THE STATE HOSPITALS BOARD FOR SCOTLAND

THE ASSESSMENT AND MANAGEMENT OF VIOLENCE AND SEXUAL VIOLENCE RISK TO OTHERS POLICY

Policy Reference Number	CP26	Issue: 4
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Advisory Group	Mental Health Practice Steering Group	
Approval Group	Policy Approval Group (PAG)	
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Accountable Executive Director	Medical Director	

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet: http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

REVIEW SUMMARY SHEET

Review 2024

Evidence base checked and there are no changes to current practice required.

Minor changes noted within policy:

- Updating of references.
- Inclusion of “the nature and type of violence” in scenario plans (p. 6).
- Minor revisions to wording to improve clarity.

CONTENTS

1 PURPOSE

The State Hospital (TSH) provides assessment, treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. Patients are admitted initially for assessment; in order to remain at TSH they must:

- Be formally diagnosed with a mental disorder.
- Represent a significant risk of causing serious harm* to others such that they require high security care.

(*Serious harm is defined in the Mental Health (Care and Treatment) (Scotland) Act (2003); *"that as a result of the patient's mental disorder it is necessary, in order to protect any other person from serious harm, for the patient to be detained in hospital, whether or not for medical treatment"*). RMA definition Risk of serious harm is defined as "the likelihood of harmful behaviour of a violent or sexual nature, which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible" (RMA, 2016, p.15)[1].

The purpose of this policy is to ensure that:

- There are appropriate, adequate and systematic processes and procedures for assessing whether or not a patient represents "a significant risk of serious harm to others".
- The standards set apply to all patients irrespective of the clinical team that is caring for them.
- No patient is admitted or remains at TSH unless he represents a significant risk of seriously harming others and can only be managed in conditions of special security.
- Any risks identified are carefully and effectively managed in order to reduce the risk of harm that any patient might present to other patients, staff, volunteers, visitors or members of the public.
- A patient's risk to others is reviewed on a regular basis.
- Appropriate training in specialist forensic and clinical risk assessment and management is made available to all levels of staff.
- Risk assessment and management processes used are appropriate to the patient population.
- Governance and review arrangements are in place to audit compliance and modify systems accordingly.

The State Hospital will adopt risk assessment and management procedures that:

- Are in accordance within the statutory powers of the Hospital staff e.g. mental health and criminal justice legislation, Data Protection Act and other laws and regulations.
- Have a legitimate aim, with a justification for any necessary breach.
- Are necessary in a democratic society.
- Are proportionate, representing the minimum interference necessary to achieve the aim.
- Are in accordance with professional practice guidelines.
- Are consistent with Risk Management Authority Guidance on Risk Assessment.

[1] https://www.rma.scot/wp-content/uploads/2022/08/Standards_and_Guidelines_for_Risk-Management_2016.pdf

2 SCOPE

This policy applies to all patients admitted to TSH for assessment and care and treatment. The Annual Operating Plan target specifies that there should be a risk assessment and management plan as part of a patient's Care Programme Review in place within 3 months of admission. This will apply to all patients without exception.

The method of assessing and managing risk forms an integral part of three other policy compilations: the PMVA (Prevention and Management of Violence and Aggression) Policies and the Care Programme Approach Policy (CPA) and the Multi Agency Public Protection Arrangements (MAPPA) Policy. These documents are located on TSH Intranet in 'Policy and Procedures'.

3 BACKGROUND

At TSH a "structured professional judgement" (SPJ) approach is used to assess and manage the potential risk of harm to others. The Risk Management Authority (RMA) Scotland who have published good practice Standards and Guidelines for Risk Assessment and Report Writing also promote the use of this approach. Although the RMA guidelines were originally written for a specific offender group (those subject to an Order of Lifelong Restriction) they are intended to have "a wider application across offender risk management in Scotland"; this includes mentally disordered offenders. The Forensic Network Review Group recommended TSH have an agreed definition of Risk Management. The RMA definition is: "to identify the measures that will be taken to manage the risk of serious harm, and to co-ordinate arrangements for the implementation and review of those measures. The risk management planning process flows from, and links explicitly to the formulation of risk. The purpose of formulation is to examine the nature, seriousness and imminence of offending and develop an understanding of how factors interact to result in an episode of offending. It creates a bridge between risk assessment and risk management, and informs the identification of measures to prevent, reduce or interrupt future occurrences of seriously harmful behaviour (RMA, 2018, p. 18)[2]. The 2018 RMA guidance refers to victim considerations namely: "consideration of victim-related issues and impact throughout. For example, every effort should be made to seek victim perspectives during information-gathering. It's also appropriate for assessors to consider victim harm within a risk formulation and produce victim safety planning measures within proposed risk management measures. It is recognised that it is not always feasible or appropriate to work directly with victims, who may opt not to be involved in such discussions. However, wherever possible efforts should be made to involve victims, and consider their role" (RMA, 2018, p.8).

The assessment guidelines emphasise the importance of being guided by relevant structured risk assessment "tool" by clearly outlining the need to collect information from a variety of sources. The SPJ tool(s) chosen must be relevant to the needs and risk of the patient. The information sources include patient interview, information from key others, medical records, MDT notes and education, social work and prison records. The need to include formal assessment of specific problems and to consider the implications of the findings for each patient's risk is also highlighted. They recommend that any assessment of risk includes:

- Gathering, reviewing and identifying relevant information (including medical, social, criminal and educational history) via a balance of interview, file and collateral information via use of the new TSH assessment structured checklist for psychological therapy services.
- Analysis of past and current offending.
- The application of assessment tools to identify relevant risk factors, with the tools being used appropriate to the risk, needs and characteristics of the individual being assessed.
- Formulation-based approach: this relevant information will be analysed and organised in line with relevant empirically supported theory to provide an explanation of the onset,

[2] https://www.rma.scot/wp-content/uploads/2024/01/Standards-and-Guidelines-for-Risk-Assessment-RMA.pdf

development, occurrence and maintenance of the offending behaviour. The formulation should articulate the pattern and nature of past offending, estimate the likelihood and seriousness of future harm, and identify the likely scenarios in which offending may occur. This will be communicated meaningfully through a narrative risk formulation.

- Scenario Planning should include:
  - Description of the nature and type of violence.
  - Those to whom the patient presents the greatest risk.
  - The likely impact and severity of harm associated with this patient.
  - Future risk scenarios for this patient under different levels of security (where relevant).
  - Factors that may increase or decrease level of risk.
- Evaluation of risk: an opinion on risk will be provided that flows logically from the formulation. It will draw from the formulation to clearly, concisely and coherently inform the recommendations for risk management.
- Recommendations about the areas that should be targeted by treatment and management strategies in order to reduce future risk in the areas of:
  - Interventions and treatment.
  - Monitoring.
  - Supervision.
  - Victim safety planning.
- Consider the appropriateness of approaching victim(s) or representatives of victims or gather victim specific information to include victim psychological and physical impact of index offending, victim factors in offence(s) such as victim selection, and future likely victim impacts related to risk assessment.

With respect to risk assessment and management, TSH accepts that "medical treatment and risk management are not the same. Irrespective of improvement and recovery in response to medical treatment, the risk posed by an individual patient will always be considered separately and determine the degree of liberty enjoyed by the patient".[3] Whilst TSH works with individuals with mental disorder; the risk of harm and the consequent management of this will always be considered as a separate although interlinked part of the care and treatment plan.

The RMA's Risk Assessment Tools Evaluation Directory (RATED)[4] provides a comprehensive review of all risk assessment tools currently available and evaluates their validity and utility for different offender groups, including their applicability to a Scottish population. Although RATED will be considered the main source of reference to use when deciding on the applicability of risk assessment tools for TSH population, risk assessment procedures will not be limited to those articulated in this document; other assessment instruments can be used at the clinical team's discretion.

Carrying out a risk assessment of an individual patient is only one of the first steps towards planning his care and treatment. The RMA have also issued Standards and Guidelines for Risk Management (RMA, 2018) and identify the need for:

- Risk Assessment as described above.
- Risk management plans and decisions will be based on a risk assessment which is of the appropriate level to support such a decision or plan. Processes will be dynamic with the capacity to respond to changes in risk, and there will be proportionality in the level and immediacy of any response to change.

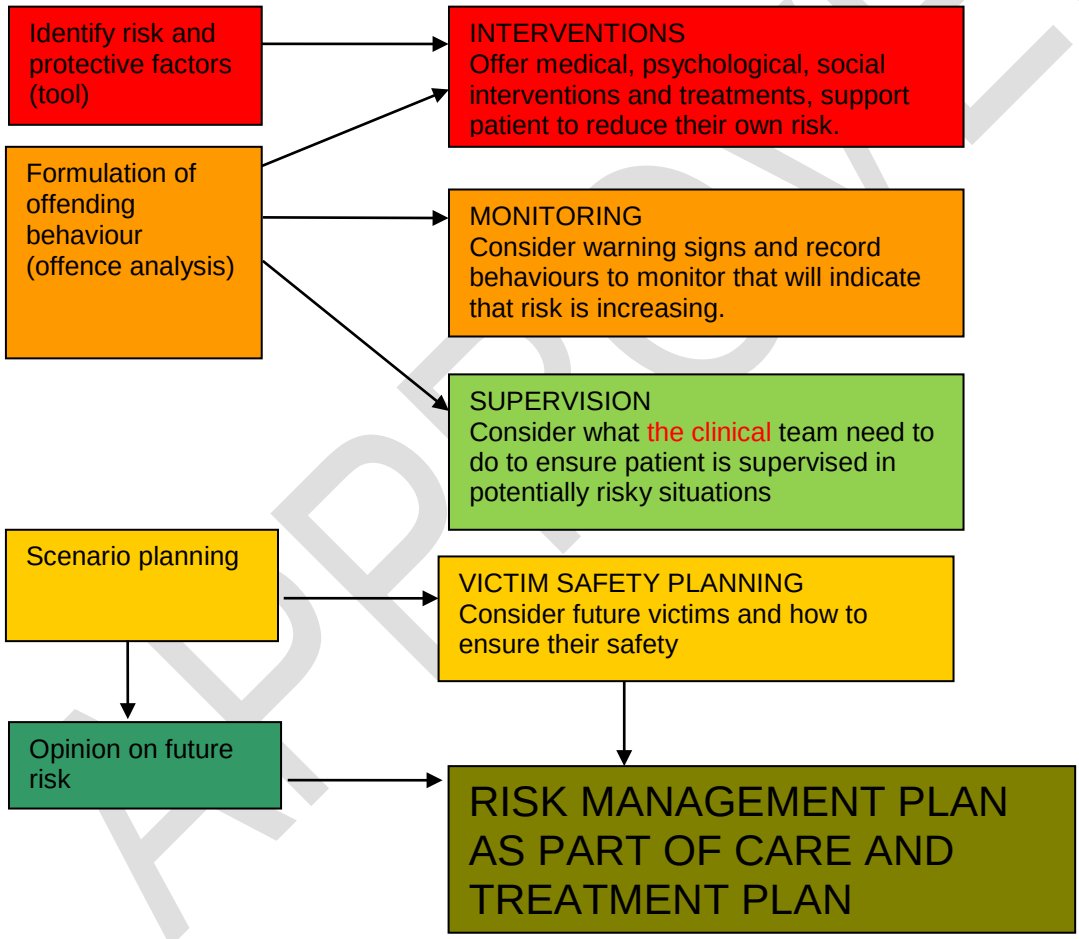
[3] Joint response by Scottish Executive, NHS Greater Glasgow City Council Social Work Department to the report of the inquiry into the care and treatment of Mr L and Mr M by the Mental Welfare Commission, March 2006

[4] Risk Management Authority (2019) Risk Assessment Tools Evaluation Directory 4th edition - https://www.rma.scot/research/rated/

- Risk strategies of monitoring, supervision, intervention and victim-safety planning will be tailored to the needs of the individual.
- Quality Assurance: individuals responsible for assessing risk, making decisions or designing plans on the basis of risk assessments, and implementing those plans will be appropriately qualified, skilled, knowledgeable and competent to carry out this work.
- Consistent and reliable co-ordination of cases.
- Clarity about multi-disciplinary roles and responsibilities.
- Effective interagency communication and agreed shared tasks.

At TSH each patient has a comprehensive care and treatment plan that includes interventions and treatments to improve physical and mental health as well as interventions to reduce the risk of harm that the patient presents to others. It is important to recognise that in relation to the management of risk of harm to others, the goal of intervention may be to develop effective risk management of the patient rather than effect substantial personal change.

Risk management can be viewed as being linked to the stages of risk assessment as follows:



Risk assessment and management is a complex process that requires significant training and skill. The process can be carried out by a sole evaluator (see glossary of terms for definition) or by a clinical team. A sole evaluation has benefits in that one person can take responsibility for the whole process and effectively acts as a risk assessment and management consultant to the team. This person should be trained to a highly specialist level in the use of risk assessment tools and have an excellent understanding of risk assessment and management theory and significant practical experience in the management of mentally disordered offender's risk. The disadvantage of having a sole evaluator who is not part of the clinical team is that the knowledge whilst shared and discussed in the clinical team is not "owned" as such by them and the members of the team

who will have to implement the management plan may not have the investment or understanding in it that is required to ensure all aspects of the plan are followed through.

Team evaluations have the potential to facilitate a shared ownership of the risk assessment and management process in that they make use of all members of the clinical teams to collate the relevant information and develop a risk management plan. However, not all members of the team are able to undertake the level of training required or gain the necessary experience that the sole evaluator has gained. In team evaluations, it is essential that at least one experienced sole evaluator within each team is able to oversee the process.

TSH will promote the use of team evaluations.

Multi-disciplinary risk assessment and management is the cornerstone of all risk management planning. Each plan will involve a number of different tasks to be undertaken by a variety of staff. This plan needs to be co-ordinated and reviewed as part of the care and treatment plan for each patient.

Decisions involving clinical risk always involve balancing the health and safety of the patient and others with the patient's quality of life, his personal growth and right to exercise choice in the care he receives. It is acknowledged that achieving this balance is often a complex task where absolute safety can never be guaranteed. TSH aims not only to minimise risks but also to manage and promote risk-taking in a planned, controlled way. Interventions following from assessments of clinical risk should be the least restrictive possible in the circumstances.

The Review of CPA guidance for Restricted patients[5], the Millan principles of the Mental Health (Scotland) Act [6], the European Convention on Human Rights [7] , the Memorandum of Procedures for Restricted patients[8] and the Management of Offenders (Scotland) Act[9] have all had an impact on the development of this policy.

4 PROCESS

4.1 The Initial Admission Risk Assessment

This will be completed either prior to admission or within the first 72 hours. It should be completed by nursing and junior medical staff taking into account risks identified by the pre-admission team. This contains information not only about violence risk factors but also about medication, physical health issues and BBV status information that may have an impact on ways of managing acute violence. The proforma is to be found on RiO in the Risk Information folder. This should be completed electronically and the form 'closed off' when it has been completed and discussed with the patient's RMO and Senior Charge Nurse (SCN).

4.2 Admission CPA violence risk assessment

An assessment of the risk the patient presents to others will form part of the assessment process for all patients. This will take place in time for the Admission CPA meeting (usually within 10 weeks of admission). There are some circumstances where an admission CPA will happen sooner (e.g. Patient admitted under the exceptional circumstances clause, patients with a prison liberation date that is less than 10 weeks from admission and patients with an assessment or treatment order where there is a likelihood of return to court without psychiatric recommendations.)

[5] Review of Care Programme Approach Guidance for Restricted Patients in Scotland
[6] Mental Health (Care and Treatment) (Scotland) Act 2003
[7] Convention for the Protection of Human Rights and Fundamental Freedoms CETS No.: 005
[8] SCOTTISH EXECUTIVE HEALTH DEPARTMENT MEMORANDUM OF PROCEDURE ON RESTRICTED PATIENTS: Guidance document for mental health professionals
[9] Management of Offenders (Scotland) Act, 2005, 2019

The admission assessment will include information from:

- Interviews with the patient and his carers (patients must provide consent to interview carers).
- Review of all available background information (prior hospital notes, prison records, social work records (including social history), educational records, police files, information from legal proceedings).
- Formal psychometric assessment (e.g. personality disorder, cognitive impairment, drug and alcohol dependence etc.) or previous psychometric assessment.
- Observations of behaviour and interactions on the ward.
- Completion of a Violence Risk Assessment and Management Profile (VRAMP) using standard structured professional judgement tool(s) appropriate to the offence committed and collating all the information above (see guidelines for CPA and Care and Treatment in TSH) and the CPA document, which includes the VRAMP in Appendix 1). Note that the CPA care plan document is currently under review.
- The VRAMP includes an "Evidence Document" for each SPJ tool used (for example the HCR-20 for violence risk assessment or the RSVP for sexual violence risk assessment). The available evidence for each risk factor is listed along with precise sources of the evidence given. There are RiO forms available for use for some of the most frequently used SPJ tools.
- The CPA document will also aim to produce a shared formulation of mental health and risk of harm to others. The formulation process covers the following headings which are found in the CPA document after the reports from various disciplines:
  - Presenting Problems and Needs.
  - Predisposing Factors and Violence Risk Factors for Illness and Risk of Harm to Others**.**
  - Precipitating Factors and Violence Risk Factors for Illness and Risk of Harm to Others**.**
  - Perpetuating Factors and Violence Risk Factors for Illness and Risk of Harm to Others.
  - Strengths and Protective Factors.
  - Summary and Underlying Mechanisms.
- The Consultant or Lead psychologist will be responsible for ensuring that the initial VRAMP is allocated to and completed by one individual member of their clinical team. This person will be trained to the standards of a sole assessor who has the professional competencies, relevant VRAMP or SPJ training and skills to complete this task. The VRAMP will be on Rio in draft to the rest of the clinical team at least one week before the Admission CPA review meeting.
- The draft VRAMP will be presented by its author at the Admission CPA review meeting. The findings will be reviewed by the clinical team, amendments made as agreed and recommendations for risk management will be included in the CPA care and treatment plan as part of the objective setting process.
- The focus for risk management will be on:
  - Interventions and treatment in which the patient can engage in order to address risk factors.
  - Monitoring to ensure that warning signs indicating any increase in risk are identified.
  - Supervision strategies that have been identified to allow staff to contain any risk of harm the patient may present to others.
  - Victim safety strategies to ensure that potential victims are adequately aware or protected from future acts of violence from the patient.
- Following the CPA meeting, the sole assessor will be responsible for ensuring that the necessary changes discussed at the CPA review meeting are made. The corrected Evidence Document(s) and the VRAMP will be updated on RiO and included as part of the formal CPA report.

- The Evidence Document(s) and the VRAMP form part of the RiO record. This can then be updated and reviewed at the next CPA meeting by the assessor allocated to the case.
- All members of the clinical team should bring newly identified records to the attention of the author of the Evidence Document and VRAMP.

4.3 Continued violence risk assessment and management planning

- The VRAMP should be seen as a first step to the assessment and management of clinical risk. For most, if not all patients, the need for further more detailed analysis of the patient's specific risks will need to be undertaken by suitably qualified and experienced members of the clinical teams. For example, offence specific work may reveal past offending patterns not previously identified, the course or understanding of the patient's mental illness may change, or new information may become available. In all these cases further specialised assessment will inform possible future changes to the risk management plan for the patient.
- Thereafter the VRAMP will be reviewed and updated after any significant event and at a minimum on a yearly basis during the CPA meeting. The Consultant or Lead Clinical Psychologist will ensure that the responsibility for this update is allocated to an individual on the team with the status of the sole assessor in advance of the CPA review. The RMO is responsible for ensuring that the VRAMP is reviewed for each patient at least annually.
- Information from the updated VRAMP will be used to inform the Care and Treatment Plan as before in terms of:
  - Treatments and interventions.
  - Monitoring.
  - Supervision.
  - Victim safety issues.

4.4 Transfer and Discharge Planning

- An updated risk assessment must be available before a patient is referred for transfer and discharge CPA. Scenario plans should be reviewed and relevant to the receiving service (if appropriate, for example return to prison setting).
- If requested by receiving services, a draft "traffic light"[10] contingency plan will be completed and agreed by the RMO (or another member of the clinical team designated by the RMO) in advance of the transfer and discharge CPA.
- It is the responsibility of the Social Work department, in conjunction with the RMO, to ensure that all relevant staff of the likely services due to receive our patients are invited to the transfer and discharge CPA. The risk assessor is required to be present in order to lead any discussions with regards to risk assessment and management.
- The VRAMP and the traffic light contingency plan will be discussed and agreed by the attendees at the transfer and discharge CPA meeting and an appropriate care and treatment objectives set at that time.
- In the case of sexual offenders and restricted patients there is a requirement for MAPPA procedures to be followed.

5 DUTIES AND RESPONSIBILITIES

5.1 The RMO is responsible for:

- Ensuring the completion and review of the Initial Risk Assessment and immediate risk management decisions, in conjunction with the SCN.

[10] The "Traffic Light" is the contingency planning documentation proposed by the Scottish Government as part of the CEL (2007) 13 **GUIDANCE FOR FORENSIC SERVICES** (Healthcare Policy and Strategy Directorate Mental Health Division)

- Identification (at the first clinical meeting after the patient's admission) of the member of the Psychology team who will complete the VRAMP including the evidence document(s). On occasions a trainee psychiatrist under the supervision of an appropriately trained and competent psychologist will complete a VRAMP.
- Signing off the final versions of the VRAMP and evidence documents, after any changes agreed.
- Ensuring the VRAMP and "traffic light" contingency plan is available for the transfer and discharge CPA.
- Making notifications and referrals to MAPPA if required. Reference should be made to the MAPPA guidance. The Social Work department provides a single point of contact (SPOC) for MAPPA and can provide advice if necessary.

5.2 The Clinical Team Forensic/Clinical Psychologist is responsible for:

- Identifying an appropriate team member to develop the formulation.
- Identifying a suitably qualified sole assessor and assistant psychologist to assist with file reviews.
- Reaching conclusions regarding overall risk in conjunction with clinical team.
- The conduct and quality of VRAMP risk assessment.

5.3 The Clinical Team Social Worker is responsible for:

- Making available relevant background information to the risk assessor.
- Contributing to risk management planning according to both the Child Protection and Adult Support and Protection policies and guidance and in accordance with their legal duties.
- Contributing to the risk management planning associated with victim safety according to the revised Suspension of Detention guidance.

5.4 Members of the Clinical Team are responsible for:

- Passing on relevant information to assist the risk assessor.
- Reviewing the draft documents when they are completed.
- Attending the clinical team meeting having read the risk assessment evidence document and formulation and be prepared to contribute to the discussion.
- Contributing to the discussion at the Admission CPA meeting.
- Reviewing and agreeing the accuracy of changes made, before sign-off by the RMO

6 SUPPORTING DOCUMENTATION / RESOURCES

- All current templates of the necessary documentation for each part of this process are available on TSH the intranet under 'CPA Documentation' CPA DOCUMENTATION. Some of these WHICH are, or will become available, on RiO. Templates available on the TSH intranet/RiO include:
  - CPA / Care and Treatment plan review (Intranet).
  - Structured professional judgement SPJ templates (such as HCR-20 evidence document) including VRAMP Violence Risk Assessment and Management Profile.
  - Nursing template for CPA review.
  - Psychology template for CPA review, including the formulation template.
  - Social work template for CPA review.
  - Pharmacy template for CPA review.
  - Occupational Therapy template for CPA review.
- Guidance notes for the completion of the CPA care and treatment plan are also available on the intranet.
- HCR-20 manuals are available within all hubs. RSVP and other SPJ Structured Professional Judgement manuals are available for loan from the psychology department.

- Where Structured Professional Judgement (SPJ) tools are used other than the HCR-20, the responsibility for these templates lie with the individuals who are competent in their use.

7 TRAINING

- Training in the use of the SPJ Structured Professional Judgement tools will be available locally in house on a regular basis. This training comprises a one or two day taught course for each tool followed by supervised practice with an experienced practitioner. It is recommended that at least five cases are undertaken under supervision before a sole assessor can be considered qualified to operate independently within on a clinical team.
- A number of professionals may already have expertise in risk assessment and management and in these cases, it may not be necessary for them to undertake supervised practice following the SPJ tool based training.
- One day of training – "Violence Risk Assessment and Management – How can you make a difference?" will be available to all registered professional clinical staff members (nursing assistants are not currently expected to attend this training) to demonstrate how to implement risk assessment and management as part of the CPA treatment planning process. (See CPA document Appendix 1). Attendance at this training is mandatory for all clinical team members.
- This training is designed to help other team members be aware of the risk assessment and management process, increase their knowledge about how to observe and monitor risk related behaviours and thereafter feedback essential information to the clinical team.

8 RESPONSIBILITIES/PROCEDURE

The operational management of the risk assessment and management process is the responsibility of the Mental Health Practice Steering Group.

9 REPORTING

The Mental Health Practice Steering Group will oversee this policy and report to Clinical Governance Group and the Clinical Governance Committee. Targets are set annually for the number of VRAMPs Violence Risk Assessment and Management Profiles to be completed by each hub.

10 EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The Equality

and Impact Assessment (EQIA) considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

The volunteer recruitment and induction process supports volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and / or engage in other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

11 STAKEHOLDER ENGAGEMENT

Following review there have been no changes to current practice required. Therefore stakeholder engagement has not been necessary for the 2024 review.

Key Stakeholders	**Consulted (Y/N)**
Patients	NIA
Staff	N/A
Carers	N/A
Volunteers	N/A

12 COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within the State Hospital via the intranet and through the staff bulletin.

The Mental Health Practice Steering Group will be responsible for the implementation and monitoring of this policy. Ongoing audit of the process takes place as part of the annual Care Programme Approach (CPA) audit.

This policy will be reviewed every three years or earlier if required.

13 GLOSSARY OF TERMS

CPA	Care Programme Approach.
HCR-20^{v3}	SPJ protocol for assessing risk for violence (Douglas, K. S., Hart, S. D., Webster, C. D. & Belfrage, H. (2013) *HCR-20 version 3: Assessing Risk for Violence.* Mental Health, Law & Policy Institute, Simon Fraser University)

ICP	Integrated Care Pathway
MAPPA	Multi Agency Public Protection Arrangements
RATED	The Risk Assessment Tools Evaluation Directory (published by the RMA).
Risk assessment tool	A formal protocol that aids in the assessment of violence risk and that has been published for use with a specific population.
RiO	The electronic patient record system used at the State Hospital
RMA	The Risk Management Authority.
RSVP^{v2}	SPJ protocol for assessing risk of sexual violence. (Hart, S. D., Kropp, P. R., Watt, K. A. *et al.* (2022) *Risk for Sexual Violence Protocol. Structured Professional Judgment Guidelines for Assessing and Management Risk for Sexual Violence.* Protect International)
Sole evaluator	A person with the skill and training to carry out a risk assessment and develop a risk management of an individual patient
SPJ	Structured Professional Judgement approach to risk assessment and management of future violence.
VRAMP	Violence Risk Assessment and Management Profile – the process by which the team identifies and records those risk issues that are important for the management of the patient's future risk of harm to others.
VAT	Variance Analysis Tool

APPENDIX 1: STATE HOSPITAL CPA DOCUMENTATION

STATE HOSPITAL CPA DOCUMENTATION

(any information that may cause serious harm to the physical or mental health or condition of the patient, or any other person; may disclose information relating to or provided by a third party who has not consented to that disclosure unless the third party is a health professional who has compiled or contributed to the health records or who has been involved in the care of the patient, or the third party who is not a health professional gives their consent to the disclosure of that information, or it is reasonable to disclose without the third parties consent should be placed in the Pre CPA Minute)

	[✓]
ADMISSION CPA	
ANNUAL CPA REVIEW	✓
INTERMEDIATE CPA REVIEW	
TRANSFER/DISCHARGE CPA	

Patient Name:
CHI No.:
Date of Meeting:
Date of Next Meeting:

	[✓]
ICP Completed	☐
Pre CPA Minute	☐

CORE DOCUMENTS

Care and Treatment Plan
Multidisciplinary Team and Attendees at CPA
Summary of Discussion

MULTIDISCIPLINARY TEAM REPORTS

Psychiatry	☐
Positive and Negative Syndrome Scale	☐
Nursing/Keyworker	☐
Pharmacy	☐
Dietician	☐
Occupational Therapy	☐
Psychological Services	☐
Security	☐
Skye Centre	☐
Social Work	☐
Other (e.g. Drug & Alcohol, or full report from psychological intervention)	☐
Risk Assessment Evidence Document	☐

PATIENT VIEWS

Advance Statement	☐
Staying Well Plan	☐

RISK MANAGEMENT

Violence Risk Assessment and Management Profile	☐

Risk Management Contingency Plan ☐

CPA DOCUMENT (incorporates Part 9 Care Plan)

*Items marked with a * required by statute for Part 9 Care Plan*

Patient Details			
Name:		Date of Birth:	
CHI Number:		Hospital Number:	
Address on Admission (or Sentencing):			
Marital Status		Occupation	
First Language		Religion	
Ethnic Origin (Standard codes)		White British (A)	
Communication Assistance Required		No	

Relationship Details	**Contact Details**
Named Person:	
Relationship to Patient:	
Primary Carer (if different):	
Next of Kin (if different):	

Service Details		
Date of Admission:	Hub:	01555 840293
Responsible Local Authority:		
Responsible Health Board:		

Legal Details	
Legal Status and Section on Admission	Restricted ☐ Non Restricted ☐
Current Legal Status and Section	Restricted ☐ Non Restricted ☐
Date of Conviction/Insanity Acquittal *	
Date Current Order Began *	
Date of most recent Statutory Review *	
Period during which next Statutory Review must be held (2 month period)*	
Date Sentence Commenced:	
For Determinate Sentences: Earliest Liberation Date/Parole Qualifying Date (For HD/TTD)	
For Life Sentences: Punishment Part	

Driving licence	
Does the patient hold a current driving licence?	Yes/No
If yes, have DVLA been informed of current status? Specify any restrictions in place.	Yes/No

Compulsory Treatment Details			
Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003		1. Detention in The State Hospital 2. Medical treatment in accordance with Part 16	
Advance Statement: If no, was issue raised with patient?	Yes/No Yes/No Date:	Date of T2/T3 Certificate:	
Reasons for decisions or medical treatment which conflict with the Advance Statement.			
Recorded Matters as determined by the Tribunal.			

Patient Subject to Other Legislation		Details and Period of Order
Notifiable under Part 2 Sexual Offences Act 2003 (2) *	Yes/No	
Schedule 1 Notification *	Yes/No	
Risk to Children	Yes/No	
Adults with Incapacity Act (2000). Subject to Welfare or Financial Guardianship	Yes/No	
Adults with Incapacity Act (2000) – Subject to Part IV Management of Patients Finances	Yes/No	
DWP Corporate Appointeeship	Yes	Standard for TSH
Adult Support and Protection (2007) Act	Yes/No	
Power of Attorney	Yes/No	

MAPPA Status	
Is Patient Subject to MAPPA?	Yes/No
Community Justice Authority and local office	
MAPPA Co-ordinator	Name:
	Telephone no.
Level (Unless otherwise indicated, all State Hospital patients will be level 1)	

Safeguarding Adults at Risk	
Is the patient likely to pose a specific risk to an adult at risk of harm?	Yes/No
Is the patient at specific risk of harm from others?	Yes/No
Adult Protection Co-ordinator:	Name:
	Telephone no:
Outcome of Adult Protection Case Conf:	

Details of those involved in CPA

Clinical Team Members		A/✓	Clinical Team Members		A/✓
RMO* (Care Coordinator)			Social Worker		
Specialty Doctor			Psychologist		
Specialist Trainee			Occupational Therapist		
Snr Charge Nurse/NTL			Security Manager		
Advanced Nurse Practitioner			Dietician		
Keyworker			Pharmacist		
Staff Nurse			Other		
Skye Centre			Other		

Patient and Named Person	Name	Date Invitation Sent	Attended Meeting (all/part)
Patient			
Named Person			
Carer/Family/Friend			
Advocacy			
Legal Representative			

Local Area Services	Name, Address and Telephone No.	Date Invite sent	A/✓
General Practitioner			
Local Area Forensic Team Representative			
Designated MHO *			
Police Link			
SPS			
Other			

Index Offence
Details of Index Offence:
Brief statement including reason for admission:
Diagnosis
1. (Primary Diagnosis)
2. (Other Diagnoses)
3.

Strengths and protective factors Outline the factors that contribute to resilience or the absence of the problem
1.
2.
3.
4.
5.

Presenting problems and needs Create a problem list which should include matters associated with any distress for the patient; risk and offending behaviour; physical health concerns and any other significant problems
1.
2.
3.
4.
5.

TREATMENT PLAN RECOVERY OBJECTIVES

Recovery Objective	Interventions from care plan dated (insert date)	Outcome and comments	Revised Action Plan	By whom and by when
1. Improve mental health				
2. Improve physical health and address health promotion				
3. Address any needs associated with diversity (including faith, sexuality, disability and ethnicity) and social inclusion				
4. Address risk assessment and management issues				
5. Tailor security levels and rehabilitation plans to level of risk				
6. Address any family, carer or other relationship issues				

Recovery Objective	Interventions from care plan dated (insert date)	Outcome and comments	Revised Action Plan	By whom and by when
7. Address any issues associated with capacity (e.g. financial and health)				
8. Address rehabilitation and educational needs with a view to enabling Recovery				
9. Address needs associated with personal care and daily living				
10. Address social care and housing needs				
11. Address legal and statutory matters including review of Advance Statement				
12. Develop future plans				

VIEWS AND DISCUSSION FROM MEETING

DISCUSSION OF WEIGHT MANAGEMENT PLAN

VIEWS OF PATIENT

VIEWS OF NAMED PERSON

The Care Plan has been agreed by those present at the multidisciplinary team meeting and signed on behalf of the clinical team

Dr
Specialty Doctor/Trainee
Date signed:

Dr
Consultant (Forensic) Psychiatrist
Date signed:

Distribution List

CPA Portfolio including risk assessment document
RiO, Electronic Patient Record, The State Hospital
Forensic Advisor, Scottish Government
Consultant (Forensic) Psychiatrist in local services
Designated MHO
Social Work Department, The State Hospital (via email)

CPA Core Document only
Patient
Named Person (if permission granted by patient on consent form)

Information collated and typed by:
Date circulated:

1. MDT REPORTS

Professional reports will include recommendations for many potential interventions. The recommendations that are included within the objective section are those that the clinical team have deemed most appropriate to take forward in the next 6 months.

1.1 PSYCHIATRIC – progress update.

Summary of psychiatric input since last review

Recent mental state examination

Side effects of psychotropic medication

Positive and Negative Syndrome Scale Table

Positive and Negative Syndrome Scale Table					
General (G) Factors	**Score (1-7)**	**Positive (P) Factors**	**Score (1-7)**	**Negative (N) Factors**	**Score (1-7)**
Somatic Concerns		Delusions		Blunted Affect	
Anxiety		Conceptual Disorganisation		Emotional Withdrawal	
Guilt Feelings		Hallucinatory Behaviour		Poor Rapport	
Tension		Excitement		Passivity/ Apathy	
Mannerisms and Posturing		Grandiosity		Abstract thinking	
Depression		Suspiciousness/ Persecution		Lack of Spontaneity	
Motor Retardation		Hostility		Stereotyped Thinking	
Uncooperativeness		**P Total**		**N Total**	
Unusual Thought Content		Admission/Baseline score and date of assessment			
Disorientation		General Psychopathology Score (P + N + G)			
Poor Attention		Composite Score (P – N)			
Lack of Judgement and Insight		**Previous Score Date (three most recent)**		**Score**	
Disturbance of Volition					
Poor Impulse Control					
Preoccupation					
Active Social Avoidance		**Completed by:**			
G Total		**Date of completion:**			

Positive and Negative Syndrome Scale Interpretation

Recommendations for Care and Treatment Plan

1.2 PHYSICAL HEALTH – progress update.

Specific chronic problems

Weight		Weight Change since last review	
Waist Circumference		BMI	

	✓
Obesity	
Diabetes	
Chronic respiratory problems	
Dyspepsia/reflux	
Blood borne virus	
Constipation	
High Cholesterol	
Hypertension	

Physical Health Summary

1. Blood tests (to be completed at Annual CPA)

   Full Blood Count:
   LFT:
   U & E:
   TFT:
   Lipid Profile:
   Serum Folate & Ferritin:
   Vitamin D:
   Blood Glucose (random or fasting):
   HbA1c (if diabetic):
   Other:

2. Medical investigations carried out over the last six months (e.g: ultrasound, CT scan, MRI, Echo)
3. Summary of any other hospital admissions during the last six months
4. Latest ECG Report
5. Summary of Annual Health Check (to be completed at Annual CPA)
6. QRISK Score
7. Physical Activity over the Last Six Months (as reported in RiO):
8. Other

Healthy Weight Management Plan

Weight Reduction Interventions to Consider	**Responsibility**	**Recommendations** **Please note if not applicable*
Diet Develop a Nutritional Care Plan, Provide 1:1 Dietary input, Special Diet	Medical / Dietitian	•
Education/Awareness Referral to Healthy Living Group and Healthy Eating Group, participation in Slim and Trim Group	Medical / OT / Skye Centre / Psychology	•
Physical Activity Encouragement or prescription of physical activity, for example: Facilitation of Ward and Hub Activity, Grounds Access, Sports and Gardens placements, animal therapy walks, escorted walks, and use of pedometers	Medical /Nursing/ Skye Centre	•
Pharmacological / Surgical Eg: Metformin, Orlistat, choosing or switching antipsychotic medication with lower propensity of weight gain, and bariatric surgery	Medical/Pharmacy	•

Recommendations for Care and Treatment Plan

Date Report was completed

1.3 KEYWORKER'S EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.4 PHARMACY – EXECUTIVE SUMMARY AND RECOMMENDATIONS

Current Medication

As Required

Sensitivities

High Dose Antipsychotics
Yes/No

% Therapy

Multiple Antipsychotics
Yes/No

Last ECG Date

Qtc (ms) interval

Reference to Medication Changes

Compliance with Consent to Treatment Form

Therapeutic Drug Monitoring

Date	Medication	Dose	Level	Comment

Recommendations from Clinical Pharmacy Report

1.5 DIETITIAN – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.6 OCCUPATIONAL THERAPY (and Other AHP Therapies) – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.7 PSYCHOLOGICAL SERVICES – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.8 SECURITY – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.9 SKYE CENTRE – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.10 SOCIAL WORK – EXECUTIVE SUMMARY AND RECOMMENDATIONS

1.11 MULTI-DISCIPLINARY FORMULATION

Predisposing factors and violence risk factors for illness and risk of harm to others Outline early life factors that make a person vulnerable to particular difficulties which contribute to the origins of the underlying mechanism

Precipitating factors and violence risk factors for illness and risk of harm to others Outline events that are close in time to the development of the problem(s) which may play some role in triggering the problem(s)

Perpetuating factors and violence risk factors for illness and risk of harm to others Outline factors that contribute to the problem being maintained

Summary and Underlying Mechanisms Provide a description of the underlying processes (i.e. psychological, social, medical or other mechanisms that are at work) that describes how the above predisposing, precipitating, perpetuating factors combine to lead to the problems identified

2 VIOLENCE RISK ASSESSMENT AND MANAGEMENT PROFILE

2.1 Violence Risk Assessment

Is there a completed violence risk assessment?	
If yes, note type of assessment and date completed:	
Is assessment attached to this treatment plan?	

Possible living situation in next year or likely future transfer plan	

Description of locality/victim issues (if applicable)	

2.2 Summary (name each item) of SPJ tool used (e.g. HCR-20, RSVP, START etc)

HCR-20	**Definite evidence**	**Possible evidence**	**No evidence**
Historical Items			
Clinical Items			
Risk management Items			

2.3 Scenario Planning

Describe the nature or kind of violence either within The State Hospital or in the community (when transfer, discharge and suspensions of detention are being considered) that the patient may commit, including risk to children.

2.3.1 The State Hospital

Scenario: hub environment		*Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Scenario: unescorted grounds access		*Likelihood/ imminence
Most Likely		

Most Serious		
Other possible scenario (e.g. specific victims)		

Scenario: Skye Centre (consider specific placements)		*Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Scenario: Child contact; SOD; Telephone; Mail; Possessions; Gifts (received and sent); Other		*Likelihood/ imminence
Most Likely Risk		
Most Serious Risk		
Other possible risk		

2.3.2 Other Possible Scenarios

Scenario: e.g. transfer to a reduced level of security; discharge; hospital appointment; rehabilitation or quality of life suspension of detention		Likelihood/ imminence
Most Likely		
Most Serious		
Other possible scenario (e.g. specific victims)		

Likelihood/imminence

*HIGH:	High chance of committing a violent act in situation described – could occur anytime
MEDIUM:	Some chance of committing a violent act in situation described – not imminent but scenario could occur if situation were to change.
LOW:	Little chance of committing a violent act in the situation described – or not in the foreseeable future
VERY LOW:	Almost no chance of committing a violent act in the situation described – scenario described very unlikely to occur.

2.3.3 Warning signs

What warning signs would indicate that this person's risk is increasing or that a violent act may be imminent? List all possible factors.

2.3.4 Risk management recommendations for Care and Treatment plan

Monitoring

- What is the best way to monitor warning signs that this person's risk may be increasing?
- What events, occurrences or circumstances should trigger a reassessment of violence risk?

Treatment

- What treatment or rehabilitation strategies could be implemented to manage the patient's violence risk?
- What deficits in psychological adjustment are high priorities for intervention?

Supervision

- What supervision or surveillance strategies could be implemented to manage the patient's violence risk?
- What restrictions on activity, movement, association or communication are indicated?

Victim safety planning

- What steps could be taken to enhance the security of likely victims?
- How might physical security or self protective skills be improved?

Additional assessments required?

- Detail

2.3.5 Transfer/Discharge or Crisis Management

Risk Management (Traffic Light) Contingency plan required:
Yes/No (If yes, please include with Care and Treatment plan)

2.4 Suicide and self-harm risk assessment

2.4.1 Does the patient have a history of suicide or self-harm? Yes/No
(If yes, provide evidence ;)

Rating	Evidence
Yes	
Maybe	
None	

2.4.2 Are there any current risk factors that might suggest an increased risk of self-harm or suicidal behaviours? (Refer to: *Suicidal Behaviour Awareness and Good Practice (Guidelines 2006)* :

Risk factors associated with illness	
Psychological risk factors	
Behavioural factors	
Organisational factors	

2.4.3 Suicide and self-harm recommendations for the Care and Treatment Plan

2.5 Current risk management strategies

2.5.1 Summary of risk behaviours:

	Historical (✓)	In the last 3 months (✓)
Violence towards others		
Conviction for sexual offence		
Sexually inappropriate behaviour		
Alcohol misuse		
Drug misuse		
Hostage taking		
Absconding or escaping		
Risk of harm to children		
Schedule 1 offence		
Self harm or suicide attempt		
Fire risk		
Use of weapons		
Rooftop incident		
Planning to subvert security and safety		
Severe destruction of property		

2.5.2 Observation level [✓]

When outwith patient bedroom	Standard		Level 2		Level 3	
Patient Bedroom	Locked door (standard)		Level 2		Level 3	

	Yes/No	Detail:
Special measures e.g. seclusion		
Time out / behavioural programme		
Specific adaptation to patient's bedroom		

2.5.3 Drug screen frequency [✓]

Very High – 2 weekly		High - Monthly		3 monthly - Medium		On request	
6 monthly - Low		Annual – Very Low		Other		Random	

2.5.4 Live tailored security measures [✓]

Incoming external mail		Outgoing external mail	
Open, Inspected & Read	☐	Inspected & Read	☐
Open & Inspected	☐	Inspected	☐
Opened in Presence of Staff	☐	Sealed / Unopened	☐

Unsupervised phone calls	Visits	High Supervision
		Medium Supervision
		Low Supervision

Grounds access:			Partial:		None	
			Ward Garden	☐		
			Skye Centre	☐		
			Central Area	☐		
Disassociations:		Last Reviewed:				
Tailored room search:						
Please detail if relevant:						

2.5.5 Suspension of detention risk management

Conditions for most recent outing

Date of outing:

Type of outing:

Number of staff	Handcuffs	Schedule 1 (notification required)	Particular locality/victim issues)

Recommendations for future outings

Type of outing:

Note specific outing conditions (e.g. absconding risk, prior behaviour on outings etc).

MAPPA referral required? Yes/No

Number of staff	Handcuffs	Schedule 1 (notification required)	Particular locality/victim issues)

State Hospital Suspension of Detention High Risk Register
Are special Suspension of Detention arrangements required due to press interest?
Yes/No

2.5.6 Child Protection Summary

Safeguarding Children			
Notifiable under Part 2 Sexual Offences Act 2003 (2)			Yes/No
Schedule 1 Notification			Yes/No
Risk to Children			Yes/No
Subject to MAPPA			Yes/No
Restricted Patient			Yes/No
Treated as Restricted Patient			Yes/No
ISB			Yes/No
Does the patient have contact with own or other children? If yes detail			Yes/No
Child's Name	Date of Birth	Relationship	
Does the patient present a risk to children?			Yes/No
Social Work Contact	Social Worker:		
	Hub:	Ext:	
Summary of child contact assessment (*highlight any areas of concern/risk/or history):*			

2.6 Predisposing factors for risk of harm to children Outline early life factors that make a person vulnerable to particular difficulties which contribute to the origins of the underlying mechanism		
	Detail	**Date**
1. Notifiable under Part 2 Sexual Offences Act 2003 (2)		
2. Schedule 1		
3. Risk to Children (evidence)		
4. Risk to Children (concern/issues)		

2.7 Precipitating factors for risk of harm to children Outline events that are close in time to the development of the problem(s) which may play some role in triggering the problem(s)		
		Detail
1. Mental Health		
2. Child Visits		
3. Home Visits/Outings		
4. Telephone Contact		
5. Mail (letters and cards)		
6. Possessions (mail/photographs/posters/magazines/DVDs)		
7. Gifts In/Out		
8. Other (specify)		

2.8 Perpetuating factors risk factors for risk of harm to children Outline factors that contribute to the problem being maintained		
	Yes/No	Detail
1. Mental Health		
2. Fantasies re Children		
3. Statements about Children		
4. Child Visits		
5. Home Visits/Outings		
6. Possessions (mail/photographs/posters/magazines/DVDs)		

7. Gifts In/Out		
8. Other (specify)		

2.9 Levels of Security and future plans

What is the least restrictive environment that this person could be managed in currently? Describe level of supervision and security needs. Give reasons for special security.

2.10 Future Plans	
Is patient being considered for transfer?	**Yes/No/N/A**
Has a Transfer/Discharge CPA referral been made?	**Yes/No/N/A**
Give details of future plans.	

The VRAMP has been agreed by those present at the multidisciplinary team meeting and signed on behalf of the clinical team

3. ADMISSION HISTORY

Sources of Information for Admission History

Reason for Admission

Mental State Examination on admission

Past Psychiatric History

Past Forensic History

Family History

Personal and Social History

Allergies

Past Medical History

Previous Head Trauma
Does the patient have a history of TBI that resulted in loss of consciousness? **Yes/No**

Does the patient have a history of TBI that led to hospital admission? **Yes/No**

Drug and Alcohol History

Medication on Admission

Physical Examination on Admission

Mini Mental State Examination on Admission

Investigations at time of Admission

Summary/ Formulation on Admission

Differential Diagnoses on Admission

- Including factors for and against each, predisposing, precipitating and perpetuating factors.

Progress Update (to be updated at every CPA review)

Dr
Specialty Doctor/Trainee
Date signed:

Dr
Consultant (Forensic) Psychiatrist
Date signed: