Review of
Care Programme Approach
Guidance for Restricted Patients
in Scotland
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MEMBERSHIP OF THE WORKING GROUP

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Members:
Membership of the main working group was not static throughout the process and each of the following members contributed by attending working group meetings.

Mr Stewart Alexander, Association of Chief Police Officers in Scotland
Ms Shaben Begum, Director of Scottish Independent Advocacy Alliance
Dr Fiona Bissett, Caldicot Guardian, Scottish Executive
Mr Peter Clarke, Social Work Team Leader, The State Hospital
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TERMS OF REFERENCE
The Management of Offenders etc. (Scotland) Act 2005 contains provisions in sections 10 and 11 which places a duty on certain responsible authorities, including the police and local authorities to establish joint arrangements for assessing and managing sex offenders and violent offenders. Health Boards are included in the joint arrangements in relation to mentally disordered offenders. This duty requires Responsible Authorities, including Health Boards to establish joint arrangements for the assessment and management of risk, posed by mentally disordered offenders. The Act provides a focus to build on the principles of the Care Programme Approach guidance and amend it as appropriate for those MDOs who fall within the remit of the 2005 Act. The Group had the following terms of reference:

“To review and revise the Care Programme Approach Guidance to ensure that the protection of the public is at the core of the decision making in respect of restricted patients’ rehabilitation. To establish joint arrangements for effective risk management requiring that all those engaged in a restricted patient’s care have an understanding of the risks presented by the patient and of the factors that might suggest a relapse in the patient’s conditions and be prepared to act where those factors appear to be manifest. The revised guidance will give clarity to the roles and responsibilities of the professionals involved in the care and treatment of the patient and the role of the agencies included in the information sharing process in order to enable the successful, safe rehabilitation of the restricted patient. To share the guidance with the Scottish Executive chaired Tripartite Group¹ and present guidance to Scottish Ministers for approval”

SUMMARY OF WORK
The Working Group first met on 7 April 2006 and subsequently met in full on a further four occasions, 9 June, 25 August, 27 September and 3 November. Additionally a literature review sub group was established and met on three occasions, 3 May, 26 May and 10 August.

At the meeting on 9 June it became clear to the group that further clarification was required as to where CPA guidance should sit in relation to Multi Agency Public Protection Arrangements (MAPPA) and a meeting was held on 10 August involving senior civil servants from both Health and Justice departments. At this meeting it way decided that CPA guidance should interact with MAPPA in a similar way to Integrated Case Management in the criminal justice system.

The Literature Review Sub Group, chaired by Dr John Crichton tackled three specific pieces of work, a review of the literature available, reviewing CPA Cases in Scotland and scoping current practice. One member of the group also attended a conference organised by the CPA Association in England on 10 May.

The report was initially drafted by Dr John Crichton and Dr Raj Darjee.

¹ Tripartite Group involved local authorities, SPS, ACPOS and Justice Department and worked with the Scottish Executive to develop legislation and develop MAPPA.
ACKNOWLEDGEMENTS

The Chair and the members of the group would like to formally acknowledge the assistance received from the restricted patients’ team at the Scottish Executive in the review of CPA cases for restricted patients and in helping with meeting arrangements at St Andrews House. Mrs Sharon Bruce, The Forensic Network Secretary has also provided invaluable assistance in coordinating diaries.

Thank you is also extended to Mr Geoff Huggins, Head of Mental Health Division and Mrs Elizabeth Carmichael, Criminal Justice Department at The Scottish Executive for helping to clarify the position of CPA within the MAPPA arrangements.

The Literature Review Sub Group would like to acknowledge the significant work that the Sainsbury Centre for Mental Health have done in compiling an extensive literature review as part of their “Back on Track?: CPA Planning for service users who are repeatedly detained under the mental health act.” This has provided the basis of the literature review for this report.

The Group is also indebted to the VISOR (Violent Offender and Sex Offender Register) team based in Kilsyth who also provided assistance to the group by meeting with Dr Raj Darjee to explain about the scope and role of the VISOR database.

Dr David James, Consultant Forensic Psychiatrist, Camelot Lodge, London, who has been involved in the implementation of MAPPA in England and Wales, has been helpful to Dr Raj Darjee in terms of understanding the English experience and the group would also like to thank him for his time and effort.
1. Introduction

This report aims to provide Forensic Mental Health practitioners with new guidance on the Care Programme Approach for Restricted Patients (CPA). This is in light of:

- new legislation particularly, Sections 10 and 11 of the Management of Offenders etc (Scotland) Act 2005; and
- the new Multi Agency Public Protection Arrangements (MAPPA)

Subsequently, the Mental Welfare Commission Inquiry into the care and treatment of Mr L and Mr M published in March 2006 further reinforced the need for revised guidance on these matters.

The implications of the Management of Offenders etc (Scotland) Act 2005 and the MAPPA will be considered in more detail in chapter 6.

The Mental Welfare Commission report identified weaknesses in the management of risk and the systems of clinical governance in local services. The requirements of the Memorandum of Procedure for Restricted Patients were found to be ineffective in addressing these weaknesses. The joint response from Scottish Executive, Greater Glasgow and Clyde Health Board and Glasgow City Council, made clear that the protection of the public is paramount and that steps must be taken to address the deficiencies identified to ensure that the public can have confidence in the services. As a result of this particular inquiry the Risk Management Authority (RMA) were invited to take forward work reviewing the risk management of restricted patients. As members of the CPA working group, and in recognition that their review and the work of the group are closely related, the RMA is conducting their review with regard to the discussions of the working group and the content of this report.

The report draws a number of conclusions associated with the management of Mr L which are of particular significance to the application of CPA, in particular for those patients on Conditional Discharge. It notes that there was not a plan to adequately identify and to respond to relapse of active psychotic symptoms. This should be part of a risk management plan. There had not been a systematic approach to risk assessment and management or the development of a contingency plan, to enable those involved in his care to identify risk indicators and respond to them appropriately. The report also notes inadequate intra and inter agency communication and liaison with the case management branch of the Mental Health Division at the Scottish Executive.

The NHS Greater Glasgow and Clyde response accepted that all restricted patients CPAs should be subject to a review cycle and supporting framework to audit communication regarding risk management, the effective interagency operation of risk assessment and management plans.

CPA is not currently integrated with a governance framework for the audit of restricted patient management.

A full outline of the policy context is attached at appendix 1 and an overview of the literature review at appendix 2.
2. Scope of current recommendations

Restricted patients are those subject to special restrictions because of the risk posed because of mental disorder. Restrictions are applied by the court, following conviction, a finding of insanity in bar of trial or acquittal on the grounds of insanity, by the making of a Compulsion Order and Restriction Order (CORO) or a Hospital Direction (HD). They are also applied following transfer of a sentenced prisoner on a Transfer for Treatment Direction (TTD). During a remand in hospital, patients are subject to certain restrictions especially in connection with suspension of detention. Restricted patients can only be given suspension of detention or transferred with permission of Scottish Ministers. Restricted patients on a Compulsion Order with Restriction Order (CORO) are detained without limit of time.

While the focus of this guidance is specifically for restricted patients, the principles can be extended to include all patients requiring the specialist care of a forensic service because of the risk they pose to others. If the population of patients identified as posing serious risk to others but not subject to a Restriction Order are not subject to the same quality of risk management there is a risk that there may be an increase in adverse events involving this population.

3. The Care Programme Approach

The Care Programme Approach was developed to help manage the personal risks posed in complex cases. It was introduced as mandatory in England and was recommended for use in Scotland in 1996 (Care Programme Approach for people with severe and enduring mental illness including dementia 1996 SWSG 16/96). CPA was endorsed as it

- formalised communication between agencies and multidisciplinary colleagues
- was explicit about the roles of each professional
- gave clarity to service user and carer
- did not need to be bureaucratic
- when properly working avoided duplication
- could be used to manage risk

4. Current CPA Practice

The group has carried out a review of current practice across Forensic Services in Scotland. This entailed collation of current paperwork from clinical teams across Scotland. It is clear from this review that practice varies considerably between different teams.

Some have a specific policy relating to the use of CPA for the forensic client group. Other areas have included the use of CPA within service operational policies and referral criteria/processes. Others again have used CPA in line with local area policy with no specific forensic consideration. In in-patient services the common practice is for CPA to be implemented at point of consideration for transfer or discharge from services. In other areas the process is also closely linked with patient review. One particular service views the use of CPA for all in-
patients as counterproductive, arguing that inclusion on CPA gives the individual a false hope about the point they are at in their individual journey through services. Due to this, CPA is often suspended following transfer from high security until it is felt that the individual is in fact ready to make the next transition to community living. In other services CPA is the main agent for regular patient review meetings and used throughout the patient journey.

In community settings CPA is not used routinely for all patients in every service. In most areas restricted patients managed by forensic community services are included on CPA. There are a small number of restricted patients within Scotland who are not managed by forensic services and not included on CPA. In some areas it is evident that practice is currently being reviewed and consideration being given to all forensic patients being included on CPA. Other areas have commented that use of CPA can be influenced by individual clinicians.

Paperwork used for CPA varies considerably throughout Scotland, ranging from very comprehensive to very basic. An aim of this work was to review paperwork used for CPA and propose a version that could be adopted throughout Scotland for use with restricted patients. There were examples of particularly good practice though some deficits were noted even there. However by amalgamating the documents it was felt that the group could devise a single document that would encompass the information required for the management of the restricted patient subject to CPA. This is further described and reproduced in Chapter 8.

5. Review of Current Restricted Patient CPA Cases

The Scottish Executive Restricted Patient team carried out an audit of the care programmes for conditionally discharged patients; this amounted to fifty (50) cases in total. In only 28 of the cases was specific CPA paperwork present. In the remaining 22 information had to be gleaned from a variety of sources including, Supervisor Reports, Community Care Assessment Forms and Part 9 Mental Health Act Care Plans.

The results were very disappointing. In the majority of cases there was no clear recording of even basic information as to the name of the RMO, the MHO, the ‘named person’, evidence of the existence of an Advance Statement, date of conviction/insanity acquittal or date of next CPA review.

Of particular concern with regard to issues of patient and public safety, the significant majority of cases had no recorded statement regarding risk present, no clear identification of risk factors and no contingency plan. There was no clear list of those in attendance and participation of the police seemed to be exceptionally rare.

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

There is a clear expectation that the revised CPA arrangements will address all these deficiencies. Following an agreed date of implementation there should be an audit carried out at the Scottish Executive Health Department ensuring that all restricted patients within 6 months of implementation should have had a CPA
meeting and that all the criteria identified in the CPA proforma have been addressed. Also the Scottish Executive Health Department should be satisfied that local services have a system of local clinical governance in place ensuring that the CPA process is running smoothly and that there is a system for collating all amber and red alerts and checking that the SEHD have been informed of all such alerts.

6. Information sharing

This chapter aims to highlight the key issues in relation to information sharing in the assessment and management of patients subject to restriction orders. Unlike England and Wales, the new Management of Offenders Act makes Health a Responsible Authority (along with the Police, Local Authorities and Scottish Executive) in such cases, rather than only having a ‘duty to cooperate.’ Health therefore has a statutory duty along with the other responsible authorities to

- Jointly establish arrangements for the assessment and management of risk posed by restricted patients who are violent or sexual offenders
- In the establishment and implementation of those arrangements act in co-operation with such persons who may be specified by Scottish Ministers (by order made by statutory instrument)
- Cooperate with each other and ‘duty to cooperate’ agencies, only to the extent that such cooperation is compatible with the exercise of their functions under any other enactment
- Along with the ‘duty to cooperate’ agencies in that local authority area draw up a memorandum setting out the ways in which they will cooperate with each other

In other MAPPA cases, i.e. in respect of non restricted patients, health is a ‘duty to cooperate’ agency. Criminal Justice and Health Departments within the Scottish Executive are working to establish protocols for information sharing as part of the implementation of MAPPA.

Multi Agency Public Protection Arrangements (MAPPA) have been established in England and Wales for 5 years. The legislative framework and policy background is different from Scotland but the MAPPA model will be the basis for the implementation of sections 10 and 11 of the Management of Offenders etc. (Scotland) Act 2005. Health will therefore have a responsibility for setting MAPPA in place in relation to restricted patients and to co-operate with MAPPA in other cases. MAPPA provide processes whereby agencies come together and share information, where necessary, to produce robust risk assessment and management plans for potentially risky individuals in the community. Scottish Executive Justice Department Circular JD 15/2006, issued in October 2006, provides guidance on the implementation of the Multi Agency Public Protection Arrangements (MAPPA) in Scotland.

There are three MAPPA levels based on the level of risk of serious harm posed by the individual and sometimes the complexity of the case. Most cases will be managed at level 1 where cases are notified to MAPPA coordinators, but MAPPA
plays no further part unless there is an escalation in risk. Level 2 cases will be discussed at regular MAPPA meetings and Level 3 cases (where there is felt to be a likelihood of serious harm imminently or perhaps where the case has a high media profile) will involve Multi Agency Public Protection Panels for the ‘critical few’. Where an individual’s risk level changes their MAPPA level would change.

The CPA process would be the process for planning a patient’s care and treatment and for risk assessment and management planning. For most restricted patients there would be notification to MAPPA but no review at MAPPA meetings. Level 2 meeting discussion may be necessary in some cases (see below) but Level 3 meetings would only be necessary in exceptional circumstances e.g. where patients are unexpectedly discharged by Tribunals despite being considered a high risk of serious harm. Even in such cases, the period following such a Tribunal decision to allow for an appeal to be lodged would give an opportunity for a MAPPA Level 3 meeting. Where a patient is discharged despite evidence of ongoing risk this should be pre-empted wherever possible with notification to MAPPA. This should be incorporated into processes such as the Early Discharge Protocol.

ViSOR (the Violent and Sexual Offender Register) is a database of violent and sexual offenders in the UK. It is primarily a risk management aid which is used by the police (and soon also criminal justice social work) to store and retrieve information on offenders. It has work control and diary functions (for the police) and allows access to an individual’s history. It has intelligence functions and can help in police investigations. When data is accessed there are clear accountability and audit trails, and the system is highly secure with controlled access.

As a basic principle information available should be no different for Mentally Disordered Offenders (MDOs). Information should be input by the Police or MAPPA Co-ordinator. The police should gather and update information in the same way as they do for other MAPPA offenders. For all MDOs ViSOR should have contact details of mental health professionals with ready access to the risk management plan (for both during and outwith office hours). Should any MDO be considered MAPPA level 2 or 3 then the same approach should be followed as for non-MDO cases.

It is best practice to engage as fully as possible with the patient regarding what information is to be shared with other agencies except when there is substantial risk of harm or the information is third party. The group did not think asking the patient's consent for information sharing would be fair as withholding consent would delay the patients progress and therefore was unlikely to ever be a choice free from such considerations for the patient. Rather the patient's assent should be sought and the principles of non-consensual disclosure followed: that only information necessary for proper risk management should be shared outside health and social care and the recipients should also treat such privileged information with necessary respect for confidentiality.

Admission to hospital
When the patient is admitted to hospital assessment should include consideration of all relevant background information. Records and other information from agencies such as SPS, local authorities, police, military, housing agencies, education, procurators fiscal and courts, as well as from other health services should be available to those assessing and treating the patient.
Specific individuals should act as conduits of such information. There may be problems with this information being shared with the patient (e.g. due to concerns about previous victims), so such information should be shared initially with a specific member of the clinical team and discussed by the clinical team. Individuals from outside agencies should be invited to help clarify any points of information. Outside agencies should be asked to highlight what information can and cannot be shared with the patient. Information not to be shared with patients should be stored in such a way as to make it clear that the information is from a third party and not to be disclosed. Problems may arise where a risk assessment or management plan contains reference to such sensitive information. If that information is not crucial to the risk assessment and management then it can easily be omitted. Where it is crucial then decisions will need to be made about whether all or part of the risk assessment and/or management plan are stored and communicated in such ways as to make sure that patients and others (e.g. named persons) do not have access to them.

Where an individual is disposed of under a CORO then the hospital or unit to which they are admitted should keep a note of the individual’s basic details in a list of patients that are subject to MAPPA. The patient’s records need to be endorsed appropriately to record that they are subject to MAPPA requirements. This should be included in the patients Care Plans.

These details need to be passed to national/local MAPPA coordinators for registration of individuals as MAPPA nominals.

**Detention in hospital**

During detention in hospital there may be a need for further information gathering, as set out above, especially if all the relevant information was not available on admission. Further information might be required from other agencies where consideration is being given to transfer, suspension of detention or discharge.

Information may need to be passed to non-health agencies where consideration is being given to suspension of detention, transfer or discharge. This will also be necessary where a patient absconds. For patients on suspension of detention there should be a contingency plan in case of absconsion where additional relevant information can be shared with police and other agencies for example a recent photograph. The police and other agencies should be invited to contribute to the risk assessment process and decisions will be made as to notification of details to MAPPA Co-ordinators.

**In the community**

Ongoing liaison with the police and other agencies should continue through the CPA process. Each service should have an identified person who acts as the main contact point for the police and should have an identified police liaison officer. This could be organized through local MAPPA processes.

Risk management plans would not be shared through MAPPA meetings routinely as restricted patients in the community would normally be managed at MAPPA level 1. MAPPA level 2 may become relevant if there are concerns about escalation in risk, but while a patient was subject to a restriction order level 3 meetings should not ordinarily be necessary. A situation where Multi Agency Public Protection Panel (MAPPP) might be necessary would be where a patient was non-cooperative and absconded whilst they were considered to pose an
immediate risk of serious harm to others. We recommend that in most cases police liaison with the CPA process should ensure that an individual noted on ViSOR as being a restricted patient will have contact details (including emergency contact) so that any intelligence or incident involving the patient can be communicated to the clinical team.

For most conditionally discharged restricted patients should their level of risk increase as to warrant MAPPA Level 2 procedures it would be normal to recall to hospital before those procedures are put in place.

7. Assessment and Management of Risk
As mentioned in the introduction to this report, following the Mental Welfare Commission report the RMA has been asked to examine the assessment and management of risk for the restricted patient group, and they are due to provide their recommendations to the Scottish Executive in December 2006.

However, it is well recognised that risk assessment (particularly of the risk of future violent and/or sexual offending and the level of harm it may cause) is a necessary and integral part of identifying the needs of forensic mental health patients and risk management is inextricable from treatment and management of this patient group. Therefore in the interests of developing coherent and supportive guidance and recommendations, this section sets out good practice with regard to risk assessment and management.

The Forensic Network has repeatedly stressed the importance of the assessment and management of risk with regard to forensic mental health patients. Most notably in the 2005 report, *Care Standards for Forensic Mental Health Inpatient Facilities in Scotland* which became Scottish policy as part of HDL (2006) 48

This report proposed three secure care standards that are relevant to all levels of security, along with eight others that are security level dependant; they have differences across high, medium and low security. Risk management is mentioned alongside care planning as part of the first generic standard:

"Standard 1: Assessment and Care Planning criteria:
The organisation is able to demonstrate evidence of audit of multi disciplinary assessment of need and risk, coupled with evidence of risk and care management and planning

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

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

The RMA publication *Standards and Guidelines for Risk Assessment* refer to risk assessment conducted under the auspices of Risk Assessment Orders and Interim Compulsion Orders and the principles of good practice within them can be applied more broadly. A further publication, *Risk Assessment Tools Evaluation Directory (RATED)*, provides information on the strengths and limitations of current risk assessment tools. In addition, the RMA will soon...
publish Standards and Guidelines for Lead Authorities who will be responsible for drawing up and implementing Risk Management Plans for persons who are subject to Orders for Lifelong Restriction, and it is expected that this document will represent current good practice in risk management planning.

**Integrated working**

CPA is used to facilitate multi-disciplinary and multi-agency working, and this is paramount in the assessment of risk, and the planning and implementation of risk management. The group recommends that local services should develop local protocols to facilitate integrated working and liaison between agencies and disciplines. It is anticipated that the arrangements being developed for MAPPA protocols and liaison will prove an invaluable resource in establishing such links.

It is recommended that a Risk Assessment Document should be prepared prior to the first CPA meeting and discussed either at a separate risk management meeting or at a long pre-CPA meeting (see info sharing flow chart at appendix four). Professionals, from various agencies, who have knowledge of the patient and information to contribute or a stake in their current or future management, should be invited to attend.

Further, information flows with regard to the implementation of care plan actions and early warning signs are recommended (see risk management/contingency plan flow chart at appendix five) to ensure that everyone involved in the management of the patient knows their responsibilities and can contribute to keeping the risk assessment current and the risk management actions appropriate.

**Patient Engagement**

A good therapeutic relationship with the patient; engagement of the patient in care, treatment and interventions; and involvement of the patient in identifying and addressing needs are key to optimising treatment. They are also key to the risk management process. Optimal treatment will contribute to diminishing the risk posed by the patient, and in many cases it will be appropriate to actively engage the patient in the risk assessment and management process, including contingency planning.

**Risk Assessment**

Risk assessment forms the basis of risk management planning. When a patient enters the CPA process an initial Risk Assessment Document should be drawn up. This will necessarily begin with a review of available information from as many sources as possible incorporating the following:

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

**Use of risk assessment tools**

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

Health services should have an awareness and understanding of approach being taken by criminal justice agencies in risk assessment. This is in order that the communication of risk between health and criminal justice agencies is facilitated.

For example, in the case of sexual offenders, the standard approaches by Police and Criminal Justice Social Work is to use risk assessment tools such as RM 2000 and the Stable Scoring Guide by Hanson and Harris. For violent offenders, criminal justice agencies, in particular Criminal Justice Social Work will use tools such as LSI-R and sections RA3 and RA4 of the Risk Assessment Guidance Framework (RAGF).

Equally, local clinical teams should endeavour to ensure that all agencies are aware of the terminology, meaning and approach that they use for risk assessment.

A good assessment of risk will not describe a patient only in terms of high, medium or low risk. Although these terms may be used, risk assessment conducted to support risk management planning will produce a description of the risk the patient poses in the following terms:

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

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

Due to the dynamic nature of risk, teams should engage in ongoing risk assessment, evaluation of the implementation of the care plan, and a review of the patient’s progress. This is to ensure the continuing suitability of the care plan as a whole and particularly the actions that they are taking to reduce risk. The Risk Assessment Document should include a date for the next routine review and also circumstances which would trigger a review prior to that date.

**Planning**

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

It is useful to think of risk management actions as acting in one of two ways. One group is the actions taken to reduce the likelihood or mitigate the severity of the risk posed; to “treat” the risk. These actions will be included in the care
plan along with actions planned to meet patients’ needs (Record of Needs section, page 5 of the documentation at appendix 3). In some cases, one action will both act to reduce risk and to meet another identified patient need.

The second and complementary group of risk management action is contingency planning for when and if the risk is exacerbated. In order to do this teams must identify how they will know that this has happened (early warning signs, relapse signature, risk indicators) how it will be communicated, and what response should occur (Contingency Plan, page 8 of the documentation at appendix 3).

8. Recommended Guidance and Documentation

8.1 Scope

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

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

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

The key function of the Care Co-ordinator is to organise meetings in a timely fashion and be responsible for proper invitation to those involved in the meeting and distribution of CPA documentation. The Care Co-ordinator will not assume responsibility for other professionals involved in the assessment or the services provided to support the agreed care plan. All the professionals involved will retain accountability for their own practice. Box 1 summarises the responsibilities of the Care Co-ordinator.
Box 1 – Responsibilities of the Care Co-ordinator
It is important that the Care Co-ordinator has a key role in the clinical care of the patient (often they will be the patient’s key-worker)

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

8.2 CPA Meetings
In appropriate cases the CPA process will have two stages:

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

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

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

Box 2 – Competencies for chairing a CPA meeting

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

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

Following on from the presentations of various team members, there should also be an opportunity for the patient or named person to state their hopes for the next stage of their journey. There should then be a review and updating of care plan objectives. Risk assessment should inform those aspects of the care plan which can reduce risk. The care plan for patients on compulsion orders with
restriction orders should fulfil all the requirements of a part 9 care plan (section 137 of the Mental Health (Care and Treatment) (Scotland) Act 2003). An important principle is that there should not be repetition of the CPA process, where one mechanism can fulfil two goals. In many cases there will be a more detailed care plan, covering particular treatment interventions (eg nursing care plan). Where a more detailed care plan exists there should be a cross reference to that documentation.

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

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

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

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

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

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

At the end of the CPA meeting there should be the opportunity for any team member to comment on whether there are gaps in the agreed treatment plan or contingency plan and the opportunity should be given to the patient to comment on the plan. Any dissenting views from a team member regarding the treatment and/or risk should be documented. The date of the next meeting should be set.
Box 3.1 – Traffic Light Approach to Contingency Planning  
(This replicates the Contingency Planning section of the CPA Documentation and provides an example of what the risk indicators and relevant traffic lights might be for an in-patient, it is important to note that these should be tailored to individual circumstances for each case)

**EXAMPLE : Mr Bloggs is a restricted patient within a low secure service.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Early Warning Signs (Relapse Indicators)</th>
<th>Contingency Actions</th>
</tr>
</thead>
</table>
| Symptoms of Mental Illness | **Green:** No evidence of symptoms of psychosis or depression  
**Amber:** Prolonged periods of anxiety, suspiciousness, pre-occupied or withdrawn  
**Red:** Command hallucinations, delusions regarding aliens | • Continue current treatment  
• Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479)  
• Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241) |
| Substances | **Green:** No positive urine drug screens despite regular monitoring  
**Amber:** Refusing urine drug test. Info from 3rd parties that patient has been taking substances on ward  
**Red:** Clear evidence intoxicated with illicit substances on ward | • Continue current treatment  
• Alco meter test. Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479)  
Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241) |
| Engagement with Team | **Green:** Compliant with medication and engaging with Psychological Therapies and Occupational Therapy  
**Amber:** Suspected non-compliance with medication. Not engaging with Psychological or Occupational Therapies  
**Red:** Clear evidence of non-compliance with medication, refusing to attend therapies | • Continue current treatment  
• Alco meter test. Suspend unescorted time out, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479)  
• Suspend all time out of clinic, increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241) |

This table provides examples of possible entries and is not proposed as a standard to be adopted.
Box 3.2 – Traffic Light Approach to Contingency Planning
(This replicates the Contingency Planning section of the CPA Documentation and provides an example of what the risk indicators and relevant traffic lights might be for an in-patient, it is important to note that these should be tailored to individual circumstances for each case)

EXAMPLE: Mr Bloggs is a restricted patient on conditional discharge in the community

<table>
<thead>
<tr>
<th>Category</th>
<th>Early Warning Signs (Relapse Indicators)</th>
<th>Contingency Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms of Mental Illness</td>
<td><strong>Green</strong>: No evidence of symptoms of psychosis or depression</td>
<td>• Continue current treatment</td>
</tr>
<tr>
<td></td>
<td><strong>Amber</strong>: Prolonged periods of anxiety, suspiciousness, pre-</td>
<td>• Review by Clinical Team, inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479)</td>
</tr>
<tr>
<td></td>
<td>occupied or withdrawn</td>
<td>• Emergency Recall Inform Duty RMO immediately (tel: 032164 16548241)</td>
</tr>
<tr>
<td></td>
<td><strong>Red</strong>: Command hallucinations, delusions regarding aliens</td>
<td></td>
</tr>
<tr>
<td>Substances</td>
<td><strong>Green</strong>: No positive urine drug screens despite regular</td>
<td>• Continue current treatment</td>
</tr>
<tr>
<td></td>
<td>monitoring</td>
<td>• Alco meter test. Inform RMO by end of next working day (Dr J Smith, tel: 03256 2561479)</td>
</tr>
<tr>
<td></td>
<td><strong>Amber</strong>: empty can or missed drug test</td>
<td>• Emergency Recall. Increase observation levels, stop access to sharp instruments. Inform Duty RMO immediately (tel: 032164 16548241)</td>
</tr>
<tr>
<td></td>
<td><strong>Red</strong>: Clear evidence intoxicated with illicit substances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>positive test.</td>
<td></td>
</tr>
<tr>
<td>Engagement with Team</td>
<td><strong>Green</strong>: Compliant with medication and keeping all appointments</td>
<td>• Continue current treatment</td>
</tr>
<tr>
<td></td>
<td><strong>Amber</strong>: Suspected non-compliance with medication, missed</td>
<td>• Inform RMO within 24 hours (Dr J Smith, tel: 03256 2561479)</td>
</tr>
<tr>
<td></td>
<td>appointment(s)</td>
<td>• Emergency Recall. Inform Duty RMO immediately (tel: 032164 16548241)</td>
</tr>
<tr>
<td></td>
<td><strong>Red</strong>: Refusing medication, refusing to attend appointments</td>
<td></td>
</tr>
</tbody>
</table>

This table provides examples of possible entries and is not proposed as a standard to be adopted.
8.3 Documentation
There are a number of core documents which support the CPA document. These will include a past historical summary, a risk assessment document, recent reports by those members of the multidisciplinary team regularly involved in the case, detailed multi professional care plan, minutes of third party discussions held in the pre CPA meeting and minutes of discussions at the CPA meeting. The main document produced specifically from the CPA meeting however is the CPA document and a copy of a proforma for the CPA document is attached at appendix 3.

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

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

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

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

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

9. Recommendations

The Current CPA arrangements are unsatisfactory. Current CPA practice across Scotland varies considerably between different teams; there is a clear need for consistency of process and documentation. While the scope and context of this guidance is restricted patients, the principles could easily be extended to relate to all mentally disordered offenders.

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

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

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

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

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

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

7. Local services should develop protocols to facilitate integrated working and liaison between agencies and disciplines in relation to Risk Management and CPA. The arrangements being developed for MAPPA protocols and liaison will provide a useful guide. Information flows with regard to the implementation of care plan actions and early warning signs are recommended in the risk management/contingency plan flowchart at appendix 4).
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Scottish Executive Health Department, (2005), *Memorandum of Procedure on Restricted Patients*. Scottish Executive Health Department.


Scottish Parliament *Mental Health (Care and Treatment) (Scotland) Act 2003*.

Appendix 1 - Policy Context

This appendix will summarise the policy context for the Review of Care Programme Approach Guidance for Restricted Patients in Scotland Report of November 2006, it aims to explain the scope and context of the guidance.

The Mentally Disordered Offender Policy

On 28th January 1999 the Minister for Health in Scotland launched the Policy Document *Health, Social Work and related services for Mentally Disorder Offenders in Scotland* (NHS MEL (1999) 5, Scottish Office 1999) (the MDO Policy). The policy statement examined the provision of mental health and social work services for MDOs (and others requiring similar services) in the care of the police, prisons, courts, social work department, the State Hospital, other psychiatric hospitals and community services.

The MDO Policy endorsed certain recommendations made, in the English context, by the *Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services* (the Reid Report, Department of Health 1992). The same set of guiding principles was adopted; that MDOs should be cared for:

- with regard to quality of care and proper attention to the needs of individuals
- as far as possible in the community rather than institutional settings
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life as near as possible to their own homes or families if they have them.

MDO Policy has subsequently been adopted by the devolved administration and continues to be Scottish Executive policy. The principle of “least restriction”, was endorsed by The Mental Health (Care and Treatment) (Scotland) Act 2003.

The Framework for Mental Health

The MDO Policy was complementary to the *Framework for Mental Health Services in Scotland* (Scottish Office 1997) (the framework). The Mental Health Reference Group had been established in 1996 to assist the Scottish Office in the first drafting of the framework, which tasked Health Boards and Local Authorities to jointly organise comprehensive integrated local mental health services, based on sound interagency agreements and protocols. Priority in the provision of care and support was to be given to those with severe and/or enduring mental health problems. Core provision included a range of inpatient facilities; from the general psychiatric to include the more specifically forensic, short and longer term inpatient care and a range of community options.
A central principle of the framework was that no patient should have a planned discharge from hospital unless services and accommodation were in place and available. The framework anticipated the concept of the “managed clinical network” as described by the Acute Services Review Report (Scottish Office, 1998). This highlighted the need for a formal relationship between components of a service based on standards of service, quality assurance and seamless provision of care.

The Risk Management Report
Following its contribution to the framework, the Mental Health Reference Group established four subgroups, one of which was tasked with producing guidance on the management of risk across mental health. In October 2000 the Risk Management Report (Scottish Executive, 2000) (the RMR) was published, which was endorsed by the Scottish Executive as guidance (HDL 2000)16. The RMR focused on personal rather than corporate risk and made reference to lessons to be learned from homicide inquiries in England linked to mental health services. There was, therefore, relevance to forensic mental health. The guidance on Risk Management was superceded by the Forensic Network Report “Secure Care Standards” (Forensic Network, 2005) which was endorsed as Scottish Executive policy in HDL (2006) 48 Forensic Mental Health Services (Scottish Executive, 2005). The role of Critical Incident Reviews (CIR) following adverse incidents or near misses was described and a model policy recommended. This included the importance of agreeing what incidents merited initiation of the procedure, decoupling the processes of a CIR from any consideration of disciplinary action, and the need for an organisation as a whole to take up and respond to any findings. Currently a review of CIR guidance is underway by another of the Forensic Network working groups.

Care Pathway Document
A review of progress of the implementation of the MDO Policy was commissioned from the Scottish Development Centre for Mental Health, “Achieving a balance: Care treatment and security. A review of the implementation of the Policy for Mentally Disordered Offenders in Scotland” (2000). Each local agency involved in the provision of services for MDOs received a digest report on progress in their area. The Scottish Executive Department of Health in 2001 published a Care Pathway Document (Scottish Executive 2001a) on the care components required in any local service, which was one part of the Scottish Development Centre report. The Care Pathway Document describes the range of health and social care interventions and services that should be made available at each stage of the criminal justice process. Joint agency, multidisciplinary MDO forums or steering groups were established on the basis of Health Board areas. Their role was to consider and advise locally on how best to advance implementation of the MDO Policy and report to the Scottish Executive by the end of September each year. This reporting mechanism was not linked to the process of Accountability Review and no longer applies.
Creation of the Forensic Network
In the autumn of 2001 a review group was set up to consider the governance and accountability of the State Hospital’s Board for Scotland. A consultation paper resulted from that review: “The Right Time, The Right Place” (Scottish Executive 2001b). Following consultation, the Forensic Mental Health Services Managed Care Network was created in 2003. The Forensic Network has the task of overseeing the development of services for mentally disorder offenders across Scotland. It is to provide a strategic overview and direction for the planning and development of forensic services.
The Memorandum of Procedure on Restricted Patients
After several years of consultation the revised Memorandum of Procedure on Restricted Patients (the MoP) was published by the Scottish Executive (2002). It has since been revised following the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 and further revisions are expected. It sets out the formal responsibilities of professionals within health and social work services in relation to those MDOs who have been subject to special restrictions. This includes the statutory duties of psychiatric and social work supervision.

As of 21 September 2006, 265 restricted MDOs (including Remand patients) were in hospital and 47 were on Conditional Discharge in the community. Of the inpatients, 141 (53% of the total) were at The State Hospital making up 67.5% of the population in high security. The Orchard Clinic had 6.8% of the total restricted inpatient population (making up 50% of the medium secure population), with the remaining 40.2% of inpatient restricted MDOs in low secure settings across Scotland.

The MoP endorses the use of the Care Programme Approach, or equivalent mechanism, and the Care Pathways Document. There is also guidance on the frequency and content of reports to Scottish Ministers. Scottish Ministers must approve a move to lower security or any Suspension of Detention for a restricted patient. As Ministers expect the MoP to be followed before allowing such progression, there is a high degree of professional compliance with the guidance. So, in contrast to much of Scottish mental health, the Care Programme Approach is operational at the State Hospital and Orchard Clinic. Once a patient is on Conditional Discharge there is less incentive to comply with CPA guidance.

The MoP requires thorough reviews following any untoward incident involving a restricted patient and endorses the use of Critical Incident Reviews as proposed by the RMR.

Mental Health (Care and Treatment) (Scotland) Act 2003
In January 2001 the review of the Mental Health (Scotland) Act 1984, chaired by the Right Honourable Bruce Millan, reported to the Scottish Parliament (Scottish Executive 2001c). The Millan Committee devoted a chapter to high risk patients and recommended that patients should have a right of appeal to be transferred from the State Hospital or a medium secure facility to conditions of lower security. That proposal was adopted in the form of a general right of appeal against the level of security of detention in hospital, in the Mental Health (Care and Treatment) (Scotland) Act 2003, Part 17, Chapter 3 and was implemented in May 2006. Currently Scottish Ministers have used discretion to limit appeals of excessive security to State Hospital patients. As of 20 September there have been 46 appeals of excessive security lodged, 8 are incomplete applications; 10 have been heard; 5 upheld; 3 adjourned and 2 have been declined.
Whilst some aspects of mental health law relating to Mentally Disordered Offenders may appear to be similar to the 1984 Act, the 2003 Act introduces significant changes in practice and procedure. All Compulsion Orders, with or without restriction, are now reviewed by the Mental Health Tribunal for Scotland. A far greater degree of consultation and participation is now required, including taking proper account of the role of the Named Person and Advance Statements. There is a greatly enhanced role for Mental Health Officers (MHO), and all those subject to an order will require a designated MHO. Also all remands to hospital are effectively restricted, significantly increasing the number of patients who will be subject the standards set in the MoP. The Act also creates principles which have to be taken into account when making any decisions pursuant to the Act.

**Forensic Mental Health Services Policy**

At the “Beyond Walls” conference on 4 October 2005 Dr Kevin Woods, Chief Executive of NHS Scotland announced that the Health Department would review the work of the Forensic Network and this has resulted in new national policy and guidance in the form of HDL (2006) 48 Forensic Mental Health Services which was issued on 28 July 2006. The HDL makes policy endorsement for Secure Care Standards, the resolution of Clinical Conflicts and Liaison between NHS Boards and Scottish Prison Service and Guidance for Services for Women, Services for Learning Disabilities and Definitions of Levels of Security.

The paper also outlines work taken forward by the Forensic Network and Chairs of the Regional Planning groups on the configuration of forensic mental health services. It also describes the national overview of patient flow/appeals against excessive security group established by the Minister and outlines areas of further work to be taken forward by the Forensic Network, including Revision of CPA guidance; supporting the RMA in the assessment and management of risk of restricted patients; developing high and low secure care standards; services in the community; review of Critical Incident Review Guidance; development of a Forensic School for Scotland; services for children and adolescents and for people with personality disorders.
Appendix 2 - Review of Literature

The Sainsbury Centre for Mental Health (SCMH) and The Mental Health Act Commission (MHAC) carried out a review of the literature on the CPA as part of their joint project looking at the CPA in relation to patients who are admitted compulsorily more than once in a three year period. The complete literature review features as Appendix 1 in the report “Back on Track? CPA care planning for service users who are repeatedly detained under the Mental Health Act” and is reproduced here.

Learning from Inquiries

The Spokes inquiry (DHSS, 1988) following an earlier homicide, of social worker, Isabel Schwartz, had influenced the establishment of CPA (Kingdom, 1994). However, despite the recommendations of Spokes and the Ritchie Inquiry (1994), an analysis of subsequent such inquiries by Crichton (2002) has supported earlier research (Shepherd (1995), Crichton and Sheppard 1996) and Prins (1998)) which concluded that care coordination and communication is often inadequate in providing good quality of care in the community to people suffering from a mental illness who are at risk of committing violent acts. In her inquiry into the care and treatment of Christopher Clunis, Ritchie (1994) exposed a catalogue of lost opportunities and poor communications reflecting a failure of inter-professional working.

In 2000 the Department of Health in England published “An Organsiation with a Memory: The report of the expert group on learning from adverse incidents in the NHS” chaired by Chief Medical Officer, Sir Liam Donaldson. The report states that

“the time is right for fundamental rethinking of the way that the NHS approaches the challenge of learning from adverse healthcare events, [t]he NHS often fails to learn the lessons when things go wrong, and has an old fashioned approached to this area compared to other sectors.”

The report suggests that the NHS should develop:

- Unified mechanisms for reporting and analysing things when they go wrong;
- A more open culture in which errors or service failings can be reported and discussed;
- Mechanisms for ensuring that where lessons are identified the necessary changes are put into practice;
- A much wider appreciation of the value of the system approach in preventing, analysing and learning from errors

These same principles could easily be applied in Scotland and the Forensic Network is about to publish new guidance for carrying out Critical Incident Reviews that should go some way to assisting services to learn from inquiries.

Recently the Stone Inquiry has been published. It identified good practice within the Forensic Community Mental Health Team attempting to engage with a difficult patient when other services may not have done so. That in some cases there may be an adverse outcome should not dissuade services from engaging with patients with the complex needs of Mr Stone involving interplay of Personality Disorder, substance misuse and associated periods of psychosis. The report highlights little more could have been done to prevent harm and praised activities of local services. Although publicity is given to adverse outcomes there is no way of highlighting what
tragedies may be prevented by such risk minimisation activities, this remains a good example of why the principle of CPA must be extended to wider patients.
INTRODUCTION
Since it was first used in 1991 as the framework for planning, monitoring and reviewing care for people with mental health problems in England, the Care Programme Approach (CPA) has been the subject of numerous reports and research studies. This review of the literature on the CPA was undertaken as part of the joint project by the Sainsbury Centre for Mental Health (SCMH) and the Mental Health Act Commission (MHAC) looking at the CPA in relation to patients who are admitted compulsorily more than once in a three year period. In view of its potential relevance to a wider audience, the literature review is also available through the SCMH web site at www.scmh.org.uk and the MHAC web site at www.mhac.org.uk.

Structure of The emergence of the CPA from the case management model in the United the review States of America is described, and the further development of the CPA since its introduction in 1991 is chronicled. Strengths and limitations of this system are reported as are a number of uses to which it has been put, including its application in service evaluation and monitoring standards. Attention is also given to service users’ views and experiences of the CPA. The review aims both to provide an understanding of the scope of current knowledge and practice, and to assess the extent to which the CPA is used as a proxy measure for evaluating quality of care.

Search strategy A computerised literature search was undertaken on material from the UK and North America published since 1980, using the International Bibliography of the Social Sciences, PsychINFO and Medline online databases. Searches were made using a combination of key words including: Care Programme Approach; CPA; care planning; case management; continuity of care; follow up; care pathways; evaluation; patient outcomes; quality of care; users’ views. More than 300 articles were identified through this method, of which 29 were thought to be relevant and were retrieved. As this review was initially undertaken with the specific SCMH/MHAC project in mind, searches were also made using the above key words in conjunction with Mental Health Act, compulsory admission, and repeat admissions, but no articles were identified through this method. Several other articles were identified from the references given in publications obtained through the computerised search. Other published material from SCMH’s own resources was examined, and several examples of CPA care planning documentation currently in use by NHS and independent sector providers of acute inpatient care were obtained. Reports of Inquiries into homicides committed by people in contact with mental health services were obtained from NHS Health Authorities and Trusts. Only information on the implementation of the CPA in England was considered, excluding material relating to the introduction of the CPA in Scotland and Wales. Altogether, 99 data sources were examined.

CASE MANAGEMENT
Case management was introduced in North American mental health services in the 1970s as a way of ensuring that services were provided in a co-ordinated, effective and efficient way. A range of case management models became widely adopted in England in the following decades (Mueser et al., 1998). In clinical case management, a professional worker uses their therapeutic...
relationship with the service user to assess needs, providing some services and arranging (brokering) others to meet them. The strengths model of case management focuses on service users’ abilities and potential for change, rather than their difficulties. Case management models include assertive community treatment, developed in the US by Stein and Test (1980) and intensive case management (Ford et al., 1993; Ford et al., 1997) which was a forerunner of assertive outreach in which low caseload sizes allowed workers to provide their clients with an intensive input (Ford et al., 2001). The Care Programme Approach can be considered a type of case management, albeit one not based on a specific case management model. Landsberg and Rock (1994), in New York State, evaluated the effectiveness of intensive case management in terms of reaching those most in need of mental health services, and of providing them with appropriate services, concluding that while it should not be taken as the only panacea for previous failures in the mental health care system, it was generally successful in “dealing with the complex problems of serving persons with serious mental illness”.

THE DEVELOPMENT AND IMPLEMENTATION OF THE CPA

The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care for people with mental health needs (DH, 1990a) in England, originally intended to be implemented by April 1991, running in tandem with the local authority Care Management system (DH, 1990b). Initially the CPA applied to current inpatients at the point of discharge, and new referrals to specialist mental health services, but this was extended to include everyone in contact with specialist mental health services. The key elements were the systematic assessment of individuals’ health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the service user’s changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users and their carers.

The Mental Health Act Code of Practice (DH & Welsh Office, 1993) made it clear that the CPA applied to all those receiving specialist mental health care, including detained and informal hospital inpatients.

The Audit Commission’s review of mental health services for adults (1994) commented on the failure of many districts to implement the CPA and made recommendations on clarifying the eligibility criteria to ensure all those who should receive care under the system did so.

Interpretation and implementation of the CPA varied widely across the country. Building Bridges (DH, 1995) provided further “guidance on inter-agency working for the care and protection of severely mentally ill people”, while stressing that CPA was a systematic “approach” to care, and there was no intention to require uniformity of operation at the local level. It suggested a tiered approach in which only the most needy service users would receive a full multidisciplinary CPA; some mental health services operated with two CPA tiers while others had three. It also introduced the concept of the elements of “disability, diagnosis and duration” jointly contributing towards a definition of “severe mental illness” towards which group the CPA was aimed.

The CPA was revised and integrated with Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the format for assessment, care planning and review of care by health and social care staff in all settings, including inpatient care (NHSE & SSI, 1999). Two tiers of CPA were established nationally, standard and enhanced, and key workers were replaced by Care Co-ordinators. Standard CPA is described as being for those people whose needs can be met by one agency or professional or who need only low key support from more than one agency or professional, who are more able to
self-manage their mental health problem, who pose little danger to self or others, and who are more likely to maintain contact with services. People on the enhanced CPA level are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services.

Standard 4 of the National Service Framework for Mental Health (DH, 1999) set out the requirement for service users to have a written copy of their CPA care plan. The care plan should: include the action to be taken in a crisis by service users themselves, their carers, and their Care Co-ordinators; advise the GP how they should respond if the service user needs additional help; and be regularly reviewed by the Care Co-ordinator.

In the Code of Practice to the Mental Health Act 1983, revised in 1999 (in Section 27, relating to aftercare following discharge from hospital) the need to implement the CPA for all patients, and the key elements of the CPA, are restated (DH & Welsh Office, 1993).

Plans to abolish Supervision Registers were conditional on Trusts establishing “robust CPA”, with the Department of Health stipulating the criteria for robust CPA (in, CPAA, 2003b).

4 BACK ON TRACK?

The Social Services Inspectorate set a number of national priorities and strategic objectives relating to the social care of mental health inpatients (SSI, 2003). These include the requirement for social care workers to be part of the CPA care planning and review process. Similarly, the Department of Health’s standards (DH, 2002) for independent providers of mental health care registered with the National Care Standards Commission (now the Commission for Social Care Inspection) included the requirement for them to have written policies and procedures for implementing the CPA and care management, which must be reviewed at least every three years. These standards also included explicit requirements for planning and reviewing individuals’ care, and for the effective planning and implementation of inpatients’ discharge.

The CPA was introduced in Scotland in 1992 (SOHHD, 1992), and more recently, in Wales in 2004 (WAG, 2002).

SUPPORTING THE IMPLEMENTATION OF THE CPA

The Care Programme Approach Association (CPAA) was established in 1996 to support the implementation, operation and development of the CPA, with members drawn from mental health service providers, commissioners and other interested groups. Their publications on national standards and auditing the CPA (CPAA, 2003b), and providing guidance for CPA Care Co-ordinators (CPAA, 2003a) stemmed from wide experience in the implementation of the CPA. They summarised the key principles of the revised CPA policy as aiming to ensure integration of health and social care, providing consistency of approach nationally through the adoption of common definitions of standard and enhanced levels of care, ensuring a streamlined approach through the collection and recording of relevant data, for example the advance setting of the date of individuals’ next review, and providing a focus on risk assessment and management.

Keys (2002) pointed out that the CPA is based on simple principles which underpin and support the delivery of complex packages of care, and identified the important role of the CPA administrator in its successful implementation.

Howells and Thompsell (2002) described a computer-based CPA system, designed to improve the quality of information in CPA care plans and assist with the delivery of care in South London and
Maudsley (SLaM) NHS Trust. This ‘eCPA’ could be emailed between community teams and inpatient wards as the service user moved through the care system, and was capable of being quickly and easily updated. The system allowed assessment and interventions for individuals on the enhanced level of the CPA to be unified and co-ordinated between health and social care services (SLaM et al., 2000).

A study by Thomas and Balls (2003) for the London Integrated Mental Health Electronic Record Project examined the progress made by the 11 Trusts which provide mental health services in London in developing an electronic record for patients on the enhanced level of CPA, with a view to generating a debate about taking a common approach. Described as being a “snapshot” rather than a comprehensive survey, it found that while most Trusts had started from scratch in designing the electronic record, they broadly captured similar information, although methods of inputting data, and rules on who could access the records, varied widely. Most of the London Trusts had, or were about to implement, an eCPA system. The authors’ argument that it would save time and money if Trusts were to collaborate on standardising both paper-based systems and eCPAs is relevant for services in the rest of the country.

Firth (2004) outlined the expectation that the needs of people on the standard level of CPA will be managed by primary care services, and highlighted the challenges and benefits this brings. He also discussed the possible effects of Fair Access to Care Services (FACS), the guidance on eligibility criteria for adult social care which applies to local authorities, mental health and social care Trusts, and health and social services organisations which are operating pooled budgets (DH, 2003). He speculated that some people may lose the service they have been receiving once Trusts fulfil their requirement to review all currently eligible service users, before concluding that the result of using the CPA as a mechanism for the application of FACS might be “to engender a much-needed fiscal reality in the delivery of services, their development and commissioning”.

EVALUATING THE IMPLEMENTATION OF THE CPA

A number of research studies have examined the implementation of the CPA on a local or wider scale. Some benefits of the system have been identified, along with a number of difficulties in fully implementing the CPA, although a few authors have been unremittingly negative.

A research project undertaken on behalf of the Department of Health to identify the factors influencing the implementation of the CPA (North & Ritchie, 1993) in four health authorities found that its implementation, and in particular its monitoring, was not very far advanced at that time. Fragmentation of service provision, and lack of joint working between health and social services, were contributing to the delays, as was resistance from staff. Some clinicians perceived the CPA as an over-inclusive, bureaucratic and time-consuming exercise, while others felt their existing systems already met its requirements, although the principles of effective assessment, care planning and joint working were widely accepted. While health staff were in the early stages of CPA implementation, their social services colleagues were grappling with the new care management system, and experiencing difficulties and delays for very similar reasons (Newton et al., 1996).

When Wolfe et al. (1997) examined CPA implementation in an inner London service, involving 80 service users who had been discharged from inpatient care, they found that although three quarters of the participants had attended a CPA meeting before their discharge, only half of them were given copies of their care plans, and only half knew who their key worker was at the point of discharge. The researchers also examined the service users’ needs as assessed by staff and compared this with what the service users themselves said they needed. Service users assessed themselves as having more needs than did the staff, although there was some agreement about the
range of interventions needed, with medication and other help for mental health problems scoring high with both groups. However, staff were more likely to identify housing and employment as problem areas than were service users, who were more likely to say they needed help with financial problems. When they were asked if they had received all the services planned in their CPA most service users said they had, and they were generally satisfied with the services they had received. This study also highlighted a low level of carers’ involvement in the CPA process.

Using the CPA as an example, Kessler and Dopson (1998) examined the difficulties of implementing change within the NHS, discussing the wider issue of the decision-making process and how an understanding of this is necessary to appreciate how policy objectives are pursued. They described the tensions between centralised and devolved management within an organisation which was driven by the competitive ethos caused by the “purchaser-provider split” and increasingly subject to performance review, and the determination of the “centre” to drive through rapid changes which many clinicians saw as merely a bureaucratic data collection exercise. The authors also presented a framework for decision-making which should assist with future changes within the NHS.

Rospopa (1998) examined the CPA’s role as a framework for multidisciplinary working, describing how one Trust had approached joint working between health and social care organisations, embracing the concepts of shared assessments and care planning. He concluded that the CPA merely formalised existing systems of good practice, and was achievable through effective communication and collaborative working between agencies.

Schneider et al. (1999) conducted a national survey of the individuals responsible for implementing and administering the CPA in all NHS Trusts in England, asking questions about the involvement of professionals in the CPA processes of care planning, key working and review, and also about the participation of service users and carers in care planning and reviews in both hospital and community settings. They found that about one fifth of service users ‘always’ attended CPA meetings, while about half ‘often’ did so; carers ‘sometimes’ attended these meetings; similar numbers of service users and carers attended CPA reviews. The study was conducted at a time when greater integration between the CPA and care management was being predicted, and it found wide variation in the extent to which health and social care organisations were achieving harmonisation.

Bindman et al. (1999) used a postal survey of all NHS Trusts in England in an evaluation of the practical application of the CPA. They found that wide variation in the number of people subject to the CPA in different areas was not associated with variations in the populations’ needs. Although the CPA is designed to ensure services are targeted at those with the highest level of need, they found that prioritisation for receiving mental health services was inconsistent and could therefore result in inequitable use of resources.

Downing and Hatfield (1999) examined the first six months of CPA implementation in one inpatient unit, through interviews with key workers, looking at whether the care given was based on a comprehensive assessment of health and social care needs, whether it was multidisciplinary, whether the service users and their carers were involved in the planning and delivery of care, and that care was co-ordinated by a key worker. The specific areas included in the needs assessment were: physical health, mental health, medication, finance, housing, social support at home, daily living skills, occupation, social networks, and legal problems, and evidence was found of both assessment and planned intervention across all the domains, although mental health symptoms and medication were the most common. The authors concluded that the CPA as it had been implemented in this acute unit included most of the key features of identified good practice.
Appleby (2000), commenting on the 1999 National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness, the Safer Services report (Appleby et al., 1999), recommended an overhaul of the CPA system to ensure priority for enhanced level care be given to service users in high risk groups, especially those with a history of violence. He also argued that CPA documentation should be redesigned and simplified to make it compatible with clinical and risk assessment, and to facilitate transfer of information between services.

Simpson et al. (2003a) reviewed the literature on case management and the CPA, identified ongoing problems with implementation ten years after its introduction, and argued that it had failed to fulfil its true potential, concluding that the CPA was a “cheaper, unbranded and ultimately faulty version of case management” which was never adequate for the purpose for which it was introduced. They argued that if the CPA had been identified as “clinical case management”, this could have given it legitimacy among clinical staff and made explicit the importance of the therapeutic relationship between service user and key worker, and had it included the principles of the strengths model, the CPA might have provided an underlying philosophy of care to unite the health and social care members of the multidisciplinary team. Further work by Simpson et al. (2003b) described the CPA as a system which was, from the start, “destined to fail”, and they concluded that this failure was due to inadequate resources, a top-down managerial approach which failed to engage with frontline clinical staff, the introduction of standards and performance targets, poorly functioning community teams and an unrealistic political agenda. The authors did, however, concede that the CPA had improved the ability of services to maintain contact with people who have severe mental health problems, and that service users value having written care plans.

Researchers have also examined the CPA from the specific viewpoint of mental health nurses. For example, Anthony and Crawford (2000) examined service users’ involvement in care planning from the mental health nurse’s perspective, set in the context of the growing “consumerist ethos”. Their small qualitative study, using semi-structured interviews, found that although nurses valued the concept of service user involvement, they also found it problematic at times, experiencing contradictions between the “consumerist ideology” and their statutory duties and responsibilities, such as those in relation to the Mental Health Act. The researchers found that factors preventing nurses from involving service users more fully included lack of time, staff shortages, the nature of individuals’ mental health problems, and negative staff attitudes. The provision of accurate information, user-friendly documentation, having the means for getting service user feedback and valuing their contributions, and high staff morale were all felt to promote and increase service user involvement. In response to this, Rush’s overview of mental health service user involvement in England (2004) concluded that the inherent conflicts in nurses’ roles, which served to inhibit meaningful service user involvement, would not be resolved unless they were made explicit and discussed with other professionals and service users.

Mental health nurses Stickley and Masterson (2003) looked at CPA documentation in current use and identified a number of shortcomings, offering advice to nurses on making the CPA less bureaucratic and de-humanising, including challenging the medical model of care, and advocating for a more user-centred assessment tool that allowed service users’ “strengths, wishes, desires, interests and hopes” to be recorded, and stressed the need to record service users’ views irrespective of the documents’ format.

The Health Advisory Service’s review of mental health inpatient care in London (HAS, 2003) highlighted difficulties caused by service providers developing individual policies and procedures relating to the CPA, and the resulting fragmentation of care. While some London Trusts were actively working to implement the CPA as required, some still reported feeling it more of a bureaucratic exercise than something of genuine use. The HAS also found many Trusts were more effective at assessing risk than at assessing individuals’ needs, and in only a very small
number of cases had the service user signed their care plan. They recommended that the London Development Centre (NIMHE) should keep copies of all London Trusts’ policies on CPA, needs assessment and risk assessment as a resource which could be accessed through the Acute Care Group.

**THE CPA AS A PERFORMANCE INDICATOR**

Health service commissioners often use evidence of CPA implementation as one of a number of quality standards to assess mental health service providers. Similarly, many service providers also use CPA audit as a relatively quick and easy way of assessing their own performance. Researchers have also reported on the use of auditing the CPA as a proxy for measuring the quality of the service provided.

As part of a multidisciplinary audit process, Perkins and Fisher (1996) examined CPA care plans in one London Trust. Stressing the need to do more than simply record the presence of a care plan as being a positive indicator, they argued that a meaningful assessment of its content and effectiveness was also required. They assessed the extent to which the care plans reflected the strengths and problems defined by staff and by the service user, how well the care plans addressed all areas of the service users’ lives (including social, work and leisure activities), whether targets were set which were not related to staff or service users’ assessments of need, and how well the targets were achieved. They found that care plans were not always based on the assessments which had taken place; that some areas of service users’ lives, especially financial issues and psychological well being, were relatively neglected; that staff-defined problems received more attention than those defined by the service users themselves; that despite the services’ adoption of a strengths model of care planning, the care plans focused more on problems than on strengths; that although a large number of targets (85%) were met overall, targets relating to leisure and work activities were less likely to be met (38% and 53% respectively). When the findings were fed back into the quality cycle, a number of improvements resulted.

By means of a thematic review (2002), Thornicroft et al. considered what types of research would be useful to mental health policy makers, identifying gaps in completed research and formulating research questions to address the missing issues. In relation to Standard 4 of the NSF – the CPA’s role as a framework for care of those with severe mental health problems – they considered that the effect of crisis plans on rates of admission to hospital and to service users’ and carers’ satisfaction had not been sufficiently investigated, and nor had the impact of giving service users copies of their care plans.

Lockwood and Marshall (1999) reported on a pilot study in which the introduction of “needs feedback” to the CPA process was aimed at making it more effective. This approach focused more on service users’ social, employment, housing, activities of daily living and financial needs, rather than the more traditional diagnosis-led medical model. This small study found significant improvements in the number of service users’ unmet needs at the six month follow up, and in the level of some symptoms of mental ill health, with some improvement also in social functioning.

Clarkson and Challis (2002) discussed the history and development of performance indicators and monitoring techniques for mental health services, and made suggestions for more meaningful future methodology to capture the quality as well as the quantity of services provided. They recommended that several questions on local CPA implementation be included in mental health services’ performance indicators, including the number of people on the enhanced CPA, information on overdue reviews, and the degree of involvement of service users and carers in the care planning process.
An examination of 199 sets of case notes of service users discharged from acute inpatient care in four Trusts (Warner & Hoadley, 2004) found that although three quarters of the inpatients had been known to mental health services before admission, only a half had a current CPA care plan. A third of inpatients in one site had the date of their next CPA review recorded in the notes at the time of discharge, with fewer examples found in the others. Similarly, while a third of the service users in one site had a copy of their care plan on discharge, only five people altogether in the three other sites received them.

**NATIONAL PERFORMANCE MANAGEMENT**

The former Commission for Health Improvement (CHI), as part of its routine clinical governance reviews in England and Wales, assessed most mental health Trusts, awarding a star rating to each based on how well they had fulfilled a number of criteria (CHI, 2003a). Among the evaluation criteria were the progress made in developing the services described in the NSF and the NHS Plan (DH, 2000), and in implementing the CPA, the specific criterion being that CPA details and care plans are held on electronic systems which are regularly updated and available 24 hour a day. Targets relating to service user involvement included the requirement for service users to have copies of their CPA care plans. A review of CHI’s findings in mental health services (CHI, 2003b) reported that “large numbers of users are not being placed on the Care Programme Approach or allocated a care plan and co-ordinator”. This was ascribed to continuing clinical resistance and the burden of the documentation in some trusts, with the result that practice surrounding the CPA “remains inconsistent”.

The Healthcare Commission (HCC) took over from CHI the responsibility to assess Trusts’ performance against the standards in the NSF in 2003. Their Performance Ratings for 2003/04 showed Trusts’ performance against a number of standards, one of which was CPA Systems Implementation (HCC, 2004a). To achieve this, care plans had to be held on an electronic central database which was regularly updated and available 24 hours a day.

In addition to key targets a number of indicators, chosen to provide a balance across a wide range of areas, were grouped together under the heading ‘A Balanced Scorecard’. Within a Clinical Focus grouping, there was an indicator called Enhanced CPA indicator (formerly the CPA/complex care indicator), for which Trusts were assessed on the CPA status of service users receiving complex specialist mental health care. This was assessed by examination of the Mental Health Minimum Data Set (MHMDS), a computerised record of all episodes of care, or finished consultant episodes (FCEs), submitted quarterly by Trusts. The HCC’s presentation of the aggregated results for the components of Clinical Focus do not show how Trusts performed on this one factor, but in 2003-04 overall 47 Trusts scored high (57%), 21 scored medium (25%), and 15 scored low (18%) on Clinical Focus.

The Healthcare Commission’s key targets for the star ratings in 2004-05 for mental health trusts again included CPA Systems Implementation, and the CPA/complex care indicator within the ‘Balanced Scorecard’ (HCC, 2004b). An additional target related to the full implementation of the MHMDS, which includes information on each service user’s CPA level, date last seen, and details of Care Co-ordinator. Performance was again assessed though examination of the quarterly MHMDS submissions.

The Healthcare Commission is now changing the way it assesses Trusts’ performance (HCC, 2005a; HCC, 2005b; HCC, 2005c). An annual health check is being introduced in 2005-06, aimed at assessing whether Trusts are getting the basics right and meeting existing targets, and also if they are making and sustaining progress towards new targets. Trusts will in future make an initial declaration of how well they are meeting the standards, and this information will be
supplemented by announced and unannounced visits, in order to arrive at an overall performance rating. The criteria for assessing core standards in mental health services still include information drawn from the MHMDS on the implementation of the CPA, and questions on care planning will be asked as part of another national patient survey. An additional standard has been added to the clinical and cost effectiveness domain, that of data on service users on the enhanced CPA who are in work, education or training.

**CPA SELF ASSESSMENT SYSTEMS**

Trusts can also audit their own performance in implementation of the CPA. The Department of Health first published an audit pack for monitoring the CPA, drawn up in collaboration with the Royal College of Psychiatrists, in 1996, and this was revised and reissued in 2001 (DH, 2001). Services were expected to use the audit tool for “reporting into NHS clinical governance structures and Local Authority Cabinets and Scrutiny Committees”. Clinical governance provides systematic feedback at the local level to those bodies with responsibility for the level and quality of services, with reporting based on service user feedback and objective data.

The CPA Association has also published an audit tool which mental health services can use to survey the views of service users on the enhanced level of CPA, with a number of different issues being examined sequentially over a three year period (CPAA, 2003b). This can be complemented by a survey of carers, an audit of case files, and a review of the organisational implementation of the CPA.

**SERVICE USERS’ EXPERIENCE OF CARE PLANNING AND THE CPA**

The importance of involving service users in care planning and the whole CPA process is explicit. Much service user-led research has explored the extent to which the CPA has been implemented, and how involved service users were in the process. Findings suggest that service user involvement in the CPA is still not widely practised, although where service users are involved in the process, they are happier with the services they receive.

Beeforth et al. (1994) examined the implementation of the clinical model of case management, from the service users’ point of view, in particular its claim to be a “client-centred approach”. Respondents were generally positive about their experience of the system, valuing the relationship with their care manager and feeling involved in setting their own priorities and goals and drawing up their care plan. Practical assistance with issues such as housing and finance made a big difference to service users’ lives, as did help with leisure and social activities. The researchers concluded that service users experienced case management as qualitatively different from – and a vast improvement on – other community-based systems of care.

The first SCMH User Focused Monitoring (UFM) project, which began in 1996, was designed to assess services users’ knowledge of, and satisfaction with, community mental health services in three London trusts (Rose et al., 1998). Interviews took place with service users on the top tier of the CPA (then equivalent to the current enhanced CPA), who all had a key worker and a care plan. It was found that less than two thirds knew they had a key worker; a third of the group knew they had a care plan, but only a fifth said they had been involved in drawing it up. A small minority knew about their CPA review, but nobody considered they were involved in the CPA review process. Two thirds of respondents felt their needs had been fully assessed, while just one third felt their strengths had been taken into account in the process. When the UFM team returned
to the area two years later (Rose, 2001), they found a statistically significant improvement in service users’ knowledge about their key worker, care plan, and CPA review.

McDermott (1998) examined the attitudes and experiences of a group of service users on the then top tier of the CPA in outer London. He found that over half the respondents did not understand the term ‘CPA’ and a third did not understand why they were subject to it, although most understood the concept of keyworking and knew the name of their key worker (now Care Coordinator). Although most had received copies of their CPA care plan, few fully understood it, and some felt under pressure to sign it, fearing readmission if they did not. Service users generally felt they were not consulted as equals by the professionals responsible for their care planning. While most felt their care had been unaffected by the introduction of the CPA, some felt it had got worse, while a smaller number reported an improvement. The author concluded that effective communication and collaboration between service users and professionals was essential to the successful implementation of the CPA.

Lawson et al. (1999) assessed the extent of service user involvement in CPA care planning in one London Trust from the users’ perspective. Through interviewing a small sample of respondents, they found that although all service users knew who their key worker was, most wanted to be more involved in planning their care and would have liked to be given a copy of their CPA care plan.

Webb et al. (2000) developed a tool to assess service users’ knowledge of, and satisfaction with, aspects of the CPA, using it to survey individuals in contact with community and hospital services in five trusts nationally. They found a third of the service users had not been told what a key worker was, and nearly one fifth did not know their key worker’s name. More than two fifths did not know what their care plan was and over half had not been involved in drawing it up, while only a third knew the date of their next review. Further analysis revealed that procedures for implementing care plans was one of the factors most predictive of overall satisfaction with the service.

Rose returned to the CPA and the issues of partnership, co-ordination of care and the place of service user involvement, exploring whether increasing co-ordination of care at a structural level was associated with greater service user involvement (2003), concluding that this was not necessarily the case, but that where service users were involved in planning their own care they were more satisfied overall with the care they received.

Valentine et al. (2003), although not directly studying the CPA, found that involving residents of a rehabilitation unit in their own care planning had positive effects in terms of the delivery of care.

In 2001, service users in Northamptonshire carried out an audit of the CPA using a postal questionnaire and interviews (Users’ Support Service, 2004). The researchers found that a third of respondents did not know they had a Care Co-ordinator, and less than half had a copy of their care plan which they had agreed and signed.

Langan and Lindow (2004) undertook research into service users’ involvement in risk assessment and management, interviewing inpatients who were considered by the clinical teams to pose a potential risk to other people. Identifying the CPA as “the bedrock of mental health policy and practice”, they found that although most service users had a CPA care plan on discharge, in only a few instances did this include a risk management or relapse plan. The authors highlighted the difference between service users being “involved in” and “having influence over” the care planning process, noting that independent advocacy could have helped individuals to have their views taken into account in shaping their care plans, and that making an informed choice about care planning was only possible when service users knew about the full range of available
services. They also observed that service users who were detained when follow-up and aftercare arrangements were being made were not in a position to refuse any aspect of the care plan.

Carpenter et al. (2004) conducted a large study in four districts in the north of England. They examined the extent to which the CPA and Care Management (CM) systems were integrated, and looked at nearly 300 service users’ involvement in, and satisfaction with, their care planning. They found that most service users felt involved in planning their care and treatment, and felt they had more choice, when in the community, but this was less often the case when they were in hospital. Altogether less than half the service users thought they had a care plan, although there were differences between the districts ranging from 37% to 60% of service users. Service users who had a care plan were generally positive about it, and nearly all service users knew who their key worker was. Service users in the two districts where CPA and CM had been integrated were statistically more satisfied with services than those in the districts where the systems were separate, and the authors concluded that service user involvement and choice are facilitated by the integration of health and social care.

The Healthcare Commission is now responsible for the programme of national patient surveys initiated by CHI, and the first patient survey in mental health was completed in 2004. This is the largest ever survey of service users in England, in which the views of more than 27,000 people were obtained by means of a postal questionnaire (Osborn et al., 2003; Picker Institute Europe, 2003). Ten questions on the CPA were included. About half the respondents said they had been given (or offered) a copy of their CPA care plan, and altogether three quarters said they definitely, or to some extent, understood what was in it. Most people agreed, at least to some extent, with what was in their care plan. Half the service users had not had a review in the past year; of those who had, most felt they had been given the chance to express their views at the meeting. Two thirds of respondents knew who their Care Co-ordinator was, and a similar number had seen them within the last month. The national report, reports for all individual Trusts, and the detailed responses for the questions on the CPA, for each Trust, are available on the HCC’s website (HCC, 2004c; HCC, 2004d).

A recent study in Devon (in, Hounsell and Owens, 2005) examined “bridges and barriers to user and carer involvement in care planning”. The service user researchers identified factors which could help or hinder the CPA process, such as the timing, venue and attendance at review meetings, while a trusting relationship between the service users and the professionals was seen as a key factor. Although the findings were based on data from a small number of people, a further, longer-term study is being planned in order to provide more information.

**FINDINGS ON THE CPA FROM HOMICIDE INQUIRIES**

Where a person in contact with specialist mental health services has committed a homicide, the Health Authority concerned must set up an independent inquiry into the circumstances. These inquiries’ terms of reference typically include the examination of the appropriateness and quality of any assessment, care plan, treatment or supervision provided to the individual. Sixteen inquiry reports published between 2000 and 2004 were obtained from Strategic Health Authorities, Primary Care Trusts and Mental Health Trusts, along with information on the action plans or progress reports relating to a further four inquiries (Armstrong et al., 2004; Bhatoa et al., 2003; Calderdale Council et al., 2004; Crissel et al., 2004; Curwen et al., 2003; Downham et al., 2003; Eldergill et al., 2001; Georgiou et al., 2004; Gledhill et al., 2004; Holwill et al., 2003; Johns et al., 2003; Joyce et al., 2003; McKay et al., 2004; Mishon et al., 2000; Price et al., 2004; Smallridge et al., 2004; West Yorkshire Strategic Health Authority, 2003a; West Yorkshire Strategic Health Authority, 2003b).
Altogether, these related to the care and treatment of 22 individuals, known to mental health services, who had committed homicides.

Many of these inquiries found evidence of incomplete or ineffective implementation of the CPA in some areas, leading to negative outcomes. Recommendations included calls for local practice to be driven by adequate local policies and procedures, based on national standards, and the need to ensure comprehensive multidisciplinary assessment, care planning, and review processes take place. Many reports stressed the need for service users and carers to be fully involved in the CPA, and for effective liaison and communication with other services. The importance of including risk assessment and management, signs of relapse, and contingency plans for working with people whose care plans fail and those who are difficult to engage with services, was noted. Some reports emphasised that service users should be placed on the appropriate level of CPA, with safeguards to ensure they are not removed from the CPA by one professional acting without agreement at a multidisciplinary review. Many reports concluded that the CPA should be supported by clear documentation, easily accessible by all agencies involved, with regular local auditing to ensure effective implementation.

**THE CPA IN RISK ASSESSMENT AND MANAGEMENT**

The assessment of risk and the development of strategies to manage it are essential elements of the CPA process. These processes should be fully integrated with the CPA and included as part of the care plan. A number of authors have examined how well this is being achieved.

When Dick et al. (2003) in Dundee examined 43 sets of case records in order to identify the past risk-related behaviour of service users who were being referred to the CPA, they found the information was not recorded in a standardised way or in a consistent part of the records, leading them to recommend that a risk summary should be included in the CPA care plan.

Paley and McGinnis (2003) described the implementation of risk assessment and care planning into the CPA process, in one northern Trust, by the addition of the FACE risk profiling system (Clifford, 1999). The authors reported that the inclusion of a standardised approach to risk assessment complemented the existing CPA assessment and care planning, enabling clinical staff and service users jointly to explore and document this key area.

**DISCHARGE PLANNING AND CONTINUITY OF CARE**

Planning for the discharge of hospital inpatients and devising care plans to support the service users when they are back in a community setting, is an important part of the CPA. The transition from hospital to community care is a period during which there is the most potential for service users to slip out of contact with services. Some authors have focused on this stage of the care planning process.

In Canada, Forchuck et al. (1998) evaluated a programme designed to help with the discharge process of inpatients in a ‘psychiatric hospital schizophrenia program’, in which inpatient nurses
provided community follow-up after discharge, and community-based nurses made ‘inreach’ visits while patients were still in hospital. When service users were asked for their views on what they found most helpful in making the transition back into the community, in addition to having an ongoing relationship with staff they reported greatly valuing being involved in the discharge planning process, particularly in relation to finance and housing issues, and with activities of daily living.

In the USA, Fortney et al. (2003) generated five indicators of continuity of care for people in community settings, which could be easily measured using routine administrative data. These were: the timeliness of the service use; the intensity of the services received; the comprehensiveness of the services received; the stability of the relationship between the service user and the provider team; and the co-ordination of service provision through the case management model, the key features of which are similar to those of the CPA in England. They suggested that these measures could be used as performance indicators for services, evaluating systems of care and their ability to engage with service users over time, and also to assess individual service users’ pattern of service use, including the identification of those at risk for poor health outcomes.

A comprehensive CPA care plan could be regarded as one which combines a full assessment of the service users’ needs and a clear plan of care and intervention (what, who by, when, etc.), collaboratively arrived at and agreed by the service user and Care Co-ordinator, with the minimum of bureaucratic effort for the mental health worker who has to complete the paperwork. The development of an electronic CPA (eCPA) has already been described (Howells and Thomsell, 2002), and it is clear from CHI’s progress report on mental health trusts (CHI, 2003b) that they expected this to become the norm.

Through SCMH’s and MHAC’s routine contact with NHS Trusts and independent mental health providers, we obtained a number of examples of CPA documentation, and examined these in the light of the CPA Handbook (2003a), and the National Standards and CPA Association Audit Tool (2003b), to assess whether all the essential elements were included. From these, the eCPA forms for the enhanced CPA provided by South London and Maudsley NHS Trust (SLaM) most closely matched the ideal, SLaM has subsequently developed ‘The Patient’s Journey’, a single, integrated clinical information process, designed to include all relevant information about patents’ care from their first contact with the Trust until their final discharge from the service (SLaM, 2004). It supports the CPA, and will also meet the requirements for the Mental Health Minimum Data Set and other statutory returns.

CONCLUSIONS

Since its introduction in 1991, the CPA has provided a framework for the systematic assessment, care planning and review of service delivery by health and social care staff in hospital and community settings, for people with mental health problems. Since its combination with care management in 1999, it has been the single care co-ordination approach for this group of service
users. Guidance on the implementation of the CPA has been provided by the CPAA, and is included in the Mental Health Act Code of Practice.

The Department of Health and the Social Services Inspectorate have monitored the use of the CPA by statutory and independent sector providers against required standards, and a number of service commissioners expect Trusts regularly to audit their own performance. The Commission for Health Improvement, succeeded by the Healthcare Commission, have also used CPA implementation as a performance indicator; this approach has also been taken by researchers seeking a proxy for measuring the quality of the services provided.

It is explicit in the CPA guidance from the DH & SSI that service users must be involved in the CPA care process. Service users’ experiences of the CPA are variable, but it has been shown that where they are properly involved in the process they are happier with the services they receive, and there is evidence that many service users welcome the care co-ordination aspects of the CPA.

CPA care planning is crucial to the process of discharge from hospital to ensure service users receive continuity of care.

CPA documentation should include a comprehensive assessment of needs, including an assessment of risk, and a clear plan of the actions and interventions to be provided, along with other necessary factual information; these should be contained within a concise format so as to encourage completion by the Care Co-ordinator. Care plans also need to be accessible to the service user, their carer, and all agencies involved. Electronic versions of the CPA have been developed which include all these features.

REFERENCES


The Care Programme Approach Association (2003b) National Standards and CPA Association Audit Tool for the Monitoring of the Care Programme Approach. Chesterfield: CPAA.


South London and Maudsley NHS Trust (2004) Further information on The Patient Journey is available from Matthew.Broadbent@slam.nhs.uk or at SLaM, Reay House, 108 Landor Road, Stockwell, London SW9 9NT.


This review of the literature on the Care Programme Approach is extracted from Back on Track? CPA care planning for service users who are repeatedly detained under the Mental Health Act

ISBN: 1 870480 65 1

This report examines the effectiveness of Care Programme Approach care planning for people who are repeatedly detained under the Mental Health Act. Areas of good practice are highlighted but it also identifies shortfalls in the implementation and shows continuing discrimination against Black and minority ethnic patients. The report is the result of a joint study undertaken between the Sainsbury Centre and The Mental Health Act Commission. It includes a practical audit tool for services to evaluate their CPA provision.

Copies of this publication can be purchased from The Sainsbury Centre for £10 plus p&p or online with credit card from our website www.scmh.org.uk

The Sainsbury Centre for Mental Health
134-138 Borough High Street
London SE1 1LB
Tel: 020 7827 8352
Fax: 020 7403 9482

We charge 10% post and packing for 25% for Europe and 35% for the rest of the World. Please note we can only invoice for orders over £25.
CPA DOCUMENT (incorporates Part 9 Care Plan)
Items marked with a * required by statute for Part 9 Treatment Plans

<table>
<thead>
<tr>
<th>Patient Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Date of Birth</td>
</tr>
<tr>
<td>Permanent Address</td>
</tr>
<tr>
<td>CHI</td>
</tr>
<tr>
<td>Unit Number</td>
</tr>
<tr>
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</tr>
<tr>
<td>Occupation</td>
</tr>
<tr>
<td>Marital Status</td>
</tr>
<tr>
<td>Ethnic Origin (standard codes)</td>
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<tr>
<td>First Language</td>
</tr>
<tr>
<td>Communication Assistance Required (Yes/No)</td>
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<tr>
<td>Religion</td>
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<table>
<thead>
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<tr>
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</tr>
<tr>
<td>Responsible Local Authority</td>
</tr>
<tr>
<td>Responsible Health Board</td>
</tr>
<tr>
<td>Clinical Team</td>
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<table>
<thead>
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<tr>
<td>Relationship to Patient</td>
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<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
<tr>
<td>Primary Carer (if different)</td>
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<td>Relationship to Patient</td>
</tr>
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<td>Address</td>
</tr>
<tr>
<td>Phone Number</td>
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<table>
<thead>
<tr>
<th>Useful Contacts:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Address &amp; Email</td>
</tr>
<tr>
<td>Office Hours Contact No</td>
</tr>
<tr>
<td>Out of Hours Contact Name and No</td>
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- CPA Co-Ordinator/Key Worker
- RMO
- MHO
- GP
## Legal Details

<table>
<thead>
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<td>Date of Conviction / Insanity Acquittal *</td>
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</tr>
<tr>
<td>Date Order Began *</td>
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<td>Date of Previous Annual Review *</td>
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<tr>
<td>Date of Next Annual Review *</td>
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</tr>
<tr>
<td>RMO Details *</td>
<td></td>
</tr>
<tr>
<td>MHO Details *</td>
<td></td>
</tr>
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</table>

### For Determinate Sentences

| Earliest Liberation Date / Parole Qualifying Date (for HD/TTD)/ |  |

### For Life Sentences

| Punishment Part |  |

## Index Offence

<table>
<thead>
<tr>
<th>Details of Index Offence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Statement</td>
<td></td>
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</table>

## Subject to requirements of other legislation

<table>
<thead>
<tr>
<th>Notifiable Under Part 2 Sexual Offences Act 2003 (2) Yes / No*</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If yes to above Detail offence(s) and period of order *</td>
<td></td>
</tr>
<tr>
<td>Schedule 1 Notification Yes / No *</td>
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</table>

## MAPPA Status

<table>
<thead>
<tr>
<th>Is patient subject to MAPPA (Yes/No)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Office</td>
<td></td>
</tr>
<tr>
<td>Co-ordinator Name</td>
<td></td>
</tr>
<tr>
<td>Contact Number</td>
<td></td>
</tr>
<tr>
<td>Level</td>
<td></td>
</tr>
<tr>
<td>Compulsory Treatment Details</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003</td>
<td></td>
</tr>
<tr>
<td>Date of T2 / T3 Certificate</td>
<td></td>
</tr>
<tr>
<td>Description of Treatments authorised by T2 or T3 certificates</td>
<td></td>
</tr>
<tr>
<td>Conditions Set for Conditional Discharge</td>
<td></td>
</tr>
</tbody>
</table>
NB – This list is not necessarily exhaustive. Please add any further roles as needed

<table>
<thead>
<tr>
<th>Record of Those Involved in CPA</th>
<th>Name</th>
<th>Address</th>
<th>Contact no.</th>
<th>Invited to meeting</th>
<th>Attended</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
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<td></td>
</tr>
<tr>
<td>Responsible Medical Officer</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Officer</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Named Person</td>
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<td></td>
</tr>
<tr>
<td>Social Worker</td>
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</tr>
<tr>
<td>Police Liaison Officer</td>
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<td></td>
</tr>
<tr>
<td>Care Coordinator</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
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</tr>
<tr>
<td>Psychology Assistant</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Pharmacist</td>
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<td>SHO/SPR</td>
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<td>GP</td>
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<td>Keyworker</td>
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<td>Other Professional</td>
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<tr>
<td>Charge Nurse</td>
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<tr>
<td>Psychiatric Advisor to Scottish Executive</td>
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<tr>
<td>Housing Officer</td>
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</tbody>
</table>

If an out of area patient please include details of home health board and local authority and people to invite.
This section sets out the identified needs in relation to Medical Treatment for mental disorder, other forms of treatment, needs in respect of current planned community care, risk management issues and should document any unmet needs. The table is populated with an example.

<table>
<thead>
<tr>
<th>Need*</th>
<th>Objective *</th>
<th>Action Plan</th>
<th>By Whom</th>
<th>Review Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Mental Health Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address Physical Health Issues</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Address Offence Related Therapeutic Issues</td>
<td></td>
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<tr>
<td>Address Relationship Issues</td>
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<td></td>
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<tr>
<td>Address Occupational and Recreational Issues</td>
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</tr>
<tr>
<td>Address Self Care Issues</td>
<td></td>
<td></td>
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<tr>
<td>Assess Self Control and Acceptance of Personal Responsibility</td>
<td></td>
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</tr>
<tr>
<td>Address other risk Management Issues</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Develop Future Plans</td>
<td></td>
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</tbody>
</table>

This is not an exhaustive list and additional headings may be included, for example media or victim issues.
This section sets out the objectives from the previous CPA documentation and should be reviewed as part of the meeting.

<table>
<thead>
<tr>
<th>Need*</th>
<th>Objective *</th>
<th>Action Plan</th>
<th>By Whom</th>
<th>Review Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Mental Health Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address Physical Health Issues</td>
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<tr>
<td>Address Offence Related Therapeutic Issues</td>
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<tr>
<td>Address Relationship Issues</td>
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<tr>
<td>Address Occupational and Recreational Issues</td>
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<tr>
<td>Address Self Care Issues</td>
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<tr>
<td>Assess Self Control and Acceptance of Personal Responsibility</td>
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</tr>
<tr>
<td>Address other Risk Management Issues</td>
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</tr>
<tr>
<td>Develop Future Plans</td>
<td></td>
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</tr>
<tr>
<td>Contingency Plan</td>
<td>Early Warning Signs (Relapse Indicators)</td>
<td>Contingency Actions</td>
<td></td>
<td></td>
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<tr>
<td>------------------</td>
<td>-----------------------------------------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms of Mental Illness</td>
<td>Green :</td>
<td>•</td>
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<tr>
<td></td>
<td>Amber:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Red:</td>
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<td></td>
<td>Amber :</td>
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</tr>
<tr>
<td></td>
<td>Red:</td>
<td></td>
<td></td>
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<tr>
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<td>Green :</td>
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<td></td>
<td>Amber :</td>
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<td></td>
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<tr>
<td></td>
<td>Red :</td>
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</table>
## RISK SUMMARY

### Offending History

<table>
<thead>
<tr>
<th>Index offence</th>
<th>Other offences</th>
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</table>

### History of ...

<table>
<thead>
<tr>
<th>Violence</th>
<th>Sexual aggression</th>
<th>Fire raising</th>
<th>Hostage taking</th>
<th>Use of weapons</th>
<th>Alcohol or substance misuse</th>
<th>Absconding/escape</th>
<th>Self-harm</th>
<th>Other factors of relevance</th>
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</thead>
<tbody>
<tr>
<td>Yes / No</td>
<td>Brief details</td>
<td></td>
<td></td>
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### Current Risk Status

<table>
<thead>
<tr>
<th>Setting</th>
<th>Likelihood, imminence, frequency and severity of harmful behaviour towards whom under what circumstances</th>
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</thead>
<tbody>
<tr>
<td>In hospital</td>
<td></td>
</tr>
<tr>
<td>In community escorted</td>
<td></td>
</tr>
<tr>
<td>In community unescorted</td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</table>

### Conditional Discharge Conditions


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

### Monitoring and Supervision Requirements

#### In Hospital

<table>
<thead>
<tr>
<th>Nursing observation level</th>
<th>Restrictions regarding contact with staff</th>
<th>Restrictions regarding access to indoor areas</th>
<th>Restrictions regarding access to outside areas</th>
<th>Restrictions on telephone use and letters</th>
<th>Room searches</th>
<th>Personal searches</th>
<th>Alcohol/drug testing</th>
<th>Access to sharps and other utensils</th>
<th>Visitors</th>
<th>Other hospital requirements</th>
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</thead>
<tbody>
<tr>
<td>Escort requirements</td>
<td>Special considerations for staff visiting patient</td>
<td>Special considerations for out-patient appointments</td>
<td>Alcohol/drug testing</td>
<td>Other community requirements</td>
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</tr>
</tbody>
</table>

#### In Community

<p>| Escort requirements       | Special considerations for staff visiting patient | Special considerations for out-patient appointments | Alcohol/drug testing | Other community requirements |</p>
<table>
<thead>
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<th>Patient / Carer Views</th>
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<tr>
<td><strong>Patient Comments</strong></td>
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<tr>
<td><strong>Carer Comments</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Arrangements Next CPA</th>
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<tbody>
<tr>
<td><strong>Date</strong></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Time</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Place</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

The Care Programme has been agreed by those concerned.

Patient: Forename Surname (verbally agreed)

Carer: __________________________________________

RMO: Dr J Smith (verbally agreed)

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

MHO: __________________________________________
RISK MANAGEMENT/CONTINGENCY PLAN

Risk Assessment Document (RAD) identifies area to be addressed in Risk Management

Pre-CPA and CPA set out Risk Management inc. Treatment, monitoring/supervision, victim safety planning, contingency, review

Treatment

- Implement appropriate treatment e.g.:
  - Medication
  - Psychological interventions
  - Therapeutic environment

Monitoring/ Supervision

- Identify those responsible and make sure all staff involved are aware of requirements

Victim Safety Planning

- All staff involved from all agencies are aware of specific issues and limitations to be placed on patients

Contingency Planning

- Set out the following:
  - Indicators, Red Amber, Green
  - Who to contact in office hours, at nights and at weekends
  - Set date and criteria to trigger early review of RAD

Review of Risk Assessment

- Share with all individuals from all agencies involved in patient’s care

- Review on ongoing basis by all involved inc. RMO/MHO/CPN

- All Green
  - Continue

- Any Amber
  - Inform and review as indicated in contingency plan

- Any Red
  - Recall and review as indicated in contingency plan

ROUTINE REVIEW

URGENT REVIEW