

**MENTAL HEALTH REFERENCE
GROUP**

RISK MANAGEMENT

October 2000

The Mental Health Reference Group evolved on 31 March 2000 to the Mental Health and Well Being Support Group. The Support Group is pleased to endorse and publish this report.

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Risk Management Introductions

Chairman's Introduction

The *Framework for Mental Health Services in Scotland*² was launched in September 1997 to assist in the process of mental health service development by setting out the key issues to be addressed by the care agencies in achieving transition to local comprehensive mental health services, provided by a broad local partnership. The Framework continues to provide a relevant template against which that wider partnership, which includes Health Boards, Primary Care Trusts, Local Authorities, voluntary agencies, users of services and those who care for them and staff at all levels, to agree priorities for action related to outcomes and to quality of process. The service elements section of the *Framework* draws attention to the importance of managing risk in service settings among many other issues.

The Mental Health Reference Group (MHRG) was set up in 1996 to assist the (then) Scottish Office working party developing the first draft of the *Framework*. Chaired originally by my predecessor, Dr Angus MacKay OBE, the Reference Group had members from all the professions involved in mental health care, representatives of Health Boards and Trusts, Local Authorities and voluntary agencies and user and carer organisations' representation. Members were from across Scotland and included Scottish Office officials. The wide acceptability of the *Framework* during the consultation period and after its launch, was greatly assisted by the ongoing advice and input of the MHRG.

After publication, it was clear that the MHRG had a continuing contribution to make. In this respect, 4 sub-groups were established, one of which was charged with developing guidance for all in mental health services on the management of risk. (The other groups are examining the *interface between primary care, secondary care and social work; needs assessment; and outcome indicators.*)

I am pleased to have been involved since the start of this report. The outcome document represents a real effort in the best spirit of joint working by pooling the diverse experience of many individuals in a complex area of practice. At this time, when Primary Care Trusts and their various partner agencies are setting out on new ways of working and clinical governance is being implemented, I believe that this document will make a useful contribution to that work. If it enables people in all parts of a mental health service to deliver timely, appropriate and effective care to service users and their carers, in partnership, then it will have been a successful outcome. Risk cannot be avoided, it has to be recognised, assessed, reduced as far as possible and well managed. Management of risk is the key to safety for staff, the patient and the public. This document endorses a collective, responsible, progressive and open approach to the whole issue. I commend its contents to you.

Since this report was commissioned the Mental Health Reference Group has evolved into the Mental Health and Well Being Support Group.

Ian Pullen
Chairman

Sub-Group Chairman's Introduction

Taking risks is part of everyday life. Those with mental health problems and those who care for them can be more vulnerable to a variety of risks than others. It is recognised that to remove risks completely may result in unwanted outcomes, not least the removal of personal dignity and human rights.

Good communication, record keeping and the sharing of relevant information are vital components in the management of risk. For this to be effective however those involved must be clear not only about their own roles and responsibilities, but also of the confidentiality policies of other agencies and the human rights dimension.

I would ask that all agencies involved in caring for, or who have regular contact with, people who have mental health problems consider the contents of this report and measure how the practices followed compare with best practice in risk management. If your organisation has a risk management group this report will be of direct relevance to their ongoing task. If not, then consider the risks you, your colleagues and your organisation are running in not having a risk management group!

I take this opportunity of thanking all the members of the Risk Management Sub-Group for their enthusiasm and hard work. In particular, I would like to thank those members of the editorial team and also Dr John Loudon and Ewen Cameron for their support and guidance.

(The sub-group membership is set out at Appendix A.)

Tony Wells
Sub-Group Chairman

Introduction

Concern about how best to reduce the risk to the individual, those who care for them, and the public is not new in the discussion of mental health services. Asylums were originally established in part to reduce risk. Since the more enlightened development of community care the need to minimise risk and awareness of how difficult it is to predict has been a continuing concern. During the 1990s, especially in England, a series of incidents such as the Christopher Clunis episode¹ heightened public awareness. For some this was taken to an exaggerated extent in considering the risk to the community arising from those with mental health problems who live within it.

Subsequent inquiries found that services had in part been at fault owing to communication breakdown and poor co-ordination of services. In Scotland less negative publicity for mental health services has arisen, in part due to a cautious considered approach to discharge and the link to after care services.

A central part of the philosophy of the *Framework for Mental Health Services in Scotland* (1997)² was that no patient should be discharged from hospital unless services and accommodation were in place and available. However, undue delays in the discharge process can constitute an infringement of the right to liberty. Mindful of the experience elsewhere it was clear that Scottish mental health services needed a good practice model to both help minimise risk and realise individual ambitions within the discharge arrangements. A system was required which linked all involved in a way which was; appropriate to need, safe, fair, and sustainable.

Risk Management

Remit

The sub-group recognised the distinction between personal risk which concerns personal safety and well being - and “commercial” risk which concerns the management of financial risk to the organisation. The sub-group consideration was confined to **personal risk**, although the wider implications for service structures, operational management and use of resources was recognised in full.

In this context risk may be defined as the probability of not only a serious unwanted event such as suicide or homicide but also of harm to self or others.

Everyone should feel safe from physical and emotional harm in any treatment plan or care setting to which they have entrusted themselves, be it hospital, at home or any community facility. Those in care against their will are especially entitled to a secure environment which includes freedom from physical or emotional harm. Included in the range of risk exposure is that involving contact with abusers of drugs and alcohol, a situation that may arise through shared access of mental health services with other users.

The problem addressed by the sub-group was not primarily the accuracy or otherwise of risk assessment for individuals by professional staff and family members, but rather the **systems** through which the services detect, record, communicate and react in order to minimise danger, interacting with the person and his/her social group.

People working with those with mental health problems should be aware of and manage risk continuously.

The accuracy of prediction depends upon relevant training, experience, acuity, possession of all related data and finally, a global assessment involving a large degree of personal judgement³.

Even within one discipline there can be a range of training, experience and access to data and the potential exists for wide variation and confusion in a multi-agency system. A systematic and co-ordinated approach is essential for best practice. Even so, **prediction can never be completely accurate and consequently there can be no absolute guarantee that untoward events will not occur.**

Against that background, the problem to be addressed is how best to make risk management an explicit part of the function of the individual and the organisation so that people may operate according to clear guidelines, protocols and audit procedures.

Aim

To produce for Health Boards, Local Authorities, the Police, NHS Trusts, housing agencies and voluntary organisations a guidance note on systems required for

assessment, recording and communication of risks in various settings. Guidance which provides the means for shared practice open to continual improvement and promotes a reduction in risk. The outcome (for all involved) should be as far as possible the organisation of services that are fit for purpose.

Final Remit

- To list the main categories of personal risk in the context of mental health care.
- To acknowledge, selectively, the strategic literature available on risk assessment for suicide, parasuicide and aggression, including comment on the usefulness (or otherwise) of existing structured instruments.
- To make recommendations on pragmatic methods of ensuring that risk assessment is actually carried out and recorded appropriately in a range of settings, including hospital and home.
- To make recommendations on requirements for training and the best ways to achieve inter-disciplinary and inter-agency communication of risk assessments and information required by others to carry out risk assessments. These agencies include the police, housing and voluntary agencies.
- To consider the risk of exposure to potentially harmful substances referring to the concerns expressed by the Mental Welfare Commission (1997)⁴, and to make suggestions for rules required to govern safe access to such substances.
- To make recommendations on how management should enable and audit risk assessment within its organisations.
- To discuss briefly the concept of the “dignity of risk”, or in other words, the extent to which complete removal of risk may also remove personal dignity and that taking risks is part of life. Trying to eliminate some risks can lead to other dangers, including service users disengaging from the service.
- To comment on associated issues of ethics and confidentiality.

Other Factors

Since the remit was agreed, the Scottish Parliament has assumed the powers and the forecast implications of the Human Rights Act (1998) which took effect from October 2000. Appendix B explores some of the implications for Scottish mental health services. Also the concepts of Clinical Governance (health)⁵ and Best Value (local authorities)⁶ have been accepted as the means by which systems of care can be assessed and improved on a continuous basis. Improving the management of risk is an important component of both approaches in the development of efficient, flexible and sensitive systems.

Executive Summary

- i. The group confined its deliberations to personal risk – of harm to self or others. Consideration was given to the needs of those with a mental health problem to feel secure, to be cared for in safe surroundings and to be separated from exposure to harmful or illicit substances.
- ii. In particular the systems through which organisations and their staff detect, record, communicate and react to minimise the danger arising from any perceived risk were addressed.
- iii. Recognition was given to the assessment of risk as a continuous activity for staff during an individual's contact with a care service.
- iv. No single worker has the ability to detect, assess severity of and make arrangements to minimise risk – a systematic and co-ordinated approach is necessary.
- v. The management of risk has quality, management and fiscal dimensions. Actions taken have to be viewed against individual human rights.
- vi. Mental health service delivery occurs through a coalition of statutory and non-statutory agencies, working in partnerships with both the users of the service and often with those who care for the user. To identify and minimise risk all components of the service need to develop robust, reliable and effective ways of mutual working.
- vii. To minimise the risk of suicide and other risk of harm to self and others, service users, and those who care for them, need to be introduced to and linked with those providing continuing care services in the community prior to any discharges from hospital.
- viii. Predictions of dangerousness should be based on reasonable evidence and expressed in terms of possibilities. The prediction should arise from actual findings – from an examination or third party evidence – and should be made with awareness of both the needs of the patient (for the best available treatment) and society (for reasonable protection).
- ix. At present there is no substitute for personal judgement in the assessment of risk. The results from the instruments or rating scales currently in development cannot be replaced. In complementing judgement, they play a useful role in the future broad approach to the minimising of risk. A checklist may be helpful only if it is used to provide as comprehensive a set of relevant detail as possible on which an informed judgement can be based.
- x. Risk is ever present and has its source in a complex interaction between factors intrinsic to the individual and the environment, including:

- life events;
 - previous life experience;
 - the effect of a mental health problem and his/her personality on a person's judgement;
 - the way an individual is perceived by others;
 - an individual's exposure to
 - stigma;
 - prejudice;
 - social exclusion;
 - the attitude to risk taking within the particular culture to which an individual belongs;
 - process of assessment and treatment (and related failures).
- x*i*. The degree of risk arising from personal feelings will not always be apparent. The process of establishing risk can depend on:
- effective communication;
 - receptiveness to information;
 - alertness to possible linkages between what is said and the significance of that to the individual;
 - awareness of the categories of risk which might arise in the wider context of mental health services.

However, there are cases where the degree of risk is quite unpredictable.

- x*ii*. Procedures protecting confidentiality must be in place within all organisations providing a mental health service. The basic requirements are:
- internal procedures involving training and supported implementation;
 - staff awareness of their responsibilities and personal response to situations;
 - regular supervision and review of procedures;
 - protocols for managing the proper transfer of information between organisations;
 - protocols for obtaining the individual's consent to the sharing of information and agreement of those circumstances where a refusal can be overridden in the individual's and others' best interests.
- x*iii*. The individual's right to confidentiality has to be balanced against the reduction of predictable risk.
- x*iv*. A network of Caldicott Guardians is being established throughout the NHS in Scotland. Their responsibilities include developing appropriate protocols for the transfer of patient related information to partner organisations.
- x*v*. Respect, empathy and personal warmth are important factors for sensitive interviewing aimed at a proper assessment of the risk of self harm. These have to be balanced by a caring, informed scepticism and independent corroboration.

xvi. The “Assessment of Risk” (Royal College of Psychiatrists 1996)⁷ is a recommended source for an acceptable basis of approach to managing the assessment, recording, discussion and support of a person thought to pose a risk.

xvii. The Care Programme Approach²⁹ remains the essential mechanism to ensure care which is lasting and fit for purpose, for those with severe and/or enduring mental health problems and complex care needs.

xviii. Organisations providing in-patient or residential care should have established policies regarding action to be taken if a user of the service consumes an illicit substance.

xix. The principles underlying clinical governance – placing delivery of care at an acceptable level (and correcting under-performance) on a par with responsible stewardship of an organisation’s resources – are recommended to all service providing organisations.

xx. Regardless of their training and awareness, staff are at risk unless they are operating as part of a system of care based on:

- affording equal and high priority to risk at all levels in the organisation;
- involvement of and respect for the service user (and the carer where appropriate) in assessing risks and planning responses;
- appropriate, regular reassessment of training requirements;
- personal commitment to the process;
- respect for the role played by partner organisations and their right to be involved in risk management process.

xxi. The Critical Incident Review (see Appendix D) is the best means by which an organisation can learn from the failures of the system, identify deficiencies and introduce change.

xxii. A confidential reporting system must complement the Critical Incident Review and properly operated allows the organisation to react positively to findings.

xxiii. It is recognised that all involved in care seek to avoid mistakes. The Critical Incident Review is the organisation’s opportunity to learn from any mistakes and do better. It is not the opportunity to blame a person or persons for the failure of the system. Only defined issues arising out of the incident should become matters of discipline and should be dealt with separately.

Chapter 1 Recommendations

1. The proper management of risk cannot be separated from good quality care and is integral to meeting the full needs of people with mental health problems.

- i. Any organisation providing mental health care should establish a group of individuals to function as a *Risk Management Committee*.
- ii. The Risk Management Committee should include the main stakeholders in care provision. For example:
 - users of the service;
 - those who care for them;
 - direct care workers, including experienced clinical staff;
 - “front of house” staff (such as receptionists and telephonists);
 - liaison workers from partner organisations;
 - those responsible for developing operational policies and their implementation;
 - the organisation’s:
 - training officer;
 - estates officer; and
 - information services manager;
 - smaller organisations should appoint a risk group even if the range of staff is not employed and the group consists of the organisation staff alone;
- iii. The main functions of the Risk Management Committee are to:
 - promote and review good practice in reducing risk;
 - ensure a regular audit of buildings and practice to minimise risk;
 - oversee the provision of comprehensive and continuing training for staff in risk management;
 - oversee the development of risk related operational policies for units delivering services;
 - stimulate safe practice by promoting appropriate mechanisms (self audit, critical incident reviews, near miss reporting and the setting up of a confidential information line);
 - identify areas of high risk (buildings, procedures and populations dealt with);
 - ensure the dissemination of lessons learned from incident reviews to other areas of the service;
 - ensure action has been taken to “complete the loop” on changes in practice, equipment or buildings required from previous reviews.

- iv. In NHS Trusts the Risk Management Committee should have close links to the senior management team by being chaired by the Medical Director or the Director of Nursing Services. A Non-Executive Board Director should be assigned to have a specific interest in all aspects of risk management and should co-ordinate a regular (quarterly) report to the Board on risk.
- v. The Risk Management Committee should form part of the Trust Clinical Governance system, but should be functionally distinct. It is for individual Trusts to decide whether one Committee should cover primary and secondary care.
- vi. Risk Management Committees should report publicly, perhaps at the Trust Annual General Meeting.
- vii. Risk Management Committees should feed into a national network to assist benchmarking and the sharing of good practice.

Chapter 2 Standards

2. All care organisations should have a comprehensive programme to develop the proper management of identified risks arising from its activities.
3. These should include clear and direct lines of responsibility and accountability for the overall quality of risk management at all levels within the organisation.
4. Policies for the management of identified risks, mechanisms to recognise new risks, staff warning, supervision, and support functions must be in place. The organisation should monitor implementation effectively.
5. Procedures must be in place and adhered to which allow all staff groups and teams to identify and improve on management of risk. Protocols should be in place which define the role of Critical Incident Reviews, their implementation, and the operation of a confidential information line.

Chapter 3 Defining Risk Management

6. The NHS Confederation (1998)⁸ defines “the aim of clinical risk management as being to improve the quality of care by preventing occurrences which harm or may harm patients with the twin intention of both reducing the risk of such adverse events for patients and of reducing the costs of such events to healthcare providers. It involves:

- *identifying risks*; using a range of data sources to find out what adverse events are happening or might happen;
- *analysing risks*; exploring both actual and potential adverse events to work out how often they happen, what impact they have on patients and on the organisation and what causes or contributes to them;
- *controlling and reducing risks*; finding ways to change clinical and organisational practices so that adverse events are eliminated or made less likely; and
- *funding risks*; recognising that some adverse events will happen and ensuring that the costs of such events are both minimised and provided for...”

7. This definition illustrates several points:

- that risk management is a quality issue;
- that it is a management issue; and
- that there has been a strong financial dimension for NHS Trusts due not least to the risk of litigation (arising from the North American experience).

8. Failure to acknowledge these points may put agencies in breach of the Human Rights Act (1998). However for mental health services in the community, working with individuals to promote personal independence and autonomy, this may mean that, at times, staff have to stand back while an individual tests out surroundings that entail some degree of risk.

Good Practice Guidance

9. The Royal College of Psychiatrists (1996)⁷ in guidance on the assessment and clinical management of the risk of harm to other people, emphasises that risk cannot be eliminated, that risk is dynamic, that the level of risk changes and that assessment therefore can only have a short-term time perspective and must be subject to review as frequently as the situation demands.

10. Some risks are general, other risks more specific, with particular potential victims. Perhaps most important of all, some interventions can increase risk while attempting to decrease it. This makes the maintenance of good relationships between members of staff and patients essential.

11. The CRAG Working Group on Mental Illness Good Practice Statement⁹ on the prevention and management of aggression (1996) stated that “*The biggest danger lies in the failure of an organisation to recognise the management of violence as a complex and technical issue which requires specific attention at all organisational levels.*”

UKCC Guidance for Nurses – Risk Management

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients. (UKCC Code of professional conduct, clause 2).

The risk management process should enable the optimum level of care to be given to a client. Risk management involves the assessment of risk relating to client care, care systems and the environment of care. The calculation of risk must be based on your knowledge, skills and competence and you are accountable for your actions and omissions. You should value the process of risk taking, following assessment and in the context of appropriate management, as it will increase your ability to help clients to achieve their potential. However, you should be aware that there may be conflicts between your professional accountability and the autonomy of the client. Although it is rarely possible to eliminate risk entirely, you are still responsible for attempting to reduce risk to an agreed acceptable level. This level should be agreed within the inter-disciplinary team and, where possible, with the client.

Local Authorities

12. There is a legal dimension to all of the work undertaken by social workers employed by the Local Authorities.

13. Under the Mental Health (Scotland) Act 1984, Local Authorities have a duty to provide aftercare services for people with a mental disorder whether or not they have been in hospital. Thus if a person with a mental disorder does not appear to have adequate aftercare support the Social Work Department may be in breach of its statutory duty.

14. Under the Social Work Scotland Act 1968, it is the duty of the Social Work Department to provide social welfare by making appropriate advice and assistance available. Under the NHS and Community Care Act 1990, Local Authorities have a duty to carry out assessments of need for anyone who requires community care services. This includes those with a mental health problem.

15. Those responsible for the care and supervision of a person, will, under the common law of duty of care, be required to take reasonable care for their safety. This duty of care may extend to areas where the person under supervision causes damage to property. Staff should take reasonable steps to avoid harm coming to those in their care if they can foresee the risk. If not, their duty of care

responsibility may be deemed to be negligent if the risk ought to have been foreseen (this has not yet been tested in a Scottish court).

Care in the Community

16. Many of the sources quoted in this report have a health emphasis. However, the *Framework* is firmly based on the development of multi-agency care in the community, with Health Boards and partner authorities commissioning services jointly. If it has been difficult for single organisations to cope with all aspects of management of risk what then of the situation where several organisations are in partnership but are coming to the task from different perspectives, different cultures, histories and priorities?

17. In a health-led facility an individual's presence is usually determined by a mental health problem. The service has a range of responses to situations of risk arising from the consequences of that problem which may, in certain situations, involve compulsory treatment or detention. Policy objectives of integration and inclusion will, however, bring some into closer contact with the wider public. Those in community residential facilities usually require support in aspects of life including socialisation, developing life skills for daily living and structuring the day. We all make choices wise or unwise. Support staff whose task is the development of the individual's competence rather than containment will have the difficult task of responding flexibly and sensitively to situations brought about by unwise choices – choices which they may know were not optimal, but which the individual has the right to make.

18. This report recognises this wider aspect to risk and promotes a joint approach between agencies in the management of risk.

Mentally Disordered Offenders

19. In January 1999, “*Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland*” was launched – the Mentally Disordered Offenders Strategy.¹⁰

20. The Strategy, which had been the subject of long and detailed public consultation, sets out the roles and responsibilities of all those agencies – the courts, Procurators Fiscal, the police, social work, criminal justice teams, and health, both at secondary and at primary care level - in providing co-ordinated services fit for the purpose of care for the mentally disordered offender.

21. Specific inter-linked roles for each agency are set out and the particular function of workers from each component to liase closely with their counterparts is established. The policy forecasts a range of provision, from high secure accommodation in the State Hospital, through local in-patient forensic facilities, to supported accommodation and community care services. Such provision will allow individuals to be cared for in a manner appropriate to their assessed risk, social and clinical need.

22. The Policy acknowledges that the security of patients is partly governed by the availability of motivated and well trained staff and by patients having access to structured day time activities and a range of accommodation, support, day home and respite care, and advocacy.

23. It is clear that as the Strategy is implemented all components of the service will have to develop the robust, reliable, and effective ways of working referred to above. The Social Work Services Inspectorate has produced helpful guidance in this area, (1998) the *Management and Assessment of Risk in Social Work Services*.¹¹

Vignette

A senior registrar was called to an Accident and Emergency Department to see a young woman with a major mental illness. As was the usual practice he was shown to a room away from the clinical area to interview her. During the interview she left and he followed and attempted to restrain her, concerned about her safety. In a brief struggle watched by A & E staff who did nothing to help, his shoulder was dislocated. She ran off and was later brought back by the police. As the senior registrar was succumbing to the sedation and analgesia required to reduce the dislocation, he had to instruct the A & E senior house officer in his use of the emergency provisions of the Mental Health (Scotland) Act 1984 to allow the woman to be detained and transferred to in-patient care. Subsequently it took 3 years to persuade the A & E department and the Acute Trust to provide proper interview facilities within the main clinical area for people who might be at risk.

Accident and Emergency Departments

24. The National Medical Advisory Committee reported¹² on “the management of patients with mental disorders and/or disturbed behaviour who present to Accident and Emergency departments” in 1998.

25. The Report recognised the increased number of presentations of individuals with mental health problems and/or disturbed behaviour to A & E departments. This has been a major challenge for A & E departments and has arisen at a time when mental health services are changing rapidly.

26. Among the Report’s recommendations is reference to the need for liaison between A & E departments, the local mental health services, and other agencies, (statutory and non-statutory), the creation of a liaison group, involving all service user organisations, the social work department, primary care and the police. The functions of the liaison group was suggested to cover local protocols, quality standards, training requirements, ensuring that mental health nursing skills were available when and where needed, safety arrangements, critical incident reviews, and monitoring arrangements.

27. The report recognised the need for improved practice, standards, and monitoring of activity, and suggested that audit and operational research was necessary. Not specified in the report but essential to its successful implementation is the identification of a responsible manager to take the matter forward.

The Risk of Suicide

28. “*Safer Services*” the 1999 report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹³ (based on data from England and Wales) found that 25% of all people who committed suicide had been in contact with mental health services in the year before death.

29. About 50% of deaths occurred in patients with a history of self-harm and either substance misuse or previous hospital admission. The Inquiry found that combinations of these risk factors indicate priority groups for mental health services. Fifty per cent of those with mental health service contact had been seen in the week before death, but the immediate risk of suicide was then estimated to be low or absent in 85% of cases.

30. When patients were seen by 2 services prior to suicide, key points of information known to one service were frequently not known by the other. Mental health teams regarded 22% of the suicides seen by them as preventable and in around 60% they believed that more could have been done to reduce risk. Improved patient compliance (with treatment) and closer supervision were seen as the factors which would have reduced risk in the largest number of cases. This begs the question of how to persuade patients to ‘comply’. In those who had mental health service contact, a quarter of suicides occurred within 3 months of discharge from in-patient care, peaking in the first week post discharge, before the first follow-up appointment for nearly half of them. There was a general pattern of weak ties to society as a whole (shown through high rates of unemployment and living alone) as well as to mental health services.

31. Key is the need for all service users, their families or friends to be introduced to and linked properly with continuing care and support services prior to any transition from one form of care to another.

32. Many of the factors which predispose individuals to suicide and deliberate self-harm are also associated with drug misuse.

33. These factors include being a young man, having mental health problems (especially a depressive disorder), having physical illness (including HIV infection and its consequences), poor family relationships, social isolation, unemployment, stressful life events (including bereavement or past/continuing physical or sexual abuse) and ready access to the means of committing suicide including through supplies of illicit drugs.

34. Links between deliberate self-harm, drug use and premature death have been reported. Suicides by young men in Scotland have increased 250% in the last 20 years.¹⁴ Suicidal thoughts and feelings appear to be motivated by complex

combinations of predisposing personal circumstances, past traumatic events, precipitating events and social exclusion.

35. Low self-esteem, a lack of psychological “resilience” and educational under-achievement also feature. Being lonely and the loss of a loved person were the most common reasons given for a suicide attempt in this group. The supportive social networks they need are absent or impoverished; there is a lack of social capital.

Safer Services

36. The report recommended:

- improving the skills of front-line staff in the recognition, assessment, and management of suicide risk;
- strengthening care planning to focus on those most at risk;
- ensuring that information related to risk is passed between agencies and components of services; and
- making the system more open to information and easier for people to use.

37. The report endorses these principles and shows a way forward for all providers of care services.

A Duty of Protection

38. Following a European Community Directive the Management of Health and Safety at Work Regulations 1999 were introduced. These provisions amplify a legal duty, previously placed by the Health & Safety at Work Act 1974, on all employers in the UK “to ensure, so far as reasonably practicable, the health, safety and welfare of their employees. This duty can extend to protecting employees from assaults”.¹⁵ As a minimum employers are required to:

- assess the risks to the health and safety of their employees and of anyone else who may be affected by their work activity;
- record any significant findings, if the organisation has more than 5 employees;
- arrange to put steps following on from this assessment into practice; this has to cover planning, organisation, control, monitoring and review;
- allocate competent people, either from within their organisation, or outside it, to help them formulate and implement the necessary measures;
- establish emergency procedures;
- ensure that employees have “adequate health and safety training and are capable enough at their job to avoid risks”

39. It is clear from the regulations that organisations providing mental health services have to take initiatives to:

- identify the extent of the problem;
- establish and maintain an efficient monitoring and reporting system; incidents need to be defined clearly to allow events to be classified;
- audit the working environment to reduce the number of incidents if they cannot be prevented altogether;
- establish and maintain in good working order a system of post incident support and counselling;
- initiate appropriate training in the recognition and management of incidents, bearing the needs of individual workers in mind; and
- maintain an organisational commitment, with prevention being the overriding objective.

Chapter 4 Literature Review

40. There would appear to be relatively few – either national or international – authorities in this field. In fact, much of the literature seems *opinion* based. It is difficult to relate the issues of practice to a body of authoritative research data, which often is descriptive rather than methodologically rigorous and it is disturbing that there is no consensus on a number of fundamental issues.
41. There are related definitional problems, in that the relatively well defined area of dangerousness has been subsumed within the wider framework of risk. The limits of risk can be more difficult to set down. A conflict was noted between the legal view (which tends to consider the issues as categorical) and professional or clinical guidelines (which emphasise the uncertainty and the danger of over-conservatism in evaluation) leading to the risk of additional harm being inflicted. A central theme is the argument as to whether actuarial (population statistics) or clinical methods offer the more reliable predictors.
42. A clinical view might be that such a distinction is artificial, as population data provides the tools to inform clinical decision making; one without the other is less robust. The apparent incompatibility of the clinical and legal views may be explained by the complexity of the phenomena and different populations. For example, an instrument used on a North American prison population may have limited predictive value, say, for a long-stay forensic patient group in Scotland. At best, actuarial tools do have the advantage of comparison with a larger population over a period of time and may help focus clinicians' considerations on all aspects of the situation.
43. Fuller and Cowan²⁷ point to inherent difficulties that narrow the application to strategic decision making and classification tasks. Further the care and management of mentally disordered offenders can involve not only the assessment of violence or criminogenic risk, but also a diversity of risk criteria over the short to medium term, including behaviour harmful to self, to others and property, psychiatric relapse, and risk to the public at large. The authors know of no actuarial risk assessment instrument, extant or in prospect, with the versatility for the task typically facing forensic services.
44. There is an increasing expertise developing in actuarial methods of risk assessment with an apparent divergence from the practicalities of risk management. As various assessment instruments are tested it seems likely that those, such as the HCR-20, that combine actuarial and clinical assessment will have greatest usefulness in terms of the individual patient and his/her care.
45. The difficult interface between risk assessment and risk management is recognised. Lindqvist and Skipworth²⁸ offer that relatively static risk factors such as personal demographics and personality characteristics are uncommon targets for rehabilitation but they acknowledge that they form the core of all risk assessment tools currently in use. The delineation of risk factors between static and dynamic

in terms of mental illness may be helpful in terms of planning treatment and risk management.

46. Risk explained in terms of probabilities may give a false veneer of precision in relation to the individual. Obviously, a high risk managed well may be safer than a low risk managed poorly. The risk exists that some falsely associated with a high actuarial risk score (false positives) will be locked up because of “guilt by statistical association”. Equally unacceptable is the risk that those with a falsely reassuring low actuarial risk score (false negatives) may be considered ready for release, despite clinical concerns. Finally, the correctly identified group with a high probability of future violence can be in danger of having the “dangerous” label attached to them. The risk here is in their being treated as if they had an immutable quality of viciousness rather than possessing a range of properties and pre-dispositions, open to modifications.

47. No system or administrative measure can compensate for a failure to invest in the resources necessary to provide balanced multi-disciplinary working throughout the services providing care.

48. There does seem to be agreement that a past history of violence is a reliable predictor of future violence. Alcohol makes the related expression of violence more likely for those with severe and/or enduring mental health problems. A past history of violence combined with substance misuse considerably increases the likelihood of violence taking place.

49. The best practical model seems to be a consistent comprehensive clinical evaluation, based on detailed information gathering, by aware and appropriately trained individuals, who keep in mind the wider picture. This is about good practice principles, but there is no robust and consistent expertise or particular skill which can be transferred to practitioners in the field. A review by Mullen¹⁶ distinguishes dispositional, historical, contextual and illness related factors and helpfully places these into an ethical framework. He suggests predictions of dangerousness should be:

- based on reasonable evidence;
- expressed in terms of probabilities (which must be taken as tentative);
- based on actual findings from examination of the individual and third party information;
- formulated to take account of the implications for the patient of the prediction (therapeutic and forensic purposes are quite different);
- motivated primarily by the intention to provide the patient with the best treatment and care (even although some compulsion or restriction may be necessary to prevent harm to self or others).

Chapter 5 Existing Practice

50. A survey undertaken in 1998/99 of Trusts in the UK identified as treating adult mentally ill patients gives an indication of current practice.¹⁷ There was a 33% response rate. The main findings were:

- Over half of respondents use a discharge protocol and over a quarter say they have one under development. One in 7 neither use one nor have one under development;
- Nearly two-thirds use a discharge checklist;
- Nearly a third use a discharge rating scale;
- In many Trusts work is underway on risk assessment scales and measures;
- The Care Programme Approach²⁹ and the associated statutory obligations appear to be the basis for many instruments, particularly checklists;
- The multi-disciplinary team bringing shared information to the decision making process is a large, shifting number of professionals. The influence of different line managers, training, professional loyalties and traditions is evident;
- Psychiatrists remain the key presence in the decision making process;
- Each patient may generate several different sets of records kept in a variety of formats, locations and under different codes;
- A common record shared by the widest possible multi-disciplinary team is not yet in widespread use. There remains the danger that bits of information, essential to making up the overall picture, are held in different places, rarely being brought together;
- Electronically stored and shared records are in use by only a very small number of Trusts, but have great potential for widely communicating and sharing information about risk;
- Practice differs in Trusts, and even within components of a single Trust – “seamless” care is often far from being a reality;
- There is evidence of joint working between health and social services, but the role of voluntary organisations is unclear, risking their exclusion;
- There is some evidence of a clear stance being taken against the use of scales – suggesting that in some cases they have been tried but discontinued. Also some staff feel uncomfortable about their use;
- Some Trusts have a well developed “suite” of instruments. Each one may be excellent in itself, but in combination with the others there is a potentially bewildering array of paperwork;
- In care plans the role of the key worker is well defined, but not the role of others;
- In many instruments there is much “pinning down” of responsibility in the form of names, signatures and dates, raising fears for some about their position in the event of an incident;
- The distinction between assessment and management/control of risk appears well understood;

- Most instruments concern themselves with a full range of risks;
- The perception of the need for a continuous cycle of assessments is evident.

51. The use of instruments can help to make the decision making process more transparent. For staff this can be a protection. For service users this can mean the process is less arbitrary. Less robust instruments including checklists may promise less but actually deliver a more practicable, widely acceptable and cost efficient aid to risk management. The dangers are that different instruments of unproven validity will give a false sense of security and will make staff less flexible in working with individuals.

52. It has been important for the development of evidence based knowledge about mental health problems that tested and standardised psychiatric assessment scales have been developed and widely used. They result in reliable diagnoses of psychiatric syndromes for clinical purposes and assessments of aspects of social function. However, reliable scientific assessment of risk is still far from being achieved. Research in this area has to continue as a matter of priority. For most practitioners there is more to be gained at present from a combination of gut feeling together with the implementation of simple risk management procedures and controls, than from the pursuit of complex instruments of unproven validity and reliability. Scales may have promise but as yet do not convince that they can deliver.

53. Those whose task it is to implement risk assessment procedures within a service should bear in mind the 13 factors identified by Potts (1995)³¹ which health professionals do not take into account sufficiently in practice, thus risking a weakening of the process. These are:

- Minimisation of historical events
- Over-reliance on recent progress
- Sudden change of view in the care team
- Extraneous factors, not openly recognised
- Infrequency and/or discontinuity of assessment
- Non-verification of statements by patient and/or others
- Not taking account of evidence contrary to patients assertions
- Not recognising patient manipulation and consequent staff discord
- Lack of thorough investigation and assessment of assertions of "insight" and "remorse"
- Lack of openness between those involved in the patient's care and treatment
- Discounting information if not supportive of hoped for outcome
- Self expectations of being decisive and successful
- Avoiding confrontation with the patient

These touch on complex matters of personal and collective attitude and behaviour. How best to allow wisdom and experience to develop?

Chapter 6 Personal Risk

54. As a consequence of illness or impairment, people with mental health problems can be more vulnerable to the variety of risks that are a part of everyday life. They can also pose an actual or perceived risk to themselves or to others. Risks vary by type and degree and are influenced by a number of variables in complex interaction. They include:

- life events or other trigger factors;
- previous life experience;
- personality;
- the effect of the mental health problems on the person's judgement and behaviour;
- how people are perceived by others in the mental health services and wider society;
- exposure to stigma, social exclusion and prejudice;
- exposure to risk associated with diagnosis, treatment, and failure of treatment;
- the attitude to risk taking of the milieu in which the person lives;
- consequences of ordinary personal choices.

55. The problem is the uncertainty of assessing from available information the likelihood that a proportion of the population will suffer certain events and, from that, calculating the odds on an individual's reaction to such events in the immediate/short-term/long-term future.

56. For instance, it has long been known that in excess of 20 risk factors leading to suicide can be identified (see table at chapter 7). Moreover, 2 or more of these being present in a person considerably increases the risk of eventual suicide.

57. Knowing they are present can inform the interview process and raise awareness for the worker or clinician. On their own they do not help to predict when a suicide attempt will take place only that the risk is higher. This may also arouse anxiety, fear – of not responding appropriately or of being blamed - and a tendency to decide on action not properly thought through.

58. Thorough assessment, informed judgement, communication to those who need to know, and a willingness to examine outcomes individually and collectively are what matters. It should never be forgotten that some individuals pose risks which may be entirely unpredictable. An organisation's practices have to be flexible and resilient enough to take all these factors into account.

59. As a consequence of their illness or impairment those with a mental health problem can be more vulnerable to the variety of risks which are a part of everyday life. They can also pose an actual or perceived risk to themselves or to others. The

particular risks vary by type and degree and are influenced by a number of variables including; the effect of the mental health problem on the person's judgement and behaviour; the people they live and associate with; the environment in which they live; life events; and exposure to risk factors associated with treatment and failure of treatment. Listed below are stages of contact with helping agencies; the individuals or groups of people in relation to whom the risks may occur; a list of potential risks; and a list of actions/omissions which may increase the likelihood of the unwanted events occurring. *It should also be borne in mind that the aim of risk assessment in mental health care should be to:*

- determine the degree of risk arising in given circumstances;
- plan appropriate steps to reduce the risks to acceptable levels;
- communicate the assessment and care plan;
- implement the plan;
- assess, modify the plan, and let others know as often as the situation warrants;
- plan what should be done by those involved if the risk cannot be averted and with whom they should communicate.

60. All individuals and organisations providing any form of mental health service should have no difficulty in subscribing to these fundamental structures.

Chapter 7 Risk Factors for Suicide (after L Appleby)¹⁸

Features of patient and relevant experiences	Particular factors
Mental state	Psychosis Depressed mood Hopelessness and joylessness Suicidal ideas Suicidal content to psychotic phenomena Communication of intent
Past history	Previous deliberate self-harm History of mental health problems > 4 years Several previous admissions History of recent change in mental state
Social and demographic	Living alone Single/divorced/widowed Unemployed Male Young
Current episode	Acute relapse Recent discharge from in-patient status Recent transition in care
Ward and staff	Staff hostility to patient High staff/patient turnover Low morale (and inadequate professional support) Insufficient observation facilities Inadequate staff expertise (and supervision)

61. Everyone has their own path through life. That things happen and have consequences usually makes sense and is accepted. Coming into contact with mental health services means that a professionally directed opinion and focus is super-imposed on that personal understanding.

62. For the professional, the process of making someone a patient or client is divided conveniently into *assessment – service provision - continuing care/follow-up – discharge/end of service*. This makes the tasks and skills more explicit.

63. For those in contact with a service, the rules tend to be made by the worker or the professional. People have difficulty in confronting a system in which they

feel unequal and in which they feel their personal experience counts for nothing. Being in contact with the care system understandably makes people anxious, often insecure and uncertain and rarely shows them at their best. In the patient's 'journey' through the care system, it is likely that there will be changes in mental state, insight, and willingness to be fully compliant with actions designed to be helpful. Thus the risk perceived by others or experienced by that person is likely to fluctuate.

64. The danger of the 'patient's journey' concept is that the journey is only fully visible in retrospect. In its course a variety of things can happen which cause deviations. The person making the journey will also come across all manner of workers from different agencies, different departments within those agencies and different disciplines. Some will have one, often brief, contact others may travel on the journey quite some way. Yet all should blend their impressions or knowledge into a coherent whole and it would help if the person's experience made sense too.

65. Generally, the more obvious and severe the personal disturbance, the wider the ripples flowing to families or carers, wider social groups, the general public, other service users, and to health, social care and voluntary workers. This process of outward spread crucially depends on:

- communication or behaviour to alert others as to what may be going on in an individual's mind;
- receptiveness on the part of others (warmth and empathy and the esteem in which they hold the person); and
- awareness and understanding by others of the significance of what is being said/done.

66. All too often assumptions, stigma, shame or simply embarrassment hinder effective communication and make subsequent developments surprising and perhaps catastrophic to those who might have been expecting to be forewarned. Some individuals who are quite unwell inwardly do not show much outward evidence of their illness. Episodes of disturbed behaviour occur unpredictably and organisations need to allow for this in their plans and practices.

Vignette

Andrew completed his university education but cut himself off from his former life and returned to his parent's home and sought work. Andrews' father became disturbed about his behaviour the following summer. He arranged for a GP and psychiatrist to visit Andrew at the home against Andrew's wishes. Andrew competently responded to their questions and they did not identify a need for care.

Over the next 18 months, Andrew's parents were convinced of a steady deterioration in his condition. They attempted many times to get Andrew to see his GP. From the GP's perspective, it was important that Andrew should visit him, but Andrew did not recognise that there was anything wrong so would not. Following a trip away from home, Andrew became convinced that he had a physical problem and agreed to visit the GP. The parents briefed Andrew's GP on their concerns before the visit but the GP did not identify a mental health problem. Under his duty to maintain patient confidentiality, he had no option but to refuse to discuss Andrew's condition with his parents.

A few months later, the parents were extremely worried by Andrew's behaviour one afternoon. It was not possible to obtain a visit by his GP. Within 3 hours, Andrew suddenly attacked a very young relative and nearly succeeded in killing him. Only the presence of relatives, able with great difficulty to restrain Andrew until the police arrived, prevented a tragedy.

Andrew is now a detained patient and, when he has recovered, has to live with the knowledge of the tragedy that his illness nearly produced. This episode illustrates the difficulties - not every untoward episode can be averted.

Stages of care/treatment	Source of risk people	Source of risk historical	Source of risk practice
<ul style="list-style-type: none"> • Personal history • Past history • Pre-assessment • Assessment • Treatment (in-patient/community) • Continuing care/follow-up • Discharge <p>(The underlying assumption in this “process” is that there will be changes in mental state, insight and concordance with treatment throughout the person’s contact with services.)</p>	<ul style="list-style-type: none"> • The patient/client • The person’s family • The person’s social group • To/from general public • To/from other service users • To/from health professionals 	<ul style="list-style-type: none"> • Accidental • Environmental • Financial exploitation • Side effects • Untoward effects and failures of treatment and medication • Ill treatment • Physical and emotional abuse • Physical neglect • Self harm • Sexual abuse/exploitation • Substance abuse • Suicide • Unrecognised mental disorder • Violence/assault • Homicide • Harassment • Abuse by professionals or informal carers 	<ul style="list-style-type: none"> • Failure of communication by staff/relatives/inter-agency • Incorrect assessment • Failure of treatment • Non compliance with treatment • Lack of use of statutory provisions • Previous history of violence • Previous history of self harm • Previous history of sexual abuse • Over tolerance by professionals of deviant behaviour • Poor and inaccurate record keeping • Lack of appropriate training • Insufficient targeting of resources • Care environments which are unacceptable to patients

Chapter 8 Communication and Confidentiality

67. The key principles when developing a communication and information strategy for effective risk management are:

- to achieve a balance between the rights of people with a mental illness and the necessary disclosure of relevant confidential information with the consent of the individual involved (or otherwise in certain specified circumstances);
- consideration of individual or public safety provide an exception to the otherwise absolute rule of professional confidentiality;
- that individuals working in any agency should have a clear understanding of their own roles and responsibilities;
- that confidential information should only be shared on an explicit need to know basis, with the knowledge of the person involved;
- that judgement about another's 'need to know' must be informed by an assessment of the likelihood of an increased risk that might be incurred if the information is not passed on.
- that organisations too have a duty to set down an explicit framework to guide staff members in collaboration with partner agencies;
- that professionals should be aware of their own personal responses to situations in order to avoid hasty assumptions or value judgements about an individual.

68. The Caldicott Committee¹⁹ was set up to review all patient-identifiable information passing from NHS organisations in England to other NHS and non NHS bodies for purposes other than direct patient care, medical research or where there is a statutory requirement for information. The NHS in Scotland has accepted the principles of the Caldicott Report. Other organisations contributing to mental health services are reviewing and developing policies in this area.

The Caldicott Principles

- Principle 1: Justify the purpose(s), (of the use or transfer of patient identifiable information).
- Principle 2: Do not use patient identifiable information unless it is absolutely necessary.
- Principle 3: Use the minimum necessary patient identifiable information.
- Principle 4: Access to patient-identifiable information should be on a strict need-to-know basis.
- Principle 5: Everybody should be aware of their responsibilities.
- Principle 6: Understand and comply with the law.

69. A key recommendation of the Caldicott Report adopted throughout the NHS in Scotland was the establishment of a network of Caldicott Guardians. Boards and Trusts must assist by developing the appropriate framework within which they will operate, including the development of protocols with partner organisations to govern the disclosure of patient-related information.

70. A Guardian will be a senior and experienced health professional, a member of the management board or an individual with responsibility for promoting clinical governance in the organisation. Guardians will be responsible for development of internal policies which are compliant with the Caldicott principles and protocols with partner organisations which will underpin the development of cross boundary working and current policy initiatives flowing from 'Designed to Care'⁵ and 'Modernising Community Care – An Action Plan'²⁰.

71. The Health Department is also addressing the need for national guidance on sharing of information between health and other agencies.

72. However, for mental health services issues of confidentiality and information exchange have moved from the relatively closed world of the NHS into the more open world of the community where there is a complex pattern of partnerships between a wide variety of services and agencies.

Vignette

Mary was referred to the project by the NHS Trust. During the assessment period every effort was made by project staff to gather all relevant information regarding Mary's history and presenting problems.

Shortly after joining the project Mary appeared to develop problems including difficulty sleeping and apparent suicidal ideation. Project staff regularly informed social workers and hospital staff who continued to maintain contact during the assessment period. Reassurances were given that Mary's difficulties were a result of resettlement and would settle in time. After a period of a couple of weeks the situation deteriorated. Mary appeared quite unwell, began to state a desire to harm others and demonstrated threatening behaviour.

Project staff contacted the duty doctor at the hospital who advised that Mary should take medication prescribed and if the situation did not settle within an hour, return to the hospital for an assessment. However, no beds were available and Mary eventually returned to the flat and slept. The following morning project staff contacted the hospital. The hospital felt the client's CPN would be best placed to deal with the situation. After numerous attempts to contact the CPN a visit was arranged to the CPN's office by Mary, accompanied by project staff. On arrival and after some delay the staff were informed that the CPN would not see Mary until a colleague arrived as the CPN felt Mary presented a risk. The project staff had not been informed of the existence of risk and were further surprised when asked if Mary's flat or person had been checked for knives. When asked to elaborate, the CPN refused, reasoning that the information was confidential, despite the fact that the project staff had assumed responsibility for Mary's care.

Mary was eventually assessed and admitted to hospital under the provisions of the Mental Health (Scotland) Act 1984.

At a debriefing meeting the social work department advised that they had not been informed of the risk identified by the CPN. The CPN refused to attend the meeting and subsequently refused to provide written information on the incident on the basis of confidentiality.

The project refused to accept the client again until they were in full possession of all relevant information. Mary's consultant psychiatrist eventually instructed the CPN to disclose all information and the situation was reviewed.

73. Given that a person with a severe and/or enduring mental health problem may come into contact with over 100 members of staff of different organisations in a 10 year history of contact, it can be seen that questions of confidentiality and the need for respect and privacy may be paramount in a service user's mind. Hitherto, the practice has been that information should not be given to a third party unless informed consent of the patient has been given, unless disclosure is required

by statute or by a court, or if the disclosure is in the public interest, to prevent an identifiable harm from occurring.

74. While risk assessment should be a shared responsibility between relevant professionals, it should not be a negative process which results in the loss of autonomy and choice for the service user or patient. To reduce the possibility of the process seeming to be oppressive and unfair, it is important that from the beginning of their contact with the service, individuals take an active central role in the assessment and utilisation of their strengths. This will highlight the contributions they can make to reduce the likelihood and seriousness of the potential harm identified.

75. It is becoming clear that both the process of community care and the European Convention on Human Rights (Appendix B) are posing major challenges to practice deriving from traditional concept of confidentiality. However, different professional organisations and the courts may respond from a fixed or dated perspective, leaving the individual staff member exposed. Given that failure to pass on information about potential risk can contribute to an increase in overall risk in clinical psychiatry, it is important that the individual worker is supported within his or her organisation in following a generally acceptable standard of practice. This is central to multi-agency working and the containment of risk. If necessary the organisation should be prepared to support the individual before the courts.

General Medical Council Guidance for Doctors - Principles of confidentiality

Patients have a right to expect that you will not disclose any personal information which you learn during the course of your professional duties, unless they give permission. Without assurances about confidentiality patients may be reluctant to give doctors the information they need in order to provide good care. For these reasons:

- When you are responsible for confidential information you must make sure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received;
- When patients give consent to disclosure of information about them, you must make sure they understand what will be disclosed, the reasons for disclosure and the likely consequences;
- You must make sure that patients are informed whenever information about them is likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission;
- You must respect requests by patients that information should not be disclosed to third parties, save in exceptional circumstances (eg where the health or safety of others would otherwise be at serious risk);
- If you disclose confidential information you should release only as much information as is necessary for the purpose;
- You must make sure that health workers to whom you disclose information understand that it is given to them in confidence which they must respect;

If you decide to disclose confidential information, you must be prepared to explain and justify your decision.

76. These principles apply in all circumstances.

United Kingdom Central Council Guidance for Nurses

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest. (UKCC *Code of professional conduct*, clause 10).

Professional practice is based upon developing a therapeutic relationship with your clients. Confidentiality within this relationship should only be broken under exceptional circumstances and only after careful consideration leading to a conclusion that this can be justified.

When working with clients, a clear standard of confidentiality should be explained to them and documented at the first point of contact. This will ensure that the client agrees that some information may be made available to others involved in their care.

77. The development of electronic recording of patient-identifiable information, and the risk of data bases accumulating sensitive information with poor controls over access has led to the formulation of principles and the development of protocols. These are complex issues and a full discussion is not appropriate here. The advance of information systems and the Caldicott requirements will affect more and more services. For a fuller discussion see Anderson (1996).²¹

Networking

78. We all belong to a number of social groups, a characteristic of which is the mutual sharing of gossip or information about each other's activities. Factual or not this has an important function in making each individual a little more predictable on a day-to-day basis in his or her reactions.

79. Professionals attempting to assess an individual, and determine the degree of risk posed, need essential access to this informal information. Demanding access as a professional right is likely to be resisted; instead a more informal shared process has to be established with family, friends, advocates and other important individuals.

80. Understanding risk comes from a discussion about an individual service user's immediate needs, an analysis of the likely consequences of their actions and what might happen if those needs are not met.

81. This discussion should be based on the 3 principles of respect for the individual, *empathy* and *personal warmth*. As these principles are by themselves

insufficient, corroboration is the key to a solid foundation of the assessment. Risk often cannot be assessed without some challenge to the person's account, some clearing up of inconsistencies in the story and a degree of caring scepticism. It is a process which is analytic, objective, and open, rather than one which is secretive, intuitive and opaque. Some individuals may pose a risk which is quite unpredictable.

82. The point of this process is to reach a common understanding about risk factors, to decide on the likelihood of the individual's coping ability being able to meet each specific risk and the responsibility of those around to address any discrepancy.

83. A formal written record must be made of the steps followed in the risk assessment process, and the information obtained and verified, carefully documented. Because risk varies from day to day, those involved with an individual should see themselves as being part of a responsible and responsive network, forward looking, open to new evidence and changing its plans and actions accordingly.

Chapter 9 Care Programme Approach²⁹

84. The Care Programme Approach (CPA)²⁹ is one means by which this process can be formalised. It has the strength of being supported as a matter of Government policy, and by local agreements involving Health Boards, Trusts, and Local Authorities.

85. It is focused on those with complex needs assessed as being at some risk to themselves or others, where care is being provided by a number of agencies. It is about identifying needs, assigning individuals or organisations to meet those needs in an agreed and co-ordinated way, and regularly reviewing progress with the people who receive the services and with those who care for them. That process of review should be attended by the individual and his or her carer and a written record should be kept, which is available to all present or involved with the consent of the person receiving the service. An Accounts Commission/Social Work Services Group review (1998)²² showed a 100-fold variation in the number of people across Scotland subject to CPA, which suggested a degree of professional reticence and organisational sluggishness until then. Out of a total of just over 1,000 people on CPA in Scotland 700 were from 4 (out of 32) social work areas.

86. Some detractors argue that the CPA process is too bureaucratic, that somehow it is an excuse for lack of resources, that it is “too stressful” for service users to be involved, that there is a “lack of control” over confidential information and that there is no evidence base for its use. The counter view is that CPA is not an intervention or treatment but a process to support joined up treatment - a quality issue in fact. Organisations and staff ignoring the CPA increase risk and individuals receiving care and those around them are also put at unnecessary risk.

87. Further arguments in favour are that CPA formalises communication and does not leave the transmission of information to chance. It need not be bureaucratic, and the process can complement other service activities. It requires all to be explicit about their roles and gives clarity to the service user or carer as to what they can expect. Effective use of the process will maximise the best use of available resources. It avoids duplication and minimises risk. The benefits of properly co-ordinating care by a number of staff and agencies, joint communication and informed involvement of both service user and carer should not be underestimated.

88. Similar principles should apply in the management of individuals and the risks which they may present by community care assessment and care management processes when the severity of the presenting problems do not justify use of the CPA.

Chapter 10 Substance Misuse

89. Recent research has emphasised the high prevalence of substance misuse among acute in-patients – close to 50%. Alcohol is the major problem drug, with illicit substances second. Mental health service staff have to be aware of the tension between received social values, actual behaviour in the community, their own personal standards, and what is required of them professionally. These should not be confused when assessing risk and delivering care.

90. The Mental Welfare Commission commented in its 1996/97 Annual Report⁴ on a growing awareness, from carrying out its statutory duties, that illicit drug and substance misuse by in-patients in psychiatric units and hospitals was increasingly presenting problems to staff in maintaining acceptable and safe care environments. Many staff voiced concerns to the Commission about the appropriate course of action to take if they suspected or discovered that a patient had, or was using, an illegal substance. The patients described by staff to the Commission appeared to fall into 2 groups, those with a history of drug related problems, and a secondary diagnosis of psychotic breakdown, and those with a primary mental health problem who used drugs recreationally, or perhaps in an attempt to reduce their symptoms. In the first group there is the risk that substance misuse would worsen the mental health problem. In the second there is the danger that the misused substance would work against the treatment medication.

91. In all cases, staff reported problems in deciding how to act in the patient's best interests, being aware of their mental state at the time, while respecting confidentiality and protecting other vulnerable patients and minimising their own legal liability. A survey of Trusts in Scotland who provided mental health services showed a worrying variety of approaches, and failure to address some of the key issues. Inaction exposes both organisation and staff to risk in an unjustifiable way. Action which is going to be effective in dealing with the issues has to maintain a balance between individual rights to privacy and wider concerns.

92. Specialisation of psychiatric services has allowed the development of innovative and more effective ways of practice. However, it is clear that individuals with mental health problems do not fit easily and simply into just one category. Boundaries between specialist services can serve to obstruct integrated comprehensive and best care for individuals. Clinical improvement cannot be achieved in this area by putting one set of problems on “hold” while the other is dealt with.

93. Thus agencies that provide mental health services need to work out with the police and their own legal advisers, clear policies and guidance for staff on:

- when it is appropriate to search in-patients and their belongings;
- implications of the legal status of individuals and their civil liberties;
- informing individuals of the harm done to their mental state by substance misuse;

- mechanisms of informing service users of services of the dangers of substance misuse, the local policy regarding searching belongings for an individual's supply and what rights an individual has;
- local agreement with police and the Procurator Fiscal about the steps to be taken if illicit substances are found;
- disposal/transfer of surrendered/discovered illicit substances;
- urine testing to screen for illicit substances;
- training staff to perform these duties sensitively.
- training which reflects the skills they need to practise there and then, updating and augmenting earlier training;
- awareness of the policies and relevant operational guidance in existence.

Service Co-operation

- essential elements of care cannot be assumed to be the responsibility of another service or team without negotiation and agreement;
- throughcare and shared care have to be defined and practised explicitly;
- services which users clearly need have to be available;
- any CPA intentions must take co-existing substance misuse into account.

“.....clearly he was under the influence.....”

94. The additional influence of intoxication, by drugs or alcohol, is a complicating factor in the assessment of the risk an individual poses to himself or others. About two-thirds of all episodes of deliberate self-harm take place under the influence of alcohol. Alcohol consumption and substance misuse add greatly to the potential for violence to self or others. Individuals present to general practitioners, A & E departments or to mental health crisis services seeking help, often admitting to suicidal thoughts but are unpredictable in behaviour and reaction. They have to receive assessment and care which is professional, humane and appropriate.

95. In a forensic context, intoxication is not a defence against conviction for a crime committed under the influence. In a mental health service context violence or damage should be dealt with by informing the police and pursuing redress. Personal responsibility continues. Yet there is a common law responsibility to care for someone temporarily “out of his mind”. Also there are professional responsibilities to behave within expected limits to an individual defined as a patient. Intoxication alone is not a reason for refusal to see a person – instead, it is a reason for that person to be seen in the right environment with the right supports available for the safety of all concerned.

96. The staff member may be irritated and feel that time is being wasted, blame the individual for getting into that state, and feel anxious because of previous adverse experiences.

97. Individuals may be anxious about approaching services and use alcohol to calm themselves. A hidden physical injury or illness may be present, affecting behaviour adversely. Every effort has to be made to speak to any informant who can give an account of the previous few hours. Has there been a previous history of self-destructive behaviour? That day? What are the risk factors known to those around the individual? Particularly are there risks to others in the individual's circle who are at risk from his behaviour while intoxicated?

98. One of the paradoxes in service provision is that emergency out-of-hours psychiatric rota may leave decision making on such anxiety provoking matters to a junior, inexperienced doctor. The availability of supervision and willing support from senior colleagues is absolutely essential. It is questionable whether an individual should be seen by just one worker – good, safe practice demands 2 at least. Operational policies should be in place to plan for the risks found especially in this situation and managers should be closely involved in monitoring events.

99. When it is decided that an admission is appropriate, in-patient nursing staff deserve to receive the additional support required to provide the care the individual needs.

100. Sending an individual away to “cool off” may increase the potential risk without attendant safeguards, such as a reliable, unintoxicated companion alert to the dangers.

Chapter 11 Clinical Governance

101. *“To improve health care we require not better professions, but better systems of work. A “system” in this sense is a set of elements inter-acting to achieve a shared aim. Here is the trick: to improve the performance of the system you need to attend more to the inter-actions than to the elements. Great (mental) health professionals do not make great health care. Great (mental) health professionals inter-acting well with all of the other elements of the health care system make great health care. Professional associations that wish to lead socially responsive improvements in technical care, service, outcomes and costs have no real choice but to invest in improving inter-dependency among individuals, professions and organisations” (Don Berwick (1997)).²³*

102. Any discussion of better care occurring even in part within a health service context cannot ignore the introduction of clinical governance.⁵ It has been defined as “the means by which organisations ensure provision of quality care, by making individuals accountable for setting, maintaining and monitoring performance standards”. The central change is that the Chief Executive of the Trust will be made equally accountable for the delivery of quality of care to the previous requirement to maintain the fiscal integrity of the organisation. As pointed out by Berwick, one of the themes emerging is that management will expect individuals from different disciplines to work together to take corporate responsibility for service improvement. The components of clinical governance – risk management, quality assurance, clinical effectiveness, audit, and continuing professional development have been around for a while. Clinical governance acts as the higher order context to make these components more than the sum of the parts. It is expected that clinical governance will be delivered within the existing budget. Here is the difficulty – is the glass half full, or is it half empty? On the one hand integrating all the components takes time to implement and for staff to contribute. The staff resources available to an organisation are finite and time spent in this way has a cost. On the other hand, systems which are efficient, effective and get it right first time save money. **Particularly in the management of risk the cost, personal and fiscal, of not getting it right first time can be very high.** There may be no second chances.

Vignette – Extract from the determination of the Sheriff after a Fatal Accident Inquiry

“The evidence revealed a casual or indifferent attitude on the part of some of the staff at ‘the Unit’ to the monitoring of unaccompanied time out. Having regard to the fact that ‘the Unit’ is for acutely unwell patients, it is not acceptable that such an attitude should exist. While I accept that the Trust has devised and published policies and guidelines in relation to the management of acutely unwell patients, they are of worth only if they are known about, acknowledged, understood and followed by all those involved in the care and control of acutely unwell patients. In order to secure such awareness, recognition, comprehension and practice, it is essential that staff at every level are provided with appropriate training. For such training to be of practical use and benefit, there obviously needs to be in place proper facilities and procedures. I consider that this Inquiry has revealed a need for a review to take place at ‘the Unit’ in relation, in particular, to the recording and monitoring of unaccompanied time out. While I accept that it is difficult to strike a balance which properly weighs the interests of individual freedom, therapy and responsibility against intervention, and while I accept that staffing levels and the recruitment, deployment and attitude of staff are difficult issues, I take the view that a real need for reassessment at ‘the Unit’ has been demonstrated by this Inquiry.”

103. Mental health care involves a partnership between different agencies, with different traditions and cultures; is clinical governance a health service driven imposition which partner agencies, and their staff, have no option but to go along with? In one sense, there can be no argument that the aims of clinical governance would be subscribed to by most health care and associated organisations. Quality assurance, effectiveness, continuous staff development, risk management and fiscal prudence are generally desirable. A source of comfort to partner agencies is that while clinical governance is a term which has been in use for 2 years, at the time of writing, nowhere can it be seen to be fully implemented. The concept is still evolving. This is because it is a revolutionary way of doing things. Instead of standards being imposed from above, with no local ownership, necessarily resulting in partial adoption and implementation at best, clinical governance can only work by a partnership between service users, carers, members of clinical and care teams and management. This allows partner agencies in the climate pervading the NHS in Scotland to contribute on the grounds of a shared set of aspirations for better services and care for people.

Accountability

104. The essence of accountability is the identification and acceptance of the mutual roles and responsibilities of each clinical or care staff member and manager. The complex nature of mental health care and the services which provide it, dictates a new approach to this task. The setting of clear standards for practice, training, communication, recording and risk assessment is crucial. Standard setting from the top down does not work well in any care system, without

continuing strenuous efforts being made to persuade workers of their appropriateness. Bottom-up standard setting, where service users and front-line workers have a major input, is much more likely to succeed. However, both staff and organisations will need to be able to demonstrate the reasonableness of the standards set, the monitoring arrangements used, and the actions taken to remedy poor service provision. Professionals will be expected to participate in internal and external peer review, and management will be expected to ensure the use of a mix of internal and external audit methods. External audit in this context might mean the Scottish Health Advisory Service, the Clinical Standards Board for Scotland, or the planned Scottish Commission for the Regulation of Care. Internal audit can be achieved by a process known as Controls Analysis or Assurance. This is a process by which the Board of a Trust or other mental health service provider can be satisfied that systems are in place to identify and manage risk.

Implementing Clinical Governance

105. The central elements are the people, the mechanisms, communication, effective care and clinical practice, the right processes and accountability.

106. The essential *people* issues are:

- the development of natural multi-disciplinary and multi-agency teams, with clear accountability and leadership;
- clear policies and procedures for the team to function, with **local ownership**;
- regular team training, with an emphasis on multi-disciplinary and multi-agency responsibility (commercial training packages are available. It will depend on an organisation's circumstances whether an in-house team can be justified);
- regular internal and external appraisal of team function;
- listening carefully and acting sensitively on what users of the service and those who care for them have to say, through advocacy if necessary.

107. The *mechanisms* will include:

- quality monitoring systems based on clear, robust standards;
- care pathways, with auditable standards defined for each step;
- accreditation of teams against operational standards;
- internal and external practice audit;
- control analysis to identify, quantify and reduce risk in areas where it is predicted to occur;
- a risk management committee;
- pathways for user input as a necessary and essential component, with advocacy as appropriate.

108. *Communication* means that all parts of the organisation find out where the risks are and what is happening by:

- control analysis;
- critical incident reporting;
- confidential reporting;

109. *Effective clinical practice* means:

- people from all disciplines looking at the research to base practice on good evidence where possible;
- staff sharing and taking personal responsibility for the development and maintenance of appropriate care standards;
- systems of supervision and mentoring must be available to staff to allow personal development plans to be formed and implemented;
- systematic implementation of relevant guidelines; and
- collecting the right information to answer the right questions about how well the team is doing, from its point of view, and the point of view of those using the service, and those caring for them.

110. The *processes* will:

- be open and transparent, to all;
- be strongly influenced by individuals who use the service and those caring for them;
- be led by care or clinical staff;
- recognise and esteem good practice and performance;
- identify and deal with poor performance;
- become part of the day-to-day work in a care or clinical setting; and
- encourage personal and collective reflection on practice.

The Critical Incident Review

111. There are 2 essential tasks – to develop and maintain practice in a way which minimises risk and to use untoward incidents constructively to show where the existing system has not worked as well as it should.

112. Critical incident reviews (CIR) often shed light on difficult areas and indeed demonstrate from life how systems function when under pressure. An organisation’s errors may well be its “greatest treasure” That treasure has to be used constructively, with a culture of sharing it responsibly throughout the service. It is only when all involved in the organisations - Chief Executive, senior managerial, clinical and care staff, and front-line workers - feel mutually supported, working to a common goal that good practice can develop reliably and consistently.

113. There are no national NHS in Scotland guidelines which CIRs should follow. In each of its annual reports the Mental Welfare Commission for Scotland exhorts clinicians to review thoroughly the circumstances surrounding a patient’s suicide, or other similar untoward incidents, but does not provide a model of practice for clinicians to follow. It is open to each Trust to produce its own protocol.

114. However, having a CIR protocol as part of Trust procedures is not enough in itself. The CIR should be part of a system of clinical risk management which is supported at every level within the Trust, from the executive board through the medical and nursing directors, the clinical governance committee, individual professional groups, down to multi-disciplinary clinical teams, working either in the wards or in community settings. Important features of such a system, which too often are ambiguous at present, include:

- a clear definition of what constitutes a critical incident;
- capture of “near misses” (analysis of which reveal just as much about potential deficiencies in care processes) ensured by;
- full reporting of critical incidents and “near misses” by staff who should be confident that the organisation’s response will not be retributive;
- support for the CIR process by senior clinical staff and relevant management;
- systematic distribution of the outcomes of the CIR through the rest of the organisation in a “What can we all learn from this?” mode;
- action taken to remedy any unmet training requirements revealed by the CIR, across the Trust;
- explicit mechanisms for support of staff, other patients or relatives or members of the public who may have been affected by the critical incident with follow up; to ensure a satisfactory outcome (this does not imply an automatic instigation of “post trauma debriefing” or counselling);
- commitment at all levels in the Trust to implement Integrated Care Pathways for the management of processes (assessment, admission, management of psychosis etc). These allow standards of practice to be developed locally in the light of prevailing good practice;
- *exception analysis* conducted on a regular basis to detect when care pathways have not been complied with, and why (this allows staff to remedy the deficiencies for an individual and to amend practice to make the omission less likely to occur);
- an information system, paper based or electronic, within the organisation which captures all of the above and can yield it in a form useable for both local clinical purposes and for review by Trust management;
- an expectation of continuing effort by local teams and managers to improve practice.

115. The protocol (Appendix D) for the conduct of CIRs is a good model derived from practical experience and, if implemented appropriately, should result in a thorough, open examination of the circumstances surrounding a particular episode.

Confidential Reporting

116. A system of risk management, based on openness and the clear assumption of responsibility should not have to rely on “whistle blowing” by an individual concerned about a particular matter. A confidential system which allows a staff

member with a concern about an episode or procedure to point to the issue can be valuable. There are obligations. The system breaks down if it is used to pursue grievances. It has to involve the staff member revealing a name. The people raising issues have to accept that their views may not prevail when balanced up against the risk management committee's perspective. Staff have the right to careful consideration of the issue, with a senior clinical manager, a member of the risk management committee, assessing issues and reporting regularly to it. Confidential means just that and a person using the system should be protected from retribution by others whose practice may be questioned as a result of the report. If trust in the system can be generated by how it is seen to operate, it allows the organisation to start to learn to do better. Only if the system is failing is an individual justified in following a route to outside agencies, such as the Mental Welfare Commission for Scotland.

Primary Care

117. The sub-group's remit was to cover mental health services. The first point in the *Service Element* section of the *Framework* covered the interface between primary and secondary health care, and social work. General practice has a major role to play in the provision of comprehensive mental health services. All members of the primary health care team, including receptionists, are involved. The continuing assessment of risk and its management is an ever present task. The existence of the Primary Care Trust with mental health services firmly embedded is an indication of the determination to move to a community focused service. The sub-group hopes that the points outlined above will be helpful to local healthcare co-operatives in working out and implementing management of risk policies. It will be for individual Primary Care Trusts to decide with their component co-operatives on whether there should be one risk management committee for the organisation, or several, one for each component. Because boundaries seem to make risk management more difficult, there is something to be said for having just one.

Chapter 12 Estates (Facility Design)

118. The environment in which care is delivered in mental health services can have a direct impact on the risk that both those using the service and those providing it experience. Whether in a community facility, a crisis house, a drop-in centre, or an in-patient ward, there are design features which make a building welcoming, easy to use, and safer.²⁴ To ignore these is courting trouble, does not comply with health and safety at work regulations and puts unneeded additional pressure on those within. When new facilities are being designed, the architects have to be briefed in a clear and consistent way. However, many services are delivered from older buildings, perhaps designed for other purposes, or erected at a time when operational practice in the service was very different to the philosophy and style described in this report.

119. No building is entirely risk free, and excessive attempts to minimise risk are likely to lead to a sterile, “clinical” atmosphere, which does not bring out the best in human behaviour. There are clashes too between the need for privacy, and some personal space, and clear sight lines. A facility which is designed obviously to deal with crises risks causing an atmosphere of tension and alarm. To have to run a gauntlet of security measures to gain access to a facility will tend to make an individual wonder whether getting in will lead to satisfactory care. Some points must be attended to – shower or bed curtain rails must not be able to bear an individual’s weight. This simple measure can be life-saving. Facilities generally should be on the ground floor whatever the precautions. Upstairs windows are fail-danger.

120. There are gender issues too. While people generally belong to social networks which contain both genders, single sex existence in the community is a matter of choice. The wish to normalise in-patient or residential care suggested that mixed sex accommodation was to be preferred, to lessen the jump from the outside world to the care situation. Now it is clear that in ward mixed sex accommodation many women feel intimidated and at risk of constant harassment, particularly in acute in-patient care. It may not be only the ward environment – corridors, entrances and lifts may all be risky places. For that reason, all Trusts in Scotland have been asked to implement changes in accommodation which will meet guidelines by 2001.³⁰

121. Individuals, unless liable to detention on an order under the Mental Health legislation should be free to come and go. Because of the high prevalence of substance misuse described in Chapter 10 and the related problems for mental health care delivery, that freedom to come and go should not be used as an opportunity to replenish supplies of an illicit drug, or to distribute those supplies to fellow service users or to consume disproportionate amounts of alcohol. For that reason a multiplicity of entrances and exits from a facility makes the management of this area of risk more difficult.

122. Another risk associated with substance misuse is the increased likelihood of assaultive and violent behaviour by an individual affected by both the substance and a mental health problem. The impact of assaults on staff and fellow residents has been documented well.²⁵ The more private and secluded individual sleeping accommodation becomes in line with good practice to promote personal dignity, the more vulnerable individuals are, out of sight and out of hearing. For that reason, many mental health services have found it necessary to install some system involving personal alarms for the protection of staff. Unobtrusive systems exist which involve individual clip-on boxes, the size of a personal pager, and detectors in every room used for clinical purposes. These are linked to a warning light external to each room which shows those coming to an individual's assistance from where the alarm call has come. A master panel near to the duty room gives those coming into the unit to give assistance from outside a clear indication of where to go. Such systems in themselves do not reduce risk. As has been said repeatedly in this report in other contexts, the alarms and indicators are viable only if they are incorporated into a system which is robust, supported, reviewed and maintained.

123. Reference has already been in a vignette (page 19) to the problems associated with assessing an individual who has been brought to an Accident & Emergency Department by the police. All too often, interview rooms have not been designed with any recognition of risk reduction.

Vignette

A mental health facility is on the edge of a District General Hospital site. The psychiatric and clinical psychology out-patient department is situated in a former nurses' home at the very edge of site, 300 yards from the DGH. The width of the corridors and layout of the rooms is unchanged from the original design. Apart from clinical staff there is just the one receptionist. There is an answerphone system but individuals frequently have difficulty operating it and the receptionist has to walk to the front door to let them in. She has an office, but there is no microphone to allow her to hear through the glass panel, so she has to go to the door and open it to speak to the individual. Some staff have alarms, but there is no pinpointing system and the alarms would only be heard if there were individuals in other offices. Each office has only one door, with a handle on the inside. The width of the corridor means that it could be easily barricaded. Calling for outside assistance would require people to be available in the DGH building and to be fit enough to run 300 yards uphill to give assistance. There is no rehearsed or reviewed security policy.

124. Rooms in which people whose behaviour is not predictable are to be interviewed and who therefore pose a potential risk should be modified to meet the following requirements:

- There should be 2 separate doors;
- Neither door should be capable of being blocked on the inside or outside ;

- Neither door should have an inside handle which could be used to stop the door being opened from the outside;
- There should be viewing panels with no curtain or shutter in both doors and the walls which permit all of the interior space to be seen;
- The furniture should be fixed to the floor;
- The rooms should be situated in an area which is staffed throughout the time period in the day when the room is expected to be used. Members of staff should carry a personal alarm, which is linked to the outside in a way which gives an immediate alert, which in-turn leads to effective action;
- The service in whose facility the room is situated must have full responsibility for maintenance and response to emergency calls.

125. The Estates Department of a Trust or service needs to be closely involved in the reduction of risk. Any facility which is used by individuals for whom the service has responsibility should be the subject of a regular audit of its fitness for purpose, paying attention to the points above, and those mentioned in any guidance material.²⁶ The results of these regular audits should feed in to the organisation's risk management committee and a senior member of the Estates Department should be a member of that committee. The organisation should be in a position to fund any modification to buildings or rooms which the audit, or the results of critical incident reviews, have indicated constitute a risk to both staff and the individuals receiving a service from there. There are wider issues concerned with the state of fabric, decoration and comfort of facilities which also contribute to risk.

APPENDIX A

Sub-Group Membership

Tony Wells (Chairman)*	Chief Executive, Tayside Primary Care NHS Trust
Mary Ward	Manager, Adult Care Services, Social Work Department, Dundee City Council
David Bertin*	Clinical Nurse Manager, Argyll and Bute NHS Trust
Joseph T O'Donnell*	Procurator Fiscal, Ayr
Jim Eaglesham	Glasgow Association for Mental Health
Shona Barcus*	Chief Executive, Scottish Association for Mental Health
David G C Owens	Reader, Dept of Psychiatry, The University of Edinburgh
Jim Connechen	Director of Nursing, Crichton Royal Hospital, Dumfries
David Hay	Acting Superintendent, Strathclyde Police representing Association of Chief Police Officers in Scotland
Colin Strang	Superintendent, Strathclyde Police representing Association of Chief Police Officers in Scotland
Mike Dean	Superintendent, Strathclyde Police representing Association of Chief Police Officers in Scotland
Jamie Malcolm	Nursing Officer, The Mental Welfare Commission for Scotland
Susan Kirkwood	Chairman, National Schizophrenic Fellowship (Scotland)
Elisabeth Hill*	Chair, Angus Mental Health Association
Chris Taylor	National Development Worker, Carr-Gomm Scotland
Neil Fraser	Clinical Services Manager, Sunnyside Royal Hospital, Montrose
Colin Gray,	Consultant Forensic Psychiatrist, State Hospital, Carstairs
Andrew Russell	General Practitioner, Wallacetown Health Centre, Dundee
John Loudon*	Principal Medical Officer, Scottish Executive Health Department
Ewen Cameron (Secretary)	Executive Officer, Scottish Executive Health Department

* Editorial Team

APPENDIX B

European Convention on Human Rights

The European Convention on Human Rights was adopted in 1950 and drafted within the Council of Europe which was itself formed after the Second World War. The Convention was a reaction to fascism which had devastated Europe in the 1940s and at the time was seen also as a bulwark against Communism. It came into force in 1953 but had to be ratified by the Member States of the Council of Europe.

For almost 50 years the UK has been subject to the Convention since the Convention itself was signed and ratified by successive UK Governments. The Convention was never directly incorporated into United Kingdom Law and therefore citizens of the UK were not able to have those Rights protected by the domestic Courts. This had the knock-on effect of forcing citizens of the UK to go to the European Court in Strasbourg which could be a lengthy and costly process.

However that has now changed with the passing of the Human Rights Act 1998 which received the Royal Assent on 9 November 1998. Section 18 (Appointment to the European Court of Human Rights) 20 (Orders etc under the Act) and 21(5) (Interpretation etc: replacement of death penalty) came into force on the passing of the Act.

Section 57 of the Scotland Act (1998) provides that a member of the Scottish Executive has no power to make any subordinate legislation or to do any act which is incompatible with any of the Convention Rights. Since 20 May 1999 the Prosecuting Authorities in Scotland have been obliged to comply with Convention Rights as defined by the Human Rights Act 1998.

Section 6 of the Human Rights Act provides that it is unlawful for a Public Authority to act in a way which is incompatible with a Convention Right and act includes a failure to act.

This Section crucially however does not apply to an act or failure to act if the Authority, as the result of other primary legislation, could not have acted differently. In other words if the Public Authority by statute is compelled to act in a certain way then acting in that way even if it breaches a Convention Right will not give rise to unlawfulness.

Not all the articles contained in the Convention are incorporated by the Human Rights Act but the most important of the Articles are.

Section 7 of the Human Rights Act provides that a person who claims that a Public Authority has acted (or proposes to act) in a way made unlawful by the Human Rights Act may bring proceedings against the Authority under the Act in the appropriate court or tribunal but only if he is (or would be) a victim of the unlawful act. (The person may rely on a right or rights deriving from the Convention in any

legal proceeding.) In other words only a person affected by the act can bring an action and not for example a third party such as a pressure group.

Section 8 of the Human Rights Act provides that in relation to any act or proposed act of a Public Authority which the court finds is unlawful it may grant such relief or remedy or make such order within its powers as it considers just and appropriate and that would include an award of damages where appropriate.

In the context of this sub group the most likely relevant Convention Rights are:

- Article 5 which is the right to liberty and security and provides that no one shall be deprived of his liberty save in specified cases and in accordance with procedure prescribed by law;
- Article 5, paragraph 1(e), allows for the lawful detention of persons for the prevention of the spreading of infectious diseases, for persons of unsound mind, alcoholics or drug addicts or vagrants;
- Article 5.2 gives a person the right to prompt knowledge of the reasons for the arrest and, if detailed for psychiatric reasons, the knowledge that he or she is detained;
- Article 5.5 gives an enforceable right to compensation for unlawful detention;
- Article 5, 4 provides everyone who is deprived of liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of detention shall be decided speedily by a court and release ordered if the detention of not lawful;
- Article 8 provides a right to respect for private and family life which includes home life and correspondence. It provides that there has to be no interference by a Public Authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and the freedoms of others;
- Article 3 also may apply which provides that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

These specific Articles bearing on mental health issues provide for procedures and safeguards relating to the detention of persons on grounds of mental illness. The term “unsound mind” in Article 5 is not precisely defined. The Court has decided that the concept is to be narrowly interpreted given the importance of the right to liberty. Before someone can be lawfully detained in terms of the Treaty that person of “unsound mind” has to be one suffering from a true mental disorder established by objective medical criteria. It has to be of a kind of degree to warrant compulsory confinement and the validity of the continued detention depends on the continuation of the disorder.

Medical authorities are allowed a certain discretion or margin of appreciation with regard to evaluating the patient’s condition and are entitled to proceed with caution

before the release of such a person is allowed. Medical authorities must conform to a legal framework imposed by domestic law.

Finally it is important that a review process is in existence to review the lawfulness of the detention and the continuing need for it.

So far as Article 3 is concerned (the prohibition on torture), the European Commission has found that compulsory medical treatment is not struck at by Article 3 if it is necessary from a medical point of view and carried out in conformity with agreed medical standards. It follows of course that stepping beyond accepted medical practice would possibly constitute a breach of this Article.

There is no specific mention in the Convention of protection of confidentiality but the considerable case law which has built up over the years in the Strasbourg Court would seem to indicate that the Convention can stretch to cover situations not obviously covered by the Articles itself.

The Commission and the European Court seem to accept the necessity to protect the confidentiality of medical records and if such records are to be disclosed to a third party then disclosure must be justified in the public interest outweighing the interest of the individual not to have disclosure.

This vital principle of confidentiality of medical data was emphasised in the case of *Z -v- Finland* and in *M.S. -v- Sweden*. In the case of *M.S. -v- Sweden* it was found legitimate for State Medical Authorities to pass onto Social Insurance Authorities details of the medical history of a claimant. It was held that the balancing exercise justified the passing on of the details and that the breach of confidentiality was justified. However in the case of *Z -v- Finland* disclosure of a witness' HIV status was not accepted as legitimate.

The existence of a Convention Right does not mean that the person alleging infringement of this right will automatically be successful.

The most important fundamental principle underlying all of the European Courts decisions is the fact that a Convention Right exists does not necessarily mean that it is paramount. Convention Rights of individuals will frequently require to be balanced with competing rights of other persons and with the interests of the community at large. In *Soering -v- UK* Series A, no 161; (1989 11 EHRR.439) the European Court of Human Rights stated that “inherent in the whole Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the individual’s fundamental rights”. It follows therefore that the Convention Rights of one party cannot be considered in isolation. For example the search of an accused’s house under warrant obviously prima facie breaches the Article 8 Convention Right to respect for home and correspondence but the interest of society at large in obtaining evidence outweighs this individual Convention Right.

This approach to balancing the competing interests has been described as “proportionality” (i.e. no sledgehammer to crack nuts). In addition the European

court has in several cases applied what is known as “the margin of appreciation”. In general this means that the State is allowed a certain measure of discretion in taking action which might breach a Convention Right. For example in the Handyside case (“the Little Red Book” case) the court had to decide whether a conviction for possessing an obscene article could be justified under Article 10 as a limitation upon freedom of expression that was necessary for the protection of morals. Also implicit in this is a realisation that a certain degree of deference is given by the European court to the judgement of National Authorities when they weigh competing public and individual interests in view of their special knowledge and overall responsibility under domestic law.

It cannot be stressed too strongly that the proper minuting of decisions taken including decisions taken not to act are crucial. The effect of the Human Rights Act is that decisions taken many years ago may be reviewed in the future and the “paper trail” is crucial. In view of the measure of discretion allowed to Authorities even a decision which might be seen to be “bad” may be held legitimate if good reasons were recorded for the making of it in the first place.

CONCLUSIONS

1. The interaction between the Scotland Act and the Human Rights Act has resulted in practical changes for the Prosecution system in Scotland.
2. The Human Rights Act brings similar changes to all other Public authorities including Health Boards.
3. The assessment of Mental Health Risk and any action taken based on that assessment may constitute a prima facie breach of a Convention Right.

The principle of proportionality and discretion will operate to protect those making decisions provided a weighing exercise has been undertaken and decisions recorded.

APPENDIX C

The Assessment of Risk (Royal College of Psychiatrists Council Report CR53 (1996))

The essentials of this report are as follows.

There are 4 general principles:

- information from a single source is never going to be enough to assess risk, and corroboration will always have to be sought out and found;
- similarly one person alone cannot do an adequate risk assessment, and access to the network of people surrounding an individual is crucial;
- people who present a risk to others are likely also to be vulnerable, to self-harm, self-neglect or exploitation; (in other words the perception of others should not be allowed to blot out the possibility of that individual also needing protection); and
- factors such as age, gender and ethnicity are unreliable predictors of risk to harm to others.

In the history taken from an individual being assessed, certain items must be enquired after:

- previous violence or suicidal behaviour;
- “social restlessness” – few relationships, frequent changes of address or employment;
- evidence of poor engagement with mental health services;
- presence of substance misuse;
- a social background promoting violence;
- any precipitants or changes in mental state or behaviour that have occurred prior to previous episodes of violence or relapse;
- recent change in any of these risk factors;
- evidence of recent severe stress, especially major losses;
- evidence that medication has recently been discontinued.

It is important to identify potential victims, particularly those who figure in abnormalities in the patient’s mental state (eg, the focus of delusions or the apparent source of hallucinations). In the patient’s mental state the emotionality with which he presents (for example irritability, anger, hostility or suspicion) is important, as are specific threats made by the patient. Also beliefs of threat, or persecution or control of mind or body by external forces is noteworthy.

In recording the assessment the following points have to be noted:

- how serious is the risk;
- is the risk specific to one person or situation, or is it general;

- how immediate is the risk;
- how volatile is the risk;
- what potential factors increase the risk, and what might decrease it;
- what specific treatment, and which management plan can best reduce the risk.

In managing risk, there are 2 basic principles:

- a person working within a mental health service, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to reducing that risk and managing it effectively; and
- in managing risk, the balance has to tip towards safety. That starts by engendering a relationship with the patient which makes him or her feel safer and less distressed.

Considerations for managing risk include:

- does he or she require admission as an in-patient;
- should he or she be detained under the Mental Health (Scotland) Act 1984;
- what level of physical security is likely to be needed;
- what level of observation is required;
- what medication should be used;
- it should be understood clearly by ward staff how the medication is to be employed;
- if there is another episode of violence, how should it be managed.

If the patient is being managed in the community, other questions come to the fore:

- is there a place for the Care Programme Approach;
- can the Mental Health (Scotland) Act be used, or is there a case for a community care order;
- what community supports are available, how effective might they be, and how can they best be assisted;
- do the carers and family have access to appropriate support and help;
- have the carers – in the family, and in other agencies – been adequately informed about the situation, how it is likely to develop, and what help they can expect to receive.

Fundamental to the management of any situation is:

- the plan of management clearly recorded in an accessible place, in legible writing;
- the date for review of the assessment and management plan should be set down, after agreement with all those involved. That date needs to be passed on to all those who need to know;
- the patient's general practitioner must be informed;
- individuals who should or are entitled to receive information should be identified and responsibility assigned to carry this out;

- the threshold for breaching confidence to ensure public safety has been defined;
- **if responsibility for the management of a plan of action is being passed on to another team or individual, it must be accepted explicitly. The information passed on must include all relevant detail.**

Responsibilities

The Clinician

- To respond as rapidly as possible when concern is expressed by a colleague or member of staff from a partner agency about an increased risk from a patient;
- Always to make a systematic assessment;
- Always to consult as widely as is possible and appropriate;
- Not only to make a decision on what needs to be done, but to make explicit the reasons for that decision and to write them down;
- Make a management plan based on the assessment;
- Record details of the management plan;
- Share the management plan as appropriate with all those who have a legitimate concern with its implementation;
- Make no assumptions about what other people will do – if their co-operation is required in carrying out a management plan, make sure that there is explicit consent;
- Make an appropriate arrangement for monitoring the management plan, making sure that a date is set and kept for subsequent review.

Clinical Teams

- Should have an agreed protocol for responding to patients showing significant risk. This protocol should identify:
 - the appropriate senior clinicians to be contacted to conduct assessment or re-assessment;
 - the means by which they should be contacted must be clear;
 - if the identified person is not contactable, a subsidiary route should be available;
 - to have agreed protocols for follow-up and review of patients;
 - to establish and maintain links with other agencies, based on mutual respect for the contribution which can be made, to involve them in the care and management of patients who present a significant risk.

Service Managers

- The effective assessment and management of people presenting increased risk of harm should be of the highest priority for allocation of resources;

- Risk assessment and clinical risk management is time consuming and expensive; the appropriate resources should be made available;
- Proper assessment and management of clinical risk cannot take place in an unsafe environment or within inadequate facilities;
- Senior staff must be expected always to be available to take responsibility for decisions about assessment and management of risk;
- Training has got to be supported and adequately resourced;
- Allowances and partnerships with other agencies should be maintained, and mechanisms put in place to ensure their maintenance.

APPENDIX D

Critical Incident Review

All organisations providing mental health care should have a procedure in place to review critical incidents. What is presented here clearly has a health bias. It is hoped that it can follow a template for others to modify and adapt for their own circumstances.

***ALL MENTAL HEALTH SERVICE PROVIDERS
POLICY DOCUMENT – THE CONDUCT OF CRITICAL
INCIDENT REVIEWS***

1. Introduction

1.1 Critical Incidents are defined as follows:

- a. Death of a resident in-patient or out-patient which is sudden or unexpected or where suicide is the most likely cause.
- b. Homicide allegedly committed by a resident, in-patient or out-patient.
- c. “Incidents”, including those which might have resulted in suicide or homicide, episodes where there is evidence of serious intent of self-harm or violence to others or which led to injury or disability.
- d. An event where an important policy, procedure, or practice was not followed by staff leading to a detriment or potential detriment of care - so called “near misses”.

Reasons for Review

1.2 There are a number of reasons why it is essential that the circumstances of such incidents are reviewed by service managers, any clinical staff or others, including those service users involved. Most importantly any factors which could have prevented the incident should be identified so that steps can be taken to reduce future risk. “Near miss” events may not have had an obvious catastrophic outcome, but luck should play no part in service delivery; the effect on others may be considerable. It is equally essential that the impact on staff members and individuals using the service of the incident is identified and that appropriate support is made available. The Review should also allow the needs of others, for example, relatives or carers of the individual, to be identified and met.

1.3 A Critical Incident Review is not part of the disciplinary procedure. Any matter involving discipline should be dealt with separately altogether (see paragraph 5).

2. Procedure:

If any member of staff is made aware of a Critical Incident as defined above he/she should report this immediately to their line manager who, in turn, will make this information available to the service manager for mental health and the lead clinician. Trusts should establish a system for the confidential reporting of incidents.

2.1 The line manager will be responsible for arranging immediate support for the immediate patient group and any members of staff involved in the incident and for ensuring that all relevant persons are informed. If there is any possibility that the event may be of interest to the media the on call general services' manager should be contacted.

2.3 On being advised of a Critical Incident the lead clinician in discussion with senior medical and nursing colleague will initiate a Review. The Review will be carried out by a senior member of staff from another part of the organisation. All available information will be taken into account as well as face-to-face contact with staff, workers from other agencies, individuals involved (accompanied by an advocate if necessary) and relatives/carers. Contact may be in a meeting or in one-to-one interviews. **The purpose of the Review is to establish matters of fact, not to attribute blame or responsibility.**

2.4 All patient records from all disciplines and including care plans must be passed onto the lead clinician immediately after the incident for safe keeping; they then will be passed onto the person carrying out the review.

2.5 The patient's RMO will inform the Procurator Fiscal of any sudden or unexpected death which falls within the categories listed in *Deaths in Hospital MEL(1996)33*.

2.6 The patient's RMO will notify the Mental Welfare Commission of the Incident and advise them that a follow-up report will be made available.

2.7 When the Review is complete a report should be made available to all relevant staff which must include the patient's General Practitioner. While the method and extent of the distribution should take account of the potential sensitivity of the information contained in the report, secrecy is not an option. The author of the report should convene a meeting of all those to whom it had been sent to discuss the contents and consider any implications. In particular, the Review should determine whether any aspect of patient care contributed to the incident and whether any recommendation should be made with regard to current clinical practice or policy.

2.8 A final report should then be prepared by the person leading the Review. This report should be forwarded to the Mental Welfare Commission and to the Medical Director of the Trust for consideration by the Clinical Governance Board.

3. Timescale:

3.1 Any member of staff made aware of a Critical Incident must report this to their line manager immediately.

3.2 If the line manager judges that there is any likelihood of media interest the on call general services manager must be advised immediately. The on call nurse manager and consultant psychiatrist should be informed immediately and the lead clinician and service manager advised of the Incident as soon as possible.

3.3 A Review should be completed within 4 weeks of the Critical Incident and the Multidisciplinary Meeting to consider its content should be completed within 6 weeks.

3.4 It is essential that the Review should involve affected patients, or carers, admitting an independent advocate if requested.

3.5 Wherever possible the Final Report should be available within 8 weeks.

4. Contents of Report:

4.1 The report should include the following factors, whatever the nature of the incident:

- a. A brief background of the service users involved, including a brief psychiatric history, any relevant personal details, a description of the assessment of the individual's needs, the risk assessment and the diagnosis.
- b. The care plan for the service user involved at the time of the incident, including an assessment of its relevance and the extent to which the planned care had been delivered to the user (and where relevant to other users of the Service).
- c. Significant events in the period before the Critical Incident.
- d. The service user's liability to detention under the Mental Health (Scotland) Act and, if voluntary, whether detention should have been considered.
- e. If the service user was in hospital comment on the level of observation.
- f. Where available the detailed circumstances of the incident.
- g. Actions proposed by the Procurator Fiscal and any comments from the Mental Welfare Commission.

h. Significant outcomes of the review with particular comments on any evidence of substandard care or recommendations to be made with regard to changes in practice, training or communication or working environment, together with a timescale.

i. Possible contribution of substance or alcohol abuse.

4.2 Where the incident has involved suicide or other sudden death reference should be made to subsequent contact with the service user's family, and what support has been offered.

4.3 Whether appropriate expressions of regret and apologies have been made to the service user(s) and carers.

5. The organisation normally will not institute disciplinary proceedings against staff as the result of the findings of a critical incident review.

Exceptions are:

- where behaviour has occurred which may amount to a criminal offence;
- where a staff member has been involved in a second similar critical incident, showing no learning from the first;
- where it is found that a staff member has failed to report an incident which meets the definitions given in paragraph 1.1;
- where behaviour is reported which is well beyond the bounds of normal professional practice.

APPENDIX E

All Mental Health Service Providers

Risk Assessment Checklist (please use black ball point pen to complete)

PATIENT/CLIENT NAME:

DATE OF BIRTH:

HISTORY

1. History of violence (ever)	<input type="checkbox"/>	Check list (tick all problems present in past year)	(ever)
0 None		Accidental harm at home	<input type="checkbox"/>
1 One incident		(eg, falling, careless smoking)	<input type="checkbox"/>
2 Two incidents		Accidental harm outside the home	<input type="checkbox"/>
3 Three incidents		(eg, wandering into road)	<input type="checkbox"/>
4 More than three incidents		Alcohol abuse	<input type="checkbox"/>
2. Most serious harm caused	<input type="checkbox"/>	Arson (deliberate fire-setting only)	<input type="checkbox"/>
0 None		Drug abuse	<input type="checkbox"/>
1 Minor injury		Overdose	<input type="checkbox"/>
2 Serious injury		Risk of abuse from others	<input type="checkbox"/>
3 Fatality		Risk to children	<input type="checkbox"/>
3. History of suicide attempts (ever)	<input type="checkbox"/>	Self-injury (eg, cutting)	<input type="checkbox"/>
0 None		Other method of self-harm (specify)	
1 One		
2 Two		Self-neglect	<input type="checkbox"/>
3 Three		Sexual assault (inc touching/exposure)	<input type="checkbox"/>
4 More than three		Violence to family	<input type="checkbox"/>
4. History of severe self-neglect (ever)	<input type="checkbox"/>	Violence to staff	<input type="checkbox"/>
0 No	1 Yes	Violence to other patients	<input type="checkbox"/>
5. History of risk to children (ever)	<input type="checkbox"/>	Violence to general public	<input type="checkbox"/>
0 No	1 Yes	Violence to specific other	<input type="checkbox"/>
6. History of containment (ever)	<input type="checkbox"/>	Other (specify)	
State Hospital	0 No 1 Yes	
Secure Care	0 No 1 Yes		
Prison	0 No 1 Yes		
IPCU/locked ward	0 No 1 Yes		
Compulsory Admission	0 No 1 Yes		
Temp Detention at Police Station	0 No 1 Yes		
7. Incidents involving the police (past year) (ever)	<input type="checkbox"/>		
0 None			
1 One	<input type="checkbox"/>		
2 More than one	<input type="checkbox"/>		
8. History of failure to take medication	<input type="checkbox"/>		
1 Yes 0 No			
9. History of unplanned cessation of contact	<input type="checkbox"/>		
1 Yes 0 No			

Detail of nature of risk

.....

.....

.....

State sources of information, who consulted and relationship to patient/client

.....

.....

Date & Time of completion Name (in Block Caps).....

Designation..... Signature

APPENDIX F

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