Contents
Introduction

A. Group Membership
B. Terms of Reference
C. Summary of Work
D. Acknowledgements

Chapters
1. Context
2. Definition of client group
3. Forensic Community Mental Health Team model
4. Information and Involvement
5. Risk Assessment and Risk Management
6. Needs Assessment
7. Enhanced Care Programme Approach

Therapeutic interventions
8a Therapeutic interventions – offender treatment programmes
8b Therapeutic interventions – non-criminogenic

9 Dual diagnosis
10 Court Liaison Service
11 Diversion from prosecution
12 Accommodation
13 Core Recommendations

Appendices
1. Risk Assessment and Management in Forensic Community Mental Health Teams – Mark Ramm, Angela Papp, Hugh McGregor
2. Needs Assessment in Forensic Community Mental Health Teams – Susan Prior, Claire Young
3. Enhanced Care Programme Approach in Forensic Community Mental Health Teams - Claire Young, Susan Prior
4. Addressing Offending Behaviour in Community Settings - Angela Papp, Mark Ramm, Hugh McGregor
5. Court Liaison Service provided by Forensic Community Mental Health Teams – Willie McFadden
6. Diversion From Prosecution in Forensic Mental Health Services - Hugh McGregor, Billy Gallacher
7. Accommodation And Housing – Colin Ross
A. Group membership

Chairperson
Rhona Morrison, Consultant Forensic Psychiatrist,
Forth Valley Forensic Community Mental Health Service

Brian Hood,
Community Forensic Services
NHS Ayrshire and Arran

Gus Leslie, Inspector - NHS Liaison Officer
Fife Police

Hugh McGregor, Justice Services Manager
South Lanarkshire Council

Willie McFadden, Community Psychiatric Nurse,
Forth Valley Forensic Community Mental Health Service

Susan Prior, Occupational Therapist,
Orchard Clinic

Mark Ramm, Clinical Forensic Psychologist,
Orchard Clinic

Colin Ross, Community Services Strategic Manager
Aberdeen City Council

Clare Young, Social Worker – Mental Health Officer
Hillfoots Community Care Team

Facilitator
Innes Walsh, Risk Management Facilitator
The State Hospital

Other contributors
Angela Papp, Forensic Psychologist
Forth Valley Forensic Community Mental Health Service

Billy Gallacher
Procurator Fiscal, Lothian

The group intend to seek specific comment from:
National Schizophrenia Fellowship (Scotland)
Deborah Baillie, Consultant in Health and Social Work Law

In the context of the full consultation process with all interested parties

The group was comprised of professionals with particular experience and/or expertise relevant to providing services to Mentally Disordered Offenders in the community. As development of services specifically designed for mentally disordered offenders has been patchy across Scotland, this approach resulted in membership based on knowledge rather than an attempt to ensure geographical representation.
B. Terms of reference
The group was given a broad remit to consider service provision for mentally disordered offenders in the community. The group determined that it would be most useful to take a practical approach and to concentrate their efforts on providing guidance and recommendations on elements of forensic community mental health services for those who are currently developing services for mentally disordered offenders in community settings.

C. Summary of Work
The group first met on 10th September 2004 in Stirling and subsequently met in full on 5 occasions including a final meeting on the 11th March 2005. Additionally, the chairperson and group facilitator met regularly at the Forth Valley Forensic Community Mental Health Team offices and the entire group was regularly updated and asked for comment between meetings via e-mail.

A body of background information was prepared by the group facilitator and distributed to the group; a full bibliography is at the end of this report. The group split into subgroups to consider particular elements of forensic community services for mentally disordered offenders. The subgroups informally consulted colleagues in order to gain as wide an appreciation of the issues associated with each aspect as possible. Each subgroup report is appended to the main report and summarised in terms of findings and recommendations in the main body of the report.

The group received a presentation from the facilitator of the Personality Disorder working group of the FMHSN, Dr Eddie Duncan, to ensure that the output from the Personality Disorder Working Group was consistent with recommendations regarding community service provision.

The draft report was submitted to the Forensic Network on 10th June 2005. The Chairperson gave oral presentations on the work of the group at Network board meeting on the 11th of March 2005 and on the 10th June 2005. It is planned to present this report at a special meeting organised by the Network on 4th October 2005 in Edinburgh.

D. Acknowledgements
As well as the members, other contributors, and reviewers, we are pleased to acknowledge the following people who have made a contribution to the work of the group and ultimately this report.

We were very grateful to Dr Edward Duncan for sharing the work of our sister group on services for those with Personality Disorder.

We thank the original authors of template documentation included in the appendices of this report for allowing us to reproduce their documents as examples.

We would also like to thank our colleagues, both those who contributed to informal consultation about community services, and those who offered their support and advice over the past eight months.
1. Introduction

The Department of Health published the Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services in 1994 (the Reed Report, Department of Health 1994).

In Scotland, “Health, Social Work and related services for Mentally Disordered Offenders in Scotland” (NHS MEL (1999) 5, Scottish Office 1999) set out proposals for a co-ordinated range of services and accommodation for mentally disordered offenders designed to meet the needs of the individual and public safety.

The Reed principles were explicitly adopted for Scotland in this NHS MEL and it was in this context that the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) was examined. This included the care provided by the police, prisons, courts, social work department, the State Hospital, other psychiatric hospitals, and in the community. In addition, these principles are consistent with the Mental Health (Care and Treatment) (Scotland) Act 2003.

Box 1: The “REED PRINCIPLES”

"Mentally disordered offenders 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 in 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."

Box 1a: The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003

Mental Health (Care and Treatment) (Scotland) Act 2003 is based on a set of guiding principles formulated by the Millan Committee, which are not contained verbatim in the Act but help to set the tone and guide its interpretation.

1. Non-discrimination - People with mental disorder should, wherever possible, retain the same rights and entitlements as those with other health needs.

2. Equality - All powers under the 2003 Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.
3. **Respect for diversity** - Service users should receive care, treatment and support in a manner that affords respect for their individual qualities, abilities and diverse backgrounds, and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. **Reciprocity** - Where society imposes an obligation on an individual to comply with a programme of treatment or care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

5. **Informal care** - Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

6. **Participation** - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be presented in an understandable format.

7. **Respect for carers** - Those who provide care to service users on an informal basis should be respected for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. **Least restrictive alternative** - Service users should be provided with any necessary care, treatment and support in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account, where appropriate, of the safety of others.

9. **Benefit** - Any intervention under the 2003 Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.

10. **Child welfare** - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the 2003 Act.

The MEL (1999) 5 proposed that mentally disordered offenders be cared for under conditions of security appropriate to the risk they present and also emphasised the importance of rehabilitation. It further implied that care be organised, as far as possible, in community rather than institutional settings.

In setting out these principles for safe services and accommodation, the separate but linked roles and responsibilities for the health, social work, housing and other agencies was acknowledged. The co-ordination of services required was acknowledged as a special challenge and one that would rely on multi agency approaches to ensure that the right services, in the right locations, were available when required.
The “Care Pathway Document” (HDL (2001) 09, Scottish Executive Health Department 2001) aimed to provide a further means of assessing what action is required in each area to completing a co-ordinated response to safe care and accommodation for mentally disordered offenders.

The Care Pathway Document also made it clear that no single agency can, or is expected to; meet all the needs and safety dimensions involved in the care and accommodation of mentally disordered offenders. The diversity and complexity of need requires a collaborative agency approach.
Diagram 1: Health, Social Work & Social Care Elements (Figure 3 from the Care Pathways Document)

Figure 3: A Care Pathway Framework - Health, Social Work & Social Care Elements

for illustrative purposes only
Joint working and planning is the preferred route to delivering better quality services and outcomes and allows for planned activity and timetables to be agreed that reflect the different starting points for each agency.

"A Joint Future" (Scottish Executive 2000) is particularly relevant to caring for mentally disordered offenders in the community. The report provided guidance generally on joint responsibilities for care provision and provided a framework of principles and approaches that have application for joint agency work. For example, guidance on shared assessments of need and multi agency care responses are covered and are relevant for planning the service and accommodation responses for the care of offenders.

It is essential that clinicians continue to adhere to new guidance issued from the Scottish Executive in relation to the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003 and any additional legislation or guidance which is forthcoming.

The Managed Care Network for Forensic Mental Health Services in Scotland has undertaken to review the process for determining the right care for mentally disordered offenders. In order to do this the Forensic Network aims to:

- Oversee the development of a pan Scotland Plan
- Provide a strategic overview and direction of the planning and development of specialist services
- Advise and support the development of local services
- Oversee the use and access to and from different levels of secure care
- Potentially have a role in dispute resolution

Part of the development of the Forensic Network is to make recommendations on elements of service. One of these is the Community Services Working Group

**Diagram 2: Levels of risk managed in Forensic Services**

- **Community Services**
- **Low Security (Forensic Unit)**
- **Medium Security (The Orchard Clinic)**
- **High Security (The State Hospital)**

Potential for increased risk if appropriate community services are not in place:

- Increased patient numbers
- Increased need for proactive monitoring (no physical security)
- Increasing risk of medication non-compliance
- Increasing access to alcohol/drugs
- Increasing access to weapons
- Increasing access to potential victims
- Increasing risk of disengagement
2. **Definition of client group**
The client group for a forensic CMHT is necessarily broader than that of other tiers of the Forensic Psychiatric service. Community services deal with mentally disordered patients with the potential to offend in addition to those who have committed an offence and therefore take on a preventative role for some cases. Risk Assessment and Management are core ongoing functions of the team, which must adapt to changing levels of risk and social circumstances on a day to day basis.

**Box 2a: Definition of client group of a Forensic Community Mental Health Service**

People suffering, or appearing to suffer, from a major mental disorder whose behaviour brings them into the Criminal Justice System and are a cause for concern; either because of the seriousness of the offence or their potential dangerousness. In addition, the service will also offer input to those with severe mental disorder who pose a risk to the safety of others but may not necessarily have been convicted of an offence. Mental Disorder as outlined in the Mental Health (Care and Treatment) Act (2003) section 227

'Meaning of “mental disorder”
(1) Subject to subsection (2) below, in this Act “mental disorder” means any—
(a) mental illness;
(b) personality disorder; or
(c) learning disability,
however caused or manifested; and cognate expressions shall be construed accordingly.

(2) A person is not mentally disordered by reason only of any of the following—
(a) sexual orientation;
(b) sexual deviancy;
(c) transsexualism;
(d) transvestism;
(e) dependence on, or use of, alcohol or drugs;
(f) behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person;
(g) acting as no prudent person would act.’
**Box 2b: Personality Disorder**

The assessment and management of people with personality disorders is an issue for mental health and social services as a whole, and is not purely the remit of forensic services. The Forensic Network Services for People with Personality Disorder Working Group has made several recommendations and the Centre for Change and Innovation produced a discussion paper on delivering improved care to this diagnostic group (“Personality Disorder in Scotland: Demanding patients or deserving people?” Centre for Change and Innovation, 2005)

Recommendations that personality disorder is not a diagnosis of exclusion from mental health services in Scotland and that services for people with personality disorders are required (given the frequency with which they are found in the criminal justice and mental health systems in Scotland) are likely to be adopted.

We would recommend that Forensic Community Mental Health Teams consider patients with Personality Disorder on a case by case basis, ensuring that they work with other agencies and within their capacity to provide a service to these patients, where appropriate.

We have not specifically considered the needs of subgroups of the forensic population, such as: learning disability; gender or age specific services (e.g. child and adolescent services, care of the elderly services) or services for those with sensory disabilities. We understand that the Forensic Network is commissioning groups to examine the needs of many of these populations. The approach we have taken identifies the components necessary for the functioning of a core forensic community mental health team and extended network of services although the experience and training of team members would require to reflect the needs of the individual sub-specialty patient groups. This may require amendment over time if additional areas of work are considered as appropriate to be added to the remit of a Forensic Community Health Team.
Diagram 3: Routes and services

PERSON

Police → Procurator Fiscal

COURT

Hospital remand → Prison remand → Bail

COURT

Community services → Open ward → Low Security → Medium Security → High Security → Prison

COURT

Prison

Not Guilty

FORENSIC COMMUNITY MENTAL HEALTH TEAM

Assessment & diagnosis
Forensic Outpatient Clinic
Forensic CPN service
Enhanced CPA scheme
PF diversion scheme
Offending behaviour programme
Therapeutic Interventions
User and carer needs assessment
Risk Assessment and Management
Dual Diagnosis
Community Rehabilitation
Multi-agency training
Court reports
Accommodation
Forensic Consultation
Liaison with prisons
Liaison with inpatient services
Joint working with CJSW

Appropriate adult Service
Procurator Fiscal diversion
Court Liaison Scheme
Court report

GP referral

Joint working with CJSW
3. **Forensic Community Mental Health Team model**

Our review of available literature produced limited numbers of papers addressing the issue of successful development of Forensic CMHT in the UK. It is therefore important that new services in Scotland consider contributing to the evidence base regarding their experiences, challenges and successes in this exciting and developing field of practice.

The group asserts that Forensic Community Mental Health Team (FCMHT) is an essential component of a comprehensive forensic mental health service. As Mentally Disordered Offenders (MDO) filter through the various tiers of forensic services it is likely that they will eventually progress from higher levels of security to the community at some point as their mental health and behaviour stabilises. It is often thought erroneously that the most risky MDO are always held at higher levels of security. However, it is the same patient with the same illness and potential risk factors who moves between tiers of the service as their illness and behaviour stabilise. These risks require to be assessed and managed in each different environment.

The area of greatest potential risk is actually the community as in this environment there is an increased risk of disengagement from services, non-compliance with medication, access to potential victims, access to weapons and access to destabilisers (e.g. social stressors, illicit drugs and alcohol). Proactive support and monitoring of mental illness and behaviour in relatively well forensic patients is required to ensure early intervention and sensitive management of risk for the protection of both the patient and the public.

A flexible, responsive, proactive team approach requires small caseloads for staff, with time to be able to carry out detailed risk assessment and risk management planning, communicate adequately (verbal and written) with all agencies involved and support carers, in addition to offering support and monitoring of the patient themselves. Enhancement of existing generic Community Mental Health Teams would not provide the capacity or expertise required for these tasks.

An Holistic approach to care utilising multiple disciplines and agencies is likely to produce the most effective, needs-led care plan. In addition to individual needs assessment, care, treatment, support and monitoring, the team requires to contribute to, and liaise with, all tiers and services contributing to the network of forensic services encountered by MDO who are in, or about to return to, the community, to ensure a seamless pathway of care.

Each patient has a right to advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003 and there is a duty on the Mental Health Officer or Hospital managers to advise patients of this right and to facilitate contact with an advocate. Where an advocate is involved with a patient, they should be invited to attend meetings and reviews with the patient.

**Box 3: The Core Team**

- Forensic Psychiatrist
- Forensic Clinical psychologist/ Forensic psychologist
- Forensic Community psychiatric nurses
- Forensic Social workers (MHO)
- CJSW
- Forensic Occupational therapist
- Support Workers (social care assistant, nursing assistant)
- Administrative staff
Psychiatry
In many teams, the consultant psychiatrist is identified as the team leader. The Forensic Psychiatrist(s) in the team have specific roles and responsibilities as Responsible Medical Officers and these are set out in the Mental Health (Care and Treatment) (Scotland) Act 2003. Core functions of the Forensic Psychiatrist include, assessment, diagnosis, treatment of mental illness, support and supervision of staff, preparation of court reports, input to the court liaison service, consulting work for other services, input to risk assessment and management and training for other staff. However, they may also have additional linked duties in providing inpatient care of forensic patients, prison clinics etc.

Psychology
Use of the term “psychologist” refers to someone who is entered on the British Psychological Society Register of Chartered Psychologists (or who is eligible to do so). In general, chartered psychologists with a clinical training (“Clinical Psychologists”) have particular competencies in relation to assessing psychological attributes such as capacity and providing psychological treatment, while chartered psychologists with a forensic training (Forensic psychologists) have particular competencies in risk assessment and addressing offending behaviour. ‘Forensic Clinical Psychologists’ have accredited expertise in both areas.

Psychological treatments are now prominent in all areas of mental disorder. Psychological treatments are used in the treatment of mental illness and are often the primary treatments in learning disability and personality disorder. Treatments for offending behaviour are also principally psychological in nature. In relation to treatment it is therefore often important to consult an appropriately qualified chartered psychologist. It is considered particularly necessary if:

a) the primary diagnosis is one of learning disability or personality disorder
b) there is need to assess any patient’s psychological needs at an in-depth level;
c) there is need to assess capacity at a complex level;
d) a complex psychological intervention is necessary as part of the treatment plan;
e) the treatment involves a manipulation of the therapeutic environment using psychological techniques such as behaviour modification programmes.

A chartered psychologist is seen as an important member of the multidisciplinary team whenever they are available. However, is not envisaged that they will always personally implement all psychological interventions and often their high level skills may be more appropriately employed in assessment, formulation, treatment planning and support of other staff carrying out psychological interventions.

Forensic Community Psychiatric Nurses
The caseloads for Forensic Community Psychiatric Nurses are much less than that of their generic Community mental Health Team colleagues in terms of number of patients, typically 10 to 15 patients. This is due to the intensive input and follow-up required by the patient group in order to manage risk. They will also have a greater link with the criminal justice system; perhaps leading a court liaison scheme. Psychosocial interventions, illness education, symptom monitoring needs assessment, CPA keyworker duties, family liaison, interface working with other agencies, in-reach to inpatient facilities and prisons, risk assessment, encouraging social reintegration, specific therapeutic interventions, medications compliance monitoring, urine testing etc. are all part of the multi-faceted role of the forensic CPN.
Social Work
There are certain essential core activities that are a requirement in the arrangement and provision of social work services as part of Forensic Community Mental Health Teams. These include the provision of assessment and care management services; Mental Health Officer services; criminal justice social work services; and effective child protection services. It is essential to have Social Workers as core members of the FCMHT. User and carer assessment, obtaining collateral family histories, arranging social care packages, advice with regard to benefits and housing, providing ongoing social work input to the case, assessing risk, input into detention and review under the Mental Health Act, participation in CPA and joint working to address offending behaviour (possibly as part of an order) are all elements of the role of forensic social work team member essential in providing a holistic needs led care package.

Forensic Occupational Therapy
The Forensic Occupational Therapist brings additional skills to the team in terms of practical assessment of the patients’ skill base within the areas of Activities of Daily Living, life roles of personal and domestic care, leisure and work. The focus of the occupational therapists’ interventions is the engagement of patients in the doing of everyday activities, in a structured manner which will promote health, and reduce or manage risk and offending behaviour. They can design care packages to address these identified skill deficits often via in-reach pre-discharge/liberation and continue to build on these skills as part of a graded community rehabilitation/reintegration care package. Assistance in coping with a new tenancy and linking with leisure, education and employment opportunities are particularly important in the care package. A special expertise in terms of working with offenders and monitoring and managing risk is essential in this role.

Support Workers
It is essential to assess the skill mix and work load within the team ad several tasks relate to practical, social, community reintegration related issues and could be carried out by support staff trained to an adequate level in terms of the risk management function of the team. They would work closely as integrated members of the FCMHT

Administrative Staff
It is essential to have adequate administrative support to cover team work, court reports and consultants additional responsibilities, and to cope with lengthy file reviews, case summaries CPA minutes, risk assessments and risk management plans. Administrative support is also essential in order to support FCMHT functions, allow clinical team members to contribute in meetings, and to maintain the commitment to sharing information within the team and with users and carers.
**Box 4: Necessary Links**

- Advocacy
- Community Alcohol and Drug Services
- Community Care Social Work
- Community Rehabilitation Services
- Criminal Justice Social Work
- Courts
- Education and employment services
- General Practitioners and Police Surgeons
- Housing and accommodation
- Police
- Prison services
- Psychiatric Services (all tiers inpatient/sector teams)
- Psychology services
- Psychotherapy services
- Voluntary Sector

**Training**

Forensic CMHT staff require to be highly skilled and regularly updated in areas specific to the knowledge and skill base expected of such a specialist team. Finance should be available to support the training needs identified at individual appraisals, linked with any service developments or to specifically address individual patient need. The emphasis should be on risk assessment and risk management skills and therapeutic interventions (criminogenic/non-criminogenic).

It is hoped that training needs highlighted can be addressed by the Forensic School training programmes. The FCMHT also has a responsibility to contribute to the training of those professionals and agencies with which they interface (e.g. court liaison, mental health awareness and importance of risk assessment/management systems etc)

**Resources**

The resources required to fund a FCMHT will vary depending on the size of the team, the skill mix, the size of the population served, demographics, number of courts and prisons in the geographical area etc.

It is essential that the functioning of the team is underpinned by clear policies, procedures and risk management systems. For example, there should be clearly documented:

- Security policy
- Enhanced CPA system
- Risk assessment and management system
- Lone worker policy
- Missing patient policy
- System of referral/allocation/tracking of outcome
- Sharing of information guideline
- Court liaison scheme pack (including template reports for the sheriff, alerts for prison staff etc)

Each facet of working and interface requires to be examined and guidance produced for staff in relation to roles, responsibilities, information sharing protocols and documentation.
The aim should always be to produce a holistic needs led care package addressing risk management, quality of life issues and illness management. Psychosocial interventions and specific therapeutic interventions are insufficient in isolation. Joint interagency, interdisciplinary working requires to be at the core of patient care and should maximise any positive input that carers have to offer (whilst ensuring that their needs are addressed).

**Forensic Community Mental Health Team Example**

An example of an existing Scottish team is given. The caseloads for forensic Community Psychiatric Nurses are 10 to 15 patients and they run the nurse-led court liaison scheme daily for three geographically spread courts. A team “base” is essential to foster regular informal peer support, a forum for meetings and formal case supervision and to aid communication and shared records. This facilitates joint working and training.

The population served is approximately 300,000 people in a large geographically spread area with a mix of urban and rural environments.

<table>
<thead>
<tr>
<th>Table 1: Forensic Consultant Psychiatrist sessional input</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultant A</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Consultant B</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

It has proved useful to have two consultants with input to the FCMHT as it helps with cross cover for annual leave, public holidays and sick leave. Staff support and supervision and medical back up for the court liaison scheme is essential.

<table>
<thead>
<tr>
<th>Table 2: Core Team (see table 1 for Forensic Consultant Psychiatrist)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Profession</strong></td>
</tr>
<tr>
<td>Forensic Psychologist</td>
</tr>
<tr>
<td>Team co-ordinator (Forensic CPN)</td>
</tr>
<tr>
<td>Forensic Community Psychiatric Nurses (x4)</td>
</tr>
<tr>
<td>Forensic psychology assistant</td>
</tr>
<tr>
<td>Social Worker (Mental Health Officer)</td>
</tr>
<tr>
<td>Criminal Justice Social Worker</td>
</tr>
</tbody>
</table>
It is essential to have adequate administrative support to cover team work, consultants additional responsibilities, and to cope with lengthy file reviews, case summaries CPA minutes, risk assessments and risk management plans. Communication is essential and must be timely.

Links with both Social Work and Criminal Justice Social Work services are essential to address: Mental Health Officer duties for detained patients; community care/support issues; to address offending behaviour; and to provide invaluable family/career assessment and support. Social Workers are essential core team members.

The FCMHT in the example have no Forensic Occupational Therapist

The team work jointly with a range of services providing treatment and social care:
- community rehabilitation teams;
- community alcohol and drugs services (shared care methadone programme);
- Criminal Justice Social Work;
- health maintenance clinics;
- specialist services for the deaf;
- psychotherapy services;
- adult mental health day hospital services;
- voluntary sector services;
- independent living services;
- supported accommodation providers;
- local psychiatric teams; and
- supraregional/national inpatient forensic services.

They hope to develop a joint health /CJSW offender treatment programme, to encourage joint working and improved access to services for those Mentally Disordered Offenders who are not currently on an order but who have offending behaviours which require to be addressed.

**Box 5: Team Functioning**

It is essential that team functioning is underpinned by clear policies and procedures and risk management systems

Adequate staffing resources and skill mix are required to fulfil the specialist functions required of this service

Training must be a high priority to upskill and maintain expertise in risk assessment, risk management and therapeutic interventions (criminogenic /non-criminogenic)

A shared team base is essential to foster support and communication
Information sharing and Involvement
(in Risk Assessment, Needs Assessment and Care Planning)

Each of these elements of the work of Forensic Community Services; risk assessment, needs assessment and care programme approach, have common requirements in terms of the management and sharing of information and involvement of stakeholders.

**Box 6: Information sharing and Involvement**

Good quality risk assessment, risk management planning, needs assessment and care planning is multidisciplinary, includes all partners from the forensic community network, and involves the user and carer.

Information sharing and gathering is fundamental to meaningful assessment and a case file review should include review of all collateral files available from all agencies.

Ongoing update of risk and needs assessment and care plans requires good information sharing and communication.

Information sharing and confidentiality issues should be clarified between agencies to facilitate joint working. Where appropriate, formal consent should be sought from the patient to facilitate access to information and information sharing.

The risk management plan should be clearly documented and regularly updated. Good risk assessment is time and resource intensive. Adequate resources need to be allocated for safe risk management of MDO in the community.

Compatibility of electronic records is preferable.

Enhanced CPA meetings and review risk meetings should be used as fora to update the risk management plan and documentation. CPA documentation in itself, needs to be clear organised and informative.

4 Risk Assessment and Risk Management in Forensic Community Mental Health Teams

Risk assessment and risk management are fundamental tasks of any forensic CMHT. Within hospital and prison settings there are varying levels of security; physical, procedural and relational which provide a component of risk management. Access to illicit drugs, alcohol, weapons and victims is limited in these settings.

In the community, there is necessarily more reliance on relational security whilst the likelihood of disengagement from services and non-compliance with medication is also increased. Within the community setting all of these risks are potentially maximised because of the limited external or environmental controls, the inevitable reduction in the level of monitoring compared with an inpatient or custodial setting and the increased access to potential destabilisers.

It is therefore essential to carry out a detailed needs assessment, produce a care plan to address these needs, carry out a full risk assessment and develop a plan.
to monitor and manage these fluctuating risks. Proactive support and monitoring to identify any early changes in mental illness, risk behaviour or social circumstances is therefore the remit of all staff involved in the enhanced CPA care plan for MDO in the community.

**Box 7: Forensic Risk Assessment and Risk Management in community settings**

Specialist, detailed risk assessment should be carried out for all FCMH service caseload patients.

Each FCMH service should have clearly set out comprehensive policies and procedures for risk assessment and risk management planning based on up to date research with regard to actuarial and structured clinical judgement risk assessment tools (e.g. HCR-20). Care should be taken to ensure that the risk assessment tool used is valid for the MDO being assessed and that staff are adequately trained in the use of the tools used.

Risk assessment and risk management is the responsibility of all agencies involved with the patient. It is an ongoing process throughout the care of an MDO and not a one-off process. Risk factors and the risk management plan should be regularly monitored, updated and evaluated throughout the care of the patient.

All risk assessments should attempt to identify the level of risk of serious offending, the nature of the risk and in what circumstances it would be most likely to occur. It is also important to highlight warning signs, risk management strategies and possible therapeutic interventions which may reduce the risk in the longer term.

Risk management plans should address the issues raised during risk assessment and should include a crisis management plan.

Research relating to risk assessment and risk management of MDO in the community is lacking and we recommend that this is supported by the Forensic Network in order to enhance our understanding and management of this group.

5 **Needs Assessment**

NHS QIS standards state that “making an accurate diagnosis, continuing to support each individual and those who care for them, identifying their needs, and planning their health and social care with them are key elements of making sure that each individual with schizophrenia has the opportunity to lead as full a life as possible”

Mentally disordered offenders often have varied and complex health and social needs including mental illness, problems with cognition and emotional control, behaviour, physical health, interpersonal problems, poor coping strategies substance misuse, lack of support within the community, offending behaviour and difficulty accessing or interfacing with services. It is therefore paramount that service delivery is targeted to address the individualised needs, which have been identified utilising a thorough needs assessment tool. Various tools are available (e.g. CANFOR the forensic version of the Camberwell assessment of need 2003)
Box 8: Needs Assessment

Services should carry out a structured, comprehensive needs assessment for all cases, which is practical and easy to administer. The model should identify level of need and whether it is currently being met; repeat assessment should inform measures of outcome.

A carers needs assessment should be carried out in recognition of the value of supporting those involved in the care plan.

Ensure access to independent advocacy support is available for both users and carers

A comprehensive needs assessment should address non-criminogenic and criminogenic needs (see appendix). Core elements should be common to all agencies.

The needs assessment should inform the enhanced CPA care plan.

6 Enhanced Care Programme Approach

The development of care plans and risk management plans for mentally disordered offenders is a time consuming and complex process involving users, carers and representatives from multiple statutory and non-statutory agencies.

Enhanced care programme approach is a well documented process and forum for all involved parties to meet, agree the needs identified and risks to be addressed, and to develop a coordinated care plan and risk management plan to address these. The outcome of the meeting should be clearly documented and circulated to all relevant parties to ensure clarity regarding roles, responsibilities and actions to be taken to support the treatment and safe management of the MDO.

Typically these meetings may involve the user, carer, advocacy, psychiatrist, psychologist, Community Psychiatric Nurse, Occupational Therapist, social worker, Criminal Justice Social Worker, police, General Practitioner, housing, voluntary sector, day hospital staff, rehabilitation team, community alcohol and drugs service etc, depending on the individual and their current need.

Consideration should be given to discussing “advance statements” as described in the Mental Health (Care and Treatment) (Scotland) Act 2003 with patients. A method should be agreed for identifying, recording, accessing and updating the details of the statement as part of the development of the care plan.
**Box 9: Enhanced Care Programme Approach**

All FCMHT cases should be managed via enhanced CPA

Adequate supports should be in place to administer the meetings process and provide prompt detailed minutes of the agreed care plan.

FCMHT should have agreed needs assessment and risk assessment/management procedures to inform the enhanced CPA care plan.

The care plan under CPA should detail the current identified needs, the treatment and care plan to address these and current risk issues and how they should be managed, a crisis plan and contact details for all agencies involved in delivering the care package (a suggested template for required information categories within enhanced CPA documentation is included).

CPA should produce a multi-agency, multifaceted care plan addressing criminogenic and non-criminogenic needs, underpinning a holistic package of treatment support and monitoring.

Meetings should be held to agree the care plan 6 monthly as a minimum and more frequently in complex cases where the patient's mental health, behaviour, circumstances or level of risk require it.

---

7 **Therapeutic Interventions**

Psychiatric services have traditionally focused on assessment, management and treatment of Mentally Disordered Offenders’ mental illness as a way of reducing the risk of associated offending and have not always focussed on specific offender treatment programmes. This is particularly problematic at lower levels of security and in the community as traditionally forensic clinical psychologists and forensic psychologists have worked in prisons, medium and high secure hospital settings. It is important to address both non-criminogenic and criminogenic needs for MDO.

8a **Therapeutic Interventions - Offender treatment programmes**

It is proposed that this is an area for future service development that would ultimately be expected to reduce the risk posed by mentally disordered offenders in the community. In the community, current offender treatment programmes are predominantly run by criminal justice social work staff and can only be accessed by MDO currently on an order to be supervised by the CJSW department. This effectively excludes the most seriously ill or dangerous patients who have initially received a hospital disposal at court or who are judged to have the potential to offend but have not yet offended.
The development of extended multi-agency training in accredited offender treatment programme work and joint (health/CJSW) delivery of programmes would hopefully address this service gap for MDO allowing a sharing of expertise and resources.

**Box 10: Therapeutic Interventions - criminogenic**

Services should be developed to provide MDO access to accredited offender treatment programmes. Health and CJSW jointly delivered programmes should be developed monitored and evaluated.

A local FCMHT should ensure training for staff to ensure the development of expertise in a range of offender treatment programmes e.g.:

- general offending behaviour,
- sex offender treatment programme
- anger management

**8b Therapeutic Interventions – non-criminogenic**

The range of therapeutic interventions for mentally Disordered Offenders requires to address: mental health issues, social skills deficits, substance misuse problems, personality difficulties and offending behaviour. Although many interventions may be similar to those required by non-offender populations their delivery may require to be individually tailored to take account of risk issues with a particular individual.

The complex interplay between the identified difficulties needs to be managed safely and sensitively e.g. a paranoid violent sex offender may require social skills training, anger management, illness education and depot medication. However, it may not be advisable for this work to be carried out by a lone female worker in his own home.

Where possible and appropriate MDO should access mainstream services to avoid unnecessary stigma or ghetto forming, but local FCMHT should ensure the training and development of expertise within the team to allow flexibility and capacity to deliver individualised therapeutic interventions for this population where necessary. Safe management of risk towards staff and the public should always be considered before agreeing the therapeutic intervention.

This complex group may also require highly specialised therapeutic intervention e.g. sex offender treatment programmes.
Box 11: Therapeutic Interventions - non-criminogenic

A local FCMHT should ensure training for staff to ensure the development of expertise in a range of therapeutic interventions. e.g.
psychologically based therapies
• cognitive and behavioural therapies
education based work
• illness education
skill based work
• social skills
• problem solving skills
consideration should be given to joint working and shared care arrangements with other partner agencies e.g. social reintegration (community rehabilitation team /FCMHT) dual diagnosis MDO patients methadone programme (CADS/FCMHT)
Therapeutic interventions should target identified needs and take account of, and manage, associated risk factors.

9 Mentally Disordered Offenders with dual diagnosis

MDO may often present with a dual diagnosis of mental illness and substance misuse. Drugs and alcohol often act as a destabiliser and increase the risk of a violent act or offending behaviour. They also contribute to relapse of illness and chaotic social functioning.

It is important that these patients are not excluded from services due to either their offending behaviour or substance misuse as they potentially pose a significant risk to the public. It is important to manage both problems simultaneously in a coordinated way, for example, as a multi-agency shared care arrangement, where needs and risks are identified and a care plan and risk management plan developed to address them.

Where more than one agency is involved, liaison procedures, fast tracking and monitoring arrangements need to be agreed to ensure efficient safe practices across specialist service interfaces. Enhanced CPA and risk management systems allow for a discussion and agreement of roles and responsibilities and documentation of the interagency shared care plan.

Box 12: Dual Diagnosis

Each area should develop a procedure/protocol for management of MDO with a dual diagnosis
Enhanced CPA and risk management systems require to be in place to facilitate safe shared care of these patients who may cross the interface between specialist services.
10 Court Liaison Service

The function of a court liaison service is to access mental health services for individuals who appear to be acutely mentally disordered or severely incapacitated by reason of mental disorder and who are deemed too unwell to proceed through the Criminal Justice system at that time. This does not exclude the individual from prosecution but may result in relocation to hospital on remand for assessment.

Local sheriff courts often require urgent advice with regard to fitness to plead for prisoners who have been in custody overnight or where the prisoner is felt to be acutely psychotic or suicidal and unfit for remand to prison.

Each local area should agree a procedure for the Procurator Fiscal to access a same day opinion in such cases and to access an acute psychiatric bed for remand for assessment when required. The aim should be to prevent inappropriate remand in custody of an offender who is acutely mentally ill.

Care should be taken to ensure that the service is not seen as a route to provision of quick psychiatric reports or as a means to avoid prosecution. It is important that offenders acknowledge the consequences of their behaviour whether mentally ill or learning disabled. Geography, workload and issues such as practical team capacity will inform the structure and mechanism of delivery of each local service.

Box 13: Court Liaison Scheme

Each area should develop a same day court liaison service for use by the local Procurator Fiscal and sheriff courts.

A clear mechanism for identification, referral, assessment, preparation of written reports and access to acute psychiatric beds should be developed in conjunction with police, Procurator Fiscal, local inpatient services, Criminal Justice Social Work and the FCMHT.

There must be capacity within the local services for approved medical practitioners to support the service, even if it is nurse led, to ensure there is the ability to detain patients under the Mental Health Act when necessary.

Agreed templates should be developed to record service contacts, opinions for court and share information with partner agencies (e.g. prisons).

The FCMHT should provide multi-agency training in mental health awareness and on the purpose and functioning of a court liaison scheme prior to initiation of the service to ensure that appropriate cases are identified.
11 Diversion from prosecution

In Scotland, Procurators Fiscal can divert any person charged with an offence from prosecution where they are of the opinion that it is not necessarily in the public interest to prosecute. In doing this they should be of the opinion that there is a sufficiency of evidence to sustain a prosecution. The practice is informal and is not governed by legislation. An assessment is sought from a specialist resource and should occur in the context of strong links between Criminal Justice Social Work and Psychiatric Services.

In the case of Psychiatric Diversion there should be recognition by the patient that the behaviour is problematic, there should be a link between the illness and offending behaviour and treatment of such should reduce the likelihood of repetition of the behaviour.

The Procurator Fiscal can either divert the case and waive the right to prosecute or defer decision on prosecution, dependant on cooperation and progress with treatment.

Box 14: Psychiatric Diversion from prosecution

FCMHT and CJSW should liaise with the local Procurator Fiscal to explore setting up a Psychiatric Diversion from prosecution scheme

Training in mental health awareness and identifying appropriate cases for diversion would be appropriate across the partner agencies

Aims and objectives of the scheme should be agreed

Systems would require to be put in place to monitor and evaluate the service and outcomes

12 Accommodation for Mentally Disordered Offenders in the community

It is important that the accommodation provided for mentally disordered offenders is appropriately planned, allocated and supported. The arrangement of appropriate accommodation, accessing funding and the actual form the accommodation takes can all have an impact on the stability of the patients life and therefore on the success and longevity of their community placement.

When a patient comes out of hospital or prison the provision of accommodation can often be allocated on the day of discharge or release. This increases the risk of an inappropriate allocation and reduces the scope for care planning by the community services.

Similarly, the way that benefits and other funding is provided can cause problems in planning and supporting mentally disordered offenders in community accommodation.

There is a lack of provision of suitable supported accommodation or ongoing low secure supervised provision. In many cases, the step from institutional care to an independent tenancy is too big and a more graded approach to accommodation provision would be preferable.
Appropriate allocation of accommodation can lead to a better outcome for patients. Unfortunately, there may be false assumptions made by neighbours due to this priority allocation and ongoing staff input, and this is a problem to be aware of. There should be sensitivity and acknowledgement of the community attitude to MDO.

Inclusion of housing staff in enhanced CPA meetings and information sharing can significantly improve appropriate assistance from the housing department.

**Box 15: Accommodation**

Despite the current statutory constraints, ideally, tenancy or accommodation allocation should be made and communicated to FCMHT before liberation or discharge of a patient, in order to facilitate care planning, decrease stress and uncertainty in the patient and reduce the risk to (and posed by) vulnerable or potentially violent patients.

Despite the current statutory constraints, ideally, a funding pool should be established jointly in order to facilitate graded discharge from hospital, home leave from prison and provision of furniture etc. This should reduce the delays and anxiety caused by benefit issues.

Appropriate step down supported accommodation should be established for Mentally disordered offenders. This should include appropriate training for staff in supported accommodation with regard to mental illness, risk management etc.

Allocation of housing should be undertaken taking account of the impact this decision can have on the patients, their families, the staff who will be looking after them and the public, including prior or potential victims.

There should, in particular, be Police involvement in allocation of accommodation (for example in the case of sex offenders or fire raisers) and consideration of placement in relation to prior or potential victims.
13 Core Recommendations

The group have taken a practical approach and concentrated their efforts on providing guidance and recommendations on elements of forensic community mental health services. This guidance is primarily for those who are currently developing services for mentally disordered offenders in community settings.

The following statements highlight the core elements and principles of development of forensic community mental health services.

1. The group recommends that each geographical area should develop a multidisciplinary forensic community mental health team (FCMHT).
2. Each FCMHT should develop a court liaison scheme to meet the needs of their geographical area.
3. Robust evidence based needs assessment, risk assessment and risk management systems must be developed
4. Needs led care should be co-ordinated via enhanced CPA system for all Forensic CMHT patients.
5. Therapeutic interventions should be developed to address both criminogenic and non criminogenic needs
6. Services should ensure that the care delivered is consistent with the principles and rights in the Human Rights Act 1998 and the Mental Health (Care and Treatment) (Scotland) Act 2003
7. Agreed methods of documentation and information sharing between partner agencies require to be developed
8. Opportunities for joint working and joint initiatives should be embraced, for example, offender treatment programmes (health and criminal Justice Social Work) and accommodation or employment schemes
9. Training, research and audit are a high priority as these highly specialised services develop to ensure high quality of care and support, robust risk assessment and risk management systems and appropriate therapeutic interventions and monitoring of outcomes.
Bibliography


Clinical Standards Board for Scotland (2001) Clinical Standards for Schizophrenia

Centre for Change and Innovation (2005) Personality Disorder in Scotland: Demanding patients or deserving people?


Department of Health (1994) Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services. (Reed report) London HMSO.


Forensic Mental Health Services Managed Care Network (2004) Definition of Security Levels in Inpatient Facilities in Scotland

Forensic Mental Health Services Managed Care Network (2004) Report of the Services for Women Working Group


Bibliography (cont.)


The Public Interest, 10, 22-54.

Research and Practice’. John Wiley and Sons, UK.

Mental Health Reference Group (2001) Needs Assessment for a Comprehensive, 
Local Mental Health Service

Muller-Isberner, R. (1996) Forensic Psychiatric aftercare following hospital order 

disordered offenders. In, S. Hodgins and R. Muller-Isberner (Eds), Violence, 
Crime and Mentally Disordered Offenders. Concepts for Effective Treatment and 
Prevention. John wiley and Sons. UK


Psychiatric Court Liason Scheme in North London. British Medical Journal 311 
531-2


Schneider J. Carpenter J. Brandon T.(1999) Operation and organisation of 
services for people with severe mental illness in the UK. A survey of the Care 


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

Scottish Parliament Housing (Scotland) Act 2001

Scottish Executive Health Department (1999) Health and Social work related 
services for mentally disordered offenders in Scotland. MEL (1999)5

Scottish Executive Health Department (2001) Services, care, support and 
accommodation for mentally disordered offenders in Scotland: Care Pathway 
Document. HDL (2001)09

Scottish Executive Health Department (2004) Community Health Partnerships 
(CHPs) and Integrated Mental Health Services HDL(2004)37

programme approach: how to make the CPA effective and credible. Journal of 
Psychiatric & Mental Health Nursing. 10(4):472-83,

an Era of Community Care: New Directions in Provision (eds Watson, W. & 
Bibliography (cont.)


Stewart (1983) *Keeping Offenders Out of Court: Further Alternatives to Prosecution,* Committee on Alternatives to Prosecution (Chairman Lord Stewart) HMSO


UK Parliament Protection from Harassment Act 1997


Appendix 1

Risk Assessment and Management
in Forensic Community Mental Health Teams

Mark Ramm, Director of clinical forensic psychology, Lothian NHS
Angela Papp, Chartered forensic psychologist, Forth Valley NHS
Hugh McGregor, Justice Services Manager, South Lanarkshire

Introduction
The assessment of risk of harm is an integral task in the functioning of any forensic CMHT and must underpin all other activity. This process involves practitioners, and whenever possible engages the client, in an objective assessment of the future risks posed by that client to others. This assessment of the potential harm to others and the specific situations under which this might occur must be used to balance the needs of the client with the safety of the public. It will therefore define core elements of the care, therapy and management plan that will be put into place for that client. Although risk assessment described here largely concerns aggressive or sexual harm to others, management plans should also consider the potential harm to the client. Indeed it should be noted that in reality there are multiple types of ‘risk’ that need predicting e.g. suicide, self-harm, absconding, harming others, and re-offending. The ultimate purpose of the risk assessment is harm reduction.

The assessment of risk has been transformed by empirical research in this area in recent years and it is expected that this will continue. Fundamental shortcomings continue to be recognised in relation to the availability of recidivism or outcome data the use of particular risk assessment instruments with Scottish or mentally disordered populations etc. Such factors mean that the practice of risk assessment by forensic CMHTs must both be able to contribute to this research knowledge-base and continually refine itself in the light of new “best practice”. It is anticipated that the new Risk Assessment Authority for Scotland will be able provide ongoing guidance in this area over time.

Clinical judgement alone has been shown to have poor predictive accuracy. Currently two different approaches to assessing risk are prominent. These are the ‘actuarial decision making’ and the ‘structured clinical judgement’ methodologies. It should be noted that these approaches are not mutually exclusive and each may have something important to contribute to a single risk assessment.

Actuarial decision making subjects collected data to statistical analysis. This standardises the assessment procedure, reduces clinical error and provides a defensible transparent decision making process. It requires no clinical judgement. Because actuarial decision making has tended to concentrate on static factors that are not open to modification it has been criticised for being unable to take account of factors that may reduce the risk of an event occurring. Other criticisms of an actuarial prediction used alone are that it is not person specific; it only gives a prediction at one point in time; it does not allow for change and it provides little help in planning risk management. However, the undoubted strength of the actuarial approach lies in risk prediction (i.e. the likelihood that a harmful outcome will occur). In decision making it is often important to try and objectively quantify this, although the method has not so far lived up to expectations that it can provide precise predictions. Examples of current practice include the Static 99 (Hanson, 1997) and the VRAG (Quinsey et al 1999).

Structured clinical judgement improves upon simple clinical judgement by providing a clear protocol for the collection and interpretation of relevant information. Guided by the current research literature, the systematic nature of the approach has been shown to improve general reliability and validity. Structured clinical judgement has been criticised for being too demanding and time-consuming for service providers as it pays more attention to dynamic factors (situational and social factors psychological and psychiatric factors) in addition to static factors, and requires highly trained practitioners in the methodology to make interpretations of the data. This clinical judgement also obviously leads to some subjectivity and potential error. However, the strength of the structured
clinical judgement approach is that it ultimately results in a risk formulation that lends itself to risk prediction and logically to a management strategy. It may make use of actuarial information, but by contrast maintains a non-reductionist approach. Current and future changes to circumstances and behaviour therefore tend to be more easily accommodated within the risk management strategy. In this way the structured clinical judgement methodology lends itself to the requirement of forensic CMHTs to have an effective system for deciding how they will manage an individual’s changing needs and risk over time and in differing situations. An example, widely used in current practice is the HCR-20 (Webster et al, 1997).

Both actuarial and structured clinical judgement approaches are likely to be useful. Andrews and Bonta (1994) identify a risk/need principle which suggests that effective work with offenders needs to match intensity of service delivery with the degree of risk posed by the offender. In time actuarial measures may be developed that take more account of both static and dynamic measures, but for the foreseeable future a degree of clinical interpretation seems essential. Risk formulation applies itself readily to the drawing up of care plans which aim to prevent, treat or manage identified risk factors in a specific environment or context.

Because the area of risk assessment is one that will continue to develop, no definitive method of risk assessment will be provided here. However it is perhaps useful to set out some basic guidance, particularly in relation to using structured clinical judgement in this document as this may be useful for those concerned with the planning and organising of forensic CMHTs.

**Risk Assessment Process Guidance Notes**

**Aims**
- The aim of risk assessment by the forensic CMHT is to identify and manage the level of risk posed by a client.
- It should be a matter of routine that a risk assessment is carried out with a client by the relevant forensic CMHT to assess whether an individual presents a risk to others and under what conditions.
- The circumstances and issues surrounding the risk should be taken into account in a client’s management.

**Clearly set out policies and procedures**
- Each forensic CMHT must have its own comprehensive protocol set out for conducting the process of risk assessment and risk management with its clients. Using a specified methodology, his must clearly set out:
  - How to gather information
  - How to share information
  - How to evaluate risk
  - How to manage defined risk

(See appendix ... for an example of one such protocol).

- Risk assessments should be carried out using assessment tools that have proven validity for the category of people that the assessed client falls into (e.g. prisoner, sex offender etc.). Where no specific assessment tool exists to fit the person being assessed, it is most valid to use a variety of assessments.
- Risk assessment is not a “one off” exercise since risk will vary over time in response to a range of situations and events. This must be recognised in the procedures.
- It should be recognised that assessment and management of risk involves balancing, sometimes contradictory, principles. Human rights and ethical issues must be recognised and addressed in the policies and procedures.
Gathering information

- Full access should be sought to all available information.
- Whenever possible collateral information should be gathered.
- It is essential that all patients should undergo a case file review.
- Sources of information should not be restricted to current files or client self-report.
- Clients should be requested to sign a consent form to allow access to all sources of information.
- Confidentiality should be maintained when possible.
- If it is considered necessary to break patient confidentiality without consent this must be defensible and the client should be told what has been said to whom (except when this would increase level of risk to others).
- Relatives and significant others should be consulted where possible.
- Existing and emerging technology should be used to its full potential.
- The assessment should attempt to place the risk the client presents in the context of their past history and current offending. This therefore include obtaining information regarding:

  Personal and family history
  Criminal history and violent history
  Substance misuse
  Psychiatric history
  Personality disorder
  Other risk factors relevant for the population (e.g. sex offender risk factors).

Team work

- A good risk management system should be multidisciplinary and involve all groups involved in the forensic community network (Health, police, social work, prison service, courts etc).
- There should be particularly close working relationships between the health service and criminal justice social work teams.
- The maintenance of good communication systems within and between agencies and services involved in patient care is essential.
- Sharing information between professionals is key.
- Obstacles or confusions (e.g. confidentiality of information) should be addressed at a systemic level.
- Decisions about risk management should never be made by one person alone. Responsibility needs to be shared.

Expertise

- Professionals must be adequately trained for their differing roles in the risk assessment process.
- Specific training in the use of particular risk assessment measures is essential.
- Professionals need to ensure that at all times they are competent, have acted reasonably and made decisions which are defensible in retrospect.
- It needs to be recognised that there is no way of developing a flawless system.
Risk Assessment

- A good risk assessment should never define a person simply in terms of high, medium or low risk. Although these terms may be reasonably used, the assessment should also include an attempt to characterise the nature of the risk the person might perpetuate in the future. This would include:

  - The kind(s) of violence the person is capable of perpetrating.
  - The likely level of physical or psychological harm.
  - The situation(s) the person is most likely to be violent in.
  - The likely victim(s) of that violence.
  - The warning signs that the person may be at risk of being violent.
  - The management strategies that need to be put in place to manage the risk of violence in the short term.
  - The least restrictive environment that the person's violence can be easily managed in.
  - The psychological, psychiatric or social treatments that may be given to help decrease the person's risk of violence in the long-term.

- A risk assessment should take note of a client’s strengths and resources as well as their difficulties

Risk Management Plans

- A risk management plan should address the issues raised by the risk assessment.
- This should be communicated and circulated to all those requiring it as appropriate.
- This should include clear and effective crisis management guidance.
- There needs to be creativity and flexibility to meet the needs of clients who do not fit the system.
- Risk management plans should take account of victim issues.
- Risk management should anticipate and reduce risk to the client as well as to others
- If the optimum course of action is not possible it should still be recorded along with the reasons for not implementing it and details of an alternative plan.

Monitoring and Evaluation

- It is important that a through-care approach is adopted in which management plans, risk factors and needs can be monitored and evaluated consistently over time during the client’s care by the team.
- The risk assessment should be continually updated by adding ongoing observations and information.
- A great deal can be learned from near misses where and incident has been averted or well managed.
- Ongoing assessment and review can be conducted through care plan meetings and risk management plan update meetings held as frequently as risk level demands.
- The monitoring process should be used to maintain the highest possible level of effective clinical practice and to maintain the established communication links between agencies.

Resources

- It should be noted that good risk assessment is time and resource intensive and there must be adequate resources provided to run the system.
- Community supervision is not a cheap option.
- Funding should reflect the amount of resources needed to supervise and monitor those clients assessed as requiring this
Research

- Although it must be recognised that risk to others cannot be totally eliminated, empirical research is likely to improve results and so this must be conducted.
- There is a lack of research relating to mentally disordered offenders in community settings and this requires to be addressed through specific funding.
- Research into risk assessment as part of its practice should be part of the role of any forensic CMHT.

SEE THE ATTACHED EXAMPLE OF A RISK ASSESSMENT PROTOCOL FOR ONE FORENSIC COMMUNITY MENTAL HEALTH TEAM
FORENSIC CMHT RISK MANAGEMENT SYSTEM

CONTENTS

1. Information Sharing Protocol

3. Risk Management Review Process
   3.1 Risk Management Review Protocol
   3.3 Guidance for Risk Management Review Summary
   3.4 Guidance for Care Programme Approach [to add]


5. Discharge Protocol

APPENDIX
   i. Information Sharing Template (form a)
   ii. Case File Review Template.
   iii. Risk Management Summary Template (Form b)
   iv. CPA Template (Form c)
   v. Crisis Management template (Form e)
   vi. Discharge template (Form f)
   vii. Consent Forms (Team consent/ police consent)

REFERENCES
Appendix 1b

INFORMATION SHARING PROTOCOL FOR FCMHT.

The FCMHT is committed to a policy of the sharing of information with other professional agencies concerning the safe and effective management of patients under the care of the team. This is for the purposes of identifying the level of risk an individual pose to themselves or to others around them.

POLICY STATEMENT.

[The Department of Health guidelines on this issue are quite clear. Generally client information can be shared if there is a concern that the client poses any kind of risk to the general public (HSG(96)18/LASSL(96)5-Health Service Guidelines, D.O.H. 2001; www.doh.gov.uk)][to fill]

Protocol:

1. On admittance to the team the key worker debriefs all patients, or other professional person involved in the patient’s care concerning the information sharing policy of the FCMHT.
2. All agencies (internal within NHS and externally for e.g. Police, criminal justice social work services, GP’s) are to be contacted by the key worker at the FCMHT.
3. It is hoped that contact names, direct contact telephone numbers and addressed can be obtained for the key workers identifies at these agencies. If this is not possible, as much information as possible needs to be identified. This includes telephone numbers, fax numbers and addresses.
4. All agencies are to be sent a completed copy of form a (see appendix i), for file record information.
5. All agency services should be invited to all risk management meetings (including reviews) and CPA's.
6. In the event of circumstances which enact the crisis management plan (see section 5), all agencies should be contacted and sent copies of the completed form e (see appendix v).
RISK MANAGEMENT REVIEW PROTOCOL

It is recommended that the following procedure be adopted in all cases requiring risk assessment and management.

1. Case File Review needs to be completed on every patient under the care of the FCMHT.
2. Patients are requested to sign the consent forms to allow access to all sources of information available to allow a case file review and risk management plan to be developed (see appendix vi). A senior member of the team working with the patient should explain this. Another member of staff should also witness it. (Note: simplified consent form for Learning Disabled clients).
   Please note; Refusal to sign consent forms does not automatically mean discharge or non-engagement with the team. However it needs to be stressed that the FCMHT service and input level will inevitably be reduced as a result, due to lack of cohesive and corroborated information which can effectively and systematically inform the risk management and care program plan.
   Patients who refuse to sign consent forms to obtain file and record information, also need to be informed that this will not affect the information sharing policy at the FCMHT for information disclosed whilst under the care of the team.
3. Case File Review to be undertaken of all relevant files, using the case file review template and guidance notes. Any qualified member of staff can undertake this. All files reviewed must be acknowledged on the file checklist.
4. Staff member who carried out the original review and the key worker or other person knowledgeable in risk assessment research prepares summary of the file review. HCR-20 should be scored by the two staff members and kept in file. Critical variables noted.
5. Keyworker writes summarizes patients current situation for meeting (for risk management review – use CPA minutes to summarize).
6. Schedule a risk management meeting and invite all staff who may have input into the management of the person’s case (for example the police or criminal justice social work) including all those likely to be involved in the patients CPA. The patient’s GP should be invited to attend. Circulate summary and risk management agenda to all staff at least 10 days before the meeting.
7. Information should be accessible and communication links established and maintained with all agencies likely to be involved with patient care and have an interest in the patient.
8. Keyworker or other person directly involved with the patient should share the summary and risk management agenda with him or her a few days before the meeting. The parents or advocates of the patient should also be given the opportunity to participate in this discussion if the patient wants them to. The summary and the agenda should be discussed with the person, but not given to them to keep. Any appropriate amendments should be noted and made available to the meeting. It should be explained that the person would not ordinarily attend the meeting. This is to allow frank and open discussion by all agencies and also to minimize distress to the client, who will be given feedback afterwards.
9. At the end of the Risk Management Meeting, the feedback to be given to the patient should be clearly discussed and one or two members of staff nominated to give that feedback (preferably the key worker or the person who initially discussed the summary and agenda with the patient). Again the patient may wish a member of his family or advocate to be present. The person should have a copy of the agenda for meeting, the summary of the risk management plans, and the last two pages detailing future plans, feedback and patient comments to keep in their possession.
10. Full Risk Management minutes circulated to all present at meeting.
11. Patients should be placed on CPA and risk management plans should feed into these (see CPA guidelines).
12. The summary of the risk management plans, and the last two pages detailing future plans, feedback and patient comments should be circulated to the professionals involved in the client’s care programme approach meeting in advance of the meeting. This should include the person’s general practitioner whether or not he or she attends the meeting.
13. Risk Management Meetings should be held every 6/9/12 months, depending on level of risk.
14. CPA information, along with all other updated information should be added to the Case File Review, and an updated risk management summary should be produced before every following risk management meeting. All contact details should be updated.

15. Staff should adhere to risk management system and be aware of protocol for crisis management plan and immediate triggers for review (see section 4).

16. The same structure of the risk management review system is conducted for ‘crisis’ risk management review meetings.

17. Staff should also adhere to information sharing protocol (see section 2).

18. Maintain up-to-date links with all agencies involved in patient care.

19. Ongoing evaluation and monitoring of risk in the interim periods between CPA and risk management meetings, will be done through regular contact with key worker [draft checklist form to be developed]
GUIDANCE FOR CASE FILE REVIEW.

Thank you for agreeing to complete this file review on your client. The Forensic Team rely on those who know the client best to provide us with the vital information that we require in order to begin the process of risk assessment and management.

We have compiled some guidelines below that we hope will assist you in this process (and information as to why risk assessment and management is necessary).

Rational for Risk Assessment and Management

- **Least Restrictive Environment**: It is the duty of Forth Valley Primary Care Trust to hold those clients with mental illness or learning disability who are considered a risk, in the least restrictive environment possible. The Forensic Team provides a Risk Management Service that helps the Trust to reach this goal.

- **Risk Assessment drives Risk Management**: Risk “Assessment” is unhelpful without Risk “Management.” Predicting how violent/sexually violent someone is likely to be is not much good unless we try to manage that risk.

- **“Nothing predicts behaviour like behaviour”** This may seem like a flippant quote, however predicting how “risky” someone is cannot be ascertained on clinical interview alone. Time and time again research has shown this to be highly unreliable. This is why we need documented evidence of as much past behaviour as we can get (the file review).

- **Sharing Client Information**: This is a valid concern among professionals dealing with clients who potentially pose a risk to themselves and others. The Department of Health guidelines on this issue are quite clear. Generally client information can be shared if there is a concern that the client poses any kind of risk to the general public (HSG(96)18/LASSL(96)5-Health Service Guidelines, D.O.H. 2001; www.doh.gov.uk)

Files Available

The file review is the collation of all the files available, the client may have been in other institutions such as prison, residential homes and the State Hospital. It is important that we try to contact these institutions and request access to these files. The client should formally consent to the Risk Management process and this consent form should be sent with any requests for file access.

Also the client may have contact with other services such as social work, police, voluntary services etc. If possible, these services should be contacted regarding any relevant information that they might have.

Information Organisation

**Dates**: You will often find that the information presented in the file is not in chronological order. It is vital that the information presented in the file review is chronological, with the earliest events or information presented first. For example, this helps those reading the file review to chart the course of a mental illness in conjunction with other life events. Also with reference to offences, chronology highlights any escalation in sexual or violent behaviour, which is very important when assessing, and managing risk.
Sources: Sources of information are crucial: Those reading the details of the file review need to be able to see the original source of the information. If you can, please make the source of the information as accurate as possible (Day/Month/Year). You may find that the date of the source of the information is different than the date of the event it is reporting. See below for example:

<table>
<thead>
<tr>
<th>9.</th>
<th>HISTORY OF MENTAL ILLNESS OR PSYCHOLOGICAL DISTURBANCE</th>
<th>Date</th>
<th>Source</th>
<th>Appx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give details of all contacts with Psychiatric/Psychological services. Include content of delusions, hallucinations, diagnosis, insight.</td>
<td>May 1992: John was suffering from visual hallucinations that involved seeing aliens in his wardrobe...</td>
<td>24.02.98</td>
<td>Dr Brown Psychiatric report</td>
<td>C</td>
</tr>
</tbody>
</table>

It is clear in the example that Dr Brown’s report of 1998 states that John was having visual hallucinations in 1992.

Appendices: Many documents in patient files contain a lot of information. Psychiatric/Psychology reports are a good example, as are Social enquiry reports. Please photocopy these and keep them as appendices, but only if they contain too much information to be represented in the file review alone. You may find very short psychiatric /psychology reports that really only cover one point. These do not need to be copied as appendices. Appendices are labelled A-Z.

Information Content
Details: It is very important to record details of behaviours, especially those that are criminal or self-injurious. Details included in the file review should cover any antecedent behaviour or reasoning behind the actions. If details such as these are absent from the information available, please state that this is the case. This will assist the person reading the file review to ascertain whether details were omitted or simply not available during the collection of the information. See example over the page

<table>
<thead>
<tr>
<th>11.</th>
<th>PREVIOUS CONVICTIONS</th>
<th>Date</th>
<th>Source</th>
<th>Appx</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all known previous convictions With dates and age of person at the time Include offences as a juvenile note recorded triggers and /or motivation behind the offence Note sentences, fines or sections under MHA</td>
<td>2nd Oct 95: Breach of the peace aged 17 yrs. Admonished. Police were called after John was seen shouting and waving a sword around in the street. He had been withdrawing from his family and locking himself in his room in the previous months.</td>
<td>12.10.95</td>
<td>Social enquiry report</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>21st Aug 98: Breach of the peace, aged 20 years. Fined £100 (no details of offence)</td>
<td>Sept 98</td>
<td>note of previous convictions</td>
<td>D</td>
</tr>
</tbody>
</table>

Sections: At the top of each section there are instructions as to what is required in that part of the file review. These Instructions for completion vary from section to section and are there to give you an idea of what information we are looking for in that particular part of the file review.
Appendix 1e

CRISIS MANAGEMENT PLAN PROTOCOL

1. When immediate review triggers become highlighted for any patient, action requires to be taken immediately and effectively.

2. Form e (see appendix vi) needs to be completed and immediacy of the situation needs to be identified.

3. All relevant agencies involved with patient care need to be informed directly and effectively. Effective methods of communication are considered to be telephone contact, fax, by letter (time permitting) or in person.

4. Once all agencies have been informed of the current change in risk status, necessary action can and should be carried out by the service responsible.

5. At this stage it is necessary for a ‘crisis’ risk management review to be called, for all services involved highlighting and discussing all necessary immediate and fluctuating concerns.

6. If the immediate review triggers have been substantially increased to warrant the action of admission/ re-admission to hospital; arrest; immediate recall by parole board at point (4), it is still necessary to arrange a ‘crisis’ risk management review meeting. This will serve the purpose of collecting and collating all information leading up to and surrounding the current crisis situation.

7. The ‘crisis’ risk management review meeting will adopt the same format as all other risk management review meetings, therefore the case file review and form b needs to be completed (see section 3, and appendix iii).

8. The ‘crisis’ risk management meeting is a necessary ‘exercise’ to ‘pool’ information for the purpose of reports and/or future management plans for the patient.

9. Such meetings will also serve as guidance and evaluation of practice, and to inform future practice and policy procedures.

10. Dependent on incident/situation outcome, it may be necessary to pass such information to future care teams/staff involved in the future/imminent management of patient.
DISCHARGE PROTOCOL FOR FCMHT

One of the inevitable goals for the FCMHT is to identify and effectively manage the level of risk posed by those referred to the team. The aim is to reduce the likelihood of this risk over time, to a point where this level of risk of further offending or harm to self or others, can be managed out with general community teams/services. Through monitoring CPA documents and risk management plans, reductions in risk will be evaluated, and judgements in the team can be made to put patients on the pre-discharge procedure. Therefore:

1. Once patient has remained mentally well; ceased engaging in behaviour warranting referral to the Forensic Team; remained as a low intensity patient, it may be agreed by key worker, RMO, other relevant professional, that the patient is appropriate for discharge from the FCMHT.

2. Once appropriate status for discharge has been identified in any one patient, the plans for discharge will be discussed at the next risk management review meeting. All services involved in the patient’s care at the present time will be involved in these plans.

3. A decision needs to be made for an appropriate discharge route for the patient at this meeting.

4. Appropriate discharge plans need to be discussed and agreed upon. Safe guarding the potential risk factors of the patients and any threats of harm to themselves or to others need to be highlighted and brought to the attention of any service which will be involved with the patient post discharge from the FCMHT.

5. The low intensity/ input stage of the pre-discharge plan needs to be discussed and agreed upon. The format, structure and implementation time scale all need to be discussed and agreed upon. Action needs to be taken to enforce this before the next CPA meeting.

6. All services to be involved with patient once discharged from the FCMHT (for e.g. general CMHT) need to be informed of the plans to discharge and also the reasons for the decision.

7. Inform patient of the discharge plan and the reason for it. The patient also needs to be debriefed on the pre-discharge plans and the timescale over which this will operate. The plans need to be discussed with the patient so they can also offer input to this process, to determine that it is a agreeable plan.

8. Implement low level, low intensity, and reduced input plan.

9. **Important;** please note. It needs to be acknowledged by all FCMHT staff that low intensity risk management plans, will be design increase the likelihood of exposure to potentially ‘risky’ situations and behaviours. Therefore, low intensity patient input does not mean low level monitoring and evaluation. Though the patient is receiving low level input and intensity contact and support, it is crucial to maintain a close communicative service network to monitor and evaluate this process. Regular liaison and contact between services that have contact with the patient need to be of a high and effective level.

10. Monitor and evaluate patient whilst under low intensity input.

11. Set date for proposed final risk management review and invite services and care teams to be involved in patient’s future management, as well as existing services involved.

12. Identify risk factors/level and produce final risk management report.

13. Discharge patient from FCMHT. Arrange to attend (or co-ordinate) patient review in 3-6 months time within new service care team.
Appendix 2

Needs Assessment in Forensic Community Mental Health Teams

Formal “needs assessment” tools are intended to define health and social needs at both a population level, and ideally, at an individual level (Thornicroft 1992, Stevens 1998, Wright 1998, Gilbody et al 2004). Gilbody et al (2004) suggest such assessment tools may be useful in identifying needs, monitoring clinical response and making clinical decision.

People who have a diagnosis of schizophrenia have varied and complex health and social needs including wellbeing, cognition/emotion, behaviour, physical health, interpersonal, society and services (Slade 2002). Caseloads of community forensic services consist of clients with complex needs; schizophrenia, other complex mental illnesses, learning disabilities, and personality disorders. In addition to the need identified by Slade (2002) forensic patients also present needs associated with their offending behaviour.

In the introduction to a Cochrane review Gilbody (2004) suggested several benefits of structured needs assessment. These are included in Table 1.

<table>
<thead>
<tr>
<th>Benefits of Structured Needs Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• identify problems which might not otherwise be recognised by clinicians or those responsible for care, triggering an appropriate response and improve the overall quality of patient care</td>
</tr>
<tr>
<td>• monitoring the course of patients’ progress over time allowing informed decision about treatment and assessment of subsequent therapeutic impact to be made</td>
</tr>
<tr>
<td>• Surveys have suggested that clinicians find these data useful in formulating a more comprehensive assessment of the patient (Young 1987 Kazis 1990), but this finding is contradicted by other researchers (Slade 1999, Gilbody 2001).</td>
</tr>
<tr>
<td>• Patients often welcome the opportunity to provide clinicians with information regarding their health status, particularly when they perceive that this information is not otherwise comprehensively assessed (Nelson 1990)</td>
</tr>
</tbody>
</table>

Table 1

There are some criticisms of needs assessment tools e.g. a failure to translate the findings into intervention and improvements in rehabilitation outcomes (Crombie 1997 Kazis 1990 Gilbody 2001). It is vital that needs assessment is recognised as one part of a comprehensive rehabilitation process (Gilbody et al 2004). However, to date, the routine use of outcome measures and needs assessment tools is unsupported by high quality evidence of clinical and cost effectiveness (Gilbody et al 2004). Some clinicians also have reservations regarding the extra workload generated by regular structured needs assessment. It is therefore vital that clinicians should judge for themselves whether the measurement of outcome and need is a reasonable use of their finite time and resources (Gilbody et al 2004). The long-term goal is for routine outcome assessment to become an integral component of clinical care, rather than an administrative burden added on to the ‘real’ work of clinicians. Carefully thought-out and well-resourced approaches to collecting and using outcome information are therefore needed, to avoid wasting effort and clinical goodwill. (Slade 2002).

Clinical Standards Board for Scotland (2001) standards suggest that

“Making an accurate diagnosis, continuing to support each individual and those who care for them, identifying their needs, and planning their health and social care with them are key elements of making sure that each individual with schizophrenia has the opportunity to lead as full a life as possible.”

The Clinical Standards Board for Scotland(2001), now part of NHSQIS, have set several standards relating to needs assessment. Implementation of these standards is regularly audited. Standards relevant to needs assessment are included in Table 2.
They acknowledge that to meet identified needs a full range of care agencies, both statutory and voluntary, including health, social work and housing, play important roles in providing care and support in partnership with the health services. NHS QIS (2004) recently highlighted that the creation of integrated care pathways (ICPs) has helped by leading to more standardised methods of assessing risk and needs.

**Clinical Standards Board for Scotland Schizophrenia Standards Relevant to Needs Assessment**

- When a person is diagnosed with schizophrenia, a multidisciplinary assessment of their needs is made and a plan of care, based on the outcomes of this assessment, is established.
- Multi-professional recording standardised approach continuous record of assessed need.
- A care plan detailing care needs, including those which are currently met and unmet, responsibilities of individuals and agencies involved in caring for the person and specifying one individual responsible for co-ordinating care should be compiled and copied to all those involved.

Clinical Standards Board for Scotland (2001)

Table 2

One needs assessment tool designed for use in severe mental illness is the Camberwell Assessment of Need, forensic version (CANFOR) (Thomas et al 2003). This tool is developed for use in all forensic mental health services including community forensic mental health services. It’s content and structure are based on the Camberwell Assessment of Need, with the addition of relevant forensic items. The validity and reliability of CANFOR were investigated in medium and high security psychiatric hospitals and a paper describing the acceptability of these findings is due to be published shortly. Domains included in the CANFOR are included in Appendix A.

Recommendations below are drawn from literature included in the reference list, in particular the Clinical Standards Board for Scotland (2001) and the mental health reference group guidelines on needs assessment (2001)

**Recommendations**

- Each service has a structured means of ensuring a comprehensive needs assessment is completed for each individual.
- Needs assessments should be clearly associated with the care programme approach. Identified needs should be translated into care plans within the CPA document.
- Needs identified within the risk assessment must be prominent within the needs assessment.
- There should be methods of auditing the process and outcomes of needs assessment.
- Service users should be involved right throughout the process and be informed of the outcome.
- Carers have a right to their own separate needs assessment. They too should be involved meaningfully as far as possible throughout the process of individual of needs assessment and informed of the outcomes (the potential for conflict with the service users views should be handled sensitively).
- Users and carers should have access to advocacy support to contribute to the needs assessment process.
- The assessment measure adopted should be practical and easy to administer by staff.
- Core elements of the assessment should be common across agencies and care sectors.
- The measure should include sections general health, mental health, social and family circumstances, housing and ways to spend daytime in meaningful activity e.g. work, training, leisure.
- The measure should be able to distinguish between low, medium and high needs and whether these needs are being met.
- The assessment should contain elements which when repeated at a later date will measure change and form part of an outcome measure.
• Compatible with electronic records
• Practical working conditions and relationships between professionals that fosters a sharing of information and records. Health, social services, police services therefore need to agree local policies for information sharing.
Appendix 2a

Camberwell Assessment of Need, forensic version
Domains

**Accommodation**
This domain refers to the person’s current housing situation in terms of how appropriate it is. The domain can be scored as 'not applicable' if the person is an inpatient, or in prison, and is likely to remain so for the next 6 to 12 months.

**Food**
This domain refers to the person’s ability to buy appropriate food and the skills to cook it by themselves. If the person is an inpatient this option is usually not available, so the domain is scored according to the appropriateness of the food provided by the services (either a met need or an unmet need).

**Looking After The Living Environment**
This domain refers to the person’s ability to keep their accommodation at a reasonable state of cleanliness. It should be noted that this should not necessarily be to the standard you might expect in your own home, but instead refers to basically clean and tidy.

**Self care**
This domain refers to the person’s ability to keep themselves clean and tidy, both in terms of bodily cleanliness and clothing. It would therefore cover areas such as washing clothes, taking baths/showers, and shaving at regular intervals. Similar to the previous domain ratings should be based on basic levels of personal hygiene.

**Daytime Activities**
This domain refers to the structure of the person’s day. Daytime activities include a broad range of possible activities including the need for, and provision of, a structured activity programme for inpatient users such as therapies, exercise and occupational therapy; further education, or perhaps day centre activities and employment opportunities for community-based users.

**Physical Health**
This domain refers to the general physical health of the user. Areas for consideration would include routine medications required for health-related conditions, physiotherapy, operations and side-effects from any medications taken.

**Psychotic Symptoms**
This domain refers to any psychotic phenomena experienced by the user. Areas for consideration when talking about this domain would include the effectiveness of psychotropic medications taken for symptomatic relief and psychological interventions on a one-to-one or group basis.

**Information About Condition and Treatment**
This domain refers to the quality and comprehensiveness of information received by the user regarding their psychiatric condition and any treatments required. The information could be received verbally or in writing and discussion in this area should include an assessment of the perceived effectiveness of this information.

**Psychological Distress**
This domain refers to any ‘out of the ordinary’ psychological distress that may be being experienced by the user. This could include adjustment difficulties, loneliness, desperation, or a sense of sadness which can not easily be explained or accounted for logically.

**Safety to Self**
This domain refers to self-harming behaviour and suicide attempts or intent. Scoring of this domain should be based on incidents of self-harm or suicide attempts in the past month and should consider the effectiveness of any interventions applied. It should be noted that answers to this question alone are not sufficient for the purposes of risk assessment and any problems identified should form the basis of further investigation with an appropriate risk assessment measure.
Safety to Others
This domain refers to violent and threatening behaviour exhibited by the user. Scoring should be based on any incidents that have occurred during the last month only, along with the implementation of preventative interventions. It should be noted that answers to this question alone are not sufficient for the purposes of risk assessment and any problems identified should form the basis of further investigation with an appropriate risk assessment measure.

Alcohol
This domain refers to problematic alcohol use. It should be noted that the lack of access to alcohol if the user is an inpatient may not detract from an underlying problem or need in this area.

Drugs
This domain refers to problematic drug use. It should be noted that the lack of access to drugs if the user is an inpatient may not detract from an underlying problem or need in this area.

Company
This domain refers to social contacts and the ability to initiate conversation and form friendships with other people. It should be noted when discussing this area that some people may be quite happy in their own company and may not want to socialise with others.

Intimate Relationships
This domain refers to closer relationships, for example with their husband/wife or partner. This can be perceived as a sensitive domain for some people to discuss so care must be taken when introducing the discussion topic.

Sexual Expression
This domain refers to difficulties the user may be having with their sex lives and sexual functioning. This can be perceived as a sensitive domain for some people to discuss so care must be taken when introducing the discussion topic.

Childcare
This domain refers to difficulties the person may be having with childcare issues. This can be particularly relevant if the person is an inpatient and family or social services are involved. This can be perceived as a sensitive domain for some people to discuss so care must be taken when introducing the discussion topic.

Basic Education
This domain refers to basic education only, i.e., the ability to read, write and count change received if paying for something. Other, more advanced, educational needs should be addressed under the 'Daytime Activities' domain.

Telephone
This domain refers to difficulties the person may have in being able to use a telephone (such as dialing numbers and using phonecards) and having appropriate access to a telephone when required.

Transport
This domain refers to difficulties the person may have with accessing transport facilities, or practical difficulties associated with the use of public transport, such as reading timetables.

Money
This domain refers to difficulties the person may have with budgeting skills. It is based around having basic money management skills that means that the person has sufficient funds to pay bills, buy food, etc.

Benefits
This domain refers to difficulties the person may have with receiving the appropriate amount of benefits, according to their personal and health situations.
**Treatment**
This domain refers to the extent to which any treatments that are required are agreed with and complied with by the person. Treatments may include medication and/or psychological interventions.

**Sexual Offending**
This domain refers to previous or current problems with committing acts of a sexual nature. This would include inappropriate sexual behaviour, the need for SOTPs, etc.

**Arson**
This domain refers to previous or current problems associated with the risk of setting fires.
Appendix 3

Enhanced Care Programme Approach (CPA) is appropriate to all patients receiving care through Forensic Community Services due to their complex needs. It builds on the established good practice of CPA systems in adult mental health services. The process of needs assessment, care planning and documentation are enhanced by more specific risk assessment and risk management planning components, hence the term “enhanced CPA”

- The purpose and processes of CPA need to be clearly understood by all involved - professionals, users, carers.
- Clear information leaflets about the purpose of CPA should be available to users, carers.
- There should be an appointed CPA Co-ordinator whose role can include the distribution of leaflets.

There is a training requirement for all parties - health and Social Work, housing, police etc. All require training with regard to the purpose and procedures of CPA.

- CPA meetings must be arranged and facilitated so that information can be shared openly and honestly.
- Professional meetings prior to the CPA might be required so that 3rd party information can be discussed.
- The documentation of 3rd party information and the dissemination of such information require careful thought and clear procedure.

The CPA meeting is not an appropriate forum for therapeutic work with the patient: issues arising from the meeting should be incorporated into the on-going care plan. Action points and those responsible for them should be clearly identified in the care plan.

Documentation needs to be clear, organised and informative, and should include:

- Contact details for all involved should be clearly and accurately recorded and updated as required. The key worker should be clearly identified.
- Patients details, including legal status, should be up-dated at each review.
- The care plan should document the current status of each area of functioning, action required, unmet need, and specific risk management strategies agreed and who is responsible for each action point.
- The documentation should take into account the range of users (of the document) and can be used to record information such as forthcoming appointments, significant dates (anniversaries etc) that will be of assistance to readers.
CPA documentation throughout Scotland is not standardised. A template for enhanced CPA that is used by all authorities might be considered as a useful tool to assist transfer of cases and information between areas but the nature of the information recorded is more important than the format. A recommendation with regard to the areas/headings covered in CPA meetings, to be incorporated in any local format, is given as follows. A detailed needs assessment for user and carer will be required to inform this process (e.g. CANFOR).

- **Diagnosis** - Detailed and changes noted.
- **Medication** - Detailed and up-dated at each review (including reasons for changes).
- **Consent to treatment** "Form 9/10" Status - to be altered appropriately for New Act.
- **Legal Status** Mental Health Act/Criminal Procedures Act/Adults with Incapacity Act. Dates of reviews and changes of status to be recorded.
- **Current Legal Issues** Outstanding charges. Plans to change detention status. Adults with Incapacity actions planned or on-going.
- **Alcohol/Substance Use/Significant History**
- **Current Mental State** Specific symptoms should also be included in the risk management section. This assists the user, carer and staff in recognition of signs of relapse or change in risk factors. (i.e. indicators for relapse)
- **Current Therapeutic Interventions** (non-criminogenic and criminogenic) Psychotherapy, CBT etc, noting who is responsible for delivery of the treatment
- **Physical Health** Issues affecting the patient that require attention in the Care Plan, including nutrition, weight, smoking, reproductive health, pain and any on-going physical complaint.
- **Living Arrangements** Suitability of accommodation. Information about others in the house. Housing problems/needs.
- **Intimate Relationships**
- **Carer and Support Networks** Including people and organisations regularly involved in the life of the patient. This should include those important to the patient who might not be obvious to, or indeed thought beneficial, by the care team. Formal support time and interventions should be logged in a timetable format if possible to allow interagency co-ordination.
- **Activities of Daily Living** Including personal care, domestic tasks. Note any available understanding of current difficulties (processing skills, planning abilities, lack of resources or housing problems).
- **Personal Safety** All issues relating to the safety of the patient of current/on-going concern, and any measures taken to reduce risk should be documented.
- **Self-harm/Suicide Risk** Including known triggers, actions etc.

- **Social Activities**
- **Employment**
- **Education**
- **Vocational Arrangements** This should be a detailed reflection of planned and current activities and might be useful to record in the form of a timetable for those with complex care packages, intensive support or busy schedules

- **Communication and Travel** Availability and ability to use telephones, buses etc.
- **Financial Circumstances** Income. Details of welfare benefits, administration of finances, debts, money management.
- **Medical/Dental/Psychiatric/Psychology etc Input** A timetable of forthcoming appointments, details of care, unmet needs to be included.
- **Current Stressors** Any current problems requiring to be noted and included in the Care Plan.
- **Risk Factors** Summary of current risk factors (to and of patient), as identified through risk assessment
- **Risk Management Plan** Clear plan to manage identified risks involving carers, relatives, professionals and the patient.
- **Third Party Information.** Information that cannot be shared with the patient (or possibly other persons (relatives/carers)) is to be recorded on a separate sheet and distributed in an agreed manner to those who require to know.
**Care Plan**

All items recorded on the review schedule that require action. Actions required should be agreed and attributed to a named individual. Recording should reflect needs, responsibilities and unmet needs.

**Administration and Documentation**

**Administration Back-up**

A CPA Co-ordinator to issue invitations, organise meetings and book rooms is required.

A minute taker is required at each review. Preferably, the minute-taker should not be a member of the care Team.

Minutes need to be prepared, checked by a member of the care team and distributed quickly so that the documentation is useful and can be used to guide interventions.

**Distribution of Information**

A decision about the process of sharing minuted information must be made and recorded at the review. The discussion should focus on the need for people to access the level of information recorded, the safety and confidentiality of information at the final destination, and the wishes of the patient. Options might include distribution of contact details but not other parts of the review, or arrangements for parties to access but not possess information where there is an identified risk of breach of confidentiality/misuse of information detrimental to the patient.

**Third Party Information**

Particular care is required in defining distribution and controlling access to this.

**Location of Meeting**

The location of the meeting should be decided with a view to facilitating and maximising attendance at meetings. Locations to consider: hospitals, clinics, social work premises, GP surgeries. The timing of meetings should be considered in the same way.

**Frequency of meetings**

Frequency should be no less than once every six months

**Key worker**

All patients should have an identified key worker. Any concerns regarding changes in risk, support, mental illness or behaviour should be reported to the key worker who is responsible for alerting staff on a need to know basis and calling an urgent meeting to amend the care plan if necessary.
Appendix 4

Addressing Offending Behaviour in Community Settings

Angela Papp (Chartered Forensic Psychologist Forth Valley NHS), Mark Ramm, (Director of Clinical Forensic Psychology Lothian NHS), Hugh McGregor, (Justice Services Manager South Lanarkshire Criminal Justice).

Background.
The possibility of reducing reoffending through offending behaviour work contradicts the widespread and well-established view about working with offenders (McGuire and Priestley, 1995). This view suggests that when attempts have been made to reduce or alter offending behaviour little or nothing has been found to work, a view which has been the basis for widespread opinion in psychology, criminology and social work for the past two to three decades. Martinson (1974) in his article titled ‘What Works?’, believed that education and psychotherapy cannot overcome the tendency of offenders to re-offend, therefore suggesting that ‘Nothing works’.

More than a decade later Gendreau and Ross (1987), reviewed the evidence of effective rehabilitation programmes and stated that “it is ridiculous to state that ‘nothing works’”. They suggest that “we are absolutely amateurish at implementing and maintaining our successful experimentally demonstrative programmes” this they suggest is “what doesn’t work”. They further suggest that progress has only been tentative in the area of examining the conditions under which effective interventions have been monitored and implemented successfully.

These results directly countered the arguments of ‘nothing works. Meta-analysis studies (Andrews et.al. 1990, Lipsey, 1992a) that have combined the findings from different experiments have enabled researchers to invalidate the ‘nothing works’ conclusion (McGuire and Priestley, 1995). What these studies showed is that there are positive effects and an average reduction of recidivism rates by 10%- 12%. Therefore they suggest, it is not a case of ‘nothing works’, but ‘What works, for whom and under what circumstances’?

‘What Works?’
McGuire and Priestley (1995), identified a number of principles concerning the design and assembly of effective programmes from these meta-analysis research studies and suggested that though there is no one outstanding approach guaranteed to work, there are empirically based guidelines which will increase the likelihood of more effective programmes;

• Risk classification needs to be sought, more effective programmes have shown to match the level of risk posed by the offender to the degree of service intervention. For example, higher risk individuals receive higher intensity programmes.
• Essential to distinguish between the criminogenic and non-criminogenic needs of offenders, those problems that are offence related to those that are not. For the purpose of reducing offending the intervention should focus on the criminogenic needs. It is the identification of this criminogenic need principle that underpins direct work on offending (McGuire and Priestley, 1995).
• Responsivity. Programmes have been shown to work best when offender can take an active participation in the work, rather than didactic methods or unstructured methods of teaching. Therefore it is important to match the style of the deliverer(s) and the client group.
• Community-based programmes. Research suggests that community based programmes are on the whole more effective than those based in secure settings. This is suggested due to the prospect of greater real-life learning, exposed to the environment and circumstances under which the re-offending is likely to occur. However, this they suggest requires clarification through further research.
• Treatment modality of programmes. This suggests that multi-modal, skills oriented programmes drawing upon method from cognitive- behavioural sources are more likely to be effective. These programmes are more likely to address a wide variety of offence-related problems and teach problem solving, social interaction and coping skills.
Programme integrity. High treatment integrity is characterised by, sound management, tight design and skilled practitioners. According to Hollin (1995) the three main threats to programme integrity are, Programme drift – this comes about as a result of the lack of management of the programme and the immediate problems of dealing with routine matters, as opposed to remaining focused on the longer term therapeutic goals. Programme non-compliance – practitioners changing or omitting parts of the programme to suit themselves or the structure of their existing organisation or workload. Individuals have been known to ‘chop and change’ sessions, drop sessions out, introduce new methods or new targets for change or change the original material; Programme reversal – this means working to reverse the effects of the programme. This is due to working from different perspectives from those within the programme style and not adhering to the manual or structure set. This is counterproductive and confusing. This also requires that adequate resources are available to achieve the aims and there is an agreed plan for monitoring and evaluation which takes place systematically.

Guidelines for Effective Programmes.
These guidelines for more effective programmes generally (McGuire and Priestley, 1995) and specifically for violence (Heilbrun and Peters, 2000) have direct implications for practice, policy, research and general overall programme management. To enact the ‘what works’ principles both sets of authors identified some of these implications and offered preliminary suggestions for the process.

Firstly, it is important for those who are involved in the management of service delivery to become more familiar with the relevant research evidence. It is important to have informed treatment programmes that are based on successful and effective results.

Secondly, if criminogenic needs are to be identified with any reliability and accuracy and applied expertly in practice, it is essential to have reliable risk assessment and needs assessment tools in place. This will allow offence related relevant risk factors to be identified for treatment intervention. It will also clearly identify risk level and intensity of treatment required to staff involved. Hollin (2002) succinctly states that accurate assessment of criminogenic needs will allow accurate decisions to be made about the allocation of offenders to programmes.

Thirdly, to engage the ‘what works’ principles will mean ramifications for managers. It is therefore necessary to ensure adequate provision of resources to implement, run and evaluate programmes. Responsivity principle as identified by McGuire and Priestley (1995) will require enhanced knowledge of individual staff members’ skills and strengths. This will in turn have ramifications for supervision, team management and staff allocation. Fifthly, ‘what works’ principles will have specific implications for staff training.

Finally, there is a distinct need to evaluate work with offenders, to provide not only scientific evidence, but also evidence from a public accountability standpoint. There are considerable gaps in the research on criminogenic needs and this work will be essential towards providing a clearer understanding of the factors that influence different forms of offence related behaviour and how they can best be addressed. Also, the different ingredients of programmes can be analysed and tested to establish the level of effectiveness, and to what degree the principles that have been formulated from institutional research can be applied to ‘real-life’ conditions. Furthermore, the wider practical policy issues relating to the application of methods within criminal justice and mental health agencies can be addressed if programmes are to become accepted features of practice.

Community Based Accredited Offending Behaviour Programmes.
Currently there has been a development of accredited offending behaviour programmes administered within the community probation settings in England and Wales. These programmes are predominantly based on cognitive-behavioural principles and adhere to the ‘what works’ principles. These offending behaviour programmes directly target criminogenic needs of attitudes and beliefs by addressing deficits in thinking and behaviour (Harper and Chitty, 2004) Hollin et al, (2002) identified elements of good practice and showed a number of important issues to be pertinent towards guiding effective practice, the implementation and delivery of programmes.
These were, the importance of the planning for implementation, good communications systems, adequate staff levels, supervision and support, necessary level of training, resources and adequate administration, adherence to referral and targeting criteria, maintenance of programme integrity and monitoring, evaluation and monitoring of programme delivery process and adequate accommodation.

It is with the identification of these elements that the following considerations for addressing and developing community based offending behaviour programmes are being suggested.

**Multi-agency Approach:**

However, it is important to firstly address the evidence for effective practice that relates to effective inter-professional and interagency working. Roberts (1995) states that no professional group can claim a monopoly over effective outcomes, and no one profession has been more successful than another at implementing effective programmes. Therefore ‘what is needed is a recognition of respective skills and competencies, and the consequent better matching of different skills and experience and to use them co-operatively to deliver the most appropriate programmes available’ (Roberts, 1995). It is also fair to say those professional notions of superiority, jealousy and exclusivity have precluded inter-professional co-operation. Roberts also states that there is a need to promote more interagency work in which the traditional boundaries are reviewed at managerial and practitioner level;

"Questions about who can best do what, rather than who has traditionally done what, need to be addressed in a wide range of settings... With an emphasis on cash limits and cost effectiveness there are real incentives for the wider development of interagency programmes and projects. All this means that greater attention must be given at practitioner and managerial level to co-ordination and partnership...” (Roberts, 1995)

It is with this in mind the following suggestions are made with community partnership, joint agency working in mind.

1. **Plan for Programme Implementation.**

It is important to develop an implementation plan that is sympathetic to the existing organisational structure of the service. (Hollin et al.2002) Roberts (1995) suggests that a clear overall organisational plan for the range and type of provision to be provided needs to be established. He states that not only the range and precise definitions need to be provided but also which practitioners and agencies will resource and deliver which elements.

The structural plan is to be agreed upon and developed at the early meeting planning stage of the implementation process. It is suggested that the structural plan should identify the organisational structures of both partnership teams involved and agree on the method for implementation within each service. It is also suggested that this structural plan should agree on communication and feedback systems that are going to exist between the two services and the way in which these will be accessed. The levels of staff involved in the programme management and delivery aspects, the training required, staff support and supervision, referral and targeting procedures, tackling problems of programme integrity and the provision of accommodation, also need to be addressed.

2. **Staffing Levels and Supervision.**

The levels of staff involved in the programme process need to be identified. Management staff from both partnership services needs to offer appropriate, consistent and reliable support to programme facilitators. Provisions need to be identified with partnership service to identify the necessary supervision requirements and the member of staff responsible for conducting it (Hollin et al, 2002). It is important to identify a high level of staff support at the implementation stage. There is a need to offer consistent and reliable methods of support to the programme delivery staff. Provisions need to be put in place within both services. Roberts (1995) suggest that one of the clear consequences for practitioners’ working with high-risk offenders is the effect on their own motivation and commitment to the work. This means that appropriate and reliable forms of support for staff have to be built in to the service provision. Furthermore he suggests that external supervision, counselling and support for staff may have to be given consideration.
3. Staff Training.
Roberts (1995) states that practitioners must have a sound theoretical and intellectual understanding of the basis of the programmes that are being used. This means that basic training in a range theories, skills and competencies are required to deliver effective programmes. Hollin et al (2002) suggests it is necessary that all facilitators of the programme should be fully trained to deliver the accredited programme. Staff responsible for programme integrity and treatment management should also be fully trained in the delivery of the programme. It is necessary that senior management only involved in implementation and service management may only need to attend management/introductory training sessions.

It is essential that good communication systems be in operation throughout the duration of the programme between partnership services (Hollin et al, 2002). These links should inform all staff involved in the programme both in the criminal justice area and the partnership service. Information needs to pass quickly and effectively between staff in both services and regular standardised communication links need to be operative. Therefore it is crucial to identify the necessary guidelines for sharing of information from the Scottish Executive and the necessary mandates and authority required doing this. This needs to be identified and dealt with at the implementation, to allow for a smooth flow of information throughout the programme process. Appropriate information sharing policy guidelines need to be developed and agreed upon at the implementation stage. These systems should also be identified and put into effect at the implementation stage. Regular meetings within each partnership service and between services need to take place to ensure effective communication between all levels of staff involved in the programme process. This is also essential for maintaining communication links between programme deliverers and senior members of staff, to keep all informed of the development of the programme and tackle any unforeseen problems quickly and effectively.

5. Accommodation.
Appropriate accommodation needs to be identified for the purpose of programme. The requirements for Nationally Accredited programmes maintain that all programme sessions should be videotaped or audio-taped. This needs to be considered when choosing appropriate location for delivering the programme. Furthermore it is necessary to deliver the programme in an environment with adequate levels of security in accordance to the group composition. Therefore an environment with adequate security measures needs to be identified. Consideration for those attending the groups as a requirement of probation order, or licence condition needs to be considered in the location of the group (Hollin et al 2002).

6. Administrative Resources and Equipment.
Programme deliverers need adequate administrative support to prepare for the programme sessions and also with the collection and data entry of the required monitoring and evaluation data. The necessary level of input of administrative support needs to be identified and allocated between the two partnership services at the implementation stage (Hollin et al 2002). The cost of the administrative support needs to be identified and shared equally between the two services.

It is necessary to conduct organisational audit to determine the effect of the implementation and delivery on the success of the programme.

"Individual and group-based programmes will have to be more accountable and open to scrutiny not only to meet the National Standards and Local Standards/Guidelines, but also need to be open and accessible to supervision and examination to ensure the application of effective methods". (Roberts, 1995)

Therefore evaluating and monitoring the programme process is an essential part of the pilot project. This will assist to inform future programme delivery and ultimately inform and maintain the highest standard of effective clinical practice.
Monitoring requirements of the programme, including psychometric testing, session registers and feedback forms need to be completed as a matter of routine practice. This information needs to be collected and recorded appropriately to facilitate effective programme evaluation.

8. Programme Integrity.

The treatment manager will monitor all monitoring and evaluation procedures throughout the duration of the programme to inform the programme integrity (Hollin, 1995). It is necessary to identify that the required standards and procedures are being met throughout the duration of the programme. Guidelines for accredited programmes suggest that all sessions should be videotaped or audio-taped. This information, along with monitoring and evaluation procedures should be feedback to the deliverers of the programme in supervision sessions to develop good practice (Hollin et al. 2002).

9. Throughput – Continuity of Care.

Nationally accredited offending behaviour programmes are designed to provide continuity of care within and between services (Harper and Chitty, 2004). Therefore it is necessary to identify offending behaviour requirements in relation to offences committed, level of service input and intensity of delivery required and also follow-up of previous programme work and consistency in content, delivery and method (Hollin et al., 2002).

To enable this process explicit referral and targeting criteria need to be identified at the implementation stage and adhered to throughout the process of the programme. This ensures that the correct offenders are targeted for the correct programmes at the correct intensity level at an appropriate time. Effective referral procedures that are monitored and adhered to facilitate the targeting process.

All staff involved at all stages of the programme should be aware of these procedures and ensure that guidelines are applied correctly when referring and targeting groupwork members. It should also be clear to staff that issues which pose a more imminent concern for offenders are more likely to take precedence over membership to the group. This ensures that intensity and provision of care is person specific.

"Success is most likely through careful matching of offenders to those interventions which are best able to address the issues that underlie offending behaviour, and which are consistent with offenders" (Roberts, 1995)

10. Costs and Budgeting.

It is essential that the necessary provisions be put in place to account for all costs involved in the implementation and delivery of programmes. The costs should be agreed and divided between partnership services according percentage input to the programme process. This budget should be established at the preliminary implementation stages to ensure adequate funding for the effective implementation and delivery.

Programmes for Violence.

More specifically, when considering programmes for violence Heilbrun and Peters (2000) suggest that programmes must prioritise the prevention of violence and criminality amongst its most important goals. It is important to communicate this goal to staff, offenders and others involved. They also suggest that increased intensity of outpatient management, skills based training programmes delivered by those who are experienced with forensic populations can help to reduce the risk of reoffending. They also suggest that the use of risk assessment tools such as the HCR-20 (Webster et al., 1997), which assess static variables and dynamic variables will have resulting implications for the intensity of intervention, the monitoring and the nature of the intervention required.

Heilbrun and Peters (2000) go on to suggest the effective functioning of the community based programmes for violence is necessary for the prevention of violence. They suggest that principles for effective community based treatment programmes for violence should;

- use probation and parole as a mechanism for designing and implementing treatment and monitoring compliance,
- have essential communication links between criminal justice and mental health personnel for success
- clarify the legal requirements for confidentiality, duty to protect, reporting demands
• balance the need between individual rights, the need for treatment and public safety
• have sound risk management procedures including risk assessment and intervention planning
• identify the criminogenic treatment needs of the offenders vii) treat and monitor high risk more intensely
• allow for increasing degrees of responsibility through progressive, less intense levels of monitoring
• develop a uniform system for treatment and supervision to be applied within a network of community services.

Offending Behaviour Programmes and Mentally Disordered Offenders.

The nature and the relationship between mental disorder and crime is unclear and is not for discussion here. However needless to say that mentally disordered offenders are categorised as those who suffer from mental disorder and who commit crimes. This refers to many different types of offenders, who may be detained in very different ways throughout the health and legal systems. Regardless of the problems noted above and how the group are labelled, they present multiple and diverse challenges to administrators and clinicians who become responsible for their care.

Along with professional ethics and public accountability there are demands that treatment is based on empirically derived evidence from effective treatment. At the present time there is no such conclusive evidence on which to base treatment (Muller-Iserbner and Hodgins, 2000). However the available evidence and clinical experience of those working with this group can be used as a starting point for developing this process.

Accredited offending behaviour programmes, as above, have been developed with structured guidelines for more effective practice and highly structured, intense programmes are starting to demonstrate effectiveness for the way forward for tackling treatment for offending behaviour (Chitty, 2004). There is however no reason why these same components for effective and successful offending behaviour treatment should not be applied to mentally disordered offenders. Research suggests that the individual characteristics that are associated with non-disordered offenders are present in mentally disordered offenders. Therefore the highly structured, intense level of intervention, which is cognitive behavioural in orientation and maintains a high degree of treatment integrity will be appropriate for this group (Hodgins, 2000).

Generally, there are patterns of characteristics of all mentally disordered offenders (personality disorders and major mental illness alike), which need to be additionally considered when developing community based offending behaviour programmes. These include a long, sustained and complicated history of difficulties including alcohol and substance misuse, severe affective and cognitive deficits, poor life and social skills, a lifestyle conducive to deviant and anti-social behaviour and a high risk of re-offending and long standing and entrenched antisocial attitude that has developed through childhood into adulthood. They are often not interested in treatment and are non-compliant. They are difficult to manage and the mental illness related problems and anti-social behaviour tend to be difficult to manage.

Therefore alongside offending behaviour programmes, treatment for mentally disordered offenders needs to be multi-faceted and target the various aspects and different problems presented by these individuals. The treatment and care plan needs to be planned and organised over the long-term. It needs to be intensive and involve outreach work and close supervision.

Comprehensive, thorough individualised assessments of criminogenic and non-criminogenic needs need to be conducted and regularly up-dated. The care package needs to include ensuring compliance with medication, with an emphasis on teaching and understanding the needs for compliance with medication. The appropriate medication needs to be taken on a long-term basis, therefore education concerning medication and illness is essential. Life skills and social skills also need to be addressed, tending to own personal hygiene and nutrition, also social interaction and conflict resolution along with illness awareness training.
All these non-criminogenic needs need to be addressed within a team of specialist carers ensuring case management and co-ordination in order to provide the support, education and supervision of individuals who have multiple problems as well as anti-social criminogenic needs. It is also important for clinicians to accept that such individuals may have learning limitations and too much pressure from the treatment programme may result in a relapse of symptoms or trigger aggressive behaviour. These individuals may require additional support and supervision whilst attending groupwork interventions and may require 1:1 support before embarking on offending behaviour programmes (Muller-Isberner, 1996; Hodgins, 1996; Hodgins, 1998).

**Risk assessment, management and assessment of non-criminogenic needs**

It is necessary to mention briefly the need for accurate, in-depth and individualised assessments for all offenders likely to be involved in offending behaviour treatment programmes.

Risk assessment and management plans are imperative to identify the level of risk of re-offending and potential for violence in the future. These include assessments of the behaviour and cognition’s and the lack of skills associated to these that are likely to contribute to the propensity for future violence. These assessments are essential to design and deliver interventions that specifically address the problems that are directly related to criminogenic needs. These assessments also give an indication of the necessary input required and if efforts are necessary at all to reduce recidivism. They also allow offenders to be effectively monitored and evaluated in order to identify levels of effectiveness and reduction in recidivism effects.

It is also important to consider individual learning capacities for interventions and this must be taken into consideration at the assessment/planning stage.

The assessment stage also needs to address the non-criminogenic needs of offenders, especially in the case of mentally disordered offenders. These problems can often be acute and chronic and are characteristics that can promote offending and often violent offending (Muller-Isberner and Hodgins, 2000). This is necessary because comorbid disorders such as alcohol and substance abuse and anti-social personality disorders are likely to increase the risk of recidivism and also complicate the treatment programme.

**Conclusions.**

Accredited offending behaviour programmes that are being made available within the community are at present considered to be the ‘best practice’ for tackling offending behaviour and criminogenic needs. Community based forensic mental health teams deal with many patients who have criminogenic need requirements similar to those present within the criminal justice social work services, regardless of their mentally disordered offender status. Evidence suggests that highly structured, intensive, long-term treatment focussing on specifically on the criminogenic needs is what is necessary for more effective reduction in recidivism (McGuire and Priestley, 1995; Muller-Isberner and Hodgins, 2000).

This therefore presents opportunities for joint partnership agency working approaches between the two disciplines, to provide the necessary interventions required for tackling different types of criminogenic needs and offence focussed work. Due to the diversity of offence focussed needs, lack of funding and resources and staffing provisions, this provides the opportunity to pool specialist professional knowledge and experience and to provide realistic, obtainable and sustainable long-term programmes with pooled resources and support to provide the necessary offending behaviour interventions.

This therefore facilitates:

- A diverse provision of programmes including:
  1. Alcohol and drug related offending
  2. Sex offending
  3. Domestic abuse
  4. Violence prevention
  5. Anger management
  6. General offending
• The provision of treatments both for mental disorder and offending behaviour based on proper assessment of need.

• The identification of individual offence focussed work for complex cases and idiosyncratic cases where standard programmes will be unsuitable (both for forensic CMHT’s and CJSW).

• Continuity in approach across the forensic network, i.e. patients can continue treatment begun in one level of security in another. For example, a patient in high security setting should be able to complete aspects of a sex offender treatment programme as they move on to medium security and then into the care of a forensic CMHT. This would allow patients to be treated within an appropriate level of restriction at any one time and allow treatment to coincide with ‘testing out’ and feedback to risk assessment and treatment considerations.

• Joint national training initiative in treatments for offending behaviour is required to develop a workforce that is sufficiently skilled and aware of interventions to provide the seamless and flexible service necessary for mentally disordered offenders. This training would require being ongoing to counteract staff movement.

• The necessary systems of support and supervision required to develop and ensure good clinical practice and treatment integrity.
Appendix 5

Court Liaison Service

In response to MEL(1999)5 – *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland*, several Health Boards throughout Scotland created community services for Mentally Disordered Offenders (MDO). One aspect of the work of these services was the creation of a Court Liaison Scheme or a similar assessment service to the courts. The aim of these services is to assist the court to competently deal with mentally disordered offenders. Court liaison services are most commonly nurse-led with the support of other professions. At present, schemes vary in the mode of delivery with some making visits to the police cells, others provide court on-call services and others having nurses based in the court. However, the function of them all remains the same; to access mental health services for individuals who appear to be acutely mentally disordered and/or severely incapacitated by reason of mental disorder and who are deemed too unwell to proceed through the criminal justice system at that time. This process does not exclude the individual from prosecution, but may result in relocation to hospital on remand.

Court liaison schemes require the co-operation of a number of bodies and may involve Health, Mental Health Officers, Social Work, Police, Solicitors, Procurators Fiscal as well as the custody officers (in some instances this may be contract Security staff). It is important that all involved in the scheme are aware of its remit and the parameters involved. There are a number of factors to consider regarding a court liaison scheme in relation to:

- Who refers?
- Who is referred?
- What are the criteria for referral?
- When should the referral be made?
- Where will the assessment be done?
- When will the assessment be done?
- Who will do the assessment?
- What is the protocol involved?
- What information is needed by the referrer?
- What information, is required by the assessor?

Confidentiality / Information sharing

The referral to the assessor should come from the single source of the Procurator Fiscal office. Multiple referral points to the assessor can lead to confusion and delay and result in the assessor lacking the information they require. Any other professional / group involved with the person who is in custody has a duty to alert the Procurator Fiscal to the need for a mental health assessment.

Agreement can then be made between the Procurator Fiscal office and the Forensic Mental Health Team as to how the referral is made, what information is required from the referrer and how, and when, that information is communicated. Court liaison should only be for persons who are held in custody and due to appear in the custody court and are thought to have severe mental disorder. There is a necessary distinction between court liaison and court reports. Court liaison is not a replacement for court reports and they should be requested in the usual manner.

Relevant information required by the assessor includes, reason for referral, a copy of the police report, including any reports relating to behaviour in custody and at interview, and any previous convictions. The assessor will then contact their own medical records department to review any present or past psychiatric contact with the individual who has been referred prior to assessing them.

Most of the forensic mental health teams involved are small services and do not have the capacity to make high numbers of assessments. It is therefore important referrals are appropriate and individuals involved all understand what constitutes an appropriate referral.
Appropriate referrals would mainly be acutely mentally disordered and/or severely incapacitated by reason of mental disorder.

We recommend “mental health awareness” and “appropriate referrals” training is provided for interfacing professionals e.g. Procurators Fiscal, Social Workers, Police (particularly the bar sergeants) and custody staff. The training should be provided by the FCMHT.

We would also recommend that court liaison is provided as an on-call service rather than provided as a daily attendance by a nurse. This is again in response to likely capacity issues within a small FCMHT.

As referrals are by telephone (although in some cases may be made in person) they should be followed up by written communication in an agreed format (example in appendix 5b). Timescales for referral, information provision and feedback to the Procurator Fiscal (example appendix 5c) should all be agreed. For example, if a referral is not made by late morning one day then an agreement can then be made to remand a person overnight to be assessed the next day prior to any court appearance.

We recommend agreed templates should be used to communicate the information required, to the assessor initially and then to the Fiscal after the assessment has been completed.

Initial assessment of the person held in custody would normally be carried out by Forensic Psychiatric Nurse and then after discussion with the team Forensic Psychiatrist and if the outcome of the assessment is that the person is well enough to continue through the criminal justice system, they will provide a report for the Procurator Fiscal (example appendix 5e). The Psychiatrist may attend in marginal or difficult to assess cases to confirm or clarify the nurse’s opinion.

However, if the person needs to access mental health services then the Psychiatrist will attend and complete the appropriate documentation to detain the person under the Mental Health Act. The Psychiatrist then has the responsibility to access an appropriate bed for the person, taking into consideration any security requirements.

Admission to hospital does not mean that the charges are dropped and the court process ends. It is sometimes important that the individual experiences the consequences of their actions and continues through the criminal justice system, even if it is likely that they will be given a mental health hospital disposal following any court appearance. Discussion can take place between the Procurator Fiscal and the Psychiatrist to determine whether the Mental Health Act or the Criminal Procedures Act is used to detain the person and the level of security needed based upon the severity of the crime.
Forensic Mental Health Team

Court Liaison Scheme Flowchart

**PERSON IN CUSTODY**
(POLICE CELLS, COURT CELLS)

↓

**HIGHLIGHTED TO FISCALS OFFICE BY**

**POLICE, SOCIAL WORK, SOLICITOR ETC**

**THAT PERSON MAY BE SUICIDAL OR PSYCHOTIC**

↓

**FISCAL COMPLETES COURT LIAISON**

REFERRAL FORM

↓

FISCAL’S OFFICE CONTACT FORENSIC CMHT AS EARLY AS POSSIBLE BEFORE 11.00hrs CUT OFF

↓

FISCALS OFFICE FAX TO FORENSIC CMHT AS EARLY AS POSSIBLE BEFORE 11.00hrs CUT OFF COURT LIAISON REFERRAL FORM + COPIES OF: COMPLAINT / INDICTMENT POLICE REPORT PREVIOUS CONVICTIONS

↓

FORENSIC CPN CARRIES OUT MENTAL HEALTH ASSESSMENT AND DISCUSSES WITH PSYCHIATRIST

↓

ASSESSED AS NOT REQUIRING TRANSFER TO MENTAL HEALTH SERVICES

FORENSIC CPN SENDS REPORT TO FISCAL

DETAILS OF ANY ALTERNATIVE MANAGEMENT PLAN HIGHLIGHTED

NO HOSPITAL REMAND REQUIRED CONTINUES CRIMINAL JUSTICE SYSTEM

↓

ASSESSED AS REQUIRING TRANSFER TO MENTAL HEALTH SERVICES

PERSON SEEN BY (FORENSIC) PSYCHIATRIST

(FORENSIC) PSYCHIATRIST SENDS REPORT TO FISCAL

HOSPITAL REMAND REQUIRED + THROUGH DETAILS OF ARRANGEMENTS RECORDED
FORTH VALLEY FORENSIC COMMUNITY MENTAL HEALTH TEAM

COURT LIAISON REFERRAL FORM

Patient Name

Date of Birth

Address

Referrer

Court

Contact Tel No.  Lunchtime Tel No.

Date of Referral  Time Referral Sent

Index Offence

Copy of Complaint/Indictment Sent  YES  NO

Copy of Police Report Sent  YES  NO

Copy of Previous Convictions Sent  YES  NO

IF ANY OF ABOVE NOT SENT, WHY NOT? (This May Result in Person Not Being Seen)

Reason For Referral  Fitness to Plead  YES  NO

Detainability  YES  NO

Suicide Risk  YES  NO

Diagnosis  YES  NO

Disposal Options  YES  NO

Bizarre Symptoms/Behaviour  YES  NO

Additional Details (Brief summary of why the person should be seen)

Person in Custody Aware of Referral  YES  NO

Appendix 5c
Forth Valley Forensic Community Psychiatric Nurse Court Liaison Report

Name: 

Date: 

Date of Birth: 

Charge: 

In response to a request from the PF Office, I interviewed the above-named in the police cells for the purpose of preparing a psychiatric nursing assessment.

Relevant Summary of Assessment:

Opinion:

Having discussed my assessment with Dr.

1. It is my opinion that the accused **will / will not** require further assessment by a psychiatrist prior to court proceedings today.
2. It is my opinion that the accused **is / is not** fit to continue with court proceedings today.
3. This report has been given on soul and conscience.
4. If liberated from custody we will endeavour to arrange the following package of care:

Nurse: 

Signature: 

Designation: **Forensic Community Psychiatric Nurse**
Forth Valley Primary Care NHS Trust
Forensic Community Mental Health Team

Notification of At Risk / Vulnerable Prisoner

Name: 
DoB:

Address:

Remand / Sentence:

The following areas of concern are noted in respect of the above

- First Custody
- Exhibiting Distress
- Current Drug User
- Suffers from Depression
- History of Self Harm / Suicidal Behaviour
- Recent Bereavement
- Expressing Delusional Thoughts
- Physical Health Problems
- Significant Family Problems
- Concerns about Custody
- Withdrawn / in shock
- Current Alcohol Use
- Suffers from Panic Attacks
- Voicing Suicidal Thoughts
- Voicing Homicidal Thoughts
- Voicing Violent Threats
- Current Psychiatric Services
- Other
- Other

Additional Comments:

Signed: 
Date:

Forensic Community Psychiatric Nurse
FORTH VALLEY FORENSIC PSYCHIATRY COURT LIAISON SERVICE

NAME: 
DATE: 

DATE OF BIRTH: 

Charge: 

In response to a request from the PF Office, I interviewed the above-named in the police cells for the purpose of preparing a psychiatric report.

Summary of Relevant History: 

Opinion:

1. It is my opinion that the accused [                           ] sane and fit to plead.
2. It is my opinion that the accused [                                                                  ] suffer from a Mental Disorder within the meaning of the Mental Health (Scotland) Act 1984 which is of a nature and degree to warrant detention in hospital.
3. I consider that the accused 
4. I respectfully recommend the following disposal:

5. I confirm that I am not related to the accused and I have no pecuniary interest in their admission to hospital.
6. This report is given on soul and conscience and I confirm that I am a medical practitioner approved by Forth Valley Health Board for the purpose of Section 20 of the Mental Health (Scotland) Act 1984.

Name: 
Signature: 
Designation: 
Qualifications: 

Appendix 5e
**Additional Information:**

**Guidance on Form Completion - For Doctor’s Use Only**

1. is / is not
2. does / does not
3. I consider the accused is suffering from Mental Illness, namely (or mental impairment).

4(a) I have no psychiatric recommendation to make in this case.

4(b) A Hospital Order may be appropriate in this case.

I respectfully suggest that the accused be remanded in hospital for further assessment.

I can confirm that a bed is available in [ ] from today, under the care of [ ].

4(c) If the Procurator Fiscal plans to drop the charges, it is possible to offer a voluntary admission to hospital or to detain the accused in terms of the Mental Health (Scotland) Act 1984, Section 24, where appropriate.

A hospital bed must be arranged in advance as in option 4(b).

4(d) I would be willing to arrange outpatient follow-up with local psychiatric services.

4(e) Other - eg, they may already be involved with local services and be willing to continue attendance there.
Appendix 5f

_Forth Valley Primary Care NHS Trust_

_Forensic Community Mental Health Team_

**Consent to Sharing Information**

Name: __________________________  DoB.  __________________

Address: __________________________  Tel No:  __________________

                    __________________________
                    __________________________
                    __________________________

I understand that there may be a requirement for information related to me to be shared, in a limited way, between agencies involved in my care. I also understand that each person involved in my care will only receive the information that they require in order that they may adequately meet my health and social care needs in a manner befitting their roles and responsibilities.

I also understand that information may be used for the purposes of audit of the service.

It is my decision to **give / withhold** (delete as applicable) my consent.

Client’s Signature: __________________________  Date: _________________

Nurse’s Signature: __________________________  Date: _________________

_Forensic Community Psychiatric Nurse_
Appendix 6

Diversion from Prosecution
in Forensic Mental Health Services

Background
There is no legislation governing prosecution practice in this area. It is an informal arrangement between Procurators Fiscal and relevant services. Diversion from prosecution was given official recognition in the Stewart Committee Report (1983) which acknowledged the benefits of diversion from prosecution, mainly in co-operation with social work services. Around the same time a diversion to forensic services was developed in Glasgow to the Douglas Inch Centre and described by Cooke (1991).

In principle procurators fiscal can divert any person charged with an offence from prosecution where they are of the opinion that it is not necessarily in the public interest to prosecute. In so doing the fiscal should be of the opinion that there is a sufficiency of evidence to sustain a prosecution.

Process of Diversion
Where the fiscal believes that it may not be essential for public interest to prosecute, but there is a sufficiency of evidence to prosecute an assessment report addressing the accused's suitability for help can be requested. This assessment could be provided by a specialist resource e.g. The Douglas Inch Centre in Glasgow or be undertaken by a member of the local authority Social Work Criminal Justice Service. The provider of such an assessment will be dependent upon local resources but it is important to stress the need for strong links between psychiatric services and local authority social work criminal justice services. The accused does not require to admit to any charge, or indicate a plea of guilty, but generally there should be an acknowledgement of problematic behaviour. In the case of mental illness there should be a link between the illness and that treatment of such could reduce the likelihood of repetition of the behaviour. This is argued to be a crucial area by clinicians in the mental health field as on some occasions hospital inpatients are not prosecuted on the grounds of "being in the appropriate treatment". It is argued that for some patients prosecution is an important “reality therapy”. In addition in some situations the seriousness of staff assault, for example should be recognised through prosecution.

Where a course of treatment could be recommended the person is deemed suitable for diversion from prosecution and the fiscal then has two choices;

1. Divert and waive the right to prosecute.
2. Defer decision on prosecution

Where the fiscal waives the right to prosecute the accused cannot be prosecuted irrespective of co-operation with the treatment programme.

Where a decision to defer has been made the fiscal can still prosecute in the light of co-operation and progress. The length of time of a deferment of decision is often determined by the time bar placed on the offence by statute. This varies according to offence and type of prosecution but places limits on the fiscal as to when an intimation of intention to prosecute must be made.

Applicability to Forensic Mental Health
Generally speaking diversion is used in more minor offences and by definition a number of those targeted by forensic services will be accused of more serious offences or have a high risk of serious or further offending which will suggest that it is in the public interest to prosecute.

It may be, however, that the accused is already receiving treatment through non criminal means. They may, for instance, be subject to Sec 18 detention which could obviate the need for prosecution, this being subject to the caveats suggested above. It could also be that an accused person is co-operating with treatment in a less formal way, or as part of a probation order.
Range of services
A person diverted from prosecution to mental health services may access one or more of the following:

- In patient services to stabilize a condition, through medication or other treatment.
- Support and monitoring of mental illness in the community to encourage compliance with a regime of medication and with a care package.
- Day services offering a combination of treatment and guidance on social functioning.
- Support packages through a multi-disciplinary approach using the Care Programme Approach.
- Counseling services and formal group work.
- Therapeutic Interventions (criminogenic/ non-criminogenic).
- Formal orders through Mental Health Legislation, and probation orders.
Appendix 7  

Accommodation and Housing

Background
This paper covers issues relating to the accommodation needs of the client group highlighting the legislative framework, guidance arising from this framework, issues relating to accommodation and examples of good practice.

Legislation
Policy and practice in relation to the provision of accommodation, homelessness and the management of such accommodation in the social rented sector (Councils and Housing Associations) is governed by the Housing (Scotland) Act 1987 as amended by the Housing (Scotland) Act 2001 and related legislation. The legislation of relevance to the client group covers 3 main areas:-

Provision of Housing
- Anyone aged 16 or over is entitled to register on a housing waiting list held by a social landlord
  - In the allocation of housing landlords must give reasonable preference to persons :-
    1. occupying houses which do not meet the tolerable standard or
    2. occupying overcrowded houses or
    3. who have large families or
    4. who are living in unsatisfactory housing conditions
  - In the allocation of housing landlords must not take into account :-
    1. the length of time an applicant has resided in its area
    2. any outstanding housing debts relating to a house where the applicant was not the tenant
    3. any housing debt on a previous tenancy which is no longer outstanding
    4. any outstanding housing debt for a which is not more than 1/12th of the annual amount payable or where an agreement to repay has been maintained for at least 3 months and is continuing
    5. any outstanding debts which do not relate to the tenancy of a house
    6. the age of the applicant provided he/she is over 16
    7. the income of the applicant
  - In the allocation of housing landlords shall take no account of whether an applicant is resident in their area if the applicant
    1. is employed or has been offered employment in the area
    2. wishes to move into the area to seek employment
    3. wishes to move into the area to be near a relative or carer
    4. has special social or medical reasons for requiring to be housed in the area
    5. wishes to move into the area because of harassment
    6. wishes to move into the area because of the risk of domestic violence

All social landlords maintain waiting lists which prioritise applicants for housing based on housing need factors. These need factors are not common to all landlords and applicants or agencies supporting applicants should ensure that contact is made with landlords well in advance of discharge to establish their clients potential priority on the waiting list based on the need factors. In many cases supporting written evidence may be required to accompany an application for housing, the support needs of the applicant will require to be established and agreed with the landlord and advice given to the applicant regarding the availability of suitable housing in the landlord’s area.

Homeless persons
Prevention of homelessness should be a key strategic aim which local authorities and other partners pursue through the local homelessness strategy. All local authority departments and all relevant local agencies should work together to prevent homelessness occurring wherever possible. It is also vitally important that, where homelessness does occur and is being tackled, consideration is given to the factors which may cause repeat homelessness and action taken to prevent homelessness recurring.
Local authorities have a duty under s.2 of the 2001 Act to secure that advice and information about the prevention of homelessness and any services which may assist in the prevention of homelessness is available free of charge to any person in the authority’s area.

Local authorities and other agencies should note the following points:

- Pre-discharge discussions are vital, particularly where individuals may be reluctant to reveal housing difficulties for fear these could delay their discharge.
- Advance planning will be required to ensure accommodation is available, in some cases planning will require to take place several years in advance where new accommodation has to be provided, particularly specialist accommodation.
- Even where accommodation is already available, it will be necessary in some cases to check that this is still suitable (for example for a person who has become physically disabled) or that support services are in place (for example for a discharged psychiatric patient). In some cases, it will also be necessary to check the availability of move-on accommodation which the discharged person may need at a later date because of likely changes in his or her condition after discharge; and always where discharge accommodation is only available for a limited period.
- In all cases, a community care needs assessment will be required.
- Care plans should provide for the position to be reassessed if a tenancy is in danger of not being sustained, (particularly if this is due to part of the care package not being delivered).
- Difficulties in dealing direct with a person at risk of homelessness, for example because he or she is living in a long stay hospital or other institution or serving with the armed forces some distance from the local authority, should not prevent their receiving the assistance to which they are entitled under homelessness legislation, or under other legislation such as the Mental Health (Care and Treatment) Scotland Act 2003.

**Leaving hospital**

Local authorities should liaise closely with Health Boards and individual hospitals in order to develop discharge protocols. Sections 53 and 57 of the Adults with Incapacity (Scotland) Act 2000 provide for welfare and/or financial intervention and guardianship orders to enable decisions to be made about the personal welfare, including health, and the management of property and financial affairs for adults whose capacity to do so is impaired. The Act imposes a duty on local authorities to apply for an order under these sections where is appears that an order is necessary and no application has or is likely to be made.

Arrangements for accommodation in the community should be made as quickly as possible, to prevent people being kept inappropriately in hospital.

**Leaving prison**

Many prisoners do not have secure accommodation available on their release, making it less easy for them to integrate successfully into the community and increasing the risks of both homelessness and re-offending. Local authorities should therefore work together with prisons, social work departments and voluntary organisations to put in place measures to prevent people becoming homeless on release from prison.

Particular difficulties may arise when an offender is detained for more than the 13 week period for which he or she is entitled to housing benefit while detained, although local authorities should explore alternative arrangements with their local benefits agencies. As a minimum people in this position should be warned of the possibility of the cessation of housing benefit, and the need to consider their future housing situation.

Local authorities should work closely with prisons in their area in order to ensure that prisoners approaching release are fully aware of their housing options and are given as much assistance as possible in securing accommodation, in order to ensure they do not
become homeless on release. Housing advice services are now available throughout the Scottish prison estate and local authorities should do as much as possible to assist these services and make connections to services in the community. Where necessary to avoid homelessness on release, local authorities should also consider whether homelessness assessments could be carried out prior to release, either by local authority staff based in the prison on a fixed or visiting basis or by prison-based staff on behalf of the local authority.

Local authorities should also be aware that prisoners currently held in other areas might also wish to make an application to them on release. They should therefore consider the need to liaise with all Scottish prisons and establish a first point of contact in these circumstances.

Local authorities and other agencies should also consider the need to ensure that a prisoner’s possessions are secure during their sentence. People leaving prison often find it very difficult to re-establish themselves in the community and this can be exacerbated where they have lost all their possessions.

**Definition of homelessness**

A person is homeless if he has no accommodation anywhere in the world. Homelessness also covers situations where the person may have accommodation but:-

1. he cannot gain entry to it
2. occupation may lead to violence or threats of violence
3. it is a moveable vehicle but there is nowhere to place it
4. it is overcrowded and may endanger the health of occupants

A person is threatened with homelessness if it is likely that he will become homeless within 2 months.

**Priority need**
The Housing (Scotland) Act 1987 (as amended) sets out that the following categories of homeless person must be considered as having a priority need for housing:-

- a pregnant woman or a person with whom a pregnant woman resides or might reasonably be expected to reside.
- a person with whom dependent children reside or might reasonably be expected to reside.
- person who is vulnerable as a result of–
  - old age;
  - mental illness;
  - personality disorder;
  - learning disability;
  - physical disability;
  - chronic ill health;
  - having suffered a miscarriage or undergone an abortion;
  - having been discharged from a hospital, a prison or any part of the regular armed forces of the Crown; or
  - other special reason

A person is considered vulnerable when they are less able to fend for themselves so that they may suffer in a situation where others will be able to cope without suffering. The above categories detail specific circumstances which may lead to vulnerability. The meanings of the categories are not defined in the legislation and local authorities should seek proper and relevant advice in relation to an applicant’s vulnerability

- a person who is homeless or threatened with homelessness as a result of an emergency such as flood, fire or any other disaster.
- a person with whom a person referred to in section 25(1)(c) or (d) of the 1987 Act resides or might reasonably be expected to reside, that is those persons who are
vulnerable or who are homeless or threatened with homelessness as a result of an emergency (see above)

- a person aged 16 or 17.

- a person aged 18 to 20 who by reason of the circumstances in which the person is living, the person runs the risk of sexual or financial exploitation or involvement in the serious misuse of alcohol, any drug (whether or not a controlled drug within the meaning of the Misuse of Drugs Act 1971 (c.38)) or any volatile substance. Risk may not be immediately apparent and each case should be considered on its merits and the risk assessed according to the individual’s circumstances.

- a person aged 18 to 20 who, at the time when the person ceased to be of school age (within the meaning of section 31 of the Education (Scotland) Act 1980 (c.44)) or at any subsequent time, was looked after by a local authority (within the meaning of section 17(6) of the Children (Scotland) Act 1995 (c.36)) and the person is no longer being so looked after.

It should not be assumed that simply because an applicant is over a specified age limit in the 2 categories above that he or she is not in priority need; vulnerability for other special reason may be apparent in other young people.

- a person who runs the risk of domestic abuse (within the meaning of section 33(3) of the 1987 Act). This definition follows that set out in the Protection from Abuse (Scotland) Act 2001 which sets out that "abuse" includes violence, harassment, threatening conduct, and any other conduct giving rise, or likely to give rise, to physical or mental injury, fear, alarm or distress.

- A person who, by reason of that person’s religion, sexual orientation, race, colour or ethnic or national origin runs the risk of violence, or is, or is likely to be, the victim of a course of conduct amounting to harassment.

References to conduct, course of conduct and harassment are to be construed in accordance with section 8 of the Protection from Harassment Act 1997. Section 8 of that Act sets out that "conduct" includes speech; "harassment" of a person includes causing the person alarm or distress; and a course of conduct must involve conduct on at least two occasions.

Intentionality
Where an applicant has been found to be homeless, or threatened with homelessness, and in priority need, the local authority must then assess whether the applicant became homeless or threatened with homelessness intentionally.

Intentionality depends on the applicant having acted, or failed to act, deliberately, and being aware of all the relevant facts. A person is not intentionally homeless if it would not have been reasonable for him or her to continue to occupy their previous accommodation. The circumstances in which a person is to be regarded as having become intentionally homeless or threatened with homelessness are set out in section 26 of the 1987 Act. There are 3 requirements - all of which must be satisfied.

- The applicant, if homeless, must deliberately have done, or failed to do, something in consequence of which he or she has ceased to occupy accommodation which was at the time available to them. To be intentionally threatened with homelessness, an applicant must deliberately have done or failed to do something the likely result of which was that he or she will be compelled to leave accommodation (section 26(2)).

- It must have been reasonable for the applicant to have continued to occupy the accommodation. The local authority may have regard to the general circumstances prevailing in relation to its area in applying this test (section 26 (4)).

- The applicant must have been aware of all the relevant facts before taking or failing to take the deliberate actions referred to above. An act or omission in good faith on the part of a person unaware of any relevant fact is not to be regarded as deliberate.
Other factors relating to an applicant that an authority may wish to take into account are youth; inexperience; education; or health (including whether or not there is a history of substance abuse).

**Local Connection**

Local connection is defined in section 27(1) of the 1987 Act as a connection which a person has with an area:

- because he or she is or was in the past normally resident in it, and this residence was of his or her own choice;
- because he or she is employed in it;
- because of family associations;
- because of any special circumstances.

Special circumstances might include, for example, the need for continuing provision of education or health treatment for a household member in a particular local authority area; or where there is no current local connection with any area, that the applicant was brought up in an area or had lived there for a considerable time in the past.

There is no bar to a local authority making arrangements for another local authority to take responsibility for an applicant household, if this accords with the wishes of the applicant. If an applicant who is threatened with homelessness has a local connection elsewhere, the local authority to which the application is made should alert the other local authority at an early stage, and seek an agreement in principle that the responsibility for rehousing the applicant, if required, should fall to that other local authority.

**Accommodation**

If an authority has reason to believe an applicant is homeless it has an interim duty to secure accommodation until it has reached a final decision on their application. This duty continues during the process of review if one is requested. Where the applicant is assessed as not having a priority need for accommodation or as being intentionally homeless, the duty is to secure that accommodation is made available for such a period as will give the applicant a reasonable opportunity to find alternative accommodation for him or herself. These applicants must also be given advice and assistance in their attempts to find alternative accommodation.

A ‘reasonable opportunity’, should be assessed in terms of the circumstances of the applicant, including consideration of factors (such as disability, addiction, mental health problems, chaotic lifestyle) which may adversely affect their ability to secure accommodation; and also local housing conditions including how readily alternative accommodation is available in the area.

The 2001 Act amended the 1987 Act to clarify that where the applicant is assessed as having a priority need for accommodation and unintentionally homeless the authority has a duty to secure the provision of permanent accommodation. Permanent accommodation is defined by section 31(5)(a) and (b) as accommodation secured by a Scottish Secure Tenancy or, in the private sector, by an assured tenancy which is not a short assured tenancy. Local authorities may provide accommodation other than permanent accommodation in the circumstances prescribed by The Homeless Person Interim Accommodation (Scotland) Regulations 2002. These circumstances are:

a) a housing support services assessment for an applicant has concluded that the applicant or any other person residing with that applicant requires housing support services which cannot reasonably be provided within permanent accommodation; and

b) as a result of that housing support services assessment, the local authority is providing an applicant or any person residing with that applicant with interim accommodation together with housing support services in connection with that interim accommodation which include-

(i) all services required in terms of the housing support services assessment;
(ii) access to independent advocacy and information services in connection with the services;

(iii) a timetable, agreed with the applicant, for the provision of the interim accommodation and housing support services;

(iv) an end or review date for the provision of services and interim accommodation, which date shall not be later than a date six months from the date on which the interim accommodation was first provided;

(v) a written record of the housing support services assessment, the services that are to be provided and the timetable; and

(vi) a mechanism to monitor the use of interim accommodation and the long term outcomes for each applicant.

Local authorities should ensure that the individual circumstances of the applicant are examined on a case by case basis and that the regulations are not invoked automatically for certain categories of applicants (e.g. young people or people with learning difficulties).

As a general rule a local authority should always rehouse a homeless family within its own area, particularly where temporary accommodation is being provided. However in rare cases the local authority may need to consider placing homeless people in another local authority’s area, although this should only be done only with the household’s consent. The local authority should retain responsibility for such outplacements.

Outplacements may be appropriate in cases of, for example, domestic abuse or external violence, or in the case of an ex-prisoner who would face local hostility if returned to his home area. In some cases such an outplacement may be nearer to the applicant’s home area than a placement elsewhere in the local authority’s area or provide suitable accommodation or access to healthcare which is not currently available in the placing local authority’s area.