# Rosie Toal

## Team Leader

## SG Health Directorate

## Updated MOP, CPA, VNS and Training

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# Introduction/Objectives

**Restricted patients – Stats, role of SG and role of MHO**

**Mock Case**

**Updated Memorandum of Procedure**

**CPA -** OLR and CPA Gold Standard

**VNS -** General outline of new provisions

**Importance of Training -** Homicide enquiries incl Peter Bryan homicide Inquiry

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# RESTRICTED PATIENT CASELOAD

| | |
|---|---|
| **Number of restricted patients (02.10.14)** | **314** |
| **Number of remand patients** (restricted status) | |
| *Male* - 21<br>*Female* - 5 | 26 |
| **Number of restricted patients** (excluding remand) in: | |
| *State Hospital – high secure* | 96 |
| *Orchard Clinic – medium secure* | 21 |
| *Rohallion Clinic – medium secure (12) low secure (7)* | 19 |
| *Rowanbank Clinic – medium secure* | 39 |
| *Local Hospitals – low secure* | 51 |
| *Conditionally Discharged*<br>*(of which 40 are transferred prisoners and 5 Hospital Direction)* | 57 |
| ***TOTAL*** | 288 |

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# Role of the Principal Medical Officer and officials in the SG Health Directorate

- The Principal Medical Officer (Forensic Psychiatry) is a psychiatrist who is responsible for liaison with the RMO and for advising Scottish Ministers and their administrative officials on clinical aspects
- Officials in MH&PRD are responsible for administrative matters generally in relation to casework on restricted patients. Decisions which are not taken personally by SMs are taken on their behalf by officials on the advice of the PMO

# Role of MHO

- A MHO is a qualified and experienced social worker
- MHOs are also expected to have undertaken some level of forensic MHO training
- A restricted patient **must** have a designated MHO at all stages of their care
- The MHO provides reports annually – see P163-177 for example of Mock MHO report in MOP
- Attendance at clinical team meetings
- Attendance at Care Programme Approach meetings

# Role of MHO (cntd)

In hospital –

- Explain to the patient their rights in relation to advocacy
- Explain to the patient their rights in relation to legal representation
- Explain the Tribunal process to the patient
- Explain the role of the named person and their right to receive full Tribunal papers
- Liaise with community services
- Contribute to risk assessment and risk management planning and consideration of SUS

# Role of MHO (cntd)

It would also be good practice for MHOs to:

- Ensure the named persons have an understanding of the reasons for the patient's detention
- Ensure named person understands that they will receive background details of index offence which may be distressing
- Support named person to sensitive nature of papers and how they may store and dispose of them
- Advise others of any changes relating to the named person

# Reporting by MHOs - CD

**Includes CD details**

- Date of CD
- Reporting interval
- Any changes to patient's social circumstances

**Meetings since last report**

- Dates of CPA meetings

**Contact with patient**

- Dates
- Compliance

**Risk Management**

- Date of recent update
- Issues re drugs/alcohol/management

# Memorandum of Procedure 2010

- An essential reference document for those involved with the management and care of restricted patients
- Takes account of:
  - Recommendations contained in Mr L & Mr M
  - RMA and CPA recommendations – NHS CEL13 (2007)
- Streamlined/web based
- Supporting multi-disciplinary teams

# MOP updating (2014)

- FRAME approach to Risk Assessment and Management – Chapter 3
- Guidance on OLRs to amplify 6.15 – CPA and RMP
- SUS – no legal authority to “suspend” SUS
- Amplify Specified Person guidance (Annex D)
- Add in role of OT and psychology in Chapter 2 as part of multi-disciplinary team
- New Guidance covering Victim sensitivities
- National protocol on drug testing
- Mock examples of completed home circumstances report
- New excessive security provisions
- Miscellaneous small updates

# Anonymised case

- For the index offence Mr X was found with a replica gun and 24 wraps of heroin. He had a previous conviction for assault to severe injury – charge reduced from attempted murder - by stabbing.
- Diagnosis of paranoid schizophrenia and personality disorder
- He was admitted to State Hospital before being transferred to local facility and conditionally discharged.
- He was recalled from CD after misusing drugs and becoming psychotic (18 months) – subsequently admitted to using flushing kits
- He was re-CD'd and has been in community for nearly 2 years

# Anonymised case (cntd)

- He continually pushes at boundaries.
- In 2010 he tested positive for illicit substances
- His attendance at structured activities declined – partly because of unwillingness to attend and also because of the closure of one of the projects
- Jan 2011 his OT reported he continued to deflect/avoid her – contact stopped but restarted again
- April 2011 tested positive for illicit substances and admitted to accruing a gambling debt

# Anonymised case (contd)

- June 2011 PMO noted marked persecutory tone
- June 2011 RMO stopped medication
- Refused to give urine sample in August
- Refused to give urine sample in September
- October – RMO described patient suffering headaches, palpitations, rashes, allergies, chest pain, jaw clenching and a number of stressors including owing money, difficulties in relationships and illnesses in family
- Urgent CPA meeting held – what would you recommend?

# Key is balanced judgement

"it is understood that there is inherent uncertainty in the processes of risk assessment and risk management. The goal is not to predict adverse events nor to have overly risk-aversive practice..... risk can be reduced and managed but never eliminated...

"SG must be satisfied that the MDT have properly identified and evaluated any risk to the public and that sound measures have been taken to manage it

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# CPA in practice

- Multi-agency working vital via CPA
- Risk Assessment Documentation should be prepared prior to CPA with contribution from all relevant agencies
- Risk Management/ Contingency Plan traffic light Flowchart for information sharing
- Patient engagement
- Risk Assessment Tools and understanding between agencies of the tools each use
- More than just High, Medium or Low risk
- Risk Assessments should be ongoing
- Planning and Contingency Planning vital

# CPA cntd

- Updated to reflect Rapid Response Report NPSA/2009/RRR003 – preventing harm to children from parents with mental health needs
- Integrating SUS – updated guidance to issue
- Supporting programme of events
- New mock examples for both CPA and CPA (OLR)

# CPA/OLR

- CPA consistent with the contents of the form of RMP set out in the Standards and Guidelines for Risk Management.<http://www.rmascotland.gov.uk/files/5313/7898/5312/Standards_and_Guidelines_for_Risk_Management_web.pdf>
- Whether meets the RMA requirements depends on the quality of the information contained in CPA and related HCR-20.
- The completed HCR-20 and CPA would have to provide this evidence to ensure that it contains the necessary elements of the RMP 'form'
- Updated Guidance circulated via the Forensic Network

# VNS

- In September 2012, the First Minister gave a commitment to consult on a Draft Mental Health Bill by the end of 2013.
- Statutory scheme to allow sharing of information with victims contained in the Mental Health (Scotland) Bill
- Bill introduced in Parliament on 19 June and published on Parliament website on 20 June
- Forensic Network invited to set up working group and to assist with guidance - Chaired by Dr John Crichton
- Membership includes Psychiatrists, Social Work/MHO, Victim Support, Hundred Families, Psychologist, Tribunal Service, Prison Service, MWC and SG

# VNS (Cntd)

- Three sub groups set up –
  - Mental Health Tribunal chaired by Russell Hunter
  - Operation of VNS scheme, Notification and Liaison with victims chaired by Dr Fionnbar Lenihan and Jo Savege, MHO
  - Victim Sensitivities chaired by Anne McKechnie, Psychologist
- Two meetings of main Group and one of sub groups held so far
- Terms of reference to be finalised and circulated
- Mental Health (Scotland) Bill, policy memorandum and explanatory notes available on the Parliament website
- Scheme will be akin to that available to victims of offenders under the Criminal Justice (Scotland) Act 2003 and will be an opt-in scheme

# VNS (Cntd)

**Right to make representations**:

- Allows the victim the right to make representations on the first occasion of unescorted SUS
- Revoking or varying the Compulsion Order
- Conditionally Discharging the patient
- Varying any conditions applying to the CD which affect the victim

**Right to information**

- Whether compulsion order has been modified or revoked, whether the restriction order has been revoked, the date of the death of the offender, any transfer of the offender to a place outwith Scotland, the conditional discharge of the offender or recall from CD
- Notification when the offender has absconded/escaped from hospital and when he/she has been returned to hospital

# VNS (Cntd)

- Health and Sport Committee will be start taking formal oral evidence on the mental health Bill from 30 September
- The Bill has to progress through the Parliamentary process and amendments may be made to any of the Bill's provisions
- oral and written evidence submitted to the Health and Sport Committee is likely to throw up points for discussion.
- http://www.scottish.parliament.uk/parliamentarybusiness/Bills/78451.aspx
- http://www.scottish.parliament.uk/visitandlearn/28753.aspx

# Some reasons why training for MHOs is important

Recommendation from the RMA

- Training should be developed and provided to multidisciplinary teams including:
  - Management of MDOs; risk assessment and management; managing restricted patients (use of the MOP); and multidisciplinary working
- Mr L & Mr M Inquiry concluded that there were clear deficiencies within the training and supervision of the FCPNs and Social Workers working with restricted patients.

# Mr L & Mr M (cntd)

- The Social Work Department must ensure that social workers have the necessary competencies and training to carry out their supervisory function.
- In the Inquiry's view, this includes mental state and risk assessment skills, as well as generic social work skills.

# Care and Treatment of Peter Bryan

"If any single lesson can be learned from the analysis of the care of Peter Bryan, it should be that responsibility for managing and treating Section 37/41 Mental health Act 1983 (MHA) patients should only be given to professionals who have sufficient experience and training to look after such individuals"

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# Training cntd

**SG RC&MHD web page provides a package of training materials which include –**

- Overview of MDO policy and care pathway
- Brief Outline of Criminal Justice system
- MHO reports for court
- Case studies
- Risk Management Training Material
- S193 legal tests

# Training

Restricted Patient team run training events which cover:

- The role of Scottish Ministers, Officials, Principal Medical Officer (Forensic) and the multi-disciplinary team
- a presentation on the legal tests set out in S193 of the Mental Health (Care and Treatment) (Scotland) Act 2003
- Memorandum of Procedure/MAPPA/Role of police – see http://www.scotland.gov.uk/Publications/2010/06/04095331/0 -
- an opportunity to meet the restricted patient team – events on 4 October and 27 February 2013

# MWC inquiry into the care and treatment of Mr F

- Report found that patient had received good care and treatment for alcohol but illness undertreated
- The team's closeness to his case did not allow them to recognise the true extent of his psychosis or the level of risk
- Complexity of patient's care needs and risks indicated a clear role for use of CPA

# Peter Bryan Homicide

- Peter Bryan was a restricted patient on conditional discharge at the time of the killing of Brian Cherry
- In March 1993 he had killed NS, the 21-year-old daughter of his employer by hitting her over the head with a hammer and received a Hospital Order and Restriction Order
- **Other than a couple of minor incidents during his 7 years at Rampton Hospital, Peter Bryan had not displayed any signs of aggressive or violent behaviour**
- *On 28 March 2001 a Tribunal concluded that he could be CD'd and deferred discharge to allow package to be put in place*
- *In July 2001 he was transferred to medium security*
- *In February 2002 he was conditionally discharged*

# General

- PB did not display the usual signs of schizophrenia, signs were subtle and he appeared to behave normally even when seriously unwell
- RMO had caseload of about 70 patients on enhanced CPA and responsibility for 14/15 inpatients
- Social Worker had only 5 months experience as a general social worker and no training in mental health
- His role was described as “more like a mentor”
- The CPN was isolated from the rest of the team and not part of the general CMHT

# General (Cntd)

- Panel found there was a lack of effective management of PB in community
- Had PB been under care of CMHT overall focus of assessment and intervention would have been on controlling his behaviour rather than attempting to normalise it and the threshold was likely to have been much lower for signs of risk or relapse
- Despite being compliant he constantly complained about conditions of CD
- Mixing with people marginalised by society and not warned of dangers
- RMO, despite telling patient it would not be appropriate to reduce medication, allowed himself to be persuaded and did so despite going on holiday for 5 weeks
- The hostel described PB's bedroom "as a schizophrenic bedroom"

# General (Cntd)

- Continued to manipulate events, behaviour more erratic, sleep pattern disturbed
- Tested positive for amphetamines
- CPN concerns about relapse; hostel raised more concern about state of bedroom, he was challenging everything
- Admitted to smoking cannabis
- Serious allegation of sexual assault by a 17 year old female
- All concerns appear to have been considered individually and none of professionals took overview of the cumulative effective
- Despite serious allegation of indecent assault no attempt was made by CPN or SW to see PB immediately
- Home Office not told about the allegations

# Recommendations

- A number of the recommendations would be met in Scotland by the use of CPA and MAPPA
- On every handover the diagnosis of a restricted patient should be reviewed specifically to include co-morbidity (in particular PD and substance misuse)
- Training should include specific training on the effective management of restricted patients

# Useful web links

- MOP: Working version is available on http://www.scotland.gov.uk/Publications/2010/06/04095331/0
- Forensic Managed Care Network www.forensicnetwork.scot.nhs.uk (including Forensic School and New to Forensic training)
- Risk Management Authority Report on Risk Assessment and Management of RPs at www.RMAscotland.gov.uk
- MAPPA guidance http://www.scotland.gov.uk/Publications/2008/04/18144823/0
- SG websites MHO Training section of site for useful documents for working with mentally disordered offenders

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# LIST OF CONTACTS

| | |
|---|---|
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| Rosie Toal – Team Leader<br>Mark Kingsman - ViSOR LPC | 0131 244 2510<br>0131 244 2133 |
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