RMA
Working towards a safer Scotland

REVIEW OF CURRENT ARRANGEMENTS FOR RISK ASSESSMENT AND MANAGEMENT FOR RESTRICTED PATIENTS

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Risk Management Authority Report

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1. EXECUTIVE SUMMARY

The Mental Welfare Commission conducted an inquiry following the murder of Mr M in October 2004 by Mr L, a restricted patient on conditional discharge from hospital. Their report[1] identifies that basic assessment and management of the risk of harm to others was not in place. The consequence of this and other governance and management failings was that when Mr L relapsed appropriate action was not taken.

The joint response from the Scottish Executive, NHS Greater Glasgow and Glasgow City Council Social Work Services to the MWC report made clear that the protection of the public must be paramount and that steps must be taken to address the deficiencies identified to ensure that the public can have confidence in services.

As a result of the MWC inquiry, the RMA was invited (April 2006) to take forward work reviewing the risk assessment and management of restricted patients.

Specifically, the RMA was asked by the Scottish Executive Health Department - Mental Health Division, on behalf of Scottish Ministers, to:

- *consider the current arrangements for the assessment of risk in respect of the management of restricted patients, both with regard to leave and transfer decisions and with regard to the management of patients in the community, from end to end and make recommendations to the Mental Health Division by the end of 2006; and*

- *following any changes to the arrangements made following from their recommendations, audit the end to end process to assess whether the arrangements in place meet the requirement to have in place a system of risk assessment that reflects the paramount importance of public safety and confidence in the arrangements and if so, accredit the end to end process.*

This report covers the first part of the remit and contains findings regarding current arrangements and the RMA recommendations.

The RMA has welcomed the opportunity provided by this work to develop its function to advise on the development of best practice in risk assessment and management. This review of current arrangements in the assessment and management of risk of harm in mental health services has been a timely undertaking, which has demonstrated a number of related problems, requiring serious attention. The organisations and individuals who have participated in the production of this report have helped to build a clearer picture of the common issues.

There is a basic need for standard documentation at national and local level to facilitate improved communication, and which should be included in the MoP with requirements for review at critical points. In addition, risk management planning must be far more widely implemented to complement risk assessment. These issues indicate a shortfall in relation to training and competences amongst those who may be asked to work with restricted patients but are not familiar with this field and who have little knowledge, experience or training in the skills required. There is a need to ensure that resources are extended to the low security and community services to ensure that the skills and facilities are in place for appropriate

[1] Mental Welfare Commission (March 2006) *Report of Inquiry into the Care and Treatment of Mr L and Mr M* available at www.mwcscot.org.uk

throughcare and adequate risk management. Finally, there is a need to ensure specified systems of clinical governance to support practitioners at a local level.

The RMA have presented a number of recommendations which are intended to address these issues and looks forward to working with the Scottish Executive to facilitate the implementation of these and to assessing the steps that have been taken with regard to them in the future. The RMA is keen to continue to work with partners in health services and the local authority as well as the Scottish Executive in developing services which will assure the public of the quality of the assessment and management of risk of harm posed by the restricted patient group.

Recommendation 1
Standard documentation for CPA such as that drawn up by the CPA for Restricted Patients Working Group (when fully consulted upon) should be promoted by the Scottish Executive Health Department and integrated into the MoP with a requirement that it is adopted by services that care for this patient group.

Recommendation 2
Employing authorities should, via specific measures as part of their clinical governance frameworks, ensure that they provide sufficient leadership and support to individuals and teams working with restricted patients and those patients who require similar services.

Recommendation 3
The Scottish Executive should promote a model of clinical governance and corporate risk management which supports and evaluates the effectiveness of organisations' systems to assess and manage the risks posed by this patient group.

Recommendation 4
The Scottish Executive should require formal risk assessment reviews at predefined key stages in the patient journey. These stages include but are not limited to those in the current MoP and subsequent associated guidance. The revised MoP should specifically map out these stages and the review requirements.

Recommendation 5
The RMA recommend that Annex B2 of the Memorandum of Procedure on Restricted Patients be expanded to include CPA documentation and required proformas for risk communication and care plans.

Recommendation 6
Training should be developed and provided to multidisciplinary teams in:

- the management of mentally disordered offenders;
- risk assessment and management;
- managing restricted patients (use of the MoP); and
- multidisciplinary working.

Recommendation 7
The MoP guidance should be amended to provide a system of risk assessment and management planning which is:

- practicable for local teams;
- flexible enough to accommodate local protocols; and
- congruent with RMA standards and guidelines and the Care Programme Approach.

Recommendation 8
The Scottish Executive should develop an evaluation system for submitted care and management plans which assesses whether all identified risks are being managed appropriately.

Recommendation 9
In order to improve services and meet the requirements of Clinical Governance, measures should be put in place to ensure adequate and appropriate resources in the community following the transfer of patients from the State Hospital.

Recommendation 10
The Scottish Executive should ensure that clinicians utilise specialist support either from the Psychiatric Advisor or a local lead forensic clinician, where appropriate. Particularly in the case of general adult psychiatry services and elderly services (i.e. services not specifically designed for forensic patients) who provide services to this patient group. The Scottish Executive should undertake to monitor provision and uptake of this support as well as provide training (Recommendation 6).

Recommendation 11
The Scottish Executive Health and Justice Departments should provide guidance and support to foster stronger links between health and local authority criminal justice services, including:

- Information sharing in the context of Community Justice Authorities and Community Health Partnerships;
- Guidance for health services as to how Care Programme Approach will inform MAPPA;
- Clarity on when and whether mandates from patients are required to access Scottish Criminal Records Office and police intelligence; and
- Consideration of an Integrated Care Pathway for Forensic Mental Health Services which would take account of links with Criminal Justice Services.

Recommendation 12
The Scottish Executive should consider a method of short term recall of conditionally discharged restricted patients which would facilitate crisis management and assessment of whether full recall is required. This could facilitate the MoP guidance which states *"Where relapse or behaviour occurs that is identified as indicating a higher risk to the public, the RMO (or other member of the care team) should report that to the Mental Health Division with an assessment from the care team to enable the Mental Health Division to determine if immediate recall is appropriate."*

2. INTRODUCTION

On 28th January 1999 the Minister for Health in Scotland issued "Health, Social Work and related services for Mentally Disordered Offenders in Scotland" (NHS MEL (1999) 5, Scottish Office 1999) (herein "the MEL"). This policy statement examined the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work department, the State Hospital, other psychiatric services in hospital, and the community. It noted that *"service provision for mentally disordered offenders is a complex and difficult field".*

The MEL, which was complementary to the Framework for Mental Health Services in Scotland,[2] tasked Health Boards with organisation of a range of inpatient facilities from the general psychiatric to more specifically forensic, short and longer term and a range of community options. This highlighted the need for a formal relationship between components of a service based on standards of service, quality assurance and seamless provision of care.

The Mental Welfare Commission (MWC) has a duty under the Mental Health (Care & Treatment) (Scotland) Act 2003 to investigate and undertake formal inquiries as necessary where it believes that a person's care or treatment has not been appropriate. Investigations and inquiries may be conducted following casework or they may be in response to particular incidents. The First Minister can also ask it to investigate where he or she has concerns. This mechanism affords mental health services the opportunity to learn from tragic incidents and put in place measures to help prevent the same events happening again.

The Mental Welfare Commission conducted such an inquiry following the murder of Mr M in October 2004 by Mr L, a restricted patient on conditional discharge from hospital. Their report[3] identifies that basic assessment and management of the risk of harm to others was not in place. The consequence of this and other governance and management failings was that when Mr L relapsed appropriate action was not taken.

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[2] NHS MEL (1997) 62, Scottish Office
[3] Mental Welfare Commission (March 2006) *Report of Inquiry into the Care and Treatment of Mr L and Mr M*

- *following any changes to the arrangements made following from their recommendations, audit the end to end process to assess whether the arrangements in place meet the requirement to have in place a system of risk assessment that reflects the paramount importance of public safety and confidence in the arrangements and if so, accredit the end to end process.*

This report covers the first part of the remit and contains findings regarding current arrangements and the RMA recommendations.

The Risk Management Authority (RMA) exists to enable and promote best practice in risk assessment and risk management. It works with the agencies and partners, organisations and individuals of the Scottish criminal justice system to facilitate the effective management of high risk offenders and ultimately, to work towards a safer Scotland. An increasing component of the work concerns the forensic mental health services and the management of mentally disordered offenders.

Formal and systematic assessment and management of risk of harm to others are developing fields in criminal justice and mental health services. The RMA recognises that the management of the risk of harm posed by some psychiatric patients is a necessary part of, and inextricable from, the care and treatment they require. It is a widely accepted principle in psychiatric services that the restriction of liberty that is appropriate for an individual patient should match the risk posed; to self, other patients, visitors, staff and the general public.[4]

Security measures are not counter to wider therapeutic goals but integral to the therapeutic process; before any treatment can take place the environment must be reasonably safe. Further, security is one aspect of overall clinical management.

"The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community."[5]

This principle can be extended more widely to risk management strategies for all forensic patients, whether in the community or inpatient settings. Individual supervision and monitoring complement therapeutic interventions, whilst contingency planning and considerations for victim safety planning provide the context for the goals of clinical and risk management.

While the present remit has been to consider restricted patients specifically, many principles can be extended to include all patients requiring the specialist care of a forensic service because of the risk they pose to others. Good quality risk management should not be reserved for the population of patients subject to a Restriction Order; it should be widened to those identified as posing serious risk to others but not subject to such an order.

[4] Department of Health (1994) *Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services.* (Reed report) London HMSO.
[5] Forensic Network (2004) *Definitions of security levels in psychiatric inpatient facilities in Scotland* adopted as guidance in HDL (2006)48

3. MENTAL HEALTH AND CRIMINAL JUSTICE IN SCOTLAND

This work has been undertaken in the context of several other initiatives in the area of mental health and criminal justice which have an impact on the management of restricted patients. This has enabled a collaborative, shared approach to identifying and promoting effective practice.

The RMA has established close working relationships with both the Mental Health Division of the Scottish Executive and the Forensic Mental Health Managed Care Network (Forensic Network), particularly regarding the management of restricted patients.

The Mental Welfare Commission Report of the Inquiry into the Care and Treatment of Mr L and Mr M

This report identified weaknesses in the management of the risk which restricted patients might pose to others in the community. Four conclusions specifically deal with the lack of a system of risk assessment and management to support the team working with Mr L. These conclusions highlighted the need for:

- adequate focus from the clinical team on the risks a patient poses;
- satisfactory risk assessment and a risk management plan;
- a crisis plan to enable those involved in a patient's care to deal with relapse in illness; and
- a systematic approach to risk assessment and management by clinical teams and the Scottish Executive with regard to the restricted patient group

NHS Greater Glasgow and Clyde and Glasgow City Council Social Work Department have done substantial work to redress this lack of a systematic approach and the RMA has met with them to discuss the implementation and evaluation of their new measures.

The report also highlights issues concerning systems of clinical governance in relation to forensic mental health services in the case of Mr L and Mr M. Risk assessment and management are not currently integrated with a governance framework for restricted patient management. The Scottish Executive has set up a working group to examine the clinical governance requirements in this area and the RMA is contributing to this work. At the time of writing the group has met twice and is considering competencies in forensic practice and communication mechanisms.

The Forensic Network

The Forensic Network has stressed the importance of the assessment and management of the risk that forensic mental health patients pose. Their 2005 report, *Care Standards for Forensic Mental Health Inpatient Facilities in Scotland* contributed to Scottish policy as part of HDL (2006) 48.[6]

[6] http://www.sehd.scot.nhs.uk/mels/HDL2006_48.pdf

Risk management is mentioned alongside care planning as part of the first generic standard of these Care Standards.

"Standard 1: Assessment and Care Planning criteria:

The organisation is able to demonstrate evidence of audit of multi disciplinary assessment of need and risk, coupled with evidence of risk and care management and planning.

Risk assessment and management should include use of appropriate risk assessment tools combined with full discussion of all risk factors within the multidisciplinary team."

The report also included separate recommended standards for risk assessment, although it was recognised at the time that *"this is an evolving area in that standards set by the Risk Management Authority are likely to be influential across all of forensic mental healthcare."*

The Management of Offenders etc. (Scotland) Act 2005

This Act contained provisions in sections 10 and 11 which place a duty on certain Responsible Authorities, including the police and local authorities, to establish joint arrangements for assessing and managing sexual and violent offenders. Health Boards are included in the joint arrangements in relation to mentally disordered offenders. Therefore, Health Boards are required to establish joint arrangements for the assessment and management of risk posed by mentally disordered offenders. The RMA is working with the Scottish Executive on the implementation of the Act.

The Memorandum of Procedure for Restricted Patients

The Memorandum of Procedure (MoP) for Restricted Patients (September 2005) has been drawn up by the Scottish Executive to give guidance to those who are involved with the management and care of restricted patients; that is, patients who are subject to the special restrictions under the Mental Health (Care and Treatment)(Scotland) Act 2003. Such patients cannot be granted suspension of detention from hospital, transferred between hospitals or returned to prison without the consent of Scottish Ministers. In the introduction of the MoP, practitioners are advised that *"explanations which this Memorandum gives and the procedures it describes should be closely noted and observed by all those involved in the care and management of restricted patients, both within hospitals and in the community."* However, they are further advised that it is *"not intended as a complete instruction document or an authoritative interpretation of the law".*

As a result of the Mental Welfare Commission report, the MoP was amended to provide fuller guidance on risk assessment and management and to include new requirements which have applied since 1 April 2006:

- ***A formal risk assessment and risk management plan must be in place before consideration is given to suspension of detention (unescorted leave).*** *Suspension of detention is generally the stage immediately preceding conditional discharge and is the point at which the patient is being tested out in the community.*

- ***All professional staff working with the patient will be required to be familiar with the risk assessment and risk management plan*** *and that there should be arrangements in place for regular discussion of the patient by that group of staff.*

- *All formal risk assessments and risk management plans will be **subject to regular formal review as required and in any case at least once every six months** with all professional staff who work with the patient engaged in that reassessment process.*

- *The formal risk assessment must offer a statement of the level of risk presented by the patient, clearly **identify risk factors particular to the patient** and behaviour that should lead to concern.*

- *Where **relapse or behaviour occurs that is identified as indicating a higher risk** to the public, the RMO (or other member of the care team) should report that to the Mental Health Division with an assessment from the care team to enable the Mental Health Division to determine if immediate recall is appropriate.*

The RMA recognises that there may not have been sufficient time to embed these new requirements when the review was conducted. However, the practical implications of the requirements were discussed with local teams, and possibilities for future audit of the new requirements were taken into consideration.

The MoP contains requirements throughout the document relating to risk assessment and management and contains a specific annex relating to the communication of risk management as part of the annual reporting requirements (Appendix A). The guidance provides a rationale for risk assessment in the case of mentally disordered offenders and details the need for good quality information and the avoidance of over-reliance on an actuarial risk assessment tool.

Implementation of the Order for Lifelong Restriction

In 2005, the RMA published *Standards and Guidelines for Risk Assessment.*[7] These relate to assessments carried out for purposes of the Order for Lifelong Restriction and refer to risk assessment conducted under the auspices of Risk Assessment Orders and Interim Compulsion Orders where an Order of Lifelong Restriction is being considered. However, the principles of good practice within them can be applied more broadly. The RMA will publish Standards and Guidelines in 2007 for the Lead Authorities who will be responsible for drawing up and implementing Risk Management Plans for persons who are subject to Orders for Lifelong Restriction. It is intended that this document will represent current good practice across the range of risk management planning for serious violent and sexual offenders.

The Care Programme Approach

At the request of Scottish Ministers the Forensic Network commissioned a short life working group to review and revise the Care Programme Approach for Restricted Patients. The group had the following terms of reference:

"To review and revise the Care Programme Approach Guidance to ensure that the protection of the public is at the core of the decision making in respect of restricted patients' rehabilitation. To establish joint arrangements for the effective risk management requiring that all those engaged in a restricted patient's care have an understanding of the risks presented by the patient and of the factors that might suggest a relapse in the patient's conditions and be prepared to act where those factors appear to be manifest. The revised guidance will give clarity to the roles and responsibilities of the professionals involved in the care and treatment of the patient and the role of the agencies included in the information sharing process in order to enable the successful, safe rehabilitation of the restricted patient. To share the guidance with the Scottish Executive-chaired Tripartite Group and present guidance to Scottish Ministers for approval."

[7] http://www.rmascotland.gov.uk/ViewFile.aspx?id=138

The RMA has contributed to the Care Programme Approach (CPA) working group report which is currently out for consultation[8]. This report emphasises that risk assessment, particularly of the risk of future violent and/or sexual offending and the level of harm it may cause, is a necessary and integral part of identifying the needs of forensic mental health patients and that risk management is inextricable from treatment and management of this patient group. The RMA contributed to the guidelines within the report for good practice with regard to risk assessment and management.

The CPA report recognises that a good therapeutic relationship with the patient; engagement of the patient in care, treatment and interventions and involvement of the patient in identifying and addressing needs, are key to the risk management process just as they are to optimising treatment. Optimal treatment will contribute to diminishing the risk posed by the patient, and in many cases it will be appropriate actively to engage the patient in the risk assessment and management process, including contingency planning.

As part of the work examining CPA for this patient group, the Scottish Executive Restricted Patient Team carried out an audit in May 2006 of the care programmes reported to them regarding conditionally discharged patients, fifty (50) cases in total. In 28 of these cases specific CPA paperwork was present. In the remaining 22, information had to be searched for and was found in a variety of sources including Supervisor Reports, Community Care Assessment Forms and Part 9 Mental Health Act Care Plans.

The CPA group agreed that this situation required immediate action. In the majority of cases there was no clear recording of basic information as to the name of the RMO, the MHO or the 'named person', evidence of the existence of an Advance Statement, date of conviction/insanity acquittal or date of next CPA review. There was no clear list of those in attendance at CPA reviews and participation of the police seemed to be exceptionally rare.

From this examination of CPA or similar systems, it was clear that current arrangements are unsatisfactory and although there are pockets of good practice, often at specific forensic centres, overall CPA is not implemented fully. Even where it is operational, documentation often does not include essential risk management information.

Current risk assessment and management practice across Scotland varies considerably between different teams; there is a clear need for consistency of process and documentation. The MoP requirements that *"All professional staff working with the patient will be required to be familiar with the risk assessment and risk management plan and that there should be arrangements in place for regular discussion of the patient by that group of staff"* may be delivered through a system of CPA.

The MoP recommends CPA and the RMA also recommend that CPA should be used for this patient group to support:

- formalised communication among agencies and multidisciplinary colleagues;
- clarity about the roles of each professional;
- involvement of the service user and carer;
- avoiding duplication of effort and bureaucracy;
- use of risk assessment findings;
- integration of the management of risk with care and treatment.

[8] December 2006 on website www.forensicnetwork.show.scot.nhs.uk.

The revised guidance devised by the CPA working group, including the standard documentation, reflects the integration of risk and clinical management and is therefore commended by the RMA as a method of embedding good quality risk assessment and management in forensic mental health practice. The report, guidance and standard documentation are currently open for consultation.[9]

Recommendation 1
Standard documentation for CPA such as that drawn up by the CPA for Restricted Patients Working Group (when fully consulted upon) should be promoted by the Scottish Executive Health Department and integrated into the MoP with a requirement that it is adopted by services that care for this patient group.

4. THE RMA STUDY

To consider the current arrangements for the risk assessment and management guidance and practice in teams and in Health Board areas, the RMA sought the views of professionals working in this area in a postal survey and met with a number of local teams. In addition, a sample of patient records held by the Mental Health Division was examined for the quality of risk assessments and management plans.

Practitioner and Service Questionnaires
In order to gather views on current two separate postal questionnaires were used. Information received is presented at Appendix B. The first questionnaire was intended for professionals working with restricted patients and covered the areas of:

- use of the Memorandum of Procedure;
- risk assessment and review;
- multi-agency risk management;
- contingency / crisis planning;
- incidents; and
- clinical governance.

This was sent to all of the professionals that the Mental Health Division had communications with, including current Responsible Medical Officers (RMOs), Mental Health Officers (MHOs), Supervising Social Workers and a few Community Psychiatric Nurses (CPNs). The response rate (Table 1) was as expected for a postal survey of this type.

The second questionnaire was devised for service managers and covered the risk management plan structure and clinical governance.

The RMA team sent out 20 questionnaires and received 10 replies (2 of which were joint responses) resulting in a 50% response rate. Several service managers provided the RMA with their treatment planning and risk management protocols.

Practitioner views of the risk management guidance provided in Memorandum of Procedure were sought. Practitioners were asked whether they were familiar with the Annex B2 and B3 of the MoP. Whilst the majority of RMO (18/20) and CPN (3/4) were, this was slightly less evident in responses from supervising social workers (27/33).

[9] Available at www.forensicnetwork.show.scot.nhs.uk.

When asked to rate MoP guidance on risk assessment and management with regard to whether it is prescriptive or supportive, most responses tended towards "supportive" although a significant minority of RMO felt that it was prescriptive (Figure 1).

When rating the MoP guidance with regard to whether it is useful or onerous (Figure 2), the responses were split, with RMO responses tending towards 'useful' and all of the CPN responses indicating that it was 'onerous'. However, the highest rating (onerous) was exclusively made up of RMOs.

Considering the MoP guidance in respect of whether it is flexible or rigid, the responses tended towards rigid (Figure 3) and all of the CPN and supervising social worker responses indicated this. This view was also supported by the RMO responses.

The MoP (Annex B2) provides a checklist for the RMO with regard to communication of the details of the risk assessment required by the Scottish Executive Health Department (Appendix A). The responses indicate that this checklist does not facilitate communication in that it does not necessarily:

- enable the SEHD to examine the quality of the risk assessment;
- enable SEHD to follow the relationship between the risk assessment and the risk management plan (both preventative and contingency); nor
- enable SEHD to be assured that the whole clinical team has access to information about early warning signs and contingency actions to be taken.

The responses to questions regarding the risk management guidance provided in annexes B2 and B3 of the MoP were fairly mixed. The guidance was described as supportive (17 of 26 respondents) but rigid (19 of 25 respondents) with practitioners split as to whether the guidance was useful (14/27) or onerous (13/27). The comments from practitioners with regard to these questions indicated that they would prefer to supply a comprehensive report which did not necessarily follow the guidance and was more specific to the patient (therefore more flexible) although they recognised that at times such a report may not provide information on all of the essential points.

The comments from respondents regarding local protocols and guidance contained in the MoP may indicate an appetite for national guidance on risk assessment and management which supports local teams and strikes the balance between resource intensity and robustness. This is discussed below in relation to recommendation 5.

Managers were specifically asked about treatment waiting lists, clinical audit reports, complaints information, incident data and lessons learned. In most cases respondents stated that Clinical Governance Committees were regularly provided with reports on these topics from services.

However, clinical governance mechanisms are not just about reporting; practitioners should be supported and know where to raise issues. The responses from the practitioner questionnaires reveal a lack of clarity regarding how and in what forum issues from teams can be raised with management. Some practitioners mentioned several fora or line management mechanisms and in some cases practitioners highlighted concern about a lack of clarity about which forum to use for which issue, lack of robust governance mechanisms or an unstructured approach.

Recommendation 2
Employing authorities should, via specific measures as part of their clinical governance frameworks, ensure that they provide sufficient leadership and support to individuals and teams working with restricted patients and those patients who require similar services.

The overarching principles of the Forensic Network report, *Care Standards for Forensic Mental Health Inpatient Facilities in Scotland* part of HDL (2006) 48, state that *"For each standard area, the organisation should be able to demonstrate clarity around governance arrangements and the effectiveness of reporting arrangements to the Board or other governing body."*

Further, corporate risk reporting arrangements that supply regular reports to the organisation's governance body are described in the overarching principles of these standards. Active and dynamic risk registers with associated risk management action plans are stipulated to demonstrate a planned approach to minimising risk.

Recommendation 3
The Scottish Executive should promote a model of clinical governance and corporate risk management which supports and evaluates the effectiveness of organisations' systems to assess and manage the risks posed by this patient group.

Review of Current Restricted Patient Files
The RMA conducted a review examining patient records held by the Scottish Executive Health Department: Mental Health Division. A sample of 40 files was selected to represent different settings and stages of the patient journey; inpatients at different levels of security and those who are conditionally discharged. These were examined for the quality of risk assessment and risk management information given to the Mental Health Division.

It was found that there was no one up to date document provided by teams which held all of the essential details of the case.

The date of the risk assessment was provided in 12 of the 40 files examined. In a few cases there was no indication of the date of the current risk assessment but there was a documented intention to review it. This highlights an issue with the review of risk assessments. Documented risk assessments should include a date for the next routine review and also circumstances which would trigger a review prior to that date.

Around three-quarters of files had a statement of the level of risk posed (29) and a similar number of files contained an indication of risk factors (33) and protective factors (29) particular to the patient. However only 14 of 40 files had documented early warning signs or behaviour that should lead to concern (Table 2).

The review of risk assessments should as a minimum take place at key points in the patient's journey including transfers, changes in level of security and suspension of detention. This will meet the April 2006 requirement *"A formal risk assessment and risk management plan must be in place before consideration is given to suspension of detention (unescorted leave)."*

Recommendation 4
The Scottish Executive should require formal risk assessment reviews at predefined key stages in the patient journey. These stages include but are not limited to those in the current MoP and subsequent associated guidance. The revised MoP should specifically map out these stages and the review requirements.

All of the cases where risk assessment tools were reported as being used, are using the HCR-20 as a minimum and other tools, including locally devised tools, are mentioned. In the teams' responses, almost all (bar 1) of the responding Responsible Medical Officers state that they use risk assessment tools. This dichotomy may have arisen due to teams providing the Scottish Executive with an annual report or review instead of the actual Risk Assessment document.

With regard to a statement regarding the level of risk, these were given in almost three-quarters of cases examined. However, there were different ways of expressing the risk, for example: in terms of high, medium, low; nature; severity; or situational context (as in secure accommodation or the community).

The majority of files contained reference to risk factors. However, in some of those cases the risk factors seemed to be direct references from risk assessment tools with little translation into what they meant for the specific patient.

Protective factors were mentioned in almost three quarters of cases, often either as 'strengths' or discussed in terms of progress.

Of particular concern with regard to issues of patient and public safety, not all cases had a recorded statement regarding level of risk or clear identification of risk factors. There seems to be a particular issue with regard to recording early warning signs; contingency plans in the files were rare. However, in questionnaire responses, all RMOs (bar 1) replied that they do document early warning signs or relapse signs in their management plans.

These findings support those of the Mental Health Commission report that there had not been a systematic approach to risk assessment and management, or the development of a contingency plan, to enable those involved in care to identify risk indicators and respond to them appropriately. The Mental Welfare Commission report also noted inadequate liaison between local teams and the case management branch of the Mental Health Division at the Scottish Executive. In the RMA review there was a notable disparity between practice described by teams and practitioners and that seen in the SEHD restricted patient team files. There are several possible explanations for this:

- The practitioners who replied to the questionnaires were not necessarily involved in the cases of the patients whose files were examined;

- Practitioners may have been describing the best case scenario of how their systems work, and this is not the quality of risk assessment, management and documentation in all cases; or

- There may be a lack of clarity for teams of exactly what information is required by the SEHD, so although they have documentation, it is not provided to SEHD.

In terms of action to combat this disparity, the RMA conclude that there is a need for both clear definition of what is required and also clear guidance and training to support all of the teams involved in caring for this patient group. The MoP should be reviewed to incorporate principles from the RMA Standards and Guidelines on risk assessment and risk management planning and the standard documentation from the CPA working group.

Recommendation 5
The RMA recommend that Annex B2 of the Memorandum of Procedure on Restricted Patients be expanded to include CPA documentation and required proformas for risk communication and care plans.

Recommendation 6
Training should be developed and provided to multidisciplinary teams in:

- the management of mentally disordered offenders;
- risk assessment and management;
- managing restricted patients (use of the MoP); and
- multidisciplinary working.

Meetings with local teams and examination of local protocols

A number of teams had developed their own risk assessment and management protocols. When asked to indicate the positive characteristics of their local protocols for risk assessment, managers pointed to the documents' ease of use, encouragement of standard practice and comprehensiveness.

Conversely, when discussing the limitations of their protocols, teams highlighted the lack of inclusion of 'formal' risk assessment tools, or the full range of risk factors that such tools include.

Risk assessment tools make a valuable contribution to the overall risk assessment of a patient, both in terms of highlighting risk factors and in structuring professional judgement about the risk posed. For example, tools such as HCR-20 and RSVP aim to support professionals in identifying pertinent risk factors and feed through to risk management planning. Although statistical (or actuarial) tools have the best predictive validity in statistical terms, these assessment tools have a limited and circumscribed role when it comes to making an individual plan of treatment or care for a patient.

Teams also recognised that their protocols were dependent on good document management processes, professional ownership and multidisciplinary working.

There was an expressed concern that the risk assessment was not explicitly linked up to the treatment plan or discharge plan, or that there was a difficulty in keeping risk assessments up to date and that they tended to be separate pieces of work for teams.

There is also an identified common problem in revising risk assessments and keeping them live (Recommendation 4).

Implications for Risk Assessment and Management

Risk assessment forms the basis of risk management planning and good quality risk assessment is reliant on good quality information. Risk assessments provided to the Scottish Executive Mental Health Division should evidence a review of available information from as many sources as possible incorporating the following:

- Personal and family history (e.g. social work reports);
- Criminal history and violent history (e.g. criminal records, police reports, incident reports);
- Substance misuse;
- Psychiatric history;
- Assessment of personality disorder; and
- Use of risk assessment tool(s) with proven validity for the patient's group (e.g. mental disorder, gender, age, sexual offending) (see Risk Assessment Tools Evaluation Directory, RMA 2006).

Information flows with regard to the implementation of care plan actions and early warning signs are recommended to ensure that everyone involved in the management of the patient knows their responsibilities and can contribute to keeping the risk assessment current and the risk management actions appropriate.

CPA is used to facilitate multi-disciplinary and multi-agency working, and this is paramount in the assessment of risk and the planning and implementation of risk management.

It is recommended by the Forensic Network CPA working group that a Risk Assessment Document should be prepared and discussed either at a separate risk management meeting or at a long pre-CPA meeting. Professionals, who have knowledge of the patient and information to contribute or a stake in their current or future management, should be invited to attend.

A good assessment of risk will not describe a patient only in terms of high, medium or low risk. If these terms are used they should be well defined and understood by the whole team and those they communicate with about risk. However, risk assessment conducted to support risk management planning must also produce a description of the risk the patient poses in the following terms:

- The nature of the patient(s) offending behaviour;
- The likely impact of the harm caused by such behaviour;
- The situation(s) the patient is most likely to offend in;
- An indication of who victim(s) may be;
- Relevant risk factors;
- Active protective factors; and
- Early warning signs that offending behaviour is imminent.

These should be considered in the context of the current environment, suspension of detention environments and any proposed receiving service.

Teams need to do more to identify changes in individual and situational factors which could increase the likelihood of risk of harm to others so that the risk management plan can be revised as appropriate. Effective monitoring and clear, swift communication of concern will also be the means by which the emergence of early warning signs is noticed and acted upon in consequent contingency action.

Risk assessment is not an end in itself but leads to a risk management plan that outlines how the risk factors identified can be managed. It will typically include: treatment or interventions to help the person to reduce any risk they pose to others in the future; observation, supervision and monitoring to ensure that the risk continues to be managed; and where appropriate, victim safety strategies.

It is useful to think of risk management actions as acting in one of two ways. One group is the actions taken to reduce the likelihood or mitigate the severity of the risk posed; to "treat" the risk. These actions will be included in the care plan along with actions planned to meet patients' needs. In some cases, one action will both act to reduce risk and to meet another identified patient need.

The second and complementary group of risk management action is contingency planning for when and if the risk is exacerbated. In order to do this teams must identify how they will know that this has happened (early warning signs, relapse signature, risk indicators), how it will be communicated, and what response should occur.

Risk is dynamic, and in order to manage it effectively there must be: an effective multidisciplinary approach to monitoring behaviours which may cause concern; regular and informed observation; and robust communication mechanisms.

Teams should also engage in: ongoing risk assessment; evaluation of the implementation of the care plan; and a review of the patient's progress. This is to ensure the continuing suitability of the care plan as a whole and particularly the actions that the team are taking to reduce risk.

Recommendation 7
The MoP guidance should be amended to provide a system of risk assessment and management planning which is:

- practicable for local teams;
- flexible enough to accommodate local protocols; and
- congruent with RMA standards and guidelines and the Care Programme Approach.

Recommendation 8
The Scottish Executive should develop an evaluation system for submitted care and management plans which assesses whether all identified risks are being managed appropriately.

Systemic Issues
A number of systemic issues relating to the management of restricted patients were highlighted in the investigations.

There was concern that the number of restricted patients per professional (particularly RMO, MHO, CPN) in the community could rise to unmanageable proportions with the transfer of patients from TSH and that resources would not necessarily follow the patients into local mental health and community services. In addition a common problem was noted of

accessing money from health boards by forensic services for posts, training and facilities. The Clinical Governance Working Group may wish to address the issue of the needs of forensic services, particularly in the community.

Recommendation 9
In order to improve services and meet the requirements of Clinical Governance, measures should be put in place to ensure adequate and appropriate resources in the community following the transfer of patients from the State Hospital.

Difficulties were experienced in the transfer of patients from forensic to general psychiatric services and there was recognition that teams which did not have a high frequency of restricted patients were not always able to keep abreast of changing requirements and might not have sufficient resources trained in the speciality.

Recommendation 10
The Scottish Executive should ensure that clinicians utilise specialist support either from the Psychiatric Advisor or a local lead forensic clinician, where appropriate. Particularly in the case of general adult psychiatry services and elderly services (i.e. services not specifically designed for forensic patients) who provide services to this patient group. The Scottish Executive should undertake to monitor provision and uptake of this support as well as provide training (Recommendation 6).

Teams discussed difficulties at the interface between health services and criminal justice agencies at the local level. This should reflect the development of information sharing which is required by the duty to co-operate set out in the Management of Offenders etc. (Scotland) Act 2005. Some teams had developed good links, but these seemed to be dependent on personal working relationships or geographical happenstance. Teams also highlighted competing approaches and priorities that arose when team members, notably MHOs, were managed by the local authority rather than the mental health service.

Recommendation 11
The Scottish Executive Health and Justice Departments should provide guidance and support to foster stronger links between health and local authority criminal justice services, including:

- Information sharing in the context of Community Justice Authorities and Community Health Partnerships;
- Guidance for health services as to how Care Programme Approach will inform MAPPA;
- Clarity on when and whether mandates from patients are required to access Scottish Criminal Records Office and police intelligence; and
- Consideration of an Integrated Care Pathway for Forensic Mental Health Services which would take account of links with Criminal Justice Services.

Concerns were expressed that measures identified in the contingency plan might not be deliverable. For example, there is a perceived negative pressure to recall patients. Clinical

teams obviously have a vested interest in the progress of their patients and recall is seen as a last resort and irrespective of clinical needs, it will take the patient and their care team some significant time to re-establish community placement. Therefore, patients with inappropriate home circumstances and crises are at times managed via informal inpatient status.

Recommendation 12
The Scottish Executive should consider a method of short term recall of conditionally discharged restricted patients which would facilitate crisis management and assessment of whether full recall is required. This could facilitate the MoP guidance which states *"Where relapse or behaviour occurs that is identified as indicating a higher risk to the public, the RMO (or other member of the care team) should report that to the Mental Health Division with an assessment from the care team to enable the Mental Health Division to determine if immediate recall is appropriate."*

5. CONCLUSION

The RMA has welcomed the opportunity provided by this work to develop its function to advise on the development of best practice in risk assessment and management. This review of current arrangements in the assessment and management of risk of harm in mental health services has been a timely undertaking, which has demonstrated a number of related problems, requiring serious attention. The organisations and individuals who have participated in the production of this report have helped to build a clearer picture of the common issues.

There is a basic need for standard documentation at national and local level to facilitate improved communication, and which should be included in the MoP with requirements for review at critical points. In addition, risk management planning must be far more widely implemented to complement risk assessment. These issues indicate a shortfall in relation to training and competences amongst those who may be asked to work with restricted patients but are not familiar with this field and who have little knowledge, experience or training in the skills required. There is a need to ensure that resources are extended to the low security and community services to ensure that the skills and facilities are in place for appropriate throughcare and adequate risk management. Finally, there is a need to ensure specified systems of clinical governance to support practitioners at a local level.

The RMA have presented a number of recommendations which are intended to address these issues and looks forward to working with the Scottish Executive to facilitate the implementation of these and to assessing the steps that have been taken with regard to them in the future. The RMA is keen to continue to work with partners in health services and the local authority as well as the Scottish Executive in developing services which will assure the public of the quality of the assessment and management of risk of harm posed by the restricted patient group.

Appendix A: Memorandum of Procedure Annex B2: Risk Management

1. The criteria for a restriction order are set down in section 59(1) of the Criminal Procedure (Scotland) Act 1995. This criterion is concerned only with risk to others: "…. Risk that as a result of his mental disorder he would commit offences if set at large…" Where a restriction order is under consideration there would be expected to be detailed consideration of the background history and current index offence and its circumstances.

2. When a person is given a compulsion order and restriction order (or equivalent) and admitted to the mental health system, the Scottish Executive Health Department (SEHD) is responsible for assessing and managing the risk that person presents. To do this it is necessary to have good quality information on particular aspects of the patient's background and their treatment and progress in hospital. Detailed risk assessment is a key part of this process.

3. Risk assessments may be carried out using protocols or assessment tools that have proven validity for the category of people that the assessed patient falls into (e.g. mentally disordered offenders, prisoners, sex offenders). In most cases where mental disorder is also an issue, the assessment should consider not just statistical (or actuarial) assessment but attempt to place the risk the patient presents in the context of his/her past history and current offending (clinical risk assessment). More specifically this means:

    - personal and family history;
    - criminal history and history of violence;
    - substance misuse;
    - psychiatric history;
    - assessment of personality; and
    - other relevant risk factors for the population group the patient falls into (e.g. sex offender risk factors).

4. In preparing reports for the SEHD it is important that the RMO should also address the issues below:

    - whether the patient is detainable under the 2003 Act and if so for what reasons;
    - the level of security which the patient requires;
    - the potential risk factors in the future (e.g. non-compliance with medication, substance abuse potential);
    - the patient's attitude to his index offence, other dangerous behaviour and any previous victims;
    - what is known about the circumstances of the victim and the victim's family;
    - whether the patient still shows undesirable interest in the victim or victim type;
    - any access to the victim or victim type and the patient's attitude towards them;
    - the outward evidence of change, how has the patient responded in stressful situations.
    - Describe any physical, verbal or sexual aggression by the patient;
    - if substance or alcohol abuse were relevant factors in the patient's previous behaviour the patient's present attitude to these and the therapeutic inputs which have addressed these;
    - any outstanding issues which need to be addressed with the patient. Set out the short and longer-term treatment plans; and
    - patient's attitude to supervision and the quality of their relationship with the multidisciplinary team.

5. Where the patient has a mental illness the report should address the following:

    - How, if at all, the patient's dangerous behaviour relates to his mental illness;
    - which symptoms of mental illness remain;
    - whether the patient's condition is currently stable and whether this been tested in various circumstances;
    - the effect of medication on the patient's illness and how important is it in maintaining the patient's stability;
    - the extent of the patient's insight into their illness and the need for medication;
    - whether the patient complies with medication in hospital, whether they do so reluctantly and whether they are likely to continue with medication outside the hospital setting; and
    - what are the early signs which indicate a relapse in the patient's illness and what signs would indicate immediate action was required by the patient's multidisciplinary team.

6. Where the patient has mental impairment:

    - whether the patient benefited from treatment or training and if so how;
    - whether their behaviour is now more acceptable, whether the patient is unpredictable or impulsive, and how this might be managed safely; and
    - whether the patient now learns from experience and takes into account the consequences of their actions.

7. Where the patient has a personality disorder:

    - which characteristics are useful and which cause problems;
    - which personality issues are considered to relate to the index offence;
    - what treatment approaches have been adopted;
    - how effective the treatment has been and in what ways this shows;
    - how generalised the patient's learning has become and shows itself and how much is context specific; and
    - which areas of functioning continue to be a problem, how this showed in the past and present, and how it may be managed in the future.

Appendix B: Tables and Figures

Table 1: Questionnaire response rates for professionals:

Profession	Sent out	responded	Response rate
RMOs	78	20	25.6%
MHOs / supervising Social Workers	40	9	22.5%
CPN	4	4	100%
Total	122	33	27.0%

Table 2: Risk Assessment documentation in SEHD mental health division files

Item	Present (40 files)
Date of RA	12
Date of RA review	23
Use of RA tools	16
Statement of the level of risk (recorded statement regarding risk)	29
Risk factors particular to the patient (are risk factors identified)	33
Early warning signs (behaviour that should lead to concern)	14
Documentation of protective factors	29

Figure 1: Respondents' ratings of Annex B2 and B3 with regard to whether they are prescriptive or supportive.

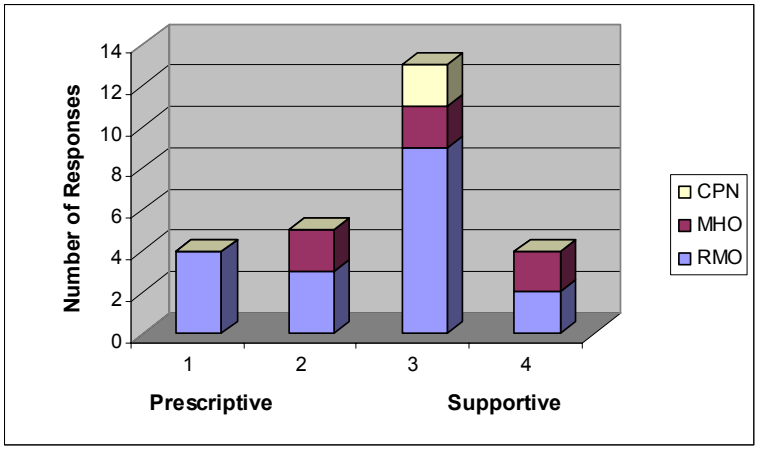

Figure 2: Respondents' ratings of Annex B2 and B3 with regard to whether they are useful or onerous.

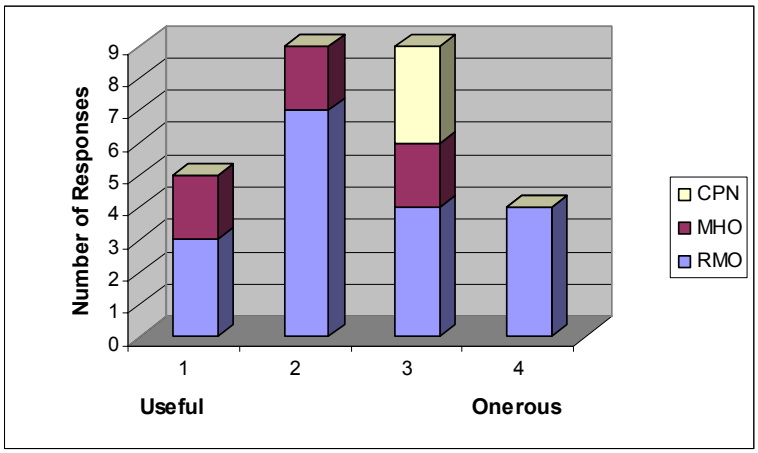

Figure 3: Respondents' ratings of Annex B2 and B3 with regard to whether they are flexible or rigid.