

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

**GUIDANCE TO SUPPORT ACTIVE ENGAGEMENT INCLUDING DID NOT ATTEND
(DNA) GUIDELINE (DISENGAGEMENT GUIDELINE)**

(INCLUDES NON-CONCORDANCE WITH TREATMENT)

(supporting CLP30 CPA POLICY)

Assurance statement

This clinical guideline sets out the process to follow for the management of service users who have been referred to or accepted into mental health community services in Essex, who start to disengagement with services or who are non-concordant with their treatment plans.

**The Director responsible for monitoring and reviewing this guidance is
Director of Nursing**

Learning points:

- If a services user does not attend an appointment the referral is not automatically closed without a review of care and treatment including history of non-engagement. Consider use of alternative venues for carrying out the assessment to support the person to engage, e.g. GP Surgery. In the case of new referrals the referrer should be involved in review and decision of next step.
- Using drugs and alcohol is not a reason for discharge.
- If a service user DNAs it can be an indicator of increased risk.
- Lack of appropriate follow up when a service user does not attend as appointment has been identified as a contributory factor in Serious Incident investigations, Domestic Homicide Reviews and Safeguarding Adults Reviews.
- In cases of Children or vulnerable adults who are not brought to appointments or have appointments which are cancelled or frequently reschedules there should be a consideration of the impact of the missed appointment and whether neglect of health needs is a concern. Consider the need to make reasonable adjustments and offer alternatives and who should be notified of a DNA i.e. – Perinatal service notifying G.P and possibly the health visitor.

This guidance applies to all people using the mental health services. Where adaptations are made for specific services these are included in the service's operational policy. Additional actions may be necessary where people are subject to the Mental Health Act or subject to conditional discharge.

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1.0 INTRODUCTION

1.1 Purpose of guideline

The purpose of these guidelines is to set out guiding principles for staff to achieve the best possible service user engagement and determining an appropriate response when people do not attend, are not supported to attend or are not brought to appointments. This guideline sits under and supports the Engagement & Supportive Observation Policy (Inpatients), CLP8. Implementation of the guideline should reduce the incidence of people not attending appointments and ensure the well-being of those service users who do not attend (DNA) appointments.

This guideline establishes a framework to ensure that:

- Care and treatment plans take into account individual preferences;
- Care and treatment is regularly reviewed;
- Mechanisms are in place to protect individuals who may be at risk if they disengage from care and treatment;
- Services take into consideration safety issues raised by family, friends, carers and other agencies.
- Service users have the right to refuse care and treatment providing that they have the capacity to understand the consequences of that refusal. This will exclude people who are subject to compulsory treatment under the Mental Health Act 1983, subject to conditional discharge and people whose care is provided under the Mental Capacity Act. Schedule A1 of the MCA outlines the interface between MCA and MHA. The MHA supersedes the MCA, so consideration should be given as to whether the person meets the threshold for detention under the MHA triggering the mechanisms to have an assessment completed. If they do not meet the threshold for detention under the MHA then the MCA should be considered.
- Appointments that are not attended, cancelled or frequently rescheduled for children and young people are managed effectively and in line with operational policy for related service and adherence to statutory guidance for children.

1.2 Definitions

Active engagement is defined as the process of taking a deliberate and planned approach to support service users to attend appointments, as well as to co-produce and participate in their care and treatment. All care and treatment plans should be developed with the involvement of the service user and where appropriate their family, friend or carer. When a service user is in receipt of Care Planning Approach (CPA) level of care the multidisciplinary team (MDT) will work together to develop and implement a comprehensive plan of care and treatment. In all cases information should be provided about any treatments and the likely consequences of non-adherence.

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DNA (did not attend) is defined as any scheduled contact or appointment a service user does not attend or is not brought to and has not contacted the service to cancel. It includes outpatient appointments, domiciliary visits, and any other agreed appointment with Trust staff.

Cancellation refers to appointments where the service user, carer or family provides notification to a staff member in the relevant service that they will not be able to attend the appointment

Adherence is defined as the extent to which a service user follows clinical advice given to them. This is a current recommended alternative term to concordance in that it is an attempt to emphasise that the patient is free to decide whether to adhere to the clinician's recommendations.

Carer is defined as a person who is paid or unpaid for their care role. An unpaid carer might be a partner, family member, friend or neighbour and the arrangement could be temporary or permanent. A paid carer is someone who is providing a caring service to the individual, this may include facilitating attendance at health appointments. Learning from incidents has demonstrated the value in involving family, friends and carers in considerations around active engagement.

Consideration must be given to the involvement of family, friends and carers in terms of the support they may be able to provide for active engagement with people who use Trust services. In doing this, the support needs of carers will need to be considered.

A paid carer is someone who is providing a caring service to the individual and this may include facilitating attendance at health appointments. When someone relies on a paid carer to support them to attend an appointment, their involvement should be considered when making plans for future active engagement.

MDT is the multi-disciplinary team that is responsible for the care and treatment of the person.

Other agencies are any other statutory or non-statutory service involved in a person's care.

Clinical Risk Assessment provides an opportunity to engage with patients, and their carers and families in order to promote the patient's safety, recovery and wellbeing. A good risk assessment will combine psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status, social stressors) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people (NCISH Report, The Assessment of Clinical Risk in Mental Health Services 2018).

This guideline will focus on active engagement with service users and set out guidance for when service users DNA or cancel without notice and decline to book another, and where persistent cancellations result in the service user not being seen.

1.3 Scope of guidance

This guideline relates to all those receiving services from EPUT mental health services. For those under a Community Treatment Order, please refer to the MHAPG30 [guidelines](#).

1.4 Principles

This guideline sets out a framework to ensure that:

- Care and treatment plans take into account individual's preferences;
- Care and treatment is regularly reviewed to take account of changing needs.
- Mechanisms are in place to protect individuals who may be at risk if they do not engage with care and treatment. It is recognised that the nature of non-engagement with services is extremely complex and there may be a number of reasons why service users do not engage with their care and treatment plan.
- This guidance is based on the belief that service users have the right to expect that EPUT will provide care and treatment which reflects their needs and preferences within national guidance and resource allocations.
- This guidance accepts that service users have the right to refuse care and treatment providing that they have the capacity to understand the consequences of that refusal; this will exclude people who are subject to compulsory treatment under the Mental Health Act 1983 and people whose care is provided under the Mental Capacity Act or subject to conditional discharge.
- This guidance is based on the principle that safety concerns raised by a friend, family member or carer will be listened to, reviewed, recorded and responded to. If a friend, family member or carer has expressed concern about risk to the person and/or others, these concerns must be addressed. They must be factored into clinical decision making and raised in a MDT discussion if warranted.
- Discuss with patients should take place at assessment and periodically through their care under what circumstances we would share information or breach confidentiality.
- It is acknowledged there may be times when the service user is unable to recognise the benefit of care and treatment and that it may be difficult to obtain their consent to share information. It may be necessary, where there is justification, to breach confidentiality. This should only be undertaken with advice from a line manager, their deputy or the senior clinician on duty and if necessary the Caldicott Guardian or a legal advisor in line with Guidance for Data Protection Regulations (GDPR).
- Children and young people have a right to medical treatment and it is the responsibility of the parent or carer to ensure that their health needs are met. When children are not brought to appointments or their appointments are regularly cancelled or rearranged a consideration of the impact on the child should be made in each individual case.

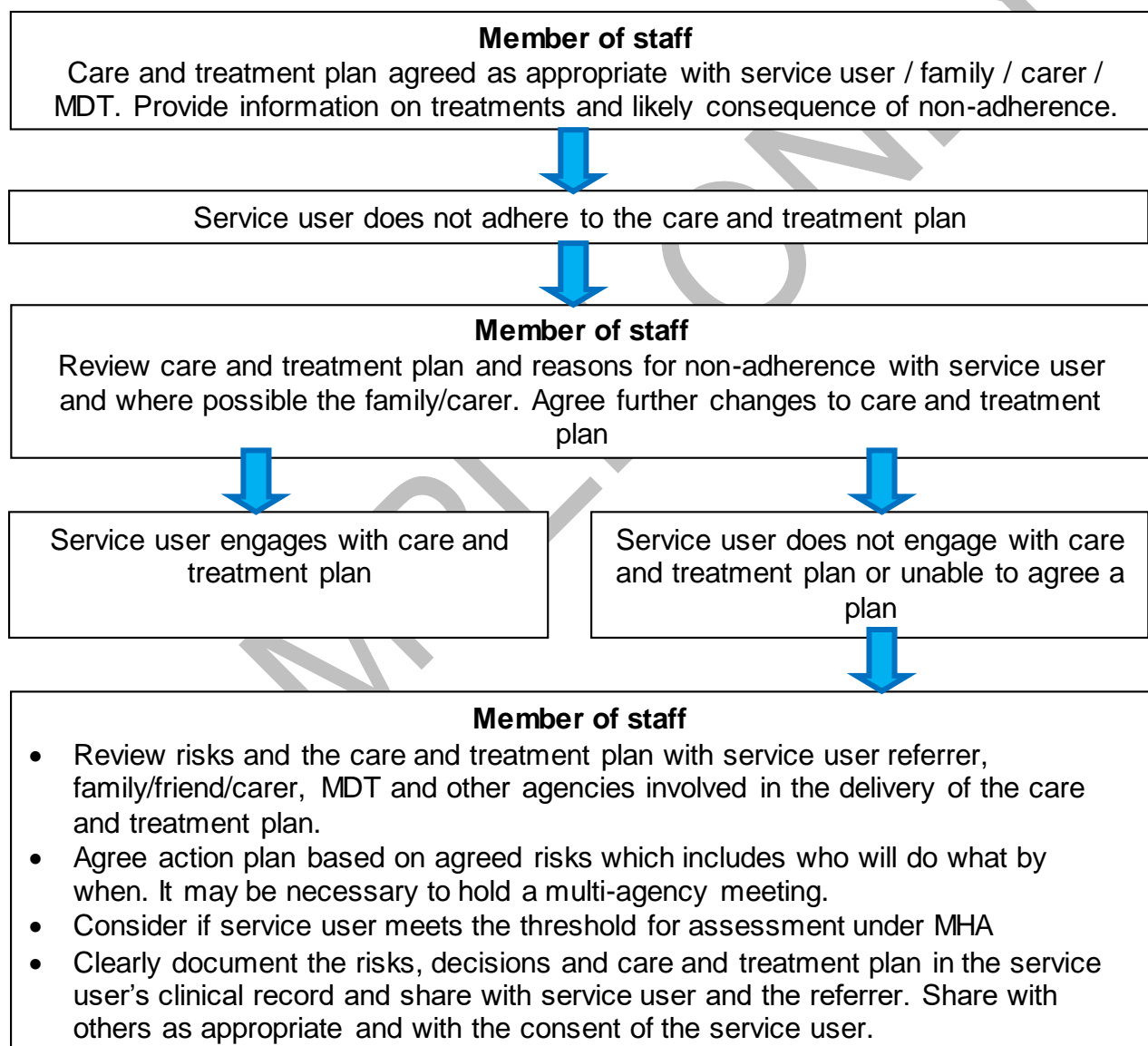
2.0 GUIDANCE STATEMENT

This guidance sets out the guiding principles to:

- Support staff in achieving positive engagement with service users and determining and appropriate response when services users do not attend, are not supported to attend or are not brought to appointments.
- Improve patient safety
- Ensure involvement of family, friends and cares in considerations around active engagement.

3.0 ACTIVE ENGAGEMENT INCLUDING NON ENGAGEMENT

3.1 Flowchart for managing non engagement



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3.2 Managing Did Not Attend (DNA) appointments and cancelled appointments

It is recognised that some service users may pose a risk to themselves or others if they do not maintain contact with EPUT services. This guidance is therefore necessary to support staff to fulfil its duty to ensure the safety of these service users. In the case of Children and Young People. Refer to the Children's Safeguarding Policy & Procedure, CLP37, for more information.

The Safeguarding Children policy contains the Child Not Brought Procedure and traffic light guidance which details the steps to be taken in such cases. Supervision should always be sought if the professional is uncertain of the action to be taken. Consideration should be given to discussing child not brought cases with the safeguarding team or making an onward referral to Children's Social Care for neglect of health needs.

Clinical Judgement

Each clinician is responsible for deciding on the action to take when a person does not attend an appointment with them. This will depend on their clinical judgement. If a service user does not attend an appointment the clinician involved must make a decision about what to do. Capacity and mental health status of the service user to make these decisions should always be taken into consideration. In making this judgement the professional must consider if they need to discuss with their team leader, supervisor and/or other members of the multi-disciplinary team.

They will consider the risk the person may pose to themselves or others, possible safeguarding children or adults issues, and their right to decide not to attend the appointment. Staff should consider the involvement of an advocate for the service user.

The Clinical Risk Assessment and Safety Management Policy and Procedure must be followed. The policy gives staff guidance and tools to assess the risk of self-harm, suicide, neglect, vulnerability and violence so that risks can be identified and managed effectively, fairly and safely.

All services including community teams, outpatient clinics, inpatient wards and any other teams arranging appointments should have mechanisms in place to minimise DNA's (e.g. provide information to service users, carers or their family about how to change or cancel appointments), offer choice of appointment to meet the service users social, employment and domestic circumstances where possible including making contact prior to the appointment.

New Referrals

When 'new referral' DNA occurs the clinician should attempt to make contact with the service user or for the young person, their parent/carer by their preferred communication method in line with the operational policy for the specific service. If contact cannot be made then the referrer should be informed as soon as possible so that they can make an up to date assessment and decide with the service on the next course of action. This should be informed by the clinician's assessment of the needs and risks of the person referred based on the information made available at the time including a review of their history for patterns of non-engagement. For children and young people please refer to the Children's Safeguarding Policy and Procedure for more information. This could result in rescheduling the appointment, cancellation of the referral, re-referral in the future or a request for an emergency psychiatric assessment.

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Follow up appointments

When a 'follow up' DNA occurs the clinician should make an assessment of any risk posed by reviewing the care and contingency plans and should decide and document the course of action to be taken. If assessment outcome is that urgent action is required this should be taken immediately without waiting for the regular MDT meeting. If the assessed risks mean that action is not considered urgent the DNA should be discussed in the MDT meeting and the team will assess the current needs. Depending on the outcome of the MDT assessment the next course of action can be determined. This might include arranging another appointment, a request for professionals or formulation meeting, a home visit, or a discussion with the GP or referrer for discharge.

All family, carers, referrer and agencies / stakeholders involved in the care of the individual should be informed about the outcomes and actions taken subject to usual rules on confidentiality.

MDT

There should be regular team caseload reviews that can identify service users who have not been seen face-to-face for 6 months or over. There must be a documented clinical review including discussion of appropriate actions and identification of who will take responsibility for those action points recorded within the service user's care record. In the case of young people this will include their school and possibly social care, if involved, and the GP. The risk assessment should be reviewed and updated to inform and reflect the decisions of the clinician or MDT in relation to choice of intervention.

Other Agencies

Where an adult service user poses a risk to others or is at risk from others, their Lead Practitioner should consider raising a Safeguarding Vulnerable Adult alert and engaging with the following; Adult Social Care; requesting a conference under Multi Agency Public Protection Arrangements (MAPPAs) and/or a Multi-Agency Risk Assessment Committee/Team (MARAC/T). If a young person poses a risk to or is at risk from others, then an urgent safeguarding children referral must be made. A referral to MARAC/T can also be considered for /young people over 16 years old. Consider third sector support such as Compass, Victim Support, Sexual Abuse Resource Centre (SARC) and other agencies dependent upon the presenting needs and situation.

If the service user does not have a GP, then straightforward arrangements should be made so they can self-refer back to the relevant locality mental health team if necessary.

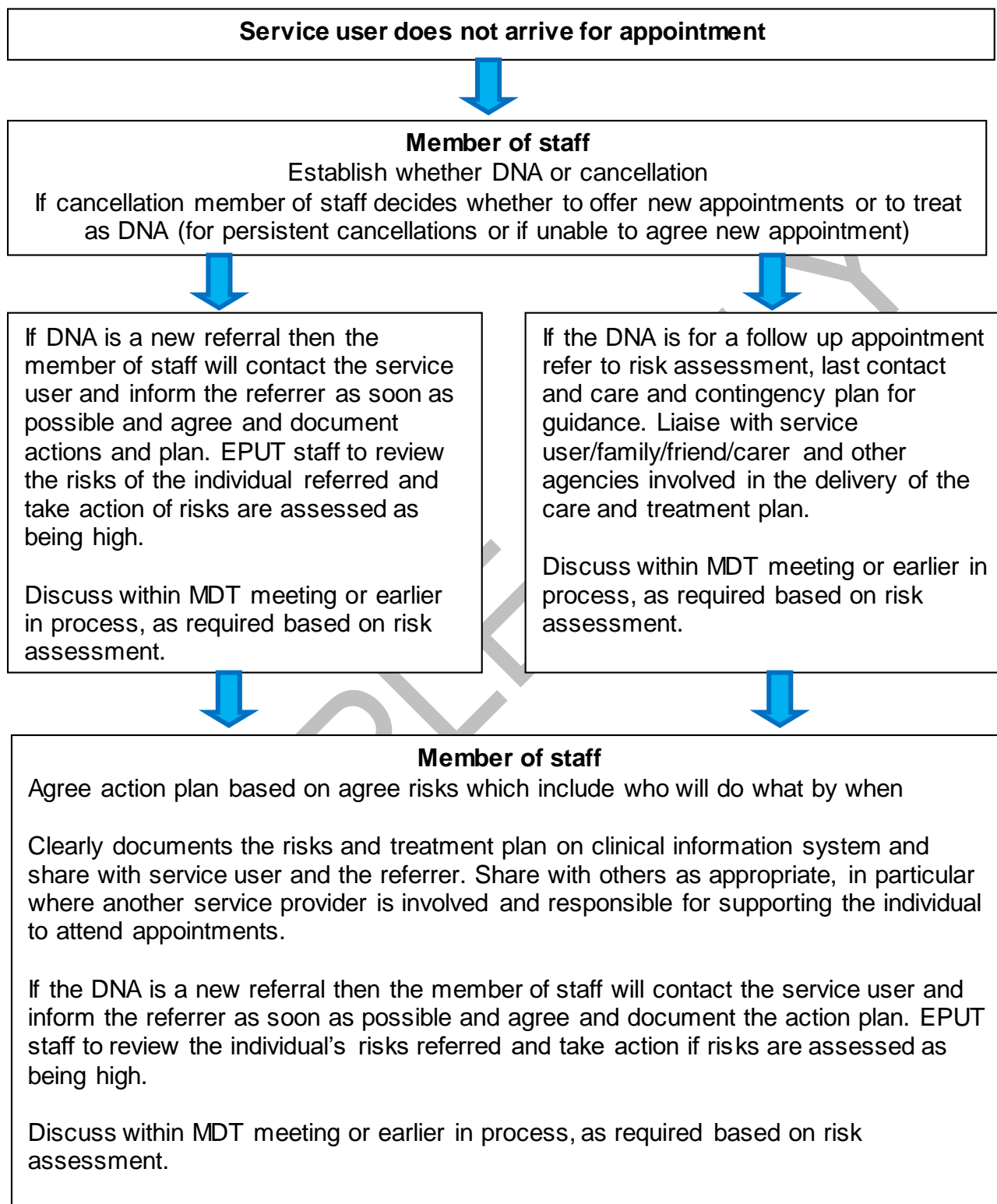
Communication

All information about the DNA / cancellation and decisions made should be clearly documented in the service user's clinical record and information should be shared with others (e.g. G.P., Police) in line with the agreed information sharing protocol.

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3.3 Flowchart for managing DNAs or cancelled appointments

(For children refer to Children's Safeguarding Policy and Procedure for more information)



4.0 FRIENDS, FAMILIES AND/OR CARERS CONCERNS

- 4.1 Concerns raised by a friend, family member or carer should be listened to, reviewed, recorded and responded to.

If a friend, family member or carer has expressed concern about risk to the person and/or others, these concerns must be addressed. They must be factored into clinical decision making and if warranted raised in a MDT discussion. If risks are present a plan must be agreed with the friend, family member or carer. This should include:

- Clearly stated methods for engagement and monitoring of the person.
- A member of the care team making contact with the person directly and helping them articulate what information they consent to being shared with the friend, family member or carer. This discussion should be clearly documented in their notes and reviewed regularly as appropriate.
- A contact point for the friend, family member or carer, in order to share ongoing concerns.
- Support and contingency arrangements for the friend, family member or carer including possible involvement of the local Carers Organisation.
- Offer of a Carer's Assessment.
- An explicit agreement of how much information can be shared with the friend, family member or carer.

It is recognised that where there is an inability to recognise the benefit of treatment, then it may be difficult to obtain the person's consent and it may be necessary, where there is justification, to breach confidentiality. This should only be undertaken with advice from a line manager and if necessary the Caldicott Guardian or a legal advisor.

5.0 ACTIONS FOR CONSIDERATION IF DID NOT ATTEND (DNA)

- 5.1 Please refer to the flow charts in Section 3 above. The follow actions will need to be considered as actions taken in light of the risks.

- Crisis plan in place and risk assessment
- Contact service user, care, family, friend, GP, other agencies
 - Another appointment to be offered as soon as possible if there are identified risks. Otherwise consider discharge or offer another appointment explaining clearly the action that will be taken if another appointment is DNA.
 - Document in the clinical information system the contact made, risk assessments and actions taken.
- Consider a home visit – refer to the lone worker policy
- Refer to the AMHP service for a Mental Health Assessment
- Refer to the Police for a welfare check
- Review the care and treatment plan and contingency plan
- Discuss within MDT meeting or earlier in process, as required based on risk assessment.
- Call a Professionals meeting or Multi-agency meeting as required indicated by the risk.

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- Discharge may be considered if service user has been made aware that this action will be taken if they DNA and there are no risk to self and/or others.
- Seek support from the MDT or line manager if further support is required.
- When someone DNA or refuses assessment or they care and treatment plan there are two main considerations regarding the MHA and MCA. The MHA supersedes the MCA, so consideration should be given as to whether the person meets the threshold for detention under the MHA triggering the mechanisms to have the assessment done. If they do not meet the threshold for detention under the MHA then the MCA should be considered.
- When someone refuses assessment e.g. at A&E consideration should be given to either the referral was made with the patient's consent or the A&E staff had concerns significant enough to warrant making the referral without the person's consent. Either way factors were present to initiate the referral. At this point the staff member may not be able to physically prevent the person from leaving, however they need identify the risks and concerns and act swiftly if action is required. Either, the risks and concerns raised to trigger the referral are not significant to pose a risk to themselves and/or others and the identified risks will be managed with current support network, or the concerns warrant action and at this point the police should be notified, information shared and request section 136. Learning from a recent case was identified that hospital security staff could have stopped someone from leaving before the assessment where there were significant concerns of risk to self and/or others.

6.0 REFERENCE DOCUMENTS

- MHA 1983 Code of Practice 2015 - <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>
- MCA - 1983 Code of Practice 2015 - <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

This guidance sits beneath CLP30, CPA and Non-CPA Policy and should be read in conjunction with this policy. It is also referenced/interlinks within other policies such as:

CLP8 – Engagement & Supportive Observation Policy and Procedure (Inpatients)
CLP28 – Clinical Risk Assessment and Safety Management Policy
CLPG28 – Clinical Risk Assessment and Safety Management Procedure
CPG60 – Information Sharing and Consent Procedure
CLP39 – Safeguarding Adults Policy
CLPG39 – Safeguarding Adults Procedure
CLP37 – Safeguarding Children Policy
CLPG37 – Safeguarding Children Procedure
RMPG17 – Lone Worker Procedural Guidelines
MHAPG30 – Community Treatment Order Procedural Guidelines

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