting imput from Nexus after being referred by ourselves last March. This will be followed up as Nexus would be the most appropriate service given his history and presentation. There are no risks to warrant any more intensive support. [The patient] did query the effectiveness of his Sertraline and I said I would mention this in our GP letter to see if this could be reviewed.”After the third assessment on 26/9/22, the assessor wrote:* “Management plan discussed with team leader.
* Routine referral to the community addictions team and information proved on Dunlewey.
* Reinforced waiting for input from Nexus-patient reported that he has submitted referral
* Agreeable to engage in Lifeline counselling commencing 27th of September
* Agreeable to Matt Thompson, (Patient Advocate) to contact him re benefits advice
* He declined referral to AMH for personal development and support reporting too much on
* Information provided on recovery college, NI helplines, post-traumatic stress disorder, depression, and low mood
* Carers information given
* Information provided on CRUSE
* Patient was reinforced of increased risks of deliberate self harm with continued alcohol misuse
* Patient was agreeable to maintain his own safety: points of contact GP, OOH-GP,

ED and Life reinforced.”After the fourth assessment on 22/11/22, the assessor wrote:Plan:1. Aware of crisis contacts.
2. No change in medication is recommended.
3. Consented to referral to AMH – patient was to contact MHAC to update on an NOK contact details as wanted to change from his brother to his daughter. However he has not contacted the MHAC regarding this.
4. Discussed with psychology for ongoing trauma work-accepted for same.
5. Discharge from mental health assessment centre.”

Comment: The patient was referred to a wide variety of sources of support and treatment, including community resources for survivors of sexual abuse, bereavement, alcohol misuse and trauma. The referral for trauma was accepted by the psychology department. In summary the care plans developed met NHS and NICE recommendations for care plans in adult mental health as references above (question 1). |

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| **8. Please advise on the process a Trust should follow to discharge a patient from its mental health services. Please refer to any relevant guidance to support your response.** |
| The process should follow mental health assessment and the development of a care plan. If that care plan does not involve the community mental health team, the patient can be appropriately discharged from that team, and the patient and GP should be informed. |
| 1. **Please advise which process the Trust in this case followed when it discharged the patient from its mental health services and whether its actions were in accordance with good practice and procedure following the assessments on:**
	1. **5 December 2021; and**
	2. **22 November 2022.**
 |
| NICE recommendations on discharge[28](#_bookmark27) are as follows:**“***What happens when my treatment or care comes to an end?**Before treatment ends or your care is transferred to another service, this should be discussed and planned with you and your family or carer (if you agree) and should not happen abruptly. With health and social care professionals, you should agree steps to help you cope with any crises and you should be advised how to contact professionals if needed. If your care is being transferred to another service, you should be offered support during the transfer.**You should be told the date you will be leaving hospital at least 2 days before you go. Before you leave, health and social care professionals will want to check that where you live is safe and comfortable.**You should be given clear information about the support available after you have left mental health services or hospital, and you should be given a number to call any time of the day or night if you have problems.”*At the assessment on 5/12/21 it was confirmed that no services from Adult Mental Health were appropriate for the patient, he had been referred to Nexus and was awaiting an assessment there, and he had questions about his medication which the GP was asked to address. As there was no role for Adult Mental Health he was not offered treatment there. This management seems to me reasonable.At the assessment on 22/11/22 he was also not found to require treatment in the CMHT. He was referred to psychology and accepted by them. The GP was managing his medication. He was therefore discharged from Adult Mental Health and this seems to me reasonable and appropriate. |

28 https://[www.nice.org.uk/guidance/cg136/ifp/chapter/What-happens-when-my-treatment-or-care-comes-to-an-end](http://www.nice.org.uk/guidance/cg136/ifp/chapter/What-happens-when-my-treatment-or-care-comes-to-an-end)

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| It seems to me that the duty of Adult Mental Health was to assess the patient and refer him to appropriate services. These were done, and at that point discharge was appropriate.The GP was informed of the discharge on 22/11/22 by the specialty doctor. “Discharge from mental health assessment centre”. |
| **The patient said the Trust failed to provide an appropriate care plan to meet his needs. He felt ‘*discarded*’ by the Trust’s decision to refer him to an external body, Nexus. He said, prior to his referral, the Trust did not consider whether he met the criteria to receive treatment from Nexus. The patient said the Trust left him without any treatment for more than 18 months (until October 2022).****9a. Did the patient’s discharges meet the NICE criteria to be offered support during****any transfer?** |
| The Trust made useful suggestions on services the patient could access after being discharged. I have given the view below that they could have followed the suggestions up so that the patient was not left without treatment. |
| **9b. Was the patient left without treatment for 18 months? If so, was the Trust responsible for this?** |
| After his first assessment on 22/3/21 he was advised to self refer to Nexus for therapy This is a reasonable piece of advice. However, when he was seen on 26/9/22, he had still not heard from Nexus. I have not seen definite evidence that he did self refer, and his literacy problems may have impacted that.Given this delay, I would think that after making the recommendation in March 2021 it would be the Trust’s responsibility to check that the self-referral had been made and to establish the approximate waiting time. As already noted above, After the second assessment on 5/12/21, the assessor wrote: “The patient reports he is still awaiting imput from Nexus after being referred by ourselves last March. This will be followed up as Nexus would be the most appropriate service given his history and presentation.” I could not find evidence that this proposed follow up was done, although it could have been done by phone and not recorded. |
| **9c. Could patient’s care needs be met outside the Trust? Trust’s consideration given****to this – reasonable and appropriate? Who was treatment plan agreed with?** |
| 22/3/21: the TRUST agreed the following recommendations with the patient:1. self referred to Nexus. This is a non Trust organisation providing therapy for people who have suffered abuse.
2. refer to SHIP: this is the Self Harm Intervention Program in Northern Ireland which is specifically for people who sell home, providing support and counselling.
3. Referred to Action Mental Health. This is an organisation which supports people with mental health problems and Northern Ireland.
4. Points of contact (Gp, Gp00H, A&E, lifeline) explained and agreed. This provides contact for use in mental health emergencies.
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| The Trust therefore identified agencies that provided support in all the NICE recommended categories, Increasing social contact (AMH), keeping well (Nexus, SHIP, AMH), Reducing risks (SHIP, points of contact).The report was sent to the GP. There is no mention of it being sent to the patient. 26/9/22Following that assessment, the plan included the above resources as well as: Community addictions teamPatient advocate for benefits adviceVarious other resources about which he was provided information Carers informationCRUSE (bereavement resource)The Trust continued to recommend agencies that increased social contact, kept him well (and aimed to improve his health) and reduced risks.The report was sent to the GP. There is no mention of it being sent to the patient.22/11/22Following that assessment, the plan included:Awareness of crisis contacts Medication adviceReferral to AMH Psychology referralThe plan at that stage continued to reflect the advice of the NICE guidelines quoted. The report was sent to the GP. There is no mention of it being sent to the patient. |
| **10. Please advise how a Trust should communicate a mental health treatment/ care plan with a patient. Please refer to any relevant guidance to support your response.** |
| The care plan should be discussed with the patient and, if appropriate, their carer. Please see my answer to Question 6. |
| 1. **Please advise how the Trust in this case communicated the treatment/ care plan to the patient following assessments on:**
	1. **22 March 2021;**
	2. **5 December 2021;**
	3. **26 September 2022; and**
	4. **22 November 2022.**
 |
| At each point there is documentary evidence that the care plans were discussed with the patient and that he agreed with them. |
| **12. Would you have advice or comment on the mental health care pathway regarding this case?** |

|  |
| --- |
| In general, the assessments provided and interventions recommended were in accordance with NICE guidance (references 1, 2 and 3 in my report) and with the Mental Health Care Pathway for N Ireland[29](#_bookmark28). It is not clear whether the care plans and advice were given to the patient in a written form and although this is not explicitly recommended, it is clear that both NICE and the MHCPNI recommend sharing of advice and information.Hence if the information was not shared (eg by copying correspondence for the GP to the patient) then that would be a recommendation I would endorse. It seems that the Trust was aware that the patient had literacy difficulties. In the assessment letter of 22/3/21 the assessor writes:“He reports the death of his wife in November 2020, and has also impacted mood as she would have been the only person he spoke with regarding CSA, and she would have helped him with activities involving reading and writing.”Knowing this, the Trust should have provided information in a way that was intelligible to the patient, either through a recording or by involving a relative such as his daughter. I did not find any evidence that this was done. |
| **Overall** |
| **13. Please provide any other advice you consider relevant not covered by the foregoing questions.** |
| None |
| **14. Have you identified any failings in the Trust’s actions? If so, what impact (if****any) did this have on the patient?** |
| Given the finding that although the Trust knew about the patient’s literacy problems, but may not have provided copies of his care plan to him and his relatives, and failed to check that the recommendation made (eg to Nexus) had been carried out and was being made available within a reasonable time I suggest that this could represent a failing which left the patient without adequate care for at least 16 months, during which time he continued to suffer distressing symptoms including self-harm. It is difficult to judge the impact of this delay on the patient, because his symptoms had been long standing especially since his wife’s death, but I would judge the impact to have been substantial in terms of distress and psychological symptoms. |
| **15. Have you identified any learning/ service improvements? If so, please elaborate on your response.** |
| None |
| **Conclusions:**The patient suffered from some very distressing symptoms related to abuse, alcohol and bereavement. He was referred to a number of community facilities which were relevant for the support and management of these problems. However, failed to ensure these referrals were realised within a reasonable time. |

29 <https://www.northerntrust.hscni.net/wp-content/uploads/2017/07/Regional-mental-health-care-pathway-1.pdf>

|  |
| --- |
| **Date:**1/8/24**Additional Advice:** 23/8/24 |
| **Name & Signature: XX XX XXXXXX** |

## Appendix 3

**Relevant extracts of guidance**

NICE Clinical Guidance on Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services,

Published 14 December 2011, Endorsed in Northern Ireland February 2012 (NICE CG136)

## Assessment

…1.3.2 before assessment begins, the health or social care professional undertaking the assessment should ensure that [the patient] understands:

* + - the process of assessment and how long the appointment will last
		- that the assessment will cover all aspects of their experiences and life…

…1.3.3 When carrying out an assessment:

* + - ensure there is enough time for the [patient] to describe and discuss their problems
		- give information about different treatment options, including drug and psychological treatments, and their side effects, to promote discussion and shared understanding
		- offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed….

…1.3.4 If a [patient] is unhappy about the assessment and diagnosis, give them time to discuss this and offer them the opportunity for a second opinion.

## Community Care

…1.4.2 Develop care plans jointly with the [patient], and:

* + - include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants
		- provide support to help the service user realise the plan
		- give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it.

…1.4.3 Support [patients] to develop strategies, including risk- and self- management plans, to promote and maintain independence and self-efficacy, wherever possible. Incorporate these strategies into the care plan.

## 1.7 Discharge and Transfer of Care

…1.7.1 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people using mental health services. Ensure that:

* such changes, especially discharge, are discussed and planned carefully beforehand with the service user and are structured and phased
* the care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis
* when referring a [patient] for an assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

…1.7.2 Agree discharge plans with the service user and include contingency plans in the event of problems arising after discharge. Ensure that a 24-hour helpline is available to service users so that they can discuss any problems arising after discharge.

…1.7.4 Give service users clear information about all possible support options available to them after discharge or transfer of care.

NHS Mental Health Assessments, Last Reviewed 17 February 2022 (NHS MH Assessment)

A mental health assessment is a conversation between you and mental health professionals to help decide what kind of support you need.

You'll need to have a mental health assessment when you go to any mental health service for help.

Information:

A mental health assessment is not a test or an exam. It is about helping you. You only have to talk about what you want to talk about. The more open and honest you are, the easier it will be to get you the right help.

## What happens during a mental health assessment?

When you have a mental health assessment, you might talk to a nurse, social worker, psychologist, specialist pharmacist, psychiatrist, or a combination of these and other healthcare professionals.

UK Trauma Council Definitions, PTSD

Post-traumatic stress disorder (PTSD) and Complex PTSD

PTSD is the diagnostic label used to describe a particular profile of symptoms that people sometimes develop after experiencing or witnessing a potentially traumatic event or events.

PTSD does not describe the full range of reactions to traumatic events; there will be many children and young people who are ‘traumatised’ by events, but their particular difficulties will not fulfil the criteria for PTSD.

What is a diagnosis?

A diagnosis is a formal label that describes a certain set of problems or symptoms. Official diagnostic criteria describe which symptoms are necessary for any particular diagnosis. A diagnosis should help the person experiencing symptoms and should always be used in the context of a wider understanding of the person’s needs, challenges and strengths when developing care plans. In mental health, diagnoses often describe a group of shared thoughts, behaviours and symptoms. Identifying these groupings helps professionals communicate effectively and, more importantly, supports research to identify what works to help people experiencing difficulties.

In some cases, a person’s particular profile of difficulties may not meet the threshold for a diagnosis, but they can still be very distressing and warrant treatment.

There are two similar but not identical, recognised sets of diagnostic criteria for mental health problems:

* The International Classification of Diseases – 11th Revision (ICD-11) produced by the World Health Organisation (WHO)[[1]](https://icd.who.int/en).
* The Diagnostic and Statistical Manual – 5th Edition (DSM-5) produced by the American Psychiatric Association (APA)[[2]](https://www.psychiatry.org/psychiatrists/practice/dsm).

People find different kinds of meaning in diagnosis. For some people it helps them explain or make sense of the experiences they have had and the impact it has had on their lives. For others it may feel stigmatising, reductive, meaningless or result in them feeling like they are being treated as a set of symptoms rather than a person.

What is post-traumatic stress disorder (PTSD)?

PTSD was first officially defined in 1980 when the APA published the 3rd edition of its diagnostic classification system the DSM-III. The actual criteria have changed a bit over time.

According to the DSM-5, in order to fulfil the criteria for a diagnosis of PTSD, the person must have experienced or witnessed a traumatic event that involved “actual or threatened death, serious injury, or sexual violence”. Whereas according to the ICD-11, the event or events must have been “extremely threatening or horrific”.

It is worth noting here that there are events that might not meet these particular criteria, but which may nevertheless be traumatic for the child or young person and may lead to the symptoms of PTSD described below, or to other significant mental health difficulties.

There are three groups of symptoms that are common to both the ICD-11 and the DSM-5 criteria. These are sometimes considered to be the core symptoms of PTSD:

* Intrusions or re-experiencing of the event (such as intrusive memories, repetitive play in which the events or aspects of it are expressed, nightmares, flashbacks, distress triggered by reminders of the event or events).
* Avoidance (such as avoiding thoughts, feelings or memories of the event or events, or avoiding people, places, conversations or situations that are associated with the event or the events).
* Arousal and reactivity or sense of current threat (such as irritability, being overly vigilant, being easily startled, concentration problems, sleep problems).

The DSM-5 has taken a much broader approach and lists many more symptoms from each of the three groups above as well as including an additional set of symptoms related to changes in thoughts and feelings, such as:

* Exaggerated negative beliefs about themselves, the world or other people;
* Having distorted thoughts about what caused the event or events and the consequences;
* Persistent negative emotions;
* Less interest in significant events;
* Feeling detached or estranged from others and finding it impossible to experience positive emotions.

This broader array of symptoms increases the overlap with other mental health difficulties but allows for a wider range of symptom profiles to be classified as PTSD. Whereas the ICD-11 has taken a more restricted approach and focused on just two symptoms from each of the three core groups above. This may make assessment more straight-forward but may also lead to some children and young people who have less-common patterns of symptoms not receiving a diagnosis of PTSD [[3]](https://doi.org/10.1002/jts.21840).



Although the ICD-11 does not have the 4th group of symptoms related to changes in thoughts and feelings, it does have a separate diagnosis called Complex PTSD which is described in more detail below.

It is common for people to experience symptoms of PTSD in the days and weeks following a potentially traumatic event. But many of them will spontaneously recover, therefore PTSD cannot be diagnosed unless symptoms have persisted for a month (DSM-5), or several weeks (ICD-11).

Because the ICD-11 and DSM-5 are not the same, there will be some children and young people whose difficulties will fulfil one set of criteria but not the other. For example, several studies have found that following particular events, of those children and young people that have PTSD according to either the ICD-11 or the DSM-5, fewer than half fulfil both sets of criteria [[4]](https://doi.org/10.1111/jcpp.12631), [[5]](https://doi.org/10.1007/s00787-017-1032-9). This means that whether or not they can be diagnosed with PTSD depends on which set of criteria is being used.

Not all children who experience potentially traumatic events will develop PTSD. Research has found that between 5% and 67% of children and young people exposed to a potentially traumatic event actually develop PTSD; and that it is more likely if they have been exposed to interpersonal events (such as assault or abuse) rather than non-interpersonal ones (such as accidents or natural disasters) [[6]](https://doi.org/10.1192/bjp.bp.113.131227). All of the following factors make it more likely that a child or young person will develop PTSD [[7]](https://doi.org/10.1016/j.cpr.2011.12.001):

* Thinking that they were going to die during the event
* Psychological difficulties before the traumatic events
* Stressful life events before the traumatic events
* Family difficulties after the events
* The carers having mental health problems after the events
* Lack of social support and social isolation after the events

We also know that children and young people from ethnic minorities are more likely to develop PTSD following a potentially traumatic event; however the reasons for this increased vulnerability are likely to be complex and require future systematic investigation.

What is Complex PTSD?

It has long been recognised that the reactions of some people following traumatic events extend beyond previous definitions of PTSD [[8]](https://doi.org/10.1002/jts.2490050305). The DSM- 5 took this into account with their wide approach as mentioned above. In contrast, the approach taken by ICD-11 was to formally define a new diagnosis of Complex PTSD. According to the ICD-11, Complex PTSD consists of the same core symptoms of (ICD-11) PTSD, but has three additional groups of symptoms (which are sometimes referred to as ‘disturbances in self-organisation’ or ‘DSO’):

* Problems in affect regulation (such as marked irritability or anger, feeling emotionally numb)
* Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event
* Difficulties in sustaining relationships and in feeling close to others

Research has indicated that the diagnosis of Complex PTSD can apply to children and young people. In one study, of those taking part in a treatment trial for PTSD, 40% of them had high levels of the additional symptoms required for Complex PTSD [[9]](https://doi.org/10.1111/jcpp.12640).

What helps with PTSD and Complex PTSD?

There are two particular interventions that are generally recommended if a child or young person has a diagnosis of PTSD [[10]](https://www.nice.org.uk/guidance/ng116): Trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). Research has consistently found that these are effective for PTSD in children and young people.

However that does not mean that they will work for all children with PTSD and some research indicates that other approaches might also be effective [[11]](https://doi.org/10.1111/jcpp.13094).

There is much less research evidence about what interventions are effective for Complex PTSD, however there is emerging evidence that what works for PTSD is likely to be effective for Complex PTSD [[9]](https://acamh.onlinelibrary.wiley.com/doi/abs/10.1111/jcpp.12640), but it may require more sessions and more focus on developing a trusting relationship [[10]](https://www.nice.org.uk/guidance/ng116).

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## Appendix 4

**Relevant extracts of policies**

Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services, As revised May 2010 (Assessment and Management Guidance)

## 1.2 Purpose



**4.2 Care Planning and Risk Assessment**



The Trust’s Procedure Regarding Individual Discharge Following Assessment by MHAC (MH/AC/P10), Publication Date June 2022





**Appendix 5**

**Relevant extracts of records regarding Trust’s assessment on**

1. **22 March 2021**
	1. Referral from GP to MHAC, 22 January 2021

Urgency: ROUTINE.

Reason for Referral / History or Presenting Complaint: Depression / Grief.

I would appreciate your review of the above patient suffering from persistent period of depressed mood since his wife’s death last year.

Totally empty since death of wife. Helpless, hopeless, mood has plummeted and no enjoyment in life. Feelings of despair over recent days and TLNWL. Depended on wife for help with reading/writing and activities of daily living.

Now lost and reliant on daughters for financial help etc – feelings of guilt, low self esteem and self worth. Repeated TLNWL and TOSH. Daughters have removed tablets from home. Denies any specific planning but unable to provide assurances or protective factors.

Losing day/night routine, spending long periods alone, tearful. Hx sexual abuse aged 12 – had confided in wife and able to manage this over the years. Now feels alone, no one else to share this with and recurrent flashbacks. Contacted Nexus but long waiting list.

Has been seen regularly in practice and attempts to commence [?] have been unsuccessful.

He was referred to CMHT but this was passed to wellbeing hub.

I feel this patient needs your assessment and would appreciate if you could review.

Risk Issues:

Suicidal Ideation: Yes, Suicidal Intent/Plan: Don’t know…Lives Alone: Yes, Vulnerable Adult: Yes, H/O Self harm: No, Any other Risk Involved: Don’t know.

* 1. Trust Triage Practitioner Screening and Outcome Form, MH/AC/F02, 25 January 2021

## Reason for referral (as per referral form):

Deterioration in mood; Persistent low mood; Non-active TLNWL.

## Additional Risks for Consideration:

Social Crisis – bereavement / trauma.

**Referral Requests**: Assessment; Request for therapy.

**Triage Urgency Outcome**: Routine

**Venue for Assessment**: MHAC tel.assess.

**Triage Outcome**: Accepted.

## Contacts Made:

**Rationale**: Accepted for routine assess- no active risk.

* 1. Letter from MHAC to GP, 25 January 2021

…After screening the referral, it would appear that the Wellbeing Hub would be the most appropriate service. I am therefore forwarding this referral to the Hub…

* 1. Letter from Trust Wellbeing Hub to patient, 26 January 2021

…if you are interested in using this service, please telephone…If I do not hear from you by 9 February 2021, I will close the case and update your GP. However, if needed, you can be re-referred by your GP at any point in the future…

* 1. Letter from MHAC to patient, 27 January 2021

I wish to offer you an appointment for a telephone assessment at out clinic as requested by your GP. At this appointment you will be assessed by a member of our Community Mental Health Team. Could you please contact the assessment centre before 10 February…to confirm you wish to have an appointment arranged for you.

* 1. Letter from MHAC to patient, 8 February 2021

I would like to offer you an appointment for a Telephone Assessment at the [MHAC on] Monday 22 March 2021 @ 9.30am.

You will be telephoned within half an hour of the appointment on the date and time above. We will telephone you the day before the appointment to confirm availability. Please allow 1 hour 30 mins for the appointment and ensure that you are in a space where you can freely discuss personal and confidential information…

* 1. MHAC’s Initial Mental Health Assessment Form F03, 22 March 2021

“Family Focus” approach to be maintained throughout completion of Assessment – with reference to Guidance Documentation.

Time of Assessment: 09:45 to 10:45am. Communication Issues: Can’t read / write.

Presenting Difficulties: Death of wife impacted mood since November 2020. From Catholic Church / Schools CSA age 12 – reported in 2014…significant impact however, was able to live well with support of wife.

Lost job – mood worsened.

Psychiatric History: Wellbeing Hub rejected. [?] – CMHT?

Nexus – waiting list.

Family History of Mental Illness: No family hx/suicide/self-harm/addictions. Previous and Current Treatment: …Sertraline 150mg (recently increased)… **Mental State Assessment**

Appearance and Behaviour: Telephone. Good rapport. Reduced reactivity. Improved when talking about [?].

Speech / Thought Form:

Mood: ….

Formulation/Summary:

Further presentation of 57 year old male presents with low mood, anxiety and TLNWL, TOSH and SI. Hx of CSA and reports how significantly impacted mental state over several years with deterioration in same following court case. Recent bereavement of wife. Presents with emotional dysregulation, reduced reactivity and reduced motivation. Hx of self-harm via cutting as a coping

mechanism. No active risk to self identified. No active plan or intent. No safeguarding concerns identified. Cites grandson as protective factor.

Action/Management Plan:

* Self refer to Nexus.
* Refer to SHIP + leaflet.
* Refer to Action Mental health + leaflet
* Identifies CSA as more significant at present than bereavement of wife.
* Info on abuse, bereavement, self-harm, anxiety.

Record of Information Given to Service User and Carer:

Points of contact (GP, GPOOH, A&E, Lifeline) explained + agreed. Expected waiting time for service: [BLANK]

* 1. Closure/Transfer Form Community Mental Health Team MH/CO7, 22 March 2021

Relevant Events: Assessment completed…

* 1. Letter from MHAC to GP, 22 March 2021 Summary and Recommendations:

Further presentation of 57 year old male presents with low mood, anxiety and TLNWL, TDSH and SI. Hx of CSA and [patient] reports how this has significantly impacted his mental state over several years with deterioration in same following court case. His wife also passed away in recent months which has impacted mood. He presents with emotional dysregulation due to CSA, reduced reactivity and reduced motivation. There is a history of self-harm via cutting as a coping mechanism. No active plan or intent was specified and no active risk to self was identified. He cites his 3 year old grandson as a protective factor…

Following the assessment, I have discussed and agreed the following recommendations with [the patient]:

* + - Self-refer to Nexus.
		- Refer to SHIP.
		- Refer to Action Mental Health (AMH).
		- Posted information on SHIP, AMH, Nexus, abuse, bereavement, self-harm and anxiety.
		- Points of contact (GP, GPOOH, A&E, Lifeline) explained and agreed.
	1. Letter from Trust Wellbeing Hub to GP, 3 June 2021

…your patient has failed to make contact with the Wellbeing Hub to arrange an appointment after several attempts to make contact. I will therefore close this case, however, please do not hesitate to make a re-referral if required…

## Appendix 5

1. **5 December 2021**
	1. GP Referral to MHAC, 9 November 2021

Urgency: ROUTINE

Reason for referral / History of presenting complaint: Low Mood.

[Patient] reports a history of low mood but he hasn’t sought support before. He was a victim of childhood abuse and court trials over recent years have been very tough. His wife died unexpectedly last year. He also has chronic back pain and is awaiting pain clinic. He lives alone but has good support from his daughters. He has TLNWL but denies TSH/SI. He feels he would like to seek some support from CMHT addressing mood issues.

Risk Issues….

* 1. Trust Triage Practitioner Screening and Outcome Form, MH/AC/F02, 9 October 2021

## Reason for referral (as per referral form):

Persistent low mood; Non-active TLNWL.

## Additional Risks for Consideration:

Other – CSA (court proceedings)

**Referral Requests**: Assessment; Re-assessment (brief); Request for therapy.

**Triage Urgency Outcome**: Routine. **Venue for Assessment**: MHAC tel.assess. **Triage Outcome**: Accepted.

## Contacts Made:

**Rationale**: Accepted for routine telephone assessment – hx trauma persistent low mood/ TLNWL – no active risk.

? Has he engaged with previous management plan??

* 1. MHAC Brief Re-Assessment/Update, 5 December 2021 Telephone assessment.

Time of assessment: 9am to 10am.

Current presentation/Changes since last Assessment: [Patient] feels there has been no major changes to his situation since his last assessment in March. His social…

Current treatment plan: [Patient] is compliant with his Sertraline and feels a small benefit from this. He attended his recent SHIP counselling in full. He continues to await Nexus counselling, as well as the pain clinic in respect of his back pain.

## Mental State Assessment

Appearance and Behaviour: Unable to fully assess [the patient] in this respect due to a telephone assessment, however he tells me there is often friction with this daughters due to extensive prompting he needs to attend to his personal care. He rarely leaves the house, due to a combination of back pain and low mood.

Mood/Affect: Feels his mood is consistently 2-3/10 with 10 being best. He engaged well in assessment but did sound low in terms of his interactions and view on his situation.

Insight: Fair insight. Aware his mood is low and why it is low. Less able to identify or motivate self to make improvements to his lifestyle.

Formulation/Summary:

Further presentation…

Action/Management Plan:

* GP to review mental health medication, GP letter sent to this effect.
* [Patient] to chase up on his Nexus self-referral.

Estimated waiting time for onward referral allocation: [BLANK]

Risk assessment update and management plan discussed and agreed with service user & carer.

Verbally agreed. 5 December 2021.

* 1. Trust MH/C07 Closure/Transfer Form CMHT, 5 December 2021 Relevant Events/Changes: [Patient’s] mood remains chronically low, with

extensive rumination on CSA he suffered as a child. He denies any plan or intent to end his life. He does superficially cut, reports this is a form or release and is infrequent.

Summary of Work Done: Brief re-assessment completed. Aims Not Achieved: None.

Reason for Closure/Transfer: No further MHAC role. Client informed of Closure: Yes.

Agreeable to Closure: Yes.

Agency/Worker Client Referred to: To await Nexus.

* 1. Trust Contact and Clinical Notes Report, 5 December 2021(10:27:07)

Brief re-assessment completed. No change identified to active risk. [Patient] declined consent to contact relatives and there were no risks to overrule this….He engaged with SHIP and will follow up on his Nexus self-referral. I agreed to also contact Nexus due to [patient’s] limited reading/ writing ability.

* 1. MHAC Letter to GP, 5 December 2021

Thank you for the routine referral of the above named patient, who engaged in a telephone assessment on 5 December 2021…

…This was a brief re-assessment as he was previously assessed in March of this year.

…He had completed a counselling course through SHIP since his last assessment to some benefit, his self-harm has reduced.

Summary and recommendations: [Patient] reports he is still awaiting input from Nexus after being referred by ourselves last March, this will be followed up as Nexus would be the most appropriate service given his history and presentation. There were no risks to warrant any more intensive supports. [The patient] did query the effectiveness of his Sertraline, and I said I would mention this to in our GP letter to see if this could be reviewed. Please be aware that all medication monitoring remains the responsibility of the GP.

## Appendix 5

1. **26 September 2022**
	1. GP Referral to MHAC, 6 September 2022

URGENT

Reason for referral / History of presenting complaint: Assessment and support. Situational crisis superimposed on low mood/past events.

[Patient] requests psychiatric assessment. Long history of low mood. Previously assessed March 2021 with acute deterioration following death of his wife. Assessed again December 2021. History of childhood abuse and chronic back pain. Awaiting counselling with NEXUS and I have also directed him towards LIFELINE. Recent increase in stress after benefits cancelled following investigation by benefit agency. History of DSH by cutting legs to relieve stress. Patient would like to be given a specific diagnosis and wants FTF appointment rather than remote. Also requests access to social worker.

* 1. Trust Triage Practitioner Screening and Outcome Form, 7 September 2022 -

## Reason for referral (as per referral form):

History of Self Harm, Deterioration in mood; Non-active TLNWL; Anxiety/panic/agitation.

## Additional Risks for Consideration:

Social Crisis.

**Referral Requests**: Re-assessment. **Triage Urgency Outcome**: Urgent. **Venue for Assessment**: MHAC. **Triage Outcome**: To be discussed. **Contacts Made**: GP

**Rationale**: Urgent – TBD not urgent. H/O self harm, mood…

* 1. Trust Contact and Clinical Notes Report, 7 September 2022

(12:34:30) Urgent to MHAC – triaged and accepted…no active risks, and current referral seems caused by benefits investigation. As per triage guidance, urgency to be discussed. Call to GP, 12:37, GP to call back. (12:46:40) Call from [patient’s GP] – he advised he was happy to downgrade to routine. I agreed, if responds will offer 6 weeks…No active intent or plan currently, and TLNWL. 1st letter to be sent.

* 1. Communication Sheet, Patient telephone complaint, 15 September 2022

Ref by Dr to MH team…Went back to Dr – said he’d been discharged. Rings up his Dr – being rereferred as wants diagnosis….

* Supposed to getting treatment due to start counselling with Nexus.
* PMStress or complex: repeated as horrific abuse.

[Patient] waiting for call back from Manager – who is on annual leave. [MHAC] did assessment over phone.

Taking to Ombudsman if not resolved wasn’t told he was discharged doesn’t understand why…

* 1. Trust Record of Complaint Form, Ref: 20551-COM, 15 September 2022

Summary Details of Complaint

[The patient] advised that he was referred by his GP to the [MHAC].

He received a telephone call from a team member…There was no further information provided so [the patient] went back to his GP to be told that he had been discharged from [MHAC].

[The patient] advised that no diagnosis had been given and he had not had any information about discharge provided to him by [MHAC].

[The patient’s] GP has had to request a second (emergency) referral, which has been set for 25 September 2022….

[The patient] does not understand why he was discharged and not even informed that he was being discharged and wishes to make a formal complaint.

* 1. Trust Contact and Clinical Notes Report, 20 September 2022 (11:15:00) Retrospective entry 20/09/22…note altered to highlight initial

agreement of being offered within 6 weeks (or 6-7 weeks from initial date of referral) of when responds (from response date) as unclear on initial note (made 20/09/22). This offer of 6 weeks was done to offer patient timely assessment in good faith rather than any specific concerns or risks.

(12:26:49) Call from [patient]….States GP made emergency referral two weeks ago . I discussed it was not an emergency rather an urgent that was agreed with GP for routine follow up…

(16:16:10) [Patient called]…requested an earlier appointment, stated he had not realised the appointment was not until October and feels ‘desperate' and in need of an earlier appointment. Appointment agreed verbally for Monday 26 September at 09:30. Points of contact reinforced…

* 1. Re-assessment Review, 26 September 2022 Location of Assessment: MHAC

Start time: 09.30hrs End time: 11.00hrs…

Current Presentation/ Changes since last Assessment Dec 2021. Loss of wife. Sudden. 50

Still waiting for NEXUS Hx CSA. 2 [?] Deterioration in mood.

Benefits stopped. Applied for PIPs….



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| --- |
| ACTION/ MANAGEMENT PLAN |
| Routine to CAT = Info [?] Continue to engage with LifelineReferred to AMH to support. Declined (too much on)Carers information/ CRUSE Agreeable for…Patient Advocate citedInformation. Anxiety. Depression Low mood. Post Traumatic Stress Disorder.Continue with NEXUS.Recovery College + NI Lifeline provided.**Estimated waiting time for onward referral alloc** |

Risk Assessment Update and Management Plan discussed and agreed with Service User & carer

**ation**



* 1. Trust Contact and Clinical Notes Report, 28 September 2022 (14:22:59)

MHAC paperwork checked for audit all in order, and had been discussed with me at time, case closed to MHAC.

* 1. Letter from MHAC to GP, 26 September 2022

Thank you for your urgent referral…[the patient] attended [MHAC] with [his brother] on 26 September 2022. He was seen by [a social worker]… Summary and recommendations:

This is a further presentation of this [patient]…reporting a deterioration in mood and increased anxiety. [The patient] reported a history of past CSA, the sudden loss of his wife and recent situational stress in respect of allegations being made against him of benefit fraud...On assessment there were nil

psychotic symptoms observed but behaviours suggestive of emotional instability, past trauma and increased alcohol misuse. [The patient] denied any thoughts of deliberate self-harm but reported chronic thoughts of life not worth living. He denied any active suicidal ideation citing his grandchildren as a protective factor.

* Management plan discussed with Team Leader….
* Reinforced waiting for input from Nexus – [patient] reported that he has submitted referral.
* Agreeable to engage in Lifeline counselling commencing 27 September…
* He declined referral to AMH: for personal development and support – reporting (too much on).
* Information provided on: Recovery College, NI Helplines, Post Traumatic Stress Disorder, Depression and Low mood.
	1. Trust Complaints Investigation Overview Report, Undated Investigation Details/ Analysis/ Findings…

…Within the complaint received on 15 September 2022, [the patient] reported he had to seek an emergency referral from his GP due to not being aware of his discharge…The referral received on 7 September 2022 was an urgent referral. Upon triaging this, the referral was discussed with the GP as it was felt this did not meet the criteria for an urgent assessment based on the MHAC Triage Guidance document, with no active suicidal plan or intent and reported longstanding TLNWL….On discussion with the GP via phone…on 7 September [2022], the referral was downgraded to routine and agreed MHAC would see the patient within 6 weeks if he responded to the first letter sent in line with MHAC procedures…The GP was agreeable that there no concerns regarding active risks…

…On 26 September 2022, [the patient] attended for the mental health assessment and this was completed by Mental Health Social Worker…and the documentation from this…evidenced…[the patient] provided his written signature that he was agreeable to the offered management plan….

…the outcome of the above assessment was as detailed: a referral to the Community Addictions Team; It was reinforced he was to continue to await Nexus; [patient] was to engage in pre-arranged counselling with Lifeline on 27 September; a consultation with the Patient Advocate was arranged for benefits advice; A referral to Action Mental Health for personal development and support was declined; Self-help information was provided along with information on Cruise Bereavement Counselling and a safety plan was agreed. [The patient]…was also given a copy of the agreed management plan.

…On 28 September 2022, the assessment paperwork was all audited and the Team Leader was agreeable with the outcomes and management plan was appropriate.

## Appendix 5

1. **22 November 2022**
	1. GP Referral to MHAC, 1 November 2022

Urgency: URGENT

Reason for Referral/History of presenting complaint: ?PTSD

The patient was referred and seen urgently in September…He was referred to addictions and seen as per attached letter. He has been discharged with a request to rerefer for assessment and psychological therapy for ?PTSD. This diagnosis has not been formally made…

[Letter from addictions]…Patient would like to be given a specific diagnosis and wants FTF appointment rather than remote. Also requests access to social worker.

* 1. Trust Triage Practitioner Screening and Outcome Form, 2 November 2022

## Reason for referral (as per referral form):

History of Self Harm – cutting; Addictions – alcohol; Deterioration in mood; PTSD Query.

## Additional Risks for Consideration:

Anger/ Aggression; Other – previous [?] Hx CSA. 2 Staff – ONGOING COMPLAINT.

**Referral Requests**: Assessment. **Triage Urgency Outcome**: Urgent. **Venue for Assessment**: MHAC. FTF.

**Triage Outcome**: Accepted – on discussion urgency.

## Contacts Made:

**Rationale**: Urgent referral. ?PTSD. Chronic TLNWL &SI. No active risks identified. Due to ongoing complaint to be seen by 2 staff. Discuss urgency.

* 1. Trust Contact and Clinical Notes Report, 2 November 2022

(09:54:01) Urgent referral, ?PTSD. Chronic TLWNL and SI. No active risks identified. Discuss urgency with GP/ discuss with spec doctor. To be seen by 2 staff due to ongoing complaint.

(10:21:41) On discussion with TL and CSM, [patient] to be reviewed by [speciality doctor], query diagnosis of PTSD. [Doc] aware of same. Still to be seen by 2 staff.

(11:54:45) Return t/c from [GP], advised that [patient] is not suitable for psychology if still misusing alcohol and that on discussion with TL that [patient] was going to be seen to spec doctor….[GP] advised that [patient] wants a diagnosis of PTSD and he has been insisting he cannot read and write and can’t leave the house. …[GP] was agreeable with referral being downgraded to 4-6 weeks.

* 1. Letter from MHAC to patient, 2 November 2022

I would like to offer you an appointment at [the SDP’s] Clinic [on] 22 November 2022 at 09.30hrs. Your appointment will last approximately 2 hours…

* 1. Trust Contact and Clinical Notes Report, 5 December 2022 (10:09:15) – [Speciality Doc]

FTF 22.11.22 [] as second member of staff. Imp No SMI, adjustments reaction following wife’s death, ongoing trauma features not diagnostic threshold for PTSD however explained to patient that does not minimise the trauma/ abuse he suffered (BG CSA), no immediate risks identified. Plan aware of crisis contacts, no change in medications – although patient not asymptomatic find mirtazapine somewhat helpful with sleep, consented to referral to AMH (previous referral completed….discuss with psychology regarding ongoing trauma work given completion of SHIP, Nexus and now abstinent from alcohol, discharge MHAC. Discussed with Dr Latimer 5.12.22 agreeable for referral to psychology for ongoing trauma work re CSA, unresolved with NEXUS…

* 1. Letter from MHAC to GP, 21 January 2023

**Clinic**: 22 November 2022, **Typed**: 5 December 2022.

I had a face to face review new patient appointment…he attended with his friend…

…he was referred urgently by your practice on 2 November 2022 query PTSD, reporting ongoing symptoms despite Nexus involvement, low mood with suicidal ideation no identified plan. Patient keen for diagnosis and social worker input….

**Mental State Examination**: …[patient] keen to engage with psychology and keen to return to baseline like he was when [his wife] was alive. He consented to the below management plan…

**Impression:** …Ongoing trauma features not diagnostic threshold for PTSD or complex PTSD, however explained to patient that does not minimise the trauma/abuse he experienced (CSA). No immediate risks identified. There was a 6 page letter written by [patient’s daughter]…this has been noted.

## Plan:

1. Aware of crisis contacts.
2. No change of medications recommended.
3. Consented to referral to AMH…
4. Discussed with psychology for ongoing trauma work – accepted for same.
5. Discharge from MHAC. Speciality Doctor in Psychiatry
	1. Trust Complaints Investigation Overview Report, Undated Investigation Details/ Analysis/ Findings…

…On 2 November 2022, a further urgent referral was received from the GP…Considering the procedures, if there are two urgent presentations within a six-month period and given the nature of the referral and having already been through MHAC, a medical review was deemed appropriate with the Speciality Doctor. It was agreed the urgency would be discussed due to the longstanding nature of the issues…the GP was contacted and a 4-6 week review with the Speciality Doctor was agreed.

…On 22 November 2022, [the patient] was seen by the Speciality Doctor in Psychiatry within the Mental Health Assessment Centre…Following [the] assessment, the Speciality Doctor…advised of the outcome and that [the patient] had raised no complaints or objections on assessment to the management plan. Furthermore, following the assessment and further complaints, the notes from the assessment…were reviewed and the management plan was considered appropriate for the presentation and there was evidence of an agreement and consent within the management plan…A referral was also completed to Action Mental Health for further support and a referral to psychology for further trauma therapy was accepted (on discussion with the Dr…Consultant Clinical Psychologist) and he was discharged from the [MHAC].

On 1 February 2023, [the patient] contacted [MHAC] and spoke to the Team Leader. He reported numerous times that he was not seen by a Psychiatrist and it was a Speciality Doctor. Despite numerous attempted to advice [the patient] [the Speciality Doctor] was a psychiatrist, he continued to disagree…He also questioned the waiting list for [the referral]…[he was] provided with a number for the secretary of [the psychology] service.