Healthcare Policy and Strategy Directorate
Mental Health Division

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The Scottish Government

CEL 13 (2007)

October 2007

GUIDANCE FOR FORENSIC SERVICES

1. This letter follows work undertaken by the Forensic Network in respect of the development of the Care Programme Approach in Scotland, work undertaken by the Risk Management Authority in respect of the arrangements for risk assessment and management of restricted patients and previous work on clinical governance by NHS Quality Improvement Scotland. It supports the implementation of MAPPA for restricted patients.

2. Please bring this letter and its annexes to the attention of relevant staff.

Yours sincerely

DEREK FEELEY

Addresses

For action
Chief Executives, NHS Boards
Chief Executive, The State Hospitals Board for Scotland
Medical Directors [to cascade to Senior Health Records Managers, Caldicott Guardians and Data Protection Officers]
Regional Planning Directors

For information
British Psychological Society, Scottish Division
Chairs, NHS Boards
Chief Constables
Chief Executive, Mental Health Tribunal for Scotland
Chief Executive, NHS Education for Scotland
Chief Executive, NHS National Services Scotland
Chief Executive, NHS Quality Improvement Scotland
Chief Executives, NHS Local Authorities
Crown Office
Chief Executive, Scottish Prison Service
Director, Mental Welfare Commission for Scotland
Directors of Social Work/Chief Social Work Officers
Home Office
Information Governance Managers
Medical Director, Forensic Network
Northern Ireland Office
Responsible Medical Officers for restricted patients
Royal College of General Practitioners Scotland
Royal College of Nursing. Scottish Division
Royal College of Psychiatrists, Scottish Division
Scottish Commission for the Regulation of Care
Scottish Partnership Forum
Scottish Social Services Council

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FORENSIC SERVICES

Clinical Governance for Forensic Patients

1. NHS Boards are accountable for the quality of care and treatment provided by their services, and for ensuring effective clinical governance arrangements are in place. NHS Boards discharge these responsibilities by achieving the NHS Quality Improvement Scotland Clinical Governance and Risk Management (CGRM) Standards (2005), and the principles of good governance outlined within that document. Annex A attaches the main elements of the CGRM Standards.

2. This accountability for governance and requirement to achieve the CGRM Standards applies fully to services provided to restricted and other forensic patients. Although Scottish Ministers have powers and responsibilities in respect of restricted patients under the Mental Health (Care and Treatment) (Scotland) Act 2003, those powers and responsibilities in no way dilute the accountability of Boards.

3. NHS Boards should assure themselves that restricted patients are being managed in accordance with the requirements set out in this CEL in respect of the Care Programme Approach (paragraphs 8 to 13). Doing so will provide for safe and appropriate care and enable NHS Boards to discharge their obligations in respect of Multi Agency Public Protection Arrangements. A check list of further actions that NHS Boards should take is attached as Annex B. In addition, each NHS Board should at least annually consider governance in respect of forensic services to assure itself that the standards are being achieved. NHS QIS will monitor this as part of their monitoring of the CGRM Standards.

4. In exercising the powers and responsibilities of Scottish Ministers, the Health Directorates gain information about the care and treatment of patients and the performance of clinicians. It is important that Health Boards have access to that information. At this time the Health Directorates will provide information about a clinicians performance if asked to do so by an NHS Board or if there are particular issues or concerns. The changes to information and reporting systems that are being developed by the Mental Health Division working with the Risk Management Authority (see paragraphs 14 to 16) mean that in future more routine performance information should be available and when that is the case Health Boards will be given access to that information on a regular basis.

5. The Health Directorates will make general information available to NHS Boards in respect of issues identified through critical incident reviews or other mechanisms.

6. In addition to these arrangements for NHS Services the Mental Health Division have also written to Directors of Social Work about the skills and knowledge required by MHOs when carrying out their duties and functions in relation to mentally disordered offenders. A copy of this letter is attached at Annex G.

Care Programme Approach

7. The Forensic Network surveyed current practice in respect of implementation of the Care Programme Approach and developed proposals and recommendations for future action on behalf of the Scottish Government. The consultation version of the Report is attached at (web link) and responses to the consultation process are available on the Forensic Network website at (web address).

8. The proposals for CPA were developed in the context of the new duties on NHS Boards established under the Management of Offenders (Scotland) Act 2005 which gives a

statutory basis for the Multi-Agency Public Protection Arrangements (MAPPA). By complying with the recommendations in the CPA Consultation Report, NHS Boards will be able to meet many or all of their obligations under MAPPA in those cases where they are the responsible authority

9. The Scottish Government, taking account of the responses to the consultation exercise, accepts and endorses the recommendations made in the consultation report. The guidance with respect to the key components of the CPA approach as outlined in section 8 of the CPA Consultation Report is adopted as policy (this is attached as Annex C1.). NHS Boards should consider the documentation to be advisory pending the further outcome of the work with the RMA (see below). The documentation is attached and is also available electronically at http://www.forensicnetwork.scot.nhs.uk/documents/reports/CPA%20Consultation/Draft%20for%20Consultation%20_inc%20appendices_.pdf

10. The Care Programme Approach should be adopted as the mechanism for regular review for all patients subject to Compulsion Order with Restriction Order (CORO), Hospital Direction (HD), Transfer for Treatment Direction (TTD) and Interim Compulsion Order (ICO). Under *Delivering for Mental Health* and the MAPPA guidance all restricted patients must be being managed under the new CPA arrangements from April 2008 when the provisions in respect of restricted patients are commenced. Other patients who are already subject to the MAPPA arrangements (at this stage those on the sex offenders register) should be managed under CPA now.

11. NHS Boards should use CPA for other cases where there are concerns about the risk to others posed by a patient, but for other cases the arrangements being developed under Integrated Care Pathways for care management will be a more appropriate process for ongoing care management.

12. The full recommendations in the CPA Consultation Report together with the Scottish Government response to each recommendation are attached as Annex D.

Risk Management Authority Report on Risk Assessment and Management of Restricted Patients

13. Following the Mental Welfare Commission inquiry report into Mr L and Mr M (**www.mwcscot.org.uk**) the Risk Management Authority were invited to take forward work reviewing the risk assessment and management of restricted patients

14. The Report by the RMA is available at (www.RMAscotland.gov.uk). It focuses on the way in which the system works to produce, share and use knowledge and information. A number of the recommendations relate to CPA and Governance and fully fit with the recommendations made by the Forensic Network and NHS QIS. The full list of recommendations together with the Scottish Government response to them is attached as Annex E.

15. The Mental Health Division is currently working with the Risk Management Authority to develop a system of risk assessment and management planning (RMA Recommendation 7) and to develop an evaluation system for submitted care and management plans which assesses whether all identified risks are being managed appropriately (RMA Recommendation 8).

Next Actions

NHS Boards will:

- **Ensure that they have appropriate local arrangements in place in respect of clinical governance for forensic mental health services.**

- **Implement the new guidance in respect of Care Programme Approach for patients for who they will become the responsible authority under the Management of Offenders (Scotland) Act 2003 from April 2008.**

Mental Health Division will:

- **Complete the work with the Risk Management Authority in respect of recommendations 7 and 8 of the RMA Report.**

- **Publish a revised version of the Memorandum of Procedure to take account of the various changes to the policy framework.**

- **Consult with the Royal College of Psychiatrists and the Forensic Network in developing training on forensic services, including in respect of this CEL.**

ANNEX A

NHS QIS CLINICAL GOVERNANCE AND RISK MANAGEMENT STANDARDS (CGRM)

1. The three main standard statements are:

- **Safe and effective care and services:** care and services are safe, effective and evidence based.

- **The health, well being and care experience**: care and services are provided in partnership with patients, carers and the public, treating them with dignity and respect at all times, and taking into account individual needs, preferences and choices.

- **Assurance and accountability**: NHSScotland is assured and the public are confident about the safety and quality of NHS services.

2. The standards also identify good governance for NHS Boards as:

- Focusing on the NHS Board's purpose and on outcomes for patients and service users.

- Performing effectively in clearly defined functions and roles.

- Promoting values for the whole NHS Board and demonstrating the values of good governance through its practices.

- Taking informed, transparent decisions and managing risk.

- Developing the capacity and capability of the NHS Board as an effective governing body.

- Engaging stakeholders and making accountability real.

GOVERNANCE CHECK LIST

Key Points for Action

Accountability

- NHS Boards have ultimate accountability for the quality of clinical services provided to patients by their services and clinicians. The NHS Board should at least annually consider governance in respect of forensic services to assure itself that the CGRM standards are being achieved. (RMA Recommendation 1).

- NHS Boards hosting regional services must be able to demonstrate the robustness of clinical governance arrangements to their fellow NHS Boards.

- If an NHS Board commissions forensic services from another NHS Board or other provider it must satisfy itself that appropriate clinical governance arrangements are in place.

- Individual clinicians have responsibility for maintaining their own professional accountability and competence to practice. Sessions for clinical governance should be included in consultant job plans. Achieving effective clinical governance should be integral to any junior medical staff training during placements with forensic psychiatry services.

- NHS Boards should ensure that there are appropriate resources in place whether within inpatient settings or in the community to allow for the safe care and treatment of patients and the protection of the public. (RMA Report Recommendation 9).

Support structures

- NHS Boards are required to have effective structures in place to ensure effective clinical governance support and reporting structures. (NHS QIS 2005). (RMA Report Recommendation 2)

- Individual clinicians and services have a responsibility to access and make best use of these support structures.

- Identifying a clinical lead for driving forward clinical governance within services has been a successful mechanism adopted by other clinical specialties.

- Not all clinicians working with restricted or forensic patients will be specialist forensic psychiatrists. NHS Boards need to ensure that they have arrangements in place to offer support and supervision to non-specialist staff. This may include through clinicians having access to the Principal Medical Officer with responsibility for Forensic Psychiatry at the Health Directorates and or through the local lead forensic clinician (RMA Report Recommendation 10).

- NHS Boards may wish to seek additional clinical governance support from the Forensic Network.

ANNEX C

CPA GUIDANCE AND DOCUMENTATION

(Taken from consultation report prepared by the Forensic Network)

Recommended Guidance and Documentation

1. Scope

The Care Programme Approach (CPA) should be adopted as the mechanism of regular review for all restricted patients in Scotland, with the exception of remand patients. Remand patients on lengthy periods of remand or for whom a hospital disposal is recommended may also benefit from the Care Programme Approach but in this case the use of the CPA is discretionary. The CPA may be of limited use for patients who have committed minor offences and who are not expected to remain within the Mental Health care system. The CPA should not simply now be limited to those patients approaching transfer or those patients in the community.

An initial CPA meeting should be held approximately 4 – 10 weeks after admission to hospital and review meetings should be held at a frequency of at least every 6 months in high security. More frequent meetings will be necessary at transitional points and where there are changes in circumstances which need to be considered particularly those that influence risk.

The Responsible Medical Officer continues to have overall responsibility for the care of the patient. To facilitate the CPA there needs, for each patient, to be a care co-ordinator. It is inappropriate for either the Mental Health Officer or the Responsible Medical Officer to be Care Co-ordinator. The Care Co-ordinator will require appropriate support from secretarial staff in order to organise meetings.

The key function of the Care Co-ordinator is to organise meetings in a timely fashion and be responsible for proper invitation to those involved in the meeting and distribution of CPA documentation. The Care Co-ordinator will not assume responsibility for other professionals involved in the assessment or the services provided to support the agreed care plan. All the professionals involved will retain accountability for their own practice. Box 1 summarises the responsibilities of the Care Co-ordinator.

Box 1 – Responsibilities of the Care Co-ordinator
It is important that the Care Co-ordinator has a key role in the clinical care of the patient (often they will be the patient's key-worker)

- Provides continuity of care co-ordination
- Maintains regular contact with the patient
- Ensures members of the relevant clinical team have access to relevant documentation
- Ensures that the patients named person and relevant others have access to relevant information about the patients care and are appropriately invited to meetings
- Alerts clinical team members with any difficulties in fulfilment of the care plan
- Advises colleagues of any changes of circumstances or any matters which may require modification to the care plan between CPA meetings
- Ensures that appropriate agencies involved in the patients care have appropriate access to the Care Programme Approach care plan and are invited to reviews
- Ensures that reviews are arranged
- Actively participates in reviews
- Ensures that every effort is made to facilitate patient involvement and access to independent advocacy
- Ensures that requisite documentation is updated within specified timescales and distributed accordingly
- Has a clear understanding of professional boundaries, roles and responsibilities of each team member
- Maintains contact with the General Practitioner advising of all the relevant circumstances
- Provides clear instruction on who should provide cover in the absence of the care co-ordinator either for planned annual leave or unexpected absences

2. CPA Meetings

In appropriate cases the CPA process will have two stages:

- Pre-CPA meeting - primarily focussed on third party information or sensitive information at which the patient is not present
- CPA meeting - at which the patient, their named person and/or advocate are present

A principle should be that whenever information can be appropriately shared with the patient and their named person or advocate then that information should be shared. Exceptions to this are primarily third party information or information which is likely to cause the patient distress. Also included in the pre CPA meeting there may be material that members of the multidisciplinary team feel uncomfortable in sharing in front of the patient, although it is vital that the Pre-CPA meeting determines that if it is appropriate that this information is shared with the patient and is included in the CPA Meeting. It is the responsibility of the chair of the meeting to decide if information in this part of the meeting should be more appropriately dealt with in the main meeting involving the patient. The pre CPA meeting will give rise to a brief minute, which would normally be considered third party information and not shared with the patient along with the rest of the CPA documentation. In many

cases where there is Police involvement it is envisaged that they will take part or contribute information that will be considered in the pre CPA meeting.

The CPA meeting should involve the patient, their named person and/or advocate. There is discretion on who chairs the meeting, box 2 offers suggested competencies for an effective chair; in most cases it will either be the Responsible Medical Officer, Care Co-ordinator or CPA Co-ordinator who chairs the meeting depending on local practice and skills. The first part of the CPA meeting should involve feedback from the various professionals who have had contact with the patient. This feedback should be a verbal summary of written submissions prepared in advance of the meeting and presented by those involved in the meeting. Responsibility for distributing those submissions lies with the Care Co-ordinator. Exceptionally submissions that have not been prepared in time can be tabled at the meeting. Services may choose to appoint a CPA Co-ordinator in an administrative role to support the Care Co-ordinator and Clinical Team.

Box 2 – Competencies for chairing a CPA meeting

- Familiar with the clinical case
- Able to ensures that objectives of the meeting and details of the care plan are set and agreed by members
- Able to identify, coordinate and steer the meeting
- Able to ensure that all members of the team fully participate in the meeting
- Able to ensure that team members remain focussed on the meeting and present information on their objectives in respect of the process
- Has the skills and attributes to lead a large meeting, keeping focus and timekeeping
- Able to adopt a facilitative style when chairing meetings to encourage full and frank discussion
- Knows when to be decisive
- Able to tackle conflict at an early stage
- Able to communicate effectively orally
- Able to negotiate and influence others to review and set objectives
- Able to take sound decisions
- Has both analytic and strategic ability
- Sensitive to the needs of the patients and carers

It is not envisaged that there needs to be a full repetition of the patient's past history at every CPA. The CPA document in itself should state where a historical summary can be found. It is assumed that members of the multi-disciplinary team will be familiar with that summary. This should include the normal information contained within a past psychiatric history summary and also a summary of the information of particular relevance to risk assessment. It may be that in part of the CPA meeting or pre CPA meeting a presentation of the past information is given, either because it is the first CPA in that particular setting following a transfer or because of the inclusion of new members into the CPA process.

Following on from the presentations of various team members, there should also be an opportunity for the patient or named person to state their hopes for the next stage of their journey. There should then be a review and updating of care plan objectives. Risk assessment should inform those aspects of the care plan which can

reduce risk. The care plan for patients on compulsion orders with restriction orders should fulfil all the requirements of a part 9 care plan (section 137 of the Mental Health (Care and Treatment) (Scotland) Act 2003). An important principle is that there should not be repetition of the CPA process, where one mechanism can fulfil two goals. In many cases there will be a more detailed care plan, covering particular treatment interventions (eg nursing care plan). Where a more detailed care plan exists there should be a cross reference to that documentation.

An essential part of the Care Programme Approach is Risk Assessment and Management. During the CPA meeting there should be clear reference to whatever Risk Management document has been produced and there should be an identification of the particular risk indicators relevant to the patient. In many cases this will include the relapse of symptoms of mental disorder and the use of illicit drugs or alcohol.

The CPA should then include what practical contingencies should be put in place in relation to the risk indicators. A traffic light approach is recommended.

For each risk indicator the factors which suggest the appropriateness of continuing the current treatment plan should be identified as a green light. For example, in the case of recurrence of symptoms of major mental illness, a green light would be identified where there is no evidence of recurrence of major mental illness: A green light for the substance risk factor would be appropriate where there were no positive results despite regular testing.

If however members of the clinical team identify factors that might signify the early return of symptoms, this would be identified as an amber light. An amber alert should always be reported to the Scottish Executive and should always herald an early review by members of the clinical team.

A red light contingency would be the presence of a major risk factor and would trigger emergency action such as urgent recall to hospital for conditionally discharged patients.

As part of the CPA review process there should be a review of any amber or red alert. Examples of the use of the traffic light system are given at box 3.

At the end of the CPA meeting there should be the opportunity for any team member to comment on whether there are gaps in the agreed treatment plan or contingency plan and the opportunity should be given to the patient to comment on the plan. Any dissenting views from a team member regarding the treatment and/or risk should be documented. The date of the next meeting should be set.

Box 3.1 – Traffic Light Approach to Contingency Planning
(This replicates the Contingency Planning section of the CPA Documentation and provides an example of what the risk indicators and relevant traffic lights might be for an in-patient, it is important to note that these should be tailored to individual circumstances for each case)

EXAMPLE : Mr Bloggs is a restricted patient within a low secure service.		
	1.1 Contingency Planning	**There may be circumstances that do not appear on this list that require action. Any professional with any concerns about this patient's circumstances or behaviour should contact the clinical team.**
Category	**Early Warning Signs (Relapse Indicators)**	**Contingency Actions**
Symptoms of Mental Illness	**Green** : No evidence of symptoms of psychosis or depression : Prolonged periods of anxiety, suspiciousness, pre-occupied or withdrawn Red: Command hallucinations, delusions regarding aliens	• Continue current treatment • Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) • Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241)
Substances	**Green**: No positive urine drug screens despite regular monitoring : Refusing urine drug test. Info from 3rd parties that patient has been taking substances on ward Red: Clear evidence intoxicated with illicit substances on ward	• Continue current treatment • Alco meter test. Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241)
Engagement with Team	**Green** : Compliant with medication and engaging with Psychological Therapies and Occupational Therapy : Suspected non-compliance with medication. Not engaging with Psychological or Occupational Therapies Red : Clear evidence of non-compliance with medication, refusing to attend therapies	o Continue current treatment o Alco meter test. Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) o Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241)

This table provides examples of possible entries and is not proposed as a standard to be adopted.

Box 3.2 – Traffic Light Approach to Contingency Planning
(This replicates the Contingency Planning section of the CPA Documentation and provides an example of what the risk indicators and relevant traffic lights might be for an in-patient, it is important to note that these should be tailored to individual circumstances for each case)

EXAMPLE : Mr Bloggs is a restricted patient on conditional discharge in the community		
	1.2 G. Contingency Planning	**There may be circumstances that do not appear on this list that require action. Any professional with any concerns about this patient's circumstances or behaviour should contact the clinical team.**
Category	**Early Warning Signs (Relapse Indicators)**	**Contingency Actions**
Symptoms of Mental Illness	**Green** : No evidence of symptoms of psychosis or depression : Prolonged periods of anxiety, suspiciousness, pre-occupied or withdrawn Red: Command hallucinations, delusions regarding aliens	• Continue current treatment • Review by Clinical Team, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) • Emergency Recall Inform Duty RMO immediately (tel: 032164 16548241)
Substances	**Green**: No positive urine drug screens despite regular monitoring : empty can or missed drug test Red: Clear evidence intoxicated with illicit substances positive test.	• Continue current treatment • Alco meter test. Inform RMO by end of next working day (Dr J Smith, tel: 03256 2561479) • Emergency Recall. Increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241)
Engagement with Team	**Green** : Compliant with medication and keeping all appointments : Suspected non-compliance with medication, missed appointment(s) Red : Refusing medication, refusing to attend appointments	• Continue current treatment • Inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479) • Emergency Recall. Inform Duty RMO immediately (tel: 032164 16548241)

This table provides examples of possible entries and is not proposed as a standard to be adopted.

3. Documentation

There are a number of core documents which support the CPA document. These will include a past historical summary, a risk assessment document, recent reports by those members of the multidisciplinary team regularly involved in the case, detailed multi professional care plan, minutes of third party discussions held in the pre CPA meeting and minutes of discussions at the CPA meeting. The main document produced specifically from the CPA meeting however is the CPA document and a copy of a proforma for the CPA document is attached at appendix 3.

The CPA document is a living document and is intended to be distributed to all those involved in the care of the patient including the patient, their named person and any carer. The first part of the document clearly identifies key demographic information of relevance to the patient. It also identifies the next of kin, named person and essential contacts, such as the GP, CPA Co-ordinator, RMO and MHO. There should be a statement of the index offence, index offending behaviour or index alleged offence and a brief descriptive statement relating to that offending behaviour together with reference to more detailed documentation.

There should be clarity about the patient's current legal status, the date of the conviction or insanity acquittal and clarity regarding whether the patient is subject to the sex offenders register or schedule 1 offender requirements and MAPPA status. There should be clarity regarding the dates of the order and the annual review. Within the CPA introductory documentation there should also be a description of what compulsory measures are authorised, details of the T2 or T3 certificate with details of conditions set for conditional discharge.

The next section of the CPA should include all those individuals involved in the CPA process and whether they have attended the most recent meeting. In certain cases there may be individuals who are simply sent minutes of the meeting but for whom there is no expectation for attendance at every meeting.

The next section of the CPA documentation also fulfils the requirements for a part 9 care plan. There should also be review points generated by the CPA discussion on each of the treatment needs and any adaptations to the treatment needs.

The next section is the contingency plan and there should be a cross reference to the risk assessment documentation. The proforma documentation demonstrates the traffic light approach. Finally there is an opportunity to note comments from the patient and their named person and arrangements for the next CPA meeting. The contents of the care plan will usually have been verbally agreed at the meeting and there is a final opportunity to document that verbal agreement.

The documentation also has a section that indicates the dates of the last CPA meeting and next CPA meeting as well as dates of the last and next risk assessment.

CPA DOCUMENT (incorporates Part 9 Care Plan)

*Items marked with a * required by statute for Part 9 Treatment Plans*

Patient Details	
Name	
Date of Birth	
Permanent Address	
CHI	
Unit Number	
Sex	
Occupation	
Marital Status	
Ethnic Origin (standard codes)	
First Language	
Communication Assistance Required (Yes/No)	
Religion	

Service Details	
Hospital	
Ward	
Phone No	
Responsible Local Authority	
Responsible Health Board	
Clinical Team	

Relationship Details	
Named Person	
Relationship to Patient	
Address	
Phone Number	
Primary Carer (if different)	
Relationship to Patient	
Address	
Phone Number	
Next of Kin	
Relationship to Patient	
Address	
Phone Number	

Useful Contacts:

	Name	Address & Email	Office Hours Contact No	Out of Hours Contact Name and No
CPA Co-Ordinator/Key Worker				
RMO				
MHO				
GP				

Legal Details	
Legal Status and Section	
Date of Conviction / Insanity Acquittal *	
Date Order Began *	
Date of Previous Annual Review *	
Date of Next Annual Review *	
RMO Details *	
MHO Details *	
For Determinate Sentences Earliest Liberation Date / Parole Qualifying Date (for HD/TTD)/	
For Life Sentences Punishment Part	

Index Offence	
Details of Index Offence	
Brief Statement	

Subject to requirements of other legislation	
Notifiable Under Part 2 Sexual Offences Act 2003 (2) Yes / No*	
If yes to above Detail offence(s) and period of order *	
Schedule 1 Notification Yes / No *	

MAPPA Status		
Is patient subject to MAPPA (Yes/No)		
Local Office		
Co-ordinator	Name	
	Contact Number	
Level		

Compulsory Treatment Details	
Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003	
Date of T2 / T3 Certificate	
Description of Treatments authorised by T2 or T3 certificates	
Conditions Set for Conditional Discharge	

NB – This list is not necessarily exhaustive. Please add any further roles as needed

Record of Those Involved in CPA					
1.1	2. Name	**Address**	**Contact no.**	**Invited to meeting**	**Attended**
2.1 atient					
Responsible Medical Officer					
Mental Health Officer					
Named Person					
Social Worker					
Police Liaison Officer					
Care Co-ordinator					
Psychologist					
Psychology Assistant					
Occupational Therapist					
Pharmacist					
SHO/SPR					
CPN					
GP					
Keyworker					
Other Professional					
Charge Nurse					
Psychiatric Advisor to Scottish Executive					
Housing Officer					

If an out of area patient please include details of home health board and local authority and people to invite.

ANNEX C

This section sets out the identified needs in relation to Medical Treatment for mental disorder, other forms of treatment, needs in respect of current planned community care, risk management issues and should document any unmet needs. The table is populated with an example.

Record of Needs identified at meeting and Plan to meet these				
Need*	**Objective ***	**Action Plan**	**By Whom**	**Review Points**
Address Mental Health Issues				
Address Physical Health Issues				
Address Offence Related Therapeutic Issues				
Address Relationship Issues				
Address Occupational and Recreational Issues				
Address Self Care Issues				
Assess Self Control and Acceptance of Personal Responsibility				
Address other risk Management Issues				
Develop Future Plans				

This is not an exhaustive list and additional headings may be included, for example media or victim issues

ANNEX C

This section sets out the objectives from the previous CPA documentation and should be reviewed as part of the meeting.

Review of Previous Objectives				
Need*	**Objective ***	**Action Plan**	**By Whom**	**Review Points**
Address Mental Health Issues				
Address Physical Health Issues				
Address Offence Related Therapeutic Issues				
Address Relationship Issues				
Address Occupational and Recreational Issues				
Address Self Care Issues				
Assess Self Control and Acceptance of Personal Responsibility				
Address other Risk Management Issues				
Develop Future Plans				

ANNEX C

Contingency Plan		
Issue	**Early Warning Signs (Relapse Indicators)**	**Contingency Actions**
Symptoms of Mental Illness	Green : : Red:	•
Substance misuse	Green: : Red:	•
Engagement with treatment	Green : : Red :	•

ANNEX C

RISK SUMMARY

Offending History	
Index offence	
Other offences	

History of ...		
	Yes / No	Brief details
Violence		
Sexual aggression		
Fire raising		
Hostage taking		
Use of weapons		
Alcohol or substance misuse		
Absconding/escape		
Self-harm		
Other factors of relevance		

Current Risk Status	
Setting	Likelihood, imminence, frequency and severity of harmful behaviour towards whom under what circumstances
In hospital	
In community escorted	
In community unescorted	
Other	

Conditional Discharge Conditions

Victim considerations		
	Yes / No	Details
Is/are there specific person (s) that patients poses a risk to		
Does the patient pose a potential risk to certain types of people (e.g. children, women, vulnerable adults)		

Monitoring and Supervision Requirements		
In Hospital	Nursing observation level	
	Restrictions regarding contact with staff	
	Restrictions regarding access to indoor areas	
	Restrictions regarding access to outside areas	
	Restrictions on telephone use and letters	
	Room searches	
	Personal searches	
	Alcohol/drug testing	
	Access to sharps and other utensils	
	Visitors	
	Other hospital requirements	
In Community	Escort requirements	
	Special considerations for staff visiting patient	
	Special considerations for out-patient appointments	
	Alcohol/drug tesing	
	Other community requirements	

ANNEX C

Patient / Carer Views	
Patient Comments	
Carer Comments	

Arrangements Next CPA	
Date	
Time	
Place	

The Care Programme has been agreed by those concerned.

Patient: Forename Surname (verbally agreed)

Carer: _____

RMO: Dr J Smith (verbally agreed)

Care Co-ordinator: A Person (verbally agreed)
(on behalf of all consulted)

MHO: _____

ANNEX C

Additional Comments

CPA Report Recommendations

1. The guidance and documentation outlined in Section 8 should be adopted as national policy for Scotland as the mechanism for regular review of patients subject to Compulsion Order with Restriction Order (CORO), Hospital Direction (HD), Transfer for Treatment Direction (TTD) and Interim Compulsion Order (ICO).

SG Response: Agreed.

2. Services should utilise this guidance for any patients requiring similar risk management arrangements, including certain remand patients. It should not be limited to those patients approaching transfer or those patients in the community.

SG Response: Agreed.

3. An initial CPA meeting should be held approximately 4 – 10 weeks after admission and review meetings held at a frequency of at least every six months in high security. More frequent meetings will be necessary at transitional points and where there are changes in circumstances which need to be considered, particularly those that influence risk.

SG Response: Agreed.

4. Following the implementation of the revised CPA guidance the Scottish Executive Restricted Patient Team should carry out a further audit of care programmes similar to the audit described in section 5.

SG Response: Agreed. The provisions in respect of MAPPA will be commenced in April 2008 when Health Boards will become a responsible authority. In addition *Delivering for Mental Health* requires the new Care Programme Approach to be implemented in 2008. Mental Health Division will monitor through performance management arrangements for *DfMH* and also through MAPPA reports and clinical governance reports.

5. The Scottish Executive Health Department should satisfy itself that local services have a system of clinical governance in place ensuring that the CPA process is running smoothly. The SEHD should also develop a system for collating all amber and red alerts and checking that they have been informed of all such alerts.

SG Response: Agreed. Policy on clinical governance is set out above in this CEL and delivery will be monitored by NHS QIS in the context of their monitoring of the CGRM Standards. The Mental Health Division is working with the RMA to develop risk assessment and management planning arrangements (RMA Recommendations 8 and 9).

6. The CPA process should fit within MAPPA arrangements as described in section 6 and there should be close regular liaison with MAPPA Co-ordinators at a local level. The sharing of information about restricted patients within ViSOR should be no different to information shared between agencies about other offenders. It is best practice to engage as fully as possible with the patient regarding what information is to be shared with other agencies except where there is substantial risk of harm or the information is third party.

SG Response: Agreed. Delivering CPA arrangements in line with the guidance and documentation established as policy by this CEL will enable NHS Boards to discharge their MAPPA responsibilities.

7. Local services should develop protocols to facilitate integrated working and liaison between agencies and disciplines in relation to Risk Management and CPA. The arrangements being developed for MAPPA protocols and liaison will provide a useful guide. Information flows with regard to the implementation of care plan actions and early warning signs are recommended in the risk management/contingency plan flowchart at appendix 4).

SG Response: Agreed.

RMA Report Recommendations

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 Memorandum of Procedure (MOP) with a requirement that it is adopted by services that care for this patient group.

SG Response: Agreed. The new documentation, which has been agreed under this CEL, will be adopted as part of the MOP

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.

SG Response: Agreed. Embedded within the governance checklist at Annex B above.

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.

SG Response: Agreed. The arrangements already established under the CGRM Standards apply to forensic services.

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.

SG Response: Agreed. The Mental Health Division wrote on 22 March 2006 requiring this and the correspondence is attached as Annex F. This requirement will be drawn into the revised MOP together with the guidance on CPA.

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

SG Response: Agreed. The new documentation, which has been agreed under this CEL, will be adopted as part of the MOP

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.

SG Response: Agreed. The Mental Health Division will consult with the Royal College of Psychiatrists and the Forensic Network in developing training, including in respect of this CEL.

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.

SG Response: Agreed. The Mental Health Division is working with the Risk Management Authority to develop this aspect of the MOP.

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.

SG Response: Agreed. The Mental Health Division is working with the Risk Management Authority to develop this aspect of the MOP.

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.

SG Response: Agreed. NHS Boards, in exercising their clinical governance function, should ensure appropriate resources are in place to support safe and effective care and treatment.

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 (RMA Recommendation 6).

SG Response: Agreed.

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.

SG Response: Agreed. The Scottish Government has issued joint Justice/Health Guidance , Criminal Justice Circular 15/2006 (3rd version) and NHS CEL (2007) 8 which offers further guidance in respect of information sharing. It is already agreed that in acting in accordance with the CPA guidance, NHS Boards will discharge their MAPPA responsibilities.

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."

SG Response: This will be considered in parallel with the review of the civil provisions of the Mental Health (Care and Treatment)(Scotland) Act 2003

ANNEX F

SCOTTISH EXECUTIVE

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Directorate of Healthcare Policy and Strategy

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Your ref:
Our ref:

22 March 2006

For Action

Responsible Medical Officers of restricted patients

For info:
Chief Executives, NHS Health Boards
State Hospitals Board for Scotland
Directors of Social Work
Local Authority Chief Executives
Directors of Nursing
Supervising Social Workers for Restricted Patients
Mental Welfare Commission
Mental Health Tribunal
Royal College Psychiatrists
ADSW
Chief Executive, RMA

Dear Colleague

MENTAL WELFARE COMMISSION INQUIRY REPORT INTO THE CARE AND TREATMENT OF MR L AND MR M

The Mental Welfare Commission have today published their Report into the care and treatment of Mr L and Mr M. Mr L was a restricted patient on conditional discharge. We have welcomed the report and today announced a number of steps that we are taking to address the deficiencies that have been identified by the Commission to ensure that the public can have confidence in the services that are provided. A joint document in response to the Commission's Report prepared by the Scottish Executive, NHS Greater Glasgow and Glasgow City Council Social Work Department is available at www.scotland.gov.uk/Inquiry/Treatment.

The following changes will take immediate effect and will apply to requests for unescorted suspension of detention for restricted patients:

- A formal risk assessment and risk management plan must be in place before consideration will be given by Mental Health Division to unescorted leave.
- 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.

- When a patient is on conditional discharge 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 requirement for a risk assessment, risk management and crisis plan should also address the questions questions set out at Annex B3. We will update the Memorandum of Procedure to reflect these changes.

Yours sincerely

GEOFF HUGGINS

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The Scottish Government

Local Authority Chief Executives / Directors of Social Work
Chief Executives Health Board
Chief Executives Special Health Boards
Director, Mental Welfare Commission
President, Mental Health Tribunal
Chief Executive Mental Health Tribunal
Copy to:
Chief Executive Scottish Social Services Council
President Association of Directors of Social Work
Royal College of Psychiatrists

Our ref: F993083
2 October 2007

Dear colleagues

Mental Health (Care and Treatment) (Scotland) Act 2003: Statutory Duties, Best Practice and Training Provision for Mental Health Officers working with Mentally Disordered Offenders (MDOs)

The purpose of this letter is to raise awareness of statutory duties and best practice for MHOs working with MDOs. This letter will also be of interest to RMOs working with MDOs.

It also highlights to local authorities (LA) that they may wish to require their MHOs involved in working with mentally disordered offenders (MDOs) to undertake the distance learning course.

Statutory Duties and Best Practice

The duties placed upon MHOs are the same after someone has been made subject to a Compulsion Order, or a Compulsion Order with a Restriction Order, as they are after someone has been made subject to a Compulsory Treatment Order.

From the outset of these Orders (CO, CORO) being made it is important that the LA upholds its duty to appoint a designated MHO for the patient. As soon as practical, the MHO must:

- make contact with the patient
- explain to the patient their rights in relation to advocacy
- explain to the patient their rights in relation to legal representation
- explain the Tribunal process to the patient; and
- explain to the patient the role of the named person and the named person's right to receive full tribunal papers in the same way as the patient does

It would also be best practice for the MHO to:

- ensure that named persons have an understanding of the reasons for the patient's detention and the events and illness which led to the order being made (subject to issues around disclosure which may require consent from the patient)
- ensure named persons are fully aware that they will receive full tribunal papers including a full transcript of any court hearing with details of any index offence, and the possible implications of this
- support named persons to consider the sensitive nature of all papers relating to such cases and how they may store and dispose of them with due care and attention
- advise others of any changes relating to the named person

Further guidance on MHO responsibilities is contained within volume 3 of the Code of Practice at part 2, chapters 2 and 3. A comprehensive summary of MHO duties is also contained within Reader 4 of the transitional training guide for MHOs. The Code of Practice and Reader 4 can be viewed on the Mental Health Law website at:

http://www.scotland.gov.uk/Topics/Health/health/mental-health/mhlaw/home

Reports to the Mental Health Tribunal

Reports from the MHO play a significant part in the Tribunal's consideration of a patient's case. It is important when an MHO is providing a report on a patient, in relation to a Tribunal hearing, to be aware that this report may be issued to a 'party' or 'relevant person' as defined in rule 2 of the Mental Health Tribunal for Scotland (Practice and Procedure) (No. 2) Rules 2005 (the Rules). Therefore, the MHO must ensure that any sensitive information not essential for the Tribunal hearing and which might cause upset to patient / named person, if disclosed, is removed from reports before being sent to Scottish Ministers or Tribunal. Where information contained within the report is essential for the Tribunal to make its determination, but may not be suitable for disclosure to a 'party' or 'relevant person', the MHO should make representation to the Tribunal as outlined in rule 46 of the Rules. The Tribunal does not remove any information before issuing reports to a 'party' or 'relevant person' unless specifically requested to do so.

Training Provision

As part of Mental Health Division's strategy to improve the knowledge and confidence of MHO practitioners working with MDOs, we have implemented a cascade training exercise whereby we have trained 37 MHO/trainers across the Scottish local authorities. These trainers now have materials which they can use in local training of MHOs in awareness of law and policy relating to MDOs and to risk assessment and management of MDOs. Some areas are well underway in rolling out the training and others are in the planning stages, but all MHOs who need it ought to expect to receive the training. On top of the general awareness training we have devised a new distance learning package for MHOs which will be launched later this year.

The need for training for MHOs who are assigned to MDOs has arisen from perceived gaps in some MHO practitioners' knowledge, as raised by MHOs themselves across Scotland. It is recognised that such assignments are both complex and high risk, as the recent "Mental Welfare Commission Inquiry Report into Mr L and Mr M" acknowledges. There are potentially serious risks in not addressing these gaps.

The introduction of this training will assist individual LAs to develop appropriate strategies to ensure that their MHO services are being developed in line with the National Standards for

MHO Services, and the law and policy roll-out in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) and the Criminal Procedure (Scotland) Act 1995.

The MHO MDO awareness training may be configured in different ways by different trainers but each sequence should last no more than two or three days, either consecutively or in separate law/policy and risk sessions. The distance learning package is restricted to necessary information and will be of about 3 days duration, capable of being undertaken in short sessions. It is also anticipated that the MHO training programmes will import some of these materials so that new generations of MHOs are better equipped to manage their duties towards MDOs, in advance of the revision of MHO training in 2009, which will carry more focused requirements in respect of acquisition and demonstration of knowledge and skills in relation to Criminal Procedures.

The distance learning package requires limited support from mentors and a short 1-day training course will be available on mentoring for those wishing to undertake this role.

It is important that each LA either has a trained mentor to support any MHOs undertaking the training or it has partnership arrangements with another LA which has one.

Yours faithfully

Geoff Huggins

GEOFF HUGGINS