Independent Investigation into SUI 2006/4924

June 2009

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Michael Clarke, Consultant Psychiatrist, Assertive Out Reach
- Mr Jess Liversley, Commissioning & Development Manager (mental health/learning disability), NHS East of England Public Health Directorate
- Dr Mary Jackson, Consultant Clinical Psychologist and Associate, Consequence UK Ltd

Acknowledgements:
The Investigation Team wishes to thank all of the staff at Leeds Partnerships NHS Foundation Trust who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide on 25 July 2006.

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EXECUTIVE SUMMARY

Intention

This report sets out the findings of the independent Investigation Team following its analysis of the care and treatment of a mental health service user (MHSU), who was involved in an incident of homicide on 25 July 2006 and subsequently sentenced on 13 December 2006 to life imprisonment with a stipulation that he serve seventeen years before being eligible for parole.

Purpose

The purpose of the work commissioned was to assess:

- The care and treatment the MHSU was receiving during the period leading up to the incident and at the time of the incident (that is, from February 2006 to 25 July 2006).
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The adequacy of the risk assessment and care plan and their use in practice.
- The exercise of professional judgment and clinical decision making.
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs.
- The extent of services' engagement with carers and the impact of this.
- The quality of internal investigation and review.

Outline of the review process

To deliver the above the following activities occurred:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A series of interviews with the NHS, probation and voluntary sector staff (from the charity Touchstone) who had been engaged in the care and management of the MHSU, or were responsible for the provision of services.
- A round-the-table discussion with a selection of staff working in in-patient services.
- A semi-structured survey of staff.

- Analysis of the interview data using the qualitative research methodology of content analysis and affinity mapping[1].

Main conclusions

As a result of this review the main conclusions are:

- That the incident that occurred on 25 July was neither predictable nor preventable by the mental health services nor any other agency who had had involvement with the MHSU.
- Between 2002 and May 2006 the MHSU's care was of a reasonable standard.
- Between 16 May and 6 June 2006 there was a breakdown in communication between the mental health service, the court liaison service and the prison service which resulted in the MHSU not receiving the mental healthcare he should have whilst in custody between 16 May and 5 June and then in prison between 6 June and 14 July 2006.
- That on discharge from prison back into the community, as far as the Investigation Team has been able to ascertain, the MHSU was not discharged back into the care of a care coordinator. He was an enhanced care programme approach (CPA) patient when he was discharged from hospital services in May 2006, and he should have had a designated care coordinator who followed him up while in prison. This individual should have been aware of his discharge date so that community mental health services could be reinstated.
- At the time of the MHSU's final contact with mental health services on 19 and 20 July 2006 the decision not to admit him to hospital was reasonable.
- The non-communication by the Crisis Resolution and Home Treatment Team (CRHT) to the MHSU's care coordinator following his assessment in A&E, whilst constituting a slip in practice, did not (in the opinion of the Investigation Team) contribute in any way to the events that subsequently occurred. The CRHT had referred the MHSU to the Leeds Addiction Service (LAU), and had provided the MHSU with all of the necessary contact details for this service. There is no record that the MHSU made independent contact with the LAU.

[1] Affinity mapping is a way of sorting large amounts of data into logical groups. Consequence UK uses it to map interview data content against the main care concerns identified in an investigation.

Main recommendations

The Investigation Team has five recommendations for Leeds Partnerships NHS Foundation Trust, and two for NHS Leeds (formerly Leeds PCT).

Recommendations for Leeds Partnerships NHS Foundation Trust.

- When a service user is arrested and a custodial sentence is passed it is important that the specialist mental health service ensures that the responsible prison healthcare team is aware of any relevant mental health history, including the care plan and risk assessments. This responsibility is held regardless of the location of arrest, e.g. hospital or community.

  The challenge for the specialist mental health service is how it becomes aware of the arrest and subsequent custodial disposal so that it can discharge its duty of care to the service user.

- Cases will continue to arise where more than one agency is involved with a service user (such as probation, voluntary agencies and secondary mental health services), and a decision is being taken by a mental health care coordinator, following an initial referral assessment, as to whether input by the community mental health team (CMHT) is required. In such cases this professional must ensure that he or she has a complete understanding not only of the engagement of the other agencies, but also of the degree of engagement of the service user with these agencies, and the communication strategy should significant changes in the service user's circumstances arise.

- The trust does need to achieve a position where all staff responsible for assessing whether or not an individual requires specialist mental health services also consider whether the individual ought to be referred to other services, for example to the local authority for a Section 47 Assessment.

  This recommendation is inextricably linked to recommendation 1.

- From time to time service users receiving active input from the trust will be arrested and placed in custody at the direction of the courts pending trial, or as a result of trial and/or sentencing. Where the trust is aware of a service user being awarded a custodial sentence, in such cases the trust needs to ensure that all staff who carry care coordination responsibility understand that it is their responsibility to continue to oversee the delivery of any required mental health service to the service user, and ensure continuity of care planning arrangements.

- All CMHTs, regardless of directorate, are required to maintain clear and auditable minutes of their weekly team meetings.

Recommendations for NHS Leeds Prison Health Services

- The head of prison healthcare must ensure that the current approach to the monitoring and audit of documentation is reviewed. The Investigation Team suggests that a peer-review approach is considered to enable health staff to reflect on the quality of their documentation and whether or it accurately portrays:
  - care and treatment given;
  - the names, positions and agencies of persons providing third party information; and
  - information relayed to third parties.

- It is recommended that NHS Leeds prison healthcare services reconsider the current design of the form it issues to general practitioners seeking health based information about new inmates.

  The current form is not particularly directive and does not state clearly the importance of the information provided to enabling the provision of appropriate healthcare to a new inmate.

1.0 BACKGROUND

On 25 July 2006 it appears that the MHSU was in a private house with a group of men who were under the influence of alcohol and/or illicit drugs. It is believed that a fight broke out and as a result one of the men died. Two men were subsequently arrested and convicted for the murder of the victim. One of these was the MHSU.

At the time of the incident the MHSU had a diagnosis of emotionally unstable personality disorder. Individuals with a personality disorder are highly complex and challenging to manage. They often do not engage with services that can assist them in achieving a manageable lifestyle. Many of the behaviours enacted by this MHSU and thus portrayed in this report are typical of someone with a personality disorder. An important example of this is this MHSU's persistent lack of engagement with any service, except where there appeared to be a direct benefit to his immediate circumstances. For example, his tenancy at his supported accomodation required him to engage with "STOP", an anger management workshop. This he did. However this is one of the only examples of the MHSU engaging in any therapeutic activity that may have enabled him to have a more manageable life.

Outline chronology

The earliest records relating to the MHSU accessed by the Investigation Team were his GP records. These note that there were social problems in his family in 1984, a year after his birth. The records also reveal that by 1987 he had been placed in foster care. In 1994 it is noted that he suffered from neurofibromatosis (Von Recklinghausen's disease). It is also noteworthy that the MHSU was prescribed Fresubin[2] (a food supplement drink) in February 2001. However the reason for this is not known. What is clear from the GP records is that the prescription was a one-off prescription and occurred soon after his registration with the practice involved.

In 1999 the GP records note his first overdose with co-proxamol and paracetamol.

The first reference to 'personality disorders' is in June 2002 when the MHSU was 19 years of age.

The analysis of the GP records also shows that the MHSU frequently changed his GP practices. This is not uncommon with individuals who have no stable home life, engage in low level criminality and have personality disorder issues. The GP records also reveal that the MHSU

[2] This is relevant because in February 2006, when the MHSU registered at the New GP practice, he reported being on food supplements. Subsequent analysis of his previous GP records revealed no contemporary history of such prescriptions. Furthermore supplementary drinks apparently have 'street value' and are sold to raise money for the purchase of illicit drugs.

was given to exaggerating his medical problems. This too is not uncommon with individuals with a personality disorder.

Examples of the diagnoses that the MHSU claimed to have but for which the Investigation Team has seen no evidence are:

- spina bifida;
- eating disorder;
- bowel cancer; and
- epilepsy.

There is also a theme of chronic back problems for which the MHSU wanted to be 'permanently on the sick' in March 2005.

The MHSU's habit of fabricating or 'colouring in' his past history continued throughout his short contacts with mental health services. This means that at times his history appears confusing and inconsistent. This is not uncommon in the reported history of an individual with personality disorder.

Overview of the MHSU's contact with mental health and probation services

2002: In 2002 the MHSU, as far as the mental health service was aware, had no known custodial sentences but had been to court for breach of the peace, stealing cars and assault.

6 June 2002: The MHSU's first contact with mental health services followed a self harming event where he took a small amount of temazepam. The precipitator to this was the breakup of his relationship with his then girlfriend.

The plan was to offer him an outpatient appointment the following day with a consultant psychiatrist. The MHSU was not satisfied with this and refused to leave the Clinical Decisions Unit unless he was admitted to hospital. He was subsequently admitted.

10 July 2002: The MHSU was discharged from inpatient services. The general opinion at this time was that the inpatient stay had been of no significant therapeutic value to this MHSU. Furthermore the staff had seen no evidence of mental illness in him. The diagnosis for the MHSU at this time was Emotionally unstable personality disorder, impulsive type (ICD-10 classification F60.30).

Following his discharge the MHSU presented at A&E on a number of occasions reporting self-harming behaviour. Following one of these attendances in August 2002, a decision was made not to admit the MHSU and he was informed of this. As a result of this information the MHSU left the interview. This was his last contact with mental health services until July 2003.

July – September 2003: During this period the MHSU's presentation, and the nature of his contacts with the mental health services, was not dissimilar to that of 2002.

September 2003 – May 2006 : The MHSU had no contact with mental health services during this time. However he was in contact with the National Probation Service for West Yorkshire (see detailed chronology in Appendix 1, page 67).

February 2004: The MHSU was given a twelve-month community supervision order (CSO). By May 2004 this had been revoked, and the MHSU was given a six week custodial sentence as he had been non-compliant with the terms of his CSO.

October - November 2004: The MHSU advised the probation service that he had begun self-harming. In November 2004 he falsely imprisoned his then pregnant girlfriend. He was arrested for this and bailed to a nominated hostel.

January 2005: The MHSU was given another custodial sentence, with a time period of ten weeks, for breach of his CSO. Because the sentence was for less than 12 months, and the MHSU was now over 21 years of age, probation input ceased upon sentencing.

July 2005: The MHSU was again detained for two months following another assault. As previously, because of the length of sentence and his age, there was no statutory probation input.

August 2005 – February 2006: There is then a seven month gap in his contacts with any service.

February 2006: The MHSU was referred by his then GP for a psychiatric assessment. The context of this was a 'new patient' assessment.

20 February 2006: The MHSU did not attend his psychiatric outpatient appointment. A request was therefore made by the medical team for one of the community psychiatric nurses (CPNs) to visit the MHSU at his place of residence.

20 March 2006: The MHSU failed to make himself available for a planned assessment with the CPN. This visit had been rearranged following cancellation of the planned visit on 13 March.

27 March 2006: The MHSU met with the CPN and an assessment was carried out.

Following this assessment a decision was made that CMHT involvement would add no additional benefit to the MHSU, than was already being afforded him via the probation service and the support of

staff at the supported accommodation hostel (the hostel) run by the charity Touchstone. However a further appointment was made for a consultant psychiatric assessment. The MHSU did not attend this, even though the CPN went to collect him from his residence.

April 2006: The MHSU was evicted from the Hostel for the use of illicit drugs on the premises. He also advised his GP that he would register with the homeless team as he did not know where he would be living.

3 May 2006: The MHSU presented at A&E following attempted self harm. His presentation in A&E was such that following an assessment by the duty psychiatric senior house officer (SHO) a member of the CHRT was asked to assess him. This assessment led to his admission to in-patient services at the Becklin Centre.

11 May 2006: A Multi Agency Public Protection Arrangements (MAPPA) meeting was held[3]. As a result of this meeting, and because the MHSU was again non-compliant with his supervision order, a warrant was issued for his arrest.

16 May 2006: By arrangement with the police, probation service and the Becklin Centre, the MHSU was arrested at the point of discharge from the Becklin Centre. He was taken into custody. He received a four-month custodial sentence and was sent to HMP Leeds.

14 July 2006: The MHSU was released from HMP Leeds.

19 July 2006: The MHSU attended at A&E on 19 July 2006 reporting that he had suicidal thoughts and was hearing voices. He was again assessed by the CHRT. The output of this assessment was that the MHSU did not require admission to hospital. He had no active thoughts of harm to self or others. He was expressing a wish to engage with the Leeds Addiction Unit and a referral to the LAU was made. The MHSU was also provided with all of the contact details for the LAU.

25 July 2006: The incident occurred.

Note:
The police domestic violence unit (DVU) became aware of this MHSU in 2002. When the probation service contacted the DVU in April 2006, it had records of 12 callouts on domestic violence issues dating back to 2002, and these records informed the probation service's risk assessment. Statements in the 2006 prison health records imply that this MHSU presented a risk to women in general, but this appears not to have been the case. None of the staff the Investigation Team spoke

[3] The behaviours and risks posed by this MHSU were not of the severity usually associated with individuals for whom a MAPPA meeting is called. However in view of his non-engagement with the probation service and the ongoing risk posed to his then girlfriend it was considered appropriate to hold such a meeting.

to thought this MHSU was a risk to anyone other than his girlfriend and therefore his child.

The MHSU's forensic history

Between 1997 and 2003 the MHSU had the following convictions:

- 7 offences against the person (1999 – 2006);
- 9 theft and related offences (1997 – 2004);
- 1 public disorder offence (2003);
- 2 offences relating to police/courts/prisons (2004); and
- 1 offence relating to a firearm/shotgun/offensive weapon (2002).

He also had two warnings/cautions relating to:

- 1 offence against the person (1996); and
- 1 public disorder offence (1999).

The convictions/cautions relating to offences to another person were:

- assault occasioning actual bodily harm on 6 December 1996 (caution);
- common assault on 8 February 1999 (12 months conditional discharge);
- battery on 10 October 1999 (supervision order);
- battery on 9 September 2004 (community rehabilitation order subsequently revoked, imprisoned);
- battery on 3-4 November 2004 (imprisoned);
- battery (x2) on 27 February 2005 (imprisoned);
- battery on 7 December 2005 (suspended sentence).

PLEASE SEE APPENDIX 1 (page i) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU'S CONTACTS WITH MENTAL HEALTH SERVICES

2.0 TERMS OF REFERENCE

The terms of reference for this Independent Investigation set by Yorkshire and the Humber Strategic Health Authority (the SHA), in consultation with Leeds Partnerships NHS Foundation Trust, NHS Leeds and Consequence UK, were:

To examine:

- The care and treatment the service user was receiving at the time of the incident (including that from non-NHS providers such as voluntary or private sector providers if appropriate.
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The adequacy of the risk assessment and care plan and their use in practice.
- The exercise of professional judgment and clinical decision making.
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs.
- The extent of services' engagement with carers and the impact of this.

To identify:

- Learning points for improving systems and services; and
- Developments in services since the user's engagement with mental health services and action taken since the incident.

To make:

- Realistic recommendations for action to address the learning points identified so as to improve systems and services.

3.0 METHODOLOGY

This was a targeted investigation of the care and management of the MHSU, concentrating on the period between February 2006 and the date of the incident on 25 July 2006.

The specific investigation and analysis tools utilised were:

- The *Consequence UK Ltd Structured Timeline*;
- simple gap analysis;
- interviewing; and
- round-the-table discussion (open and structured).

The primary sources of information used to underpin this review were:

- the MHSU's mental health records held by Leeds Partnerships NHS Foundation Trust;
- the MHSU's GP records;
- a report provided by Leeds Probation Service;
- the prison healthcare records – electronic summary February 2005-June 2007;
- the psychiatric and psychology reports prepared for the MHSU's defence in court;
- Leeds Partnerships NHS Foundation Trust staff engaged in the care and management of the MHSU;
- staff at Leeds Partnerships NHS Foundation Trust who were not actively engaged in the MHSU's care and treatment but who could provide valuable insight into key systems and processes, for example prison in-reach and psychological services;
- managers of the CRHT;
- staff employed by Touchstone who were engaged with the MHSU;
- staff working for Leeds Probation Service who either had case management responsibility for the MHSU or managerial responsibility for those staff;
- the manager of prison healthcare; and
- local and national guidance documents.

4.0 CONTACT WITH THE FAMILY OF THE MHSU AND THE FAMILY OF THE VICTIM

At the commencement of the investigation the Investigation Team wrote to the MHSU advising him of the investigation, offering him the opportunity to meet with the Investigation Team and seeking his permission to have access to his medical and police records. The MHSU did respond to this communication. Although he expressed no wish to meet with the team he did give his consent to its having access to his records.

A letter was sent to the mother of the MHSU inviting her to make contact, and offering the opportunity to meet with the Investigation Team. No response to this correspondence was received.

Further correspondence via 'signed for delivery' was sent to the MHSU in January 2009 advising that the investigation was nearing completion, and again offering the opportunity to meet with the investigation team to go through the report. At this time the MHSU was also asked if he would provide further contact details for his family.

No response to this correspondence was received.

Involvement and engagement of carers
The MHSU was estranged from his family during the time he was in contact with specialist mental health services so there was no opportunity to engage the family of this MHSU. This issue is therefore not explored within this report.

5.0 FINDINGS OF THE INVESTIGATION

The terms of reference for this investigation required the Investigation Team to:

- Assess the adequacy of the care and treatment of the MHSU by the then Leeds Mental Health Teaching NHS Trust (LMHTT) in the period leading up to the incident.
- Assess the adequacy of communications between LMHTT and any other organisation engaged with the MHSU.
- Take a view with regard to the predictability and preventability of the incident that occurred on 25 July.
- Comment on the trust's own internal investigation.

This section of the report therefore sets out the Investigation Team's findings in relation to these issues. However, before addressing the above, the Investigation Team believes it important to note some particular areas of good practice in the service offered to the MHSU.

5.1 The appropriateness of the MHSU's care and treatment – positive feedback.

There were a number of notable elements of good practice in the service offered to this MHSU. These were:

- It is notable that that this trust did not exclude the MHSU from the mental health service once a diagnosis of personality disorder was made. Exclusion from some services was not uncommon at this time.
- 14 June 2002: there is good evidence of liaison between the mental health service and a voluntary agency.
- June 2002: the MHSU was encouraged to take responsibility for himself and not to develop unhealthy dependency on others.
- 20 June 2002: the key worker document and plan are of good quality. They show that the views and opinions of support workers were valued.
- June 2002: one gets a real sense from the records that consultant psychiatrist 1 (CP1) and his team did try and help this young man. He was in hospital for three weeks. Efforts were made to sort out his housing needs and also to encourage him to engage in counselling. He was also referred to the occupational therapy (OT) service.
- The MHSU was provided with the contact details of an organisation called Archway which was located in his catchment area at the time. It was an organisation set up

purely for young people offering support, activities and counselling. CP1 advised the Investigation Team that they would involve Archway in the care plan for younger people, as mainstream psychiatry is not always in the young person's best interests.

- July 2002: the discharge of the MHSU was in his best interests. Although he was threatening to harm himself, the Investigation Team is satisfied that he was developing an unhealthy reliance on the ward staff and that these threats were in keeping with an individual who is trying to manipulate the situation to gain a desired outcome. To have maintained the MHSU as an inpatient would have been questionable therapeutically.
- Mid-July 2002: there is evidence of effective cross-team communications between the psychiatric liaison service and CP1 in mid-July 2002 when the MHSU was frequently attending in A&E. This enabled consensus management to occur.
- July 2003: bloods were taken for toxicology screening. This shows that the use of illicit drugs was on the minds of professionals even though this was not explicitly stated.
- February 2006: a good rapport between the MHSU and his key worker at the Hostel was reported. The Investigation Team were impressed by this individual's clear recollections and knowledge of the MHSU and the methods utilised to effect positive engagement with him. The information she provided to the Investigation Team demonstrated clearly that with the right inducements, it was possible to engage this MHSU in therapeutic activities[4].
- February to the end March 2006: the efforts of the CPN to try and facilitate the MHSU's attendance at outpatients for psychiatric assessment are notable, as are his efforts to try and assess the MHSU himself.
- May 2006: the MHSU's admission to the Becklin Centre was appropriate given his clear threats of harm to self and others at the time.
- The MHSU's reported diagnosis of epilepsy was explored. It was only discounted after appropriate medical examinations and not merely because of the personality disorder diagnosis.
- May 2006: The coordination of the MAPPA meeting as a means to expedite his custodial sentence and contain the risk

[4] It is notable that following the incident in July and his imprisonment, this MHSU was soon appointed to a job within HMP Leeds prior to his transfer to HMPO Garth. He also trained with the Samaritans as a 'listener'.

he posed to his girlfriend and child[5] was sensible. It is also noted that although the CPN could not attend he did compile a report for probation which they were appreciative of.

- 15-16 May 2006: There was good cooperation of in-patient services with probation services, for example, delaying the MHSU's discharge so that a warrant for his arrest could be served and acted on at discharge.

5.2 The Investigation Team's findings in relation to the terms of reference

Because the Investigation Team have no criticism of the MHSU's care and management between 2002 and 2003, the period of care that is included in the following analysis of the MHSU's mental health care and treatment is February 2006 to 25 July 2006.

In order to deliver the terms of reference the Investigation Team agreed that there were a number of questions that needed to be answered. These were:

- 5.2.1 Was the care and management of AW reasonable? In answering this question we focus on:
  - 5.2.1.1 Staff's efforts to engage him following his re-referral to mental health services in February 2006.
  - 5.2.1.2 The management of his personality disorder.
  - 5.2.1.3 The quality of the MHSU's mental health care following his arrest on 16 May and his subsequent release from HMP Leeds in July 2006.
  - 5.2.1.4 The assessment undertaken in A&E and by the CRHT on the last occasion he was seen by mental health services in July 2006.
- 5.2.2 Were staff cognisant of his risks and were appropriate measures taken to enable the containment of these?
- 5.2.3 Were the communications between health, primary care, the probation service and the voluntary sector appropriate and effective in relation to essential information exchange?
- 5.2.4 Were the boundaries of responsibility between health, the probation service and the voluntary sector clear, in relation to who was taking the lead in coordinating the monitoring of the MHSU?

[5] There is some uncertainty regarding the number of children this MHSU had. The probation records refer only to one daughter. The Investigation Team understands that at no time was the child thought to be at direct risk from the MHSU. She was not on the 'at risk register' and it is the Investigation Team's understanding that her mother was thought to be sufficiently 'street wise' and informed to be able to appropriately protect herself and her daughter.

- 5.2.5 Were there effective communications between secondary care inpatient services, the primary care service and the prison in-reach service in HMP Leeds in May 2006?

The Investigation Team's findings in relation to each of these questions are detailed in the following pages of this report.

5.2.1 Was the care and management of AW reasonable in 2002–2003 and then again in 2006?

Overview
As previously stated the care and management of this MHSU was of a reasonable standard between 2002 and September 2003 and an in depth analysis of this period of his contact with mental health services was not considered necessary.

However, it is clear from the clinical records, and from the interviews undertaken with trust staff, that he was a challenging individual to engage. There is sufficient documentary information to show that staff did offer him a range of therapeutic activities and appropriate follow up in outpatients. The MHSU persistently did not engage with the opportunities offered to him.

Such non-engagement was not unusual for him, as his contacts with the probation service revealed. With this service there were clear inducements for the MHSU to engage with what was required of him, but on numerous occasions he did not, resulting in the revoking of his community service order on at least two occasions and subsequent short custodial sentences.

With regards to the MHSU's care and treatment between February 2006 and July 2006, although much of the professionals' contact with him was of a reasonable standard, there were some aspects that the Investigation Team feels could have been better. The discharge of the MHSU from the Becklin Centre and the subsequent lack of communication with the prison in-reach team by his care coordinator are examples of this.
For ease of reading each of the bulleted points 5.2.1.1 to 5.2.1.4 (tabled on the previous page) are individually dealt with below.

5.2.1.1 Staff's efforts to engage him following his re-referral to mental health services in February 2006.

This question will be examined from the perspective of each of the agencies involved in turn.

General practice
The MHSU was re-referred to the mental health service in Leeds on 1 February 2006. The reason for this was primarily because the MHSU was a new patient to The GP practice and on review of his existing general practice (GP) records it was apparent to his new GP that he had not been assessed by the mental health service for over two years. Prior to this date the MHSU had moved GP practice approximately every six months for approximately two years.

However, the GP was also concerned about the MHSU and hoped that the community mental health team would take him on. The MHSU fell into her category of persons who "may have some serious mental illness". The MHSU's GP recalled that he had a range of "wants" including the prescribing of Fortisip that he said he had been prescribed before. She was not entirely convinced as he looked to be a fit healthy young man. However she did provide him with a limited prescription for this. Fortisip, she advised the Investigation Team, has a resale value on the street. Proceeds from its sale are known to be used to purchase illicit drugs.

A tactic her surgery uses to try and engage with individuals who they believe will be challenging to engage with is to offer limited prescriptions. This way the GP practice can encourage re-attendance every two weeks. This was the rationale with this MHSU. Unfortunately when his previous GP records arrived at the The new GP practice, it became apparent that he had never been prescribed Fortisip. This prescription was therefore ceased immediately. The GP recalls the MHSU not being very impressed by this course of action. He did re-attend the surgery on 7 April 2006, again requesting Fortisip, and tried to get it from two other GPs. He was not successful in obtaining a prescription.

The MHSU's last contact with the surgery was on 27 April 2006, after his eviction from the hostel. He advised the surgery that he was going to register with the homeless team.

Specialist mental health services
The MHSU was offered an appointment with a specialist registrar (SpR) for 20 February. He did not attend this appointment. Consequently the SpR discussed the situation with his supervising consultant psychiatrist (CP2) and a decision was made to write to the CMHT requesting that a home assessment be undertaken.

An experienced community psychiatric nurse (CPN) was assigned to undertake the assessment and the MHSU was offered an appointment on 13 March. The MHSU cancelled this but another was made. When the CPN attended the Hostel where the MHSU was living, he was not available. Another appointment was made, with the support of the hostel staff, for 27 March when the CPN did manage to meet with the MHSU at the hostel.

The correspondence from the CPN to the consultant psychiatrist following this assessment sets out information that the MHSU revealed to him and to the student nurse accompanying him. The correspondence notes that the MHSU:

- complained of ideas about hurting people;
- said he often had nightmares and once woke up with a spanner in his hand;
- said he had had voices arguing in his head since he was 17 years old;
- reported that he believed people could read his mind; and
- said that the voices in his head told him to hurt himself. As a consequence he had previously cut himself and taken overdoses of medication.

The letter also notes that the MHSU gave a history of spending most of his life in care and of having anger issues. He could apparently "flip at owt" and was scared of "lashing out and hurting people" especially as he now had a "little girl to think about".

During the assessment the MHSU admitted to the CPN that he had previously assaulted his father and, two years previously, his girlfriend. At the time of the meeting he was on a Community Supervision Order (CSO).[6] The MHSU admitted to having a police record which noted at least six assaults.

At the end of the letter it is noted that the MHSU had an appointment with the SpR on 10 April and it is also stated that "no role has been identified for the CMHT in his care".

The correspondence does not detail the impressions the CPN had of the MHSU nor provide any rationale for why he did not perceive there to be a benefit to the MHSU of CMHT input.

How the CPN formulated the decision was therefore of interest to the Investigation Team. The CPN advised the Investigation Team that the assessment process followed a reasonably standard format that covered:

- A consideration of the presenting problems. A service user would be encouraged to describe why they wanted CMHT input.

[6] Community Supervision Order

- Finding out about a service user's past history - medical, risk, forensic, and personal.
- Finding out about how a service user likes to spend their day, or simply how they spend their day.
- Gaining an understanding of how a service user copes with problems and difficulties, and whether they have any coping strategies.

To try and validate any information collected it would be usual for contact to be made with persons who were significant in an individual's current situation, where the service user gave permission for this.

In the case of this MHSU, the CPN advised that he did recall speaking to the Hostel staff before and after his assessment of the MHSU, as he needed their support in arranging to see him and also to get an insight into his risk issues and history. In this particular case the CPN did not feel it was necessary to seek the MHSU's permission to talk with his father, as he believed he had sufficient information from his communications with the Hostel and the MHSU himself.

The CPN told the Investigation Team that had he been concerned about the MHSU's forensic history, or thought that information was being withheld, there was a risk management officer employed by the trust who would have contacted the police on his behalf to find out more. In this case the MHSU spoke openly about his police record so this was not necessary.

With regards to the CPN's rationale for not offering further CMHT support to this MHSU, he advised that:

- The MHSU's mental health issues were not defined and that he needed further psychiatric evaluation.
- His housing needs were being managed by Touchstone.
- The MHSU did not want to be involved in any activities.
- He, (the CPN) did not believe he could add anything to what Touchstone and the probation service were offering the MHSU.
- The MHSU was seeing the Citizen's Advice Bureau about his benefits.
- The MHSU was going to be receiving advice about self harm from a support worker at the Hostel.
- The MHSU's anger management issues were being dealt with by an attendance at a "Start Treating Others Positively" (STOP) course.
- The MHSU had a crisis plan to contact the CPN or the duty worker at St Mary's House during office hours. Out of hours

the MHSU was to contact the crisis team via NHS Direct. This plan was open to the MHSU's key worker at the Hostel and also the probation service.

Given the circumstances of this MHSU, the CPN believed it to be appropriate that the agency that held responsibility for oversight of what was happening with this MHSU was the probation service.

The CPN did highlight to the Investigation Team that the decision not to offer CMHT input to the MHSU would not have been a decision made in isolation. The routine in the CMHT is to take information from all new assessments to the Wednesday team meeting and to discuss the merits of CMHT input there. The CPN can recall no reason why this established practice would not have occurred in the case of this MHSU. Unfortunately the Investigation Team were not able to validate this as minutes of the weekly team meeting were not kept at this time.

The CPN was aware that the MHSU would benefit from further psychiatric assessment, but he (the MHSU) had refused to be seen. In the judgment of the CPN (who had assessed the MHSU), at this stage there were no grounds to conduct an assessment under the auspices of the Mental Health Act. The Independent Investigation Team concurs.

Although the CPN determined that the MHSU did not require CMHT input, he did continue to try and support the MHSU by offering to transport him to his planned psychiatric assessment. He also liaised further with the probation service on 7 April, agreeing to advise the probation service of the outcome of the MHSU's psychiatric assessment. The CPN also wrote to the probation service on 18 April to notify it that he would not be involved with the MHSU and that no CMHT service was being provided to him. He also provided a report to the probation service in lieu of his attendance at a MAPPA meeting to discuss this MHSU as he was to be on annual leave on this date. This represents good practice and was noted as such by the probation service.

Medical assessment

The investigation team spoke with the SpR who first sent the MHSU an appointment and the consultant psychiatrist who was to have assessed him on 10 April 2006. It was the opinion of both doctors that the assessment and perspective of the CPN was reasonable. Furthermore if on medical assessment it was considered that CMHT follow up would be desirable, then this would have been instigated. Unfortunately the MHSU declined to attend for any medical assessment.

Because of the MHSU's lack of engagement with the mental health service, CP2 communicated verbally and in writing to the probation service that he considered that a referral to the Personality Disorder

Clinical Network (PDCN)[7] might be appropriate. Because of the probation service's statutory involvement with the MHSU, he considered that suggesting this to them was a reasonable way forward as the PDCN did accept referrals from the probation service. As CP2 had never seen the service user (in spite of repeated attempts to do so) it was not appropriate for him to refer the MHSU himself. The referring professional should be the one who had seen the MHSU or had regular contact with him.

The PDCN also requires the service user to attend for meetings and to make some effort to engage with the service. CP2 told the Investigation Team that he is not convinced that, even had he made a referral to the PDCN himself, the MHSU would have engaged if offered an appointment. This however would not have deterred him from making a referral had he had the opportunity to assess the MHSU.

Comment: Although it was unlikely that the PDCN would have offered the MHSU an appointment given his clear unwillingness to engage with the community mental health service at this time, and the Investigation Team agrees that the actions of CP2 were reasonable given the circumstances at the time, we are of the opinion that to have sought direct advice from the PDCN may have been prudent.

Touchstone Housing (providers of 'the Hostel' accommodation)
The key worker[8] for the MHSU recalls that he was referred from Pennington Place, an emergency access hostel. The referral date was 13 January 2006. He was subsequently assessed on 18 January and he moved into one of the rooms at the Hostel on 24 January. The basis for him being offered accommodation was anxiety and depression. He was also considered to be at some risk of self harm and of becoming homeless. The MHSU was resident at the Hostel until 10 April 2006.

The MHSU's key worker told the Investigation Team that from the moment he arrived at the Hostel it was clear that he had anger issues. This was, she reported, self-evident from his interactions with other clients. She advised the Investigation Team that it is the practice of the staff at The Hostel to support a new client in completing an assessment form. This process goes right back to their childhood to try and gather information about what issues in particular might be bothering them. Clients are also assigned a risk rating. This MHSU was assigned a risk rating of "11". The key worker told the Investigation Team that a person scoring more than six is considered to be more risky than one scoring below six. It was noted that the risk issue for this MHSU was that he might be aggressive physically, or verbally, to property or to

[7] Please see section 5.2.1.2 (page 28) for an explanation of what the PDCN does.
[8] A key worker is not the same as a care coordinator. For the voluntary sector agencies specialising in mental health services the key worker is an identified individual responsible for the case management of the client. The key worker may not have a dedicated mental health qualification but they will have received appropriate NVQ and in-house training to be able to deliver their responsibilities to the client.

people. However the key worker advised the Investigation Team that there was nothing remarkable about this MHSU in her experience. She and her colleagues were, and still are, used to dealing with individuals who far more unwell and with more marked issues than this MHSU. This MHSU had a reasonably run-of-the-mill range of issues in her experience.

The Investigation Team was advised that one of the criteria of acceptance at The Hostel is that the new resident is expected to sign up to the living rules and regulations. These cover:

- visitors (age, times they can visit, etc);
- booking in and out of the hostel;
- requirement for no drugs or alcohol;
- benefits, such as Housing Benefit forms;
- an occupancy agreement; and
- engaging with staff.

The MHSU's key worker advised that the occupancy agreement is the most important in her view as it encompasses things such as breach of terms, reasons for eviction, rules and regulations, what residents should expect from The Hostel staff and so on. Residents also get a handbook which sets out the rules of the hostel in a more interesting way and explains various things they need to know.

For clients in breach of the rules there is a warning system. This has two strands. One is breaches of rent and accommodation charges. The other is breaches of behavioural boundaries. This MHSU breached the behaviour rules quite a few times in relation to drugs and alcohol. When he was first offered tenancy at the hostel there was no knowledge of his drug and alcohol misuse. The previous emergency hostel where the MHSU had temporarily lived had not noted anything untoward and the client did not admit to active misuse problems. However they emerged soon after he was offered his tenancy. The MHSU also had problems with his rent from time to time.

With regard to engaging with this MHSU, his key worker advised that she spent one-to-one time with him. She recalls that he was attending the STOP group weekly for his anger management problems. She recalls that on one occasion the MHSU requested more input than STOP. The reason for this as far as the key worker could remember was that the MHSU reported being very angry about past abuse he had experienced and the effect it was now having on his behaviour[9]. His key worker told the Investigation Team that they discussed looking for further support for him around this. They talked about him attending for counselling at the Market Place - a self referral voluntary support agency. The MHSU was provided with all of the contact details so that he could make contact if he wanted to. A significant aim of the staff at The Hostel was to support the residents in taking responsibility for themselves and their actions and therefore their passage to a more

[9] There was no recorded history of abuse as far as the investigation team is aware.

manageable life. It was however the staff's experience that often they set up meetings for residents but they did not attend. There was no power of enforcement at the hostel. Suggestion and encouragement was all that could be offered - the rest was up to the resident him or herself.

However, the key worker did share that the staff at The Hostel tried to use a resident's continuing tenancy as a more persuasive lever to get them to engage with activities such as STOP. This was the case with this MHSU. Attendance at STOP was a condition of his tenancy. His key worker recalls that he went to this programme with another resident.

With regard to the MHSU as a person, she recalls that he spoke to her in a respectful way, but did not seem to respect other staff. He would shout at them when he was wound up with a particular resident and staff would have to intervene to calm the situation. This was when it was hard to work with him and hard to reason with him about his behaviour. His key worker recalls that she used to pull him up about his behaviour and that he would apologise to the other staff unprompted. She recalls that when he talked about his behaviour he would often describe it as `blacking out' and felt bad about his behaviour afterwards.

The MHSU's key worker recalls that she would ring the probation service as the MHSU had a lot of court dates. But her recollection is that court dates would be cancelled or so the MHSU would say. He used to tell her that they had just phoned. As far as she could remember there were some court issues around debt and some around other issues[10].

With regards to his truthfulness the MHSU's key worker recalls with hindsight that possibly the MHSU may have told stories with an angle on them that favoured him. She did however believe that his concerns regarding his children were genuine. The key worker told the Investigation Team that she did not think that this MHSU would tell lies just for the sake of it. This opinion was based purely on her own experience of working with him.

The probation service

The probation service had a statutory duty to be involved with the MHSU as he had been given a suspended custodial sentence with a requirement of supervision in March 2006. If an offender fails to comply or engage with a statutory order then enforcement or breach action is taken. In the case of a suspended sentence order, custody is a likely outcome.

[10] The behaviours described in this section are not untypical of an individual with a diagnosis of personality disorder. However they are also behaviour traits that are not uncommon in individuals who have had an unstable home life in their formative years, as was the case for this MHSU.

It is important that the reader of this report properly understands the role of probation and the limitations of the service. The following information is intended to facilitate this.

In the case of this MHSU he was arrested for an offence of common assault, the victim was his partner at the time. A pre-sentence report (PSR) was prepared by the offender manager for the probation service in February 2006. This report identified concerns with the MHSU's mental health and recommended a psychiatric assessment to assist the court in accurately determining the potential for harm and to aid sentencing. The court did not support the recommendation. Instead on 13 March 2006 the MHSU was sentenced to a suspended sentence supervision order (SSSO) comprising four months' custody suspended for 12 months, plus a 12 month supervision requirement. The probation service was responsible for the MHSU's supervision.

The MHSU attended only two appointments with the probation service, on 23 March and 31 March 2006, prior to the SSSO order being revoked on 6 June 2006. He had been provided with an enforcement letter on 21 March and 7 April. The letter of 7 April confirmed to him that breach action was to be taken.

The breach summary report was completed by the offender manager (OM) and was countersigned by a team manager on 8 May 2006. This summary noted that the MHSU had mental health problems and that he had involvement with a CPN. The report noted that the Court should be mindful of the MHSU's mental health issues and his history of self harm and suicide attempts. It also noted that the receiving institution should be made aware of the mental health issues. In addition to the report a fax was sent to West Yorkshire Police on 15 May 2006 regarding the proposed arrest of the MHSU at the Becklin Centre and highlighted the concerns probation had regarding the potential for self harm and suicide, along with the risks he posed to women, his partner and his child.

Note: there was never sufficient cause for concern about the child's safety to bring her to the attention of social services. Her mother was considered to be capable and able to provide for and protect her child appropriately. The child was considered to be vulnerable by the probation service as a consequence of the more tangible threat the MHSU posed to her mother.

A warrant for the arrest of the MHSU was issued and executed by the police at the Becklin Centre on 16 May. The MHSU was produced before the local magistrates' court on the same day. He was remanded in custody to enable a full PSR to be prepared.

As a result of the MHSU's breach of his SSSO the court decided to revoke the sentence, activate the suspended sentence, and impose the

four month custodial sentence issued in March. The probation service does not have any statutory involvement with offenders who are sentenced to prison sentences of less than 12 months. The probation service therefore ceased any involvement with the MHSU on 6 June 2006, the date of his sentencing.

Comment by the Investigation Team
On balance the Investigation Team believes that the mental health service, the MHSU's GP and the staff at The Hostel did their best to try and engage the MHSU with their services and in additional activities that they believed would be of benefit to him. The individual himself showed a persistent lack of willingness to engage with anything other than the STOP anger management group. The primary motivator for this engagement was his ongoing tenancy at The Hostel. It is tempting to suggest that the MHSU could have been more proactively referred to the Personality Disorder Clinical Network (PDCN) by his nominated consultant psychiatrist. However, as the MHSU did not attend even one of the outpatient appointments he was offered to enable an assessment to occur, it is extremely unlikely that the PDCN would have taken the MHSU on. Even if it had agreed to assess him it is extremely unlikely that he would have turned up for his appointment. As stated previously the Investigation Team is satisfied that the consultant psychiatrist's recommendation to the probation service that the MHSU be referred to the PDCN was appropriate in the circumstances at the time.

With regards to the probation service the rules under which it works are extremely robust, and although its records show that its staff tried to encourage the MHSU to engage with the service, he did not, and therefore failed to comply with the conditions of his SSSO. Consequently the probation service took the only course of action open to it. That is to invoke the 'in breach' warning system and liaise with the police so that a warrant could be issued for his arrest.

5.2.1.2 The management of his personality disorder

Appendix 3 (page xv) of this report provides an overview of personality disorder and sets out key features of appropriate care and treatment for an individual with a personality disorder.

In 2006 LMHTT did have the PDCN, whose role it was to provide a service to individuals such as the MHSU. This service has been operational since 2004.

The two main aims of the PDCN are to:

- work directly with persons who have personality disorder and who pose a high risk; and
- enhance the wider capacity of mental health services to improve their effectiveness with people with a diagnosis of personality disorder.

The only express exclusions from the service are:

- if an individual is under the age of 18; and
- if an individual has a primary substance misuse problem. However, the PDCN would still be agreeable to assessing an individual. This would then lead to a case formulation, or offer of future treatment. The PDCN may not however, take the client on its case load.

When the PDCN first started it only took referrals from the community mental health teams and from the Community Forensic Service. In 2007 this changed and the PDCN started taking referrals from 'any source', including self-referral. The main enabler for change was the increased capacity of the PDCN and also the increased confidence within the service in its ability to deliver its aims and objectives via more flexible referral routes.

Prior to 2007 the PDCN would take referrals from any agency on a consultative basis – that is, if an opinion from the PDCN was thought to be beneficial then this was always accommodated.

With regards to this MHSU it is agreed amongst the consultant psychiatrists who either met with him or were asked to see him between 2002 and 2006, that the MHSU may have been a suitable candidate for the PDCN. However, in the early years of the MHSU's contact with the mental health service in Leeds there was no such service. It was set up after the MHSU had disengaged from the service. It was however operational in 2006 when he was re-referred to the service.

It is clear that the consultant psychiatrist to whom he was referred in 2006 believed the PDCN service to be of relevance as he recommended it to the probation service on 11 April 2006. His letter states:

"*Given the information before me, I would recommend that the MHSU is referred to the Leeds Personality Disorder Clinical Network for an assessment. They are based at Unity Court, 431 Meanwood Road, Leeds LS7 2LD. Their telephone number is Leeds 2954587".*

The letter was also copied to the MHSU's GP and the CPN who had assessed him.

The probation records note that on 10 April 2006 the MHSU's consultant did call and speak with the trainee probation officer assigned to the MHSU. The record of this contact states:

"*Call in from the MHSU's Consultant Psychiatrist. The MHSU failed to attend two appointments with him. From the evidence heard the Consultant feels he may have a personality disorder but no serious*

mental health needs. Concerns shared over risk of harm and child protection issues"

The reason the probation service was not able to progress the consultant's recommendation regarding referral to the PDCN was because the MHSU had disengaged from them. They therefore had no contact with him. The PDCN operates on a voluntary basis. Mental health service users have to want to engage with the service and therefore need to support any referral made. There was no opportunity for the probation service to have this conversation with the MHSU. Consequently no referral was made.

By 13 April the MHSU was in breach of the conditions of his SSSO and had not responded to the warning letters sent to him. Consequently on 11 May a warrant was requested for his arrest. The MHSU's solicitors advised the probation service that at this time he was an in-patient at the Becklin Centre and had been since 4 May.

The precipitator to his attendance at A&E, and subsequent admission to the Becklin Centre, was an act of self-harm and threats to harm his girlfriend. On admission he was considered to be having an acute psychotic episode. He told the assessing SHO (who was the same doctor who assessed him in A&E the night before) that he:

- was hearing voices;
- thought someone was going to stab him and others wanted to kill him;
- was very scared;
- had reduced sleep and reduced food intake because he thought he might be poisoned.

It is also noted that he had been experiencing these symptoms for the previous two weeks. He also told the doctor that he had been isolating himself at home, and that in A&E he scratched his throat as a result of a command hallucination.

The MHSU also told the SHO that he was on venlafaxine 125mg and sodium valproate (Epilim) 300mg at night for epilepsy[11].

The MHSU was reviewed on the same day by the in-patient consultant psychiatrist on his ward round. The result of this assessment was:

- five minute observations;
- for an EEG and a CT scan to investigate the claim of epilepsy;
- to encourage an increase in his fluid and dietary intake;
- to commence a weight and blood pressure chart;
- to commence risperidone 2mg at night;
- for a urine drug screen;
- no leave from the ward, and

[11] There was no evidence following medical examination that this individual ever had epilepsy. The history of this gentleman suggests that he did fabricate stories to gain medical attention. This is not uncommon in individuals with personality disorder.

- if the MHSU tried to leave he was to be assessed under the Mental Health Act.

On 8 May the MHSU was again assessed by the consultant psychiatrist. He reported that the voices had subsided but not completely and that he had no plans to harm his girlfriend. He also denied drug use but also refused to provide a urine specimen for drug screening. The plan was to continue with:

- the investigations around the MHSU's claim of having epilepsy; and
- the risperidone.

It was agreed that the MHSU could go to the job centre to sort out his financial affairs.

On 10 May the MHSU was again reviewed by the in-patient consultant. By this time the MHSU's case notes and past history had been received by the Becklin Centre. His diagnosis of emotionally unstable personality disorder was revealed. There was also a suspicion that the MHSU was using drugs on the ward at this time. The plan therefore was:

- to plan the MHSU's discharge as soon as possible;
- the chase up the EEG and CT scan;
- to refer the MHSU to the relevant CMHT for allocation of a care coordinator; and
- for the MHSU to speak with a social worker regarding accommodation.

At interview the in-patient consultant psychiatrist advised the Investigation Team that because the MHSU had not yet been engaged with a CMHT, and the plan was now for him to be on enhanced CPA and managed by a CMHT, referral to the PDCN would be considered within the community once the MHSU's willingness to engage with services had been more fully assessed. This, the Investigation Team believes, was reasonable.

The discharge CPA meeting took place on 15 May. In attendance were:

- the in-patient consultant psychiatrist;
- the SpR to the in-patient consultant;
- a staff nurse; and
- the nominated care coordinator for the MHSU.

At this meeting it was noted that the MHSU's probation officer had contacted the ward, and advised that the MHSU was in breach of his probation contract and that a warrant had been issued for his arrest.

The MHSU at this time was not accepting that he had had past admissions to hospital and contact with mental health services.

The MHSU told the professionals present that:

- he did not plan to return to his girlfriend's;
- he was aware that he was being discharged the following day;

- he had been in touch with his social worker regarding housing;
- his ex-girlfriend was sending him threatening text messages; and
- he felt all right now and he had no particular concerns.

The plan therefore was to proceed with discharge on 16 May. The MHSU was prescribed two weeks medication of risperidone 2mg, and an outpatient appointment was to be arranged with his sector consultant.

As events transpired the MHSU was arrested at the point of discharge from the Becklin Centre and taken into custody.

With regards to the management of the MHSU's personality disorder up until his discharge from the Becklin Centre on 16 May, it is difficult to see how any of the health professionals at the then LMHTT, or the probation officers, could have done anything remarkably different given the MHSU's unwillingness to engage with the community mental health team or the probation service.

The Investigation Team does however have some concerns about what happened in relation to the MHSU's ongoing mental health care needs following his arrest. It appears, from the information that we have been able to gather, that this MHSU received no mental health care during the period he was in prison. This was a missed opportunity to conduct a fuller assessment of him in relation to his personality disorder. The prison in-reach team are very experienced and would, they informed the Investigation Team, have considered the value of progressing the community consultant psychiatrist's recommendation for a referral to the PDCN for assessment.
The Investigation Team considers the lack of mental healthcare provision while the MHSU was in prison to have been a significant slip in the service provided to this MHSU. Consequently it is addressed in the following section of this report.

5.2.1.3 The quality of the MHSU's mental healthcare following his arrest on 16 May and his subsequent release from HMP Leeds in July 2006.

As highlighted above this MHSU did not receive any mental healthcare during the time he was in prison. Given that he was on enhanced CPA at the point of discharge from the Becklin Centre on 16 May, how there came to be a lack of care provision needs to be understood.

Unfortunately the care coordinator allocated to his case was not available for interview. She no longer lives in the UK and her whereabouts are not known. However, there was a letter from this individual to the last known GP for the MHSU, advising of his admission

to the Becklin Centre, arrest and detention into custody. This letter notes:

"*Due to his arrest and detention in custody on the same day, his probation officer informed me she would refer him to the Prison In-Reach service. If you would like further community mental health team involvement in the future, please refer again."*

From a technical perspective this care coordinator should have remained in contact with this MHSU until sentencing took place, and then there should have been a hand over to the prison in-reach team (IR team).

A team member for the IR team advised the Investigation Team:

"Once an individual is sentenced the IR team take over care coordination responsibility. However, if a person is in custody and awaiting sentence the care coordination responsibility rests with the community care coordinator, and they should therefore carry on with their clinical visits. The IR team will provide support if requested."

In this case the MHSU was in custody for 16 days prior to sentencing.

The Investigation Team understands that in the initial years following the setting up of the IR team it was not uncommon for community care coordinators to discharge an individual from their case load if they were imprisoned, or to 'freeze' their care contact, until the individual returned to the community. Although this perspective has not been validated with the care coordinator concerned, the Investigation Team believe that this approach would not have been uncommon.

In trying to understand precisely what happened with this MHSU following his arrest, the probation service and prison healthcare team were very helpful in assisting the Investigation Team to understand what should have happened, and what appears to have happened.

The analysis by the Probation Service revealed that after the MHSU's arrest at the Becklin centre on 16 May, he was produced before the local magistrates' court that same day. He was subsequently remanded in custody to enable a full PSR to be compiled. This summarised the concerns regarding the MHSU's mental health and the recent contact with the Becklin Centre. Within the report it was noted that the offender manager (OM) understood that the MHSU would be assessed by a prison psychiatric nurse. At the time of the PSR this had not occurred.

The Leeds Probation Service were able to confirm that on 16 May the court duty officer (CDO) contacted the OM and confirmed that she would telephone the prison in-reach/prison healthcare team to arrange an assessment. This contact is recorded on the probation database. There is no corresponding record made by the CDO to show that she

undertook this action, but there is an entry in the prison healthcare records that show that the CDO did make contact with the prison healthcare team. This record notes that

"*the MHSU had spent time in the Becklin Centre for mental health assessment. No mental illness. "attention seeker"."*

The words "attention seeker" are highlighted in quotation marks within the prison records suggesting that they represented a direct quote from the CDO. The content of this record is concerning, particularly given the MHSU's enhanced CPA status.

The probation records also revealed that the OM contacted the MHSU's nominated care coordinator (CC) on 16 May and confirmed to her that the MHSU had been remanded in custody. The probation records show that the OM[12] provided the CC with the IR team telephone number so that she could contact and liaise with it as necessary.

The Investigation Team was informed, by the probation service, that West Yorkshire Criminal Court work policy notes that staff will assist in the identification and onward transmission to the prison service of initial issues that need to be taken into account in the management of prisoners. Consequently a copy of the PSR would have been sent with the prison escort service and provided to the prison reception team on 6 June 2006. In addition the probation service advised the Investigation Team that at the point of sentence, the systems in place in 2006 should have provided the prison with access to an electronic copy of an Oasys[13] assessment, which included details of the mental health concerns and the MHSU's contact with the Becklin Centre. It also recorded that the MHSU had been assessed by his consultant psychiatrist as not suffering from a treatable mental illness, and noted the request for a psychiatric assessment at HMP Leeds while the MHSU remained in custody.

The Investigation Team understands that the operational procedure "Prison Service Order (PSO) 0500" sets out the required procedures and actions that must be completed within the first two to three hours after arrival in an establishment. The PSO includes a number of mandatory actions including assessment of the new prisoner's healthcare needs, and identified risk of self harm/suicide. Where it is identified that a prisoner has had previous mental health contact in the community, best practice would indicate that a referral to the mental health IR team should always be made and information about previous history actively sought and subsequently used.

[12] This record provides a different interpretation of the telephone conversation than the letter from the care coordinator to the MHSU's GP which suggests that the CDO was to contact the prison in-reach team.

[13] Oasys is a national criminogenic assessment tool completed by the probation service. It includes sections relating to emotional health and well being.

In addition to the above, PSO 0500 sets out the requirements for prisoner induction. The PSO states that this must include follow up to the healthcare assessment on reception within a week of arrival, by an appropriately trained member of the healthcare team.

According to the prison healthcare team, while on Wing D of HMP Leeds in May 2006, the MHSU was offered a place on the safer custody programme run by the primary care team and funded by the drug services. However, the MHSU did not attend the safer custody programme because he requested a wing transfer and at that time the safer custody programme was only being offered on Wing D. The requisite health assessments were however undertaken using the tool developed by Prof Don Grubin from Newcastle University.

Note: Safer custody[14] is all about boosting prisoner well-being and (the other side of the equation) reducing prisoner distress. Every prison is required to have a "multidisciplinary, multi-agency, whole-prison approach" to safer custody (a direct quote from Standard 60 on suicide prevention and self-harm management). HMP Leeds now offers the safer custody programme in all of its wings.

Prison health services

The computerised print out of the prison health record shows that the primary care service within HMP Leeds was aware that the MHSU had been an inpatient at the Becklin Centre. This information was communicated to them by the court probation officer on 17 May, the day after the MHSU's arrest. There is however no mention that the MHSU required any mental health input. The records state:

"*The MHSU has spent time in the Becklin Centre for mental health assessment. No mental illness. "attention seeker.""*

On this same day the MHSU was assessed by the registered mental nurse (RMN) from the safer custody unit as an automatic referral.

On 18 May there is a further entry in the prison health record that says:

"*phone call received about this man from his outside probation department. Since being in prison last time he has been in the Becklin Centre. No diagnosis of any mental illness, only attention seeker noted.*

[14] To read more about safer custody and standard 60 go to: http://www.hmprisonservice.gov.uk/assets/documents/1000312560_suicide_prevention_oct_07.pdf and prison service order 2700 http://pso.hmprisonservice.gov.uk/pso2700/PSO%202700_-_front_index_and_PSO_itself.htm#CHAPTER4

They advised us to be very wary of the potential risks of this man's behaviour. All nursing staff please be aware[15]."

The last entry in the prison health record prior to the MHSU's release from HMP Leeds on 14 July was on 20 June. The entry related to the MHSU's treatment for insomnia with zolpidem in the short term.

The current safer custody/mental health lead at HMP Leeds advised the Investigation Team that on the basis of the Prof Don Grubin assessment tool completed with the MHSU in medical reception, he would have expected him to have been referred to the RMN clinic.

Given the passage of time this individual was unable to explain with any certainty why this did not happen. However, he did advise that in 2006 the RMN clinic was heavily over-subscribed, with gentlemen waiting to be seen. This was predominantly due to persons being inappropriately put on the RMN clinic list in the first place, and the clinic being held on a somewhat ad-hoc basis as a result of RMNs being diverted from this activity to assist treatments being provided in the wing-based treatment rooms and the methadone clinics.

The safer custody/mental health lead also advised the Investigation Team that on medical reception the assessing nurse usually only has access to information volunteered by the patient. In the case of this MHSU he advised that he had schizophrenia with paranoia. Rarely is information provided to the prison healthcare team from a patient's community mental health team, or from the probation service. Information if it is communicated tends to go direct to the IR team which is managed by specialist mental health services.

This is a particular frustration for prison health services. Although they are NHS-run services, and therefore bound by the same rules as all other NHS healthcare facilities, the transfer of essential information to facilitate appropriate care and management of a patient in prison continues to require the express consent of that patient.

With regards to the references made to the MHSU being an "attention seeker" in the prison healthcare records the mental health lead agrees with the Investigation Team that this was wholly inappropriate and would have contributed to the MHSU not receiving any mental health assessment and/or care while in prison between 16 May and 14 July 2006.

For further information relating to the provision of mental health care at HMP Leeds please see appendix 4 page xvii.

[15] The Independent Investigation Team has not read anything in the probation, mental health or pre-sentencing psychiatric or psychology reports that suggests that this MHSU was a generalised risk to women.

Comment by the Investigation Team:

Whatever the rationale of the nominated care coordinator (CC) for the MHSU on 16 May 2006, the passing of the responsibility for notification to the IR team of the MHSU's residency at HMP Leeds to the court probation officer should not have occurred.

Furthermore it does seem as though there may have been a communication failure between the CC and the probation officer as the letter written by the CC appears to conflict with what is recorded in the probation records. Also nowhere is it stated in the correspondence between the CC and the probation service that the MHSU had been discharged from the Becklin Centre on enhanced CPA and would therefore need a mental health assessment within seven days of the discharge date, which was by 23 May when he remained in custody. It was the duty of the CC to ensure that this seven-day follow up visit and assessment occurred.

In the opinion of the Investigation Team, in all instances where the mental health service becomes aware that a service user receiving active input has been arrested or is in custody, it must remain the responsibility of the identified care coordinator to ensure that all relevant prison health services or custody officers, including the prison in-reach team, are aware of the service user's mental health diagnosis and current care plan. This responsibility should be stated explicitly within the operational policies of Leeds Partnerships NHS Foundation Trust.

5.2.1.4 The assessment undertaken in A&E and by the CHRT on the last occasion he was seen by mental health services in July 2006.

On 19 July 2006 the MHSU presented in A&E, and was assessed by the duty psychiatric SHO and the Crisis Resolution and Home Treatment Team (CRHT). The outcome of this second assessment was that an inpatient admission was not required. The MHSU was therefore discharged home with a referral to the Leeds Addiction Unit. Because this assessment was the last time the MHSU was seen by mental health services prior to the incident, it was important to establish whether or not the decision to discharge the MHSU was reasonable.

When the MHSU presented at A&E on the afternoon of 19 July the duty SHO felt that the MHSU needed admitting to hospital for in-patient psychiatric care. The MHSU had a history of substance misuse and was reporting a clear history of self-harm, including thoughts of suicide. The SHO therefore, appropriately communicated with the CRHT to conduct a further assessment of the MHSU and to make the final decision regarding the appropriateness of an in-patient admission.

The CRHT notes at 13.05hrs say:

"*Phone call from SHO, who has assessed MHSU – who is deemed physically fit. The MHSU states "he was given an overdose of Procylidine…..possibly by someone else". Also he states he tried to hang himself recently. States he is hearing voices and has ongoing suicidal thoughts*"

The CRHT undertook to fax to the SHO the most recent discharge summary from the Becklin Centre on 16 May, as the team believed it contained important information that the SHO needed to be aware of.

At 03.45hrs on 20 July the SHO re-contacted the CRHT and requested a CRHT assessment.

The assessment was performed at 04.45hrs.

The pertinent information elicited as a result of this assessment was:

- The MHSU no longer remembered taking an overdose or how many tablets were involved.
- He was not registered with a GP.
- He had been discharged from prison three weeks previously.
- The MHSU was getting addicted to smoking "weed" and using ecstasy.
- If he had not used any illicit drugs his temper would "go".
- His mood was suicidal and paranoid, his sleep pattern was about two hours a night.
- He heard voices telling him to hurt himself and others. These experiences increased when he was using illicit drugs. However the assessment notes that the MHSU was not having any such thoughts at the time of the assessment. The assessment also notes that the only formal records of self harming attempts were in 2002 and 2003 respectively.
- He subjectively described psychotic symptoms but objectively remained calm. He showed no signs of agitation or restlessness.
- The MHSU worried that the illicit drug use negatively impacted on his relationship with his girlfriend.
- His mental state assessment revealed good eye contact, insightful, good rapport, no restlessness or agitation. Furthermore he was appropriately dressed for the season and looked well-kempt.
- The CRHT assessment revealed that the MHSU had underplayed his forensic history and reported no history of

domestic violence. (Note: the assessing professional does refer to the previous CRHT assessment of 4 May regarding this).

As a result of the assessment the documented plan was:

- for a referral to the Leeds Addiction Unit (LAU)– this had been done on the 19 July. The MHSU was also given the LAU contact number; and
- for the MHSU to make proactive contact with the LAU himself.

The CRHT record also clearly notes that the MHSU had no immediate plans to harm himself or others. It notes that he was expressing willingness to engage with the LAU for help and support with his substance misuse problems, and that the MHSU accepted that the symptoms he was experiencing might be influenced by his illicit drug use.

The clinician who assessed the MHSU told the Investigation Team that the MHSU was very cooperative with the staff conducting the assessment and gave the clear impression of seeking help.

The thing that struck the assessor about the MHSU was that he did not present as acutely psychotic or acutely depressed. He was in fact very focused, and responded well to open-ended questions. He was not agitated or restless. His eye contact was good. He did not appear confused or intoxicated. His speech was unremarkable.

In addition to the impressions formed by the face-face contact with the MHSU, the Investigation Team were informed that the CRHT professionals reviewed the previous CRHT assessment on 5 May. The Investigation Team were advised that having insight as to how individuals have previously presented, and any available historical information, provides vital information about past responses to an individual's presentation. Thus, formulating a plan of action on the basis of this current presentation was not undertaken in isolation.

On this occasion the CRHT team member recalls that the MHSU was clearly asking for help with his illicit drug use which he knew was impacting adversely on his life. On the basis of this and the assessment conducted the CRHT professionals found nothing that suggested that an inpatient stay would be at all beneficial to the individual. Neither was there anything that suggested there was an immediate public safety risk that might be managed with an inpatient admission.

The CRHT team member stated plainly to the Investigation Team:

1. "*There was no clinical evidence to suggest to me that the MHSU was acutely psychotic or acutely depressed and required inpatient input*"

In May 2006:

2. "*he presented with specific risks when he was assessed by the CRHT which subsequently led to his inpatient admission".*

Furthermore on July 20:

3. "*There was no evidence to suggest that had he had an inpatient admission,* (when he and his colleague assessed him) *it would have prevented the incident he was involved in. He requested help with his illicit drug use and his focus, and our focus, was about how the MHSU needed urgent contact with the LAU."*

Comment: There is always a danger when looking at the care and management of service users retrospectively, that one wants to find something that might have prevented the needless death of another. In this case although it was well recognised that the MHSU was a risk to his girlfriend, there was no evidence to suggest that he was a risk to the passer-by on the street. His girlfriend was noted to be 'street wise' as far as the MHSU was concerned and was not afraid to contact the DVU if his behaviour towards her was unacceptable. Furthermore her due diligence with her own and her daughter's safety meant that their situation was not sufficiently concerning that they had been noted as 'at risk' under the auspices of safeguarding children.

In relation to this last assessment of the MHSU by the CRHT on 20 July 2006, the Investigation Team agrees that there is nothing to suggest that an in-patient admission would have been appropriate. The CRHT are the gatekeepers of all inpatient admissions and they are particularly skilled in making the fine and careful judgments about which individuals an inpatient stay is necessary for.

Whilst others may like to think they could have acted differently, this Investigation Team supports the decision made by the CRHT not to admit on this occasion.

5.2.2 How cognisant were all agencies of the risks the MHSU posed to others?

All agencies involved with this MHSU were aware of his domestic violence risk. It was this risk that enabled a MAPPA meeting to take place on 11 May 2006. The containment of this risk was achieved by the MHSU's subsequent arrest because of his breach of his community supervision order and custodial sentence.

However none of the agencies involved with this MHSU saw him as a notable risk to the general public. He had no history of attacking persons not associated with himself and all of his criminal records related to breaches of the peace and assault on his father and girlfriend.

All agencies were aware that there were inherent risks associated with the MHSU's use of illicit drugs and periodic abuse of alcohol. These behaviours however were not within the control of any of the agencies who tried to support this individual. The only person who had control over these behaviours was the individual himself.

He was offered support with his substance misuse issues from the moment he came into contact with mental health services in 2002. He continued to be offered support whenever he came into contact with mental health and probation services, right up until the middle of July 2006 which was his last period of contact with mental health services. He chose not to avail himself of the support networks offered at any stage as far as the Investigation Team can ascertain.

The Investigation Team is satisfied that appropriate and reasonable risk assessments were undertaken, in relation to this MHSU, and that the risk management focus was appropriately targeted towards the management and containment of his risk of harm to his girlfriend and child.

The Investigation Team does not believe that the incident which occurred in July 2006 was any more predictable for this individual than it is for any individual with anger management problems who also abuses illicit drugs and alcohol.

Note: The detailed chronology in appendix 1(page i) of this report shows clearly that sufficient risk assessments were undertaken with appropriate cross-agency communications taking place.

5.2.3 Were communications between the agencies appropriate and effective and was each agency's role, and the limitations of its role, properly understood by each of the agencies involved?

As the previous sections of this report demonstrate, it is clear from the interviews with the mental health staff, the probation officers and the staff at The Hostel that all three agencies were in communication with each other about the MHSU between March and May 2006. The interviews with staff and the analysis of the clinical records show that important information about risk was effectively communicated from the probation service to the mental health service. The staff at The Hostel were not involved with the MHSU from the beginning of April 2006.

As already highlighted, an aspect of interagency communication that was lacking was in relation to the provision of ongoing mental health care following the MHSU's arrest in May 2006 through to his release from prison on 14 July 2006.

All of the mental health professionals we spoke with were consistent in their view that it is the care coordinator's responsibility to communicate with the prison IR team. This endorses the view of the Investigation Team. However the IR team advised the Investigation Team that it is not consistently notified about individuals taken into custody, or given a custodial sentence, who have known mental health issues. The team said the situation is better than it was in 2006 but room for improvement remains. The team believes that some of the inconsistency may relate to the initial purpose of the IR team when it was set up in 2002. At its inception the purpose of the IR team was to work with service users with behavioural traits linked to personality disorder, as opposed to severe and enduring mental illness.

However, the IR team was able to reassure the Investigation Team that if an individual is on enhanced CPA before going to prison, the care coordinators do now more reliably contact the team and there is a proper transfer meeting (as there would be if a client were moving residence and needing to be transferred from one CMHT to another). These meetings are attended by the prisoner, the prison staff, and the prisoner's family. The meetings are considered to be useful and the general opinion is that prisoners on CPA should have the same standard of care as they would if they were living freely in the community.

Another aspect of interagency communication that was unsatisfactory was between the MHSU's GP and the prison healthcare team. When an individual is processed into prison it is standard practice for the prison primary care team to write to the last known GP to seek information about the prisoner. The form sent out is relatively simple and allows for the provision of any important information. However the form does not guide the person completing it with regard to the nature

and quality of information required. The quality of information provided by the GP surgery was poor. For example, although the form indicated that the MHSU had been in contact with mental health services, no detail of this was provided. Neither was any of the contact details for the consultant psychiatrist to whom the MHSU was initially referred in February 2006 provided. The data on the form would not have triggered a referral to the prison IR team. When the Investigation Team discussed this with the GP and the practice manager at interview, it became very apparent that they did not realise the importance of the form. They advised the Investigation Team that they often feel overrun by forms to complete and the presentation of this form did not communicate its gravitas.

Finally, the only other aspect of communication that the Investigation Team feels could have been improved was again at the point of discharge, and arrest, from the Becklin Centre. It is not customary for the discharge summary to be sent to the prison healthcare team. It was this document and this document alone that identified that the MHSU was on enhanced CPA and could therefore have triggered the onward referral of the MHSU to the IR team. Given that the prison healthcare team effectively becomes the surrogate GP for the time an individual is in prison, it would seem sensible for this service to have had a copy of the MHSU's discharge summary relating to his admission between 5 and 16 May 2006.

With regard to the situation following the MHSU's release from HMP Leeds on 14 July, it is an individual's responsibility to register with a GP. Clearly if the MHSU had been discharged from prison into the care of a CC then some encouragement could have been given to the MHSU regarding this. Furthermore had there been appropriate liaison with the IR team during this prison episode, this would have meant that when the CRHT became involved in the assessment of the MHSU on the 19/20 July it would have had up-to-date knowledge of the MHSU's CC.

5.2.4 Understanding of mutual roles and role boundaries between the mental health and probation services

When the Investigation Team interviewed the CPN and the probation officers involved with the MHSU it did not get the impression that either had a clear understanding of each other's roles and the boundaries between these roles.

Therefore we believe it is relevant here to set out the role and responsibility of a care coordinator and also the probation service.

Care coordinators:
Care coordinators need to do a number of things to ensure that the services people with a mental health diagnosis receive are appropriate and coordinated so as to be most effective. They need to:

- Make sure that other services understand what the service user needs, by organising a proper assessment of their mental health and social care needs.
- Ensure that the right services are brought together in a planned way to meet the assessed needs, and that there is a written plan of care that the user and the care team can share.
- Explain to the service user what is being done to help them.
- Explain to the care team what the user's main concerns are and what is the best way to help them.
- Make sure the care plan is carried out as agreed and take appropriate action if it is not.
- Be aware of how the service user's needs may be changing and how the plan of care might need to change in response, and hold reviews of the care plans when necessary.
- Make sure that any carer's needs are understood by organising a carer's assessment and putting them in touch with the right support services.
- Ensure that the care team recognise the role of the carer and shares information with them in an appropriate manner.
- Where the service user moves around, either between different care settings or to different localities, ensure continuity of care by ensuring the people providing care have the right information and that the care plan is continued, wherever possible.

Limits to the responsibility of care coordinators
The responsibilities of the care coordinator are not without boundaries. They are not responsible for the actions or non-actions of other professionals or agencies. Their role is to highlight and to try to

coordinate the service for the service user as best they can. However if there are problems in care delivery and agency engagement that can be anticipated, then the care coordinator does have a responsibility for letting the whole care team know there is a problem and for making contingency plans, as necessary, to ensure that the user receives the care they need.

Essentially effective care coordination is about getting the user in the right place, at the right time, with the right interventions.

Role and responsibility of the probation service and probation officer[16]

Where the probation service is involved with an offender[17], its principal responsibility is to protect the public from crime. Probation officers work with some of society's most difficult, damaged and dangerous people - a role which demands a firm and disciplined approach, but at the same time a compassionate understanding of people and their problems. It is a service that is strictly governed by standard operating policies and statutory requirements, and the probation service rigorously works within these rules.

In their work, probation officers will assess the risk an offender may pose to the community, and how that risk should be contained. The aim of probation supervision is to reduce the likelihood of further offending, to ensure the proper punishment of offenders, to rehabilitate the offender back into the community and thus to reduce crime.

The National Probation Service is the only agency that is involved in every step of the criminal justice process - from the moment an offender appears before the court, when the probation officer may prepare a report to help with bail and sentencing decisions, to the end of the court order for supervision in the community, or the expiry of an ex-prisoner's period of supervision on licence. This is complex work and probation officers use a range of techniques to enable people to address their offending behaviour effectively. Some work is done individually, some through accredited group work programmes, and some in liaison with partnership agencies in the community.

Probation officers work in a variety of settings. Most work in field teams preparing court reports and supervising offenders in the community. However, some work in specialist settings such as prisons, probation hostels, group work teams and drug/alcohol agencies.

[16] Information about the role of the probation officer has been taken from the North West Probation Officer Training Consortium Website: http://www.probation-northwest.co.uk/role.htm

[17] Note: the probation service does not work with all offenders. Many will appear before the court and be sentenced which will not involve assessment, contact or supervision by the probation service.

What probation officers do
Probation officers make assessments to advise courts and others about the risk posed by individual offenders and about other pertinent needs such as mental health issues. These assessments culminate in the pre-sentence report (PSR). This report will set out relevant personal information about the offender, an analysis of the offences, an assessment of risk and will also, in most cases, make a proposal about the manner in which the offender should be sentenced. Some officers work at court most of the time and represent the probation service as liaison officers.

Probation officers also have a responsibility to ensure that the court's orders are carried out. In the course of a probation order, the officer will work to change the probationer's behaviour in ways that make further offending less likely. This may involve, for instance, participation in group programmes (usually run by specially trained probation officers), which research has shown to influence behaviour in this way.

Probation officers work with prisoners during and after sentence to assist in their resettlement and to implement the requirements of their licence. They also assist in sentence management and make arrangements when an individual is due to be released from prison, so that he or she is settled in the community in a way that minimises the likelihood of reoffending. Some probation officers work in prisons directly with offenders and others, to change the offenders' behaviour and to reduce the risk of harm. The probation service encourages its staff to make full use of other agencies, with whom the probation area may be in partnership and who may be better placed to undertake the necessary work.

Comment by Investigation Team
The above information is illuminating and enables a more balanced reflection around the interface between the probation service and the CPN who determined that there was no beneficial role for the MHSU in receiving a service from the CMHT.

Initially the Investigation Team were concerned that the limited knowledge the CPN had of the role and responsibility of the probation service may have errantly informed his decision making process. However the summary above shows that at the time this MHSU was assessed, the decision of the CPN was appropriate. Probation was the only service who statutorily could take positive action if the MHSU did not engage with them. It is also clear that the probation service does carry responsibility for identifying and coordinating with agencies that it believes will benefit the health and well being of its client, as well as the reintegration of the individual into the community.

The only residual concern the Investigation Team has is that we remain unconvinced that each agency had clarity at the time about each other’s roles and responsibilities and it was therefore by chance that

the CPN's decision not to offer the MHSU a service from the CMHT was appropriate.

A telephone conference between probation, Touchstone and the CPN would have enabled a clear plan of communication to be agreed, brought clarity about who was doing what, and helped to develop contingency plans. For example what was the plan should the MHSU be evicted from The Hostel? What was the position in relation to the MHSU's contacts with the probation service? The CPN was not aware, when he made the decision not to offer a CMHT service to the MHSU, that he was so non-compliant with his community supervision order.

The Investigation Team appreciates that achieving a face-to-face meeting probably is not realistic in such circumstances. However, ensuring that there is clarity of understanding across all services, even under circumstances where CMHT input is not offered, should be eminently achievable. There are now many affordable pay-as-you-go teleconference facilities available. These offer the opportunity of virtual round-the-table discussion without anyone having to travel to another agency's base. Resources, both financial and in terms of time availability, therefore should not be an impediment to such case conferences.

5.2.5 Were there effective communications between secondary care inpatient services, the primary care service and the prison in-reach service, in HMP Leeds in May 2006?

This question has we believe been answered within the information provided in sections 5.2.1 – 5.2.4.

To summarise, the communication between the agencies prior to 16 May 2006 was reasonable. Communications between the agencies during the MHSU's period of time in HMP Leeds, (16 May -14 July 2006) was unsatisfactory.

6.0 OTHER ISSUES ARISING FROM THE INVESTIGATION

The issues that are of specific relevance to this report are:

- fair access to care; and
- the management of personality disorder and the effective use of psychological services.

Consequence sought a range of staff opinion in relation to both of these issues via the face-to-face interviews, a structured round-the-table discussion with in-patient nursing staff and via the distribution of 70 semi-structured questionnaires across all in-patient wards and CMHTs within the trust's Directorate of Adult Services. Questionnaires were also distributed by the medical director to a selection of medical staff working within this service. A total of 80 questionnaires were distributed and 30 were returned. The bulk of these were from mental health nurses. There was only one questionnaire returned by a member of the medical team.

The overall response rate was 37.5% which was disappointing. Our usual experience when utilising this method of information gathering is a response rate between 50 and 65%. Although the number of respondents is less than one would wish for robust statistical analysis in a research-based report, nevertheless the information contributed by staff is valuable in giving an insight to staff's perspectives. Of particular note is the fact that the information provided via the questionnaire analysis validated and underpinned information elicited from the one-to-one interviews held with staff involved with the MHSU and staff who participated in the round-the-table discussion.

The aggregated information revealed by these activities is set out below.

Fair Access to Care

Fair access to care (FAC) relates to the eligibility criteria used by councils to determine whether or not an individual is entitled to adult social services. National guidance entitled `Fair access to care services – guidance on eligibility criteria for adult social care' was issued by the Department of Health for implementation by April 2003[18].

Leeds Partnerships NHS Foundation Trust is a 'partnership' trust. It is not unusual for a partnership trust to have a Section 75 agreement in place with the local government authority to enable better integrated mental health and social services provision to individuals suffering from a mental health disorder[19]. Therefore, during the investigation of the MHSU's care and management, staff that had had face-to-face contact

[18] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_40009653

[19] Towards the end of the investigation process the Investigation Team discovered that LPFT does not have any section 75 responsibilities and is a partnership trust in name only.

with the MHSU were asked about assessment under FAC. It became very apparent that there was a lack of understanding about FAC and its purpose. Because it was the firmly held belief of one of the Investigation Team that the MHSU should have been assessed under FAC[20]. To test this out a small number of social workers not connected with this case were presented with a scenario similar to that of this MHSU. They were asked a) whether they would have considered his needs under FAC and b) whether they believed FAC to have been applicable in his case.

Their aggregated responses are detailed in table 1.

Table 1: Social workers' views of whether FAC would apply

Professional	FAC considered	FAC applicable
Staff SW1	Yes	Yes
SW2	Yes	No
SW3	Yes	Yes
SW4	Yes	No
SW5	Yes	Yes

The responses show that all would have considered FAC but that two of the five professionals would not have thought FAC would be applicable. The key point for the investigation team is that all would have considered FAC, whereas it was not considered at all in the case of this MHSU.

The responses provided to questions about FAC in the questionnaire issued to staff suggest that it would have been very unlikely for FAC to have been considered at all by adult services RMNs working in the community for Leeds Partnerships NHS Foundation Trust.

Staff were asked:
"What do you understand by Fair Access to Care?"

Nine out of 26 respondents (35%) said that they did not know or that they had not heard of it before.

The remaining respondents provided a range of explanations which are detailed below. The nine responses that reveal a reasonable understanding are denoted by a (✓) symbol.

- A framework that all local authorities use to decide what social services people are entitled to (x 6 respondents). (✓)
- People's disabilities not to prejudice them gaining the right care at right time, right place. (✓)
- Not discriminating (this response suggests some insight but insufficient understanding).

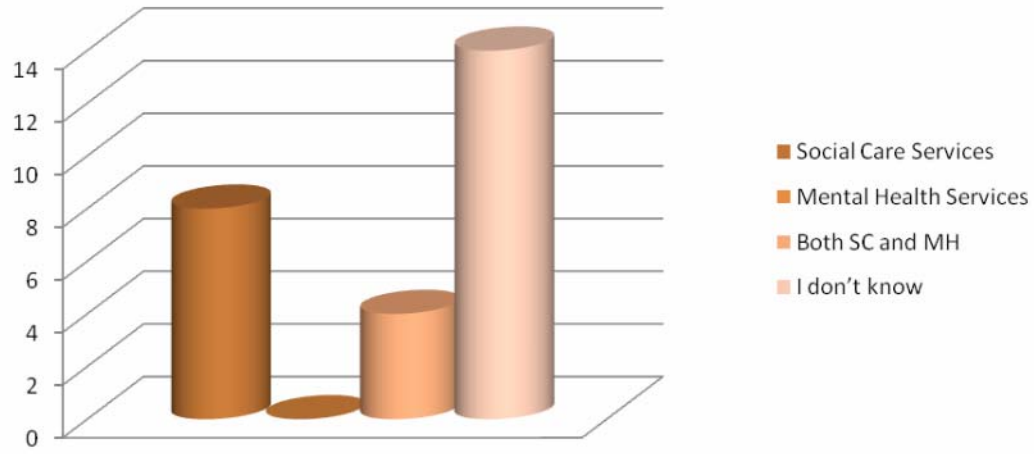
[20] This regardless of the Trust's section 75 status. The Trust's staff should be aware of FAC and know how to facilitate assessment of a service user by social services.

- Understanding that the service user can read their nursing notes and them to be involved in their care.
- An assessment by social workers to ascertain eligibility to services/care. (It is concerning that FAC is seen as a social worker's responsibility).
- The service user should be able to access service regardless of their background, status etc. (✓)
- Care available to all if eligible - an assessment to decide this (big form!). (✓)
- Equal access based on clinical need.

Staff were also asked:
"Who usually undertakes a Fair Access to Care assessment?"
The number of respondents was 26. Graph 1 below depicts the responses.

Graph 1

Social care services (SC)	8
Mental health services (MH)	0
Both SC and MH	4
I don't know	14



Although the numbers of respondents are low the responses do highlight that Leeds Partnerships NHS Foundation Trust may have a potential knowledge deficit in its adult services in relation to FAC. Although LPFT does not have any section 75 responsibilities all staff involved with the assessment of patients, should know how to ensure that a service user is able to access an assessment from social services under section 47 of the NHS and Community Care Act (NHSCCA) with a view to such an assessment being carried out, presenting needs identified and services being provided to meet eligible needs.

Psychological therapies and the management of personality disorder.

In view of the pivotal role of psychological therapies in the care and management of service users with diagnoses of personality disorder, the Investigation Team considered it appropriate to gain some insight into staff knowledge of psychological therapies, and also their access to psychological services for advice and support in the planning of care.

The information that emerged from the round-the-table discussion with a small number (12) in-patient staff (of bands 5-7) suggested that there was a general sense of frustration with their ability to access advice and support from the psychological therapy (PT) department. This was less so where forward-thinking ward managers utilised their budget to purchase regular input to the ward from the PT department. This however was not common place across inpatient services. The investigation team were left with a sense that the quality of experience with the PT service was person dependent and that all staff believed that the situation could be much improved. Because of this, the following questions were asked of a broader range of staff in the questionnaire:

- Have you received any training in the delivery or awareness of talking therapies?
- How easy is it to access advice from the Psychological Therapies Department in designing an appropriate plan of care of a service user?
- Have you any personal experience of contacting psychological therapies for advice?
- Was the advice you received helpful?
- Is there a clearly defined process in the trust for accessing ad hoc advice and support from the psychological therapy department?
- Are you aware of any in-house training workshops provided by the psychological therapy department for staff working in adult services?
- If yes, have you attended any of their workshops?
- If yes, what workshops have you attended?

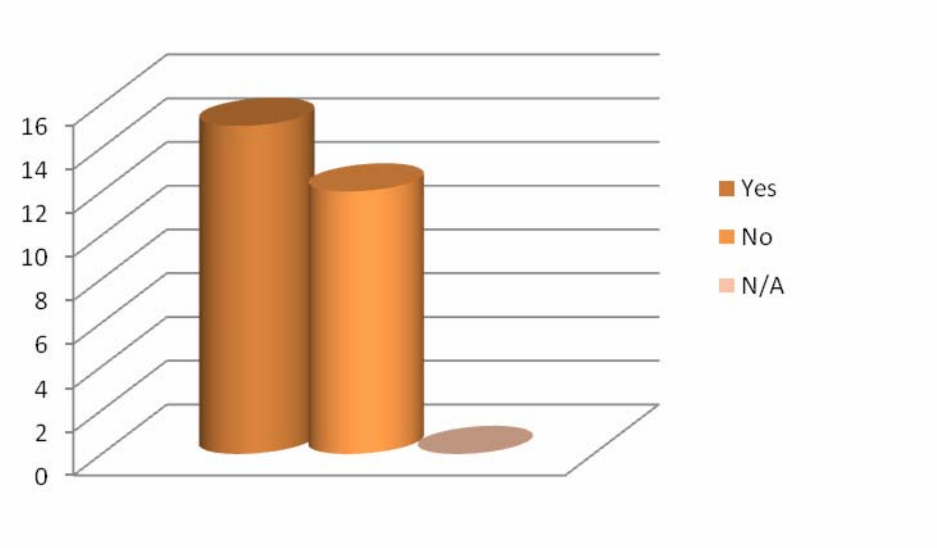
The following graphs depict staff responses to our questions.

Graph 2

Have you received any training in the delivery or awareness of talking therapies?

Number of respondents: 27

Yes	15
No	12
N/A	0

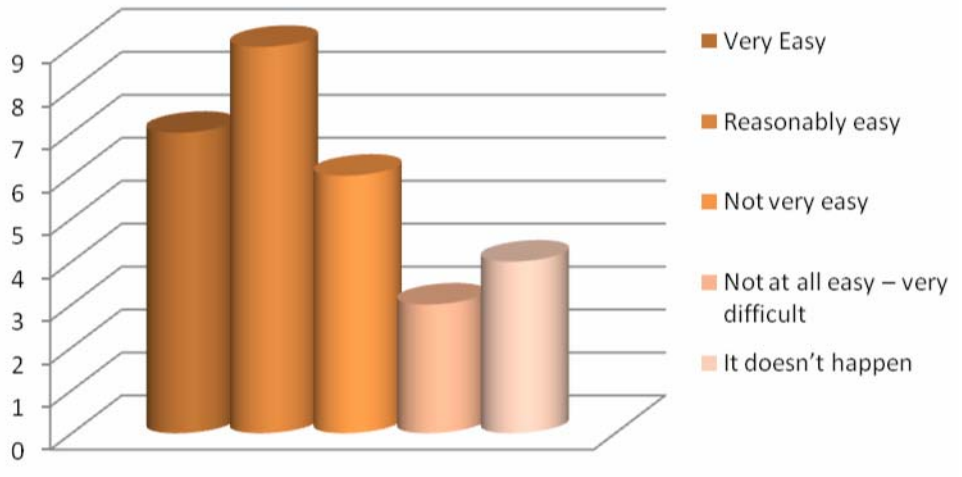


Graph 3

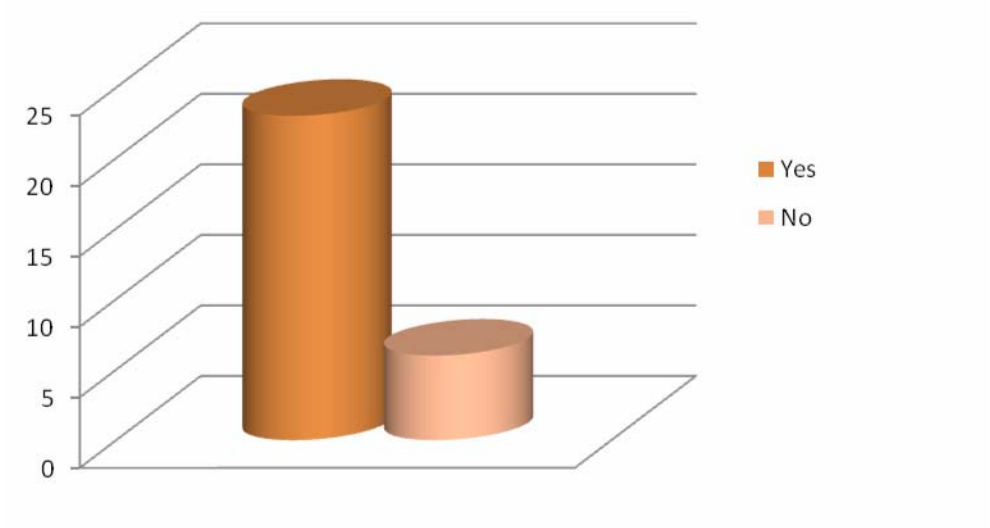
How easy is it to access advice from the Psychological Therapies Department in designing an appropriate plan of care of a Service User?

Number of respondents: 29

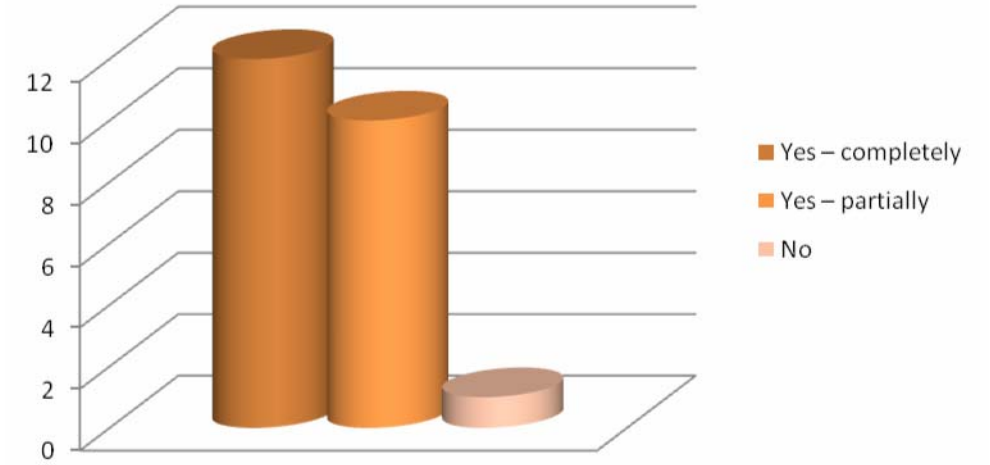
Very easy	7
Reasonably easy	9
Not very easy	6
Not at all easy – very difficult	3
It doesn't happen	4



Graph 4
Have you any personal experience of contacting psychological therapies for advice?
Respondents: 29
Yes 23
No 6

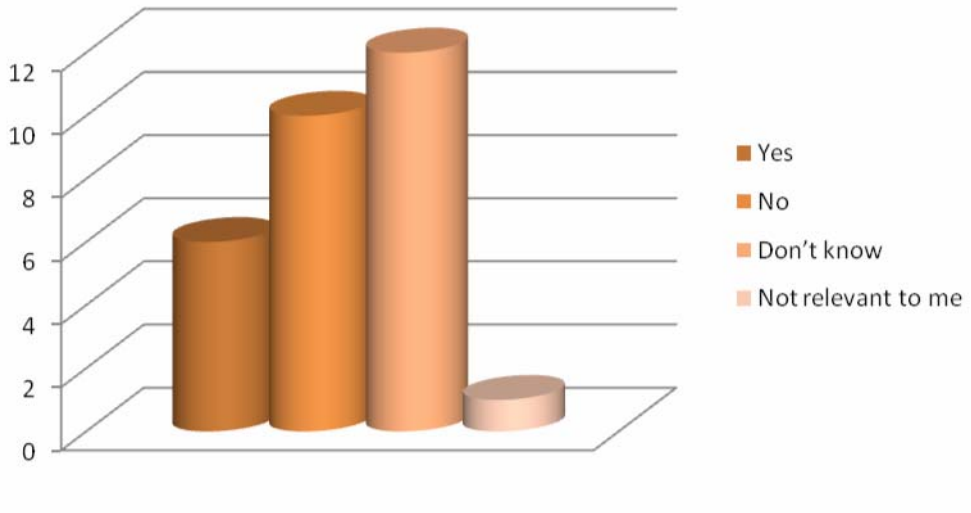


Graph 5
Was the advice you received helpful?
Number of respondents: 23
Yes – completely 12
Yes – partially 10
No 1



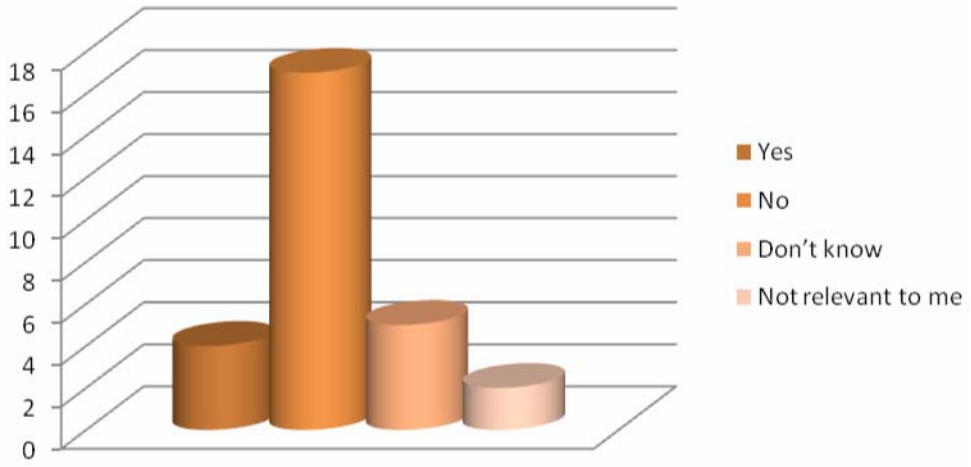
Graph 6
Is there a clearly defined process in the trust for accessing ad hoc advice and support from the psychological therapy department?
Number of respondents: 29

Yes	6
No	10
Don't know	12
Not relevant to me	1

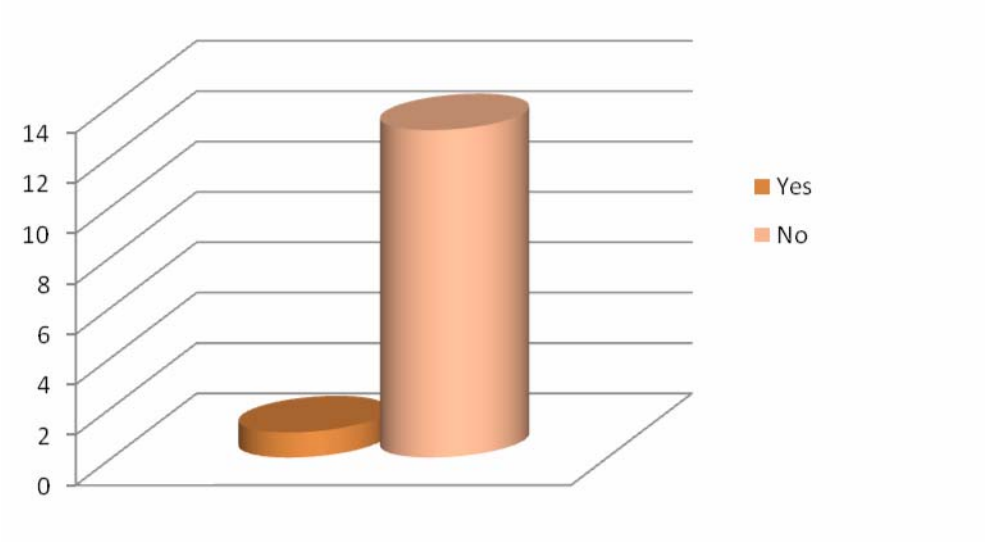


Graph 7
Are you aware of any in-house training workshops provided by the psychological therapy department for staff working in adult services?
Number of respondents: 28

Yes	4
No	17
Don't know	5
Not relevant to me	2



Graph 8
If yes have you attended any of their workshops?
Number of respondents: 14
Yes 1
No 13



The responses to the final question, “If yes what workshops have you attended?” were as follows:

- ”addiction diploma”;
- ”motivational interviewing”; and
- “Having done BSC (Hons) in therapeutic ?. I have regular clinical supervision from a psychotherapist.”

Note: The number of respondents to the questionnaire is too small to make significant recommendations in relation to how the psychology department provides advice and support to clinicians engaged in the day-to-day management of service users. However, the information provided does suggest that how the department makes effective use of its skills and knowledge across in-patient and community mental health services needs to be examined. In particular there needs to be clarity and consistency in how staff can seek and receive guidance and advice from psychological services to achieve effective care planning for service users.

7.0 CONCLUSIONS OF THE INVESTIGATION TEAM

As a result of this investigation the conclusions of the Investigation Team are as follows:

- That the incident that occurred on 25 July 2006 was neither predictable nor preventable by the mental health services nor any other agency that had had involvement with the MHSU between February and July 2006.
- That between 2002 and May 2006 the MHSU's care was of a reasonable standard.
- That between 16 May and 6 June 2006 there was no clear communication to the prison healthcare service that the MHSU was on enhanced CPA and therefore required the input of the prison in reach mental health team (IR team).
- That between 16 May and 6 June 2006, the MHSU's nominated care coordinator should have retained responsibility for delivering him a mental health service and should have ensured that his seven-day post discharge assessment occurred. This individual should also have retained the responsibility for liaising with the IR team.
- That on discharge of the MHSU from prison back into the community there was no notification to mental health services. This, the Investigation Team believes, was influenced by the lack of active follow up of the MHSU during his remand in custody by the mental health service in Leeds.
- At the time of the MHSU's final contact with mental health services on 19/20 July 2006 the decision not to admit him to hospital was reasonable. The team members from the CRHT did undertake a satisfactory risk assessment that was cognisant of the previous information gathered by a colleague in early May 2006, and also the discharge summary complied by the Becklin Centre when the MHSU was discharged from this service on 16 May 2006.
- The non-communication by the CRHT to the MHSU's care coordinator following his assessment in A&E on the 19/20 July, whilst constituting a slip in practice did not, in the opinion of the Investigation Team, contribute in any way to the events that subsequently occurred. The CRHT had referred the MHSU to the Leeds Addiction Service (LAU), and had provided the MHSU with all of the necessary contact details for this service. There is no record that the MHSU made independent contact with the LAU.

8.0 RECOMMENDATIONS

The Investigation Team has five targeted recommendations for Leeds Partnerships NHS Foundation Trust as a result of this investigation and one recommendation for the prison health service at HMP Leeds.

Where a recommendation has relevance for the Probation Service and/or Touchstone this is made explicit.

Recommendation 1:
When a service user is arrested and a custodial sentence is passed[21] it is important that the specialist mental health service ensures that the responsible prison healthcare team is aware of any relevant mental health history, including the care plan and risk assessments. This responsibility is held regardless of the location of arrest, e.g. hospital or community.

The challenge for the specialist mental health service is how it becomes aware of the arrest and subsequent custodial disposal so that it can discharge its duty of care to the service user.

Because this can be a complex area the Investigation Team is reluctant to make a fixed recommendation. However it does ask the Associate Medical Director for Adult Services to consider the following in trying to address this issue:

- Highlighting to the Medical Liaison Committee the opportunity for proactive notification to mental health services by the service user's GP when they receive requests for health information about the service user from the relevant prison.
- Working with the NHS Leeds prison healthcare team and the probation service to define an information pathway so that care coordinators and/or the service users consultant psychiatrist are reliably informed when a service user is arrested and a period of time in custody, and/or a custodial sentence is expected.

Note: Any such sharing of information needs to be cognisant of local information sharing protocols, Caldicott guardianship and data protection principles. However, staff need to recognise that there will be few occasions where the withholding of information from agencies involved in delivering care and treatment to a service user would be warranted.

Target audience: the associate medical director and associate director for adult services – mental health.

[21] i.e.at the direction of the Courts pending trial, or as a result of trial and/or sentencing.

Recommendation 2:
Cases will continue to arise where more than one agency is involved with a service user (such as probation, voluntary agencies and secondary mental health services), and a decision is being taken by a mental health care coordinator, following an initial referral assessment, as to whether input by the community mental health team (CMHT) is required. In such cases this professional must ensure that he or she has a complete understanding not only of the engagement of the other agencies, but also of the degree of engagement of the service user with these agencies, and the communication strategy should significant changes in the service user's circumstances arise.

One way of achieving this could be via telephone conference involving all agencies so that each has a grounded understanding of:

- each other's roles and boundaries;
- any pertinent information that may affect the ongoing coordination of care and service input; and
- any contingency plan.

In addition a virtual round-the-table discussion will enable a communication strategy between the agencies to be agreed.

At minimum the assessing professional or care coordinator must ensure that he or she is fully conversant with the three bullet points above in relation to each involved agency before finalising the decision that no CMHT input is required.

To ensure action occurs
This expectation needs to be formalised within the operational policy for community mental health teams in Leeds Partnerships NHS Foundation Trust, and within the operational procedures for staff working within Touchstone and for staff working with the probation service.

Target audience

- The associate medical director and associate director for adult services – mental health.
- The clinical service manager for CMHTs, adult mental health.
- In addition the management team for the National Probation Service in Leeds and Touchstone in Leeds need to consider how they can action the principle embodied in this recommendation.

Recommendation 3:
This is linked to recommendation number 2.

The face-to-face interviews and responses provided to relevant questions in the questionnaire revealed an unsatisfactory level of understanding amongst the nursing staff about Fair Access to Care (FAC) and the trust's statutory obligations in respect of this. The trust may wish to further explore staff knowledge and understanding regarding FAC before implementing any far-reaching educational plan.

The trust does need to achieve a position where all staff responsible for assessing individuals (whether or not these individuals require, or are eligible for the trust's services) must consider their eligibility for services under Fair Access to Care, and clearly document their decisions.

Actions that may assist in achieving the above stated aim:

I. Consideration needs to be given to the feasibility of including information on FAC in existing CPA training opportunities, or whether a standalone education programme is required.

II. A suggested measurement for determining the successful implementation of the recommendation is that all staff carrying care coordination responsibility should know precisely what FAC is, what the assessment criteria are and what the local policy arrangement is.

III. As Leeds Partnerships NHS Foundation Trust develops its electronic documentation, consideration needs to be given to incorporating a question about FAC in relevant sections of the documentation tools.

Recommendation 4:
This recommendation is inextricably linked to recommendation 1.

From time to time service users receiving active input from the trust will be arrested and placed in custody at the direction of the courts pending trial, or as a result of trial and/or sentencing. Where the trust is aware of a service user being awarded a custodial sentence, in such cases the trust needs to ensure that all staff who carry care coordination responsibility understand that it is their responsibility to continue to oversee the delivery of any required mental health service to the service user, and ensure continuity of care planning arrangements.

For example, the care coordinator should liaise with the prison in-reach team if specialist mental health support is required. It is not acceptable for a care coordinator to leave a third party, who cannot deliver the care, to pass on information about care requirements to the team who

can. If this is unavoidable the care coordinator remains responsible for ensuring that it has happened.

To ensure action occurs

- The CPA policy document and CPA paperwork need to reflect these responsibilities clearly and unambiguously.
- It is also recommended that this area of care coordinator responsibility is highlighted in the trust's training for care coordinators and within any generalised CPA training workshops.
- It is suggested that a partnership audit is conducted between specialist mental health adult services, the prison in-reach team, and the prison primary care team (mental health) covering the following questions:
    - How many individuals admitted to prison in the last six months were actively engaged with specialist mental health services at the time of sentencing?
    - Of these how many were on enhanced CPA and how many on standard CPA? (note as of October 2008 there is only one level of CPA)
    - For how many of these individuals is there any evidence of proactive communication to the prison in-reach team, and/or the prison primary care team (mental health)?
    - What were the circumstances of the service users arrest? (Here one is trying to gain an insight into the location of the arrest, and where the SU was taken prior to being sent to prison. This information may influence the development of any information sharing protocol).
    - For identified inmates, who have been discharged from prison at the time of the audit, is there any evidence of any discharge planning between either the prison in-reach team and the individual's care coordinator and/or the prison primary care team (mental health) and the care coordinator?

  The data fields suggested are not exhaustive and the teams identified above may wish to expand on these.
  In making this recommendation, it is expected that the outcome of the audit will result in a quality improvement plan involving all three services.

Timescale
The Investigation Team suggests that such an audit could be designed and conducted within six months of the publication of this report.

Target audience
The assistant medical director and associate director for adult services – mental health.
The trust CPA and risk management coordinators.
The governance group for adult services.
The manager and team leader for the prison in reach service.
The head of prison health care.
The safer custody and mental health lead at HMP Leeds.

Recommendation 5
It was identified by the Investigation Team that at least one CMHT does not take minutes of its weekly team meeting where clinical decisions are made. This is not sensible in contemporary times. It is therefore recommended that all CMHTs, regardless of directorate, are required to maintain clear and auditable minutes of their weekly team meetings. The Investigation Team would expect these minutes to clearly detail:

- ‘of concern’ clients who are discussed and any action points agreed;
- a brief record of discussions about any other client on the CMHT case load and action points agreed; and
- key business or team management issues discussed.

If a CMHT uses any risk identification system for its clients, such as colour-coding, it is expected that the colour-coding and any change to this would also be noted.

It is important to note that the maintenance of meeting minutes is good governance but this does not mean that it replaces the requirement for good quality contemporaneous clinical records.

To ensure action occurs

- It is recommended that this is discussed at the trust Governance Committee, and agreement is sought to have the requirement for clear meeting minutes enshrined within each service’s operational policy.
- It would be prudent for the Directorate of Adult Services, and all service governance committees, to agree a standardised template for the recording of CMHT team meeting minutes.
- A date for service-wide implementation needs to be agreed by 1 April 2009. The success of implementation can then be audited within six months of this date.

Target group
The trust’s medical director and nursing director.
The associate medical director and associate director for adult services – mental health.
The associate medical directors and associate directors for child and adolescent, older persons, and forensic and specialist services.

Recommendation 6
Although it appears that the standard of, and provision of, mental health services within the prison population has improved, the Investigation Team were very concerned about the lack of accurate documentation of information provided to the prison healthcare team by the court liaison officer and probation service.

The Investigation Team therefore recommends that the head of prison healthcare reviews the current approach to the monitoring of and audit of documentation. We suggest that a peer review approach is considered to enable health staff to reflect on the quality of their documentation and whether or it accurately portrays:

- care and treatment given;
- the names, positions and agencies of persons providing third party information; and
- information relayed to third parties.

We also suggest that the review of documentation is a core activity within the context of clinical and management supervision.

Utilization of quantitative record keeping audit tools designed to collect information that requires no clinical assessment or interpretation will not be sufficient to met the intention of this recommendation.

Target audience:
Head of governance NHS Leeds.
Head of prison health care, NHS Leeds.
The safer custody/lead for mental healthcare, HMP Leeds

Note: It is recommended that the senior managers and senior clinicians across all involved agencies embrace the key message in this recommendation which is the need to ensure:

- clear;
- accurate; and
- concise

recording of information provided by another agency, including the name and position of the information giver.

Recommendation 7
It is recommended that NHS Leeds prison healthcare services reconsider the current design of the form it issues to general practitioners seeking health based information about new inmates.

The current form is not particularly directive and does not state clearly the importance of the information provided to enabling the provision of appropriate healthcare to a new inmate.

With regards to information pertaining to the mental health needs of an individual the following minimum data set should be requested:

- Does the individual have a mental health diagnosis? Yes ❒ No ❒
- If yes what is this:
- Is the individual on CPA? Yes ❒ No ❒
- What is the name of the individual's consultant psychiatrist?
- What is the name of the individual's care coordinator

It is presumed that the prison health team will have information relating to the CMHT sectors that provide a service to the GP surgeries in Leeds.

APPENDIX 1 – Chronology of the MHSU's contacts with LMHTT

This chronology gives a comprehensive picture of the MHSU's contacts with LMHTT between 6 June 2002 and 20 July 2006.

Date	Contact
6 June 2002	This was the MHSU's first contact with mental health services. His St James' University Hospital A&E record shows that he arrived in the department at 12.43pm, having taken an overdose of three tablets of temazepam, and requested psychiatric help. At this time he was assessed as being of moderate risk of self harm but it was felt that hospital admission was not required. He was advised to engage with his GP.
11 June 2002	The MHSU was assessed in the Clinical Decisions Unit (CDU). He was noted to be increasingly depressed and suicidal. He had superficial cuts and also had tried to carve his girlfriend's name into his arm – it was not infected. The plan was for the MHSU to stay in CDU overnight and to be assessed by the parasuicide team in the morning. It is noted in the CDU notes that the MHSU's friends were quite demanding when they came to see him and he, having been settled before, was visibly teary when his friends were around. It was also noted that the MHSU's friends reported that he was hungry and cold. However prior to this he had made no complaints.
12 June 2002	The MHSU was assessed by a psychiatric senior house officer. The records note that he presented at A&E aged 21 years, complaining of difficulty in coping. The MHSU is noted as saying that he couldn't be bothered with life anymore and that he felt hopeless and helpless. He was offered and refused an outpatient appointment, and wished to be admitted. This was accommodated for a period of assessment and the MHSU was advised that his admission would be for a short period of time only. The records show that borderline personality traits were noted at the time of the assessment.

Date	Contact
12 June 2002 continued	During this assessment the MHSU gave a history of being suicidal since the age of 14. Prior to his presentation there was no formal contact with psychiatric services, however there was a history of overdosing behaviour in the six months prior to June 2002. At this time he had no fixed address, however three weeks prior to presentation he had been provided a flat in the Gipsil Project. (Gipton Supported Independent Living, a community-based project providing housing for young people). The clinical records note that there was a history of domestic violence between the MHSU and his girlfriend. This had led to them parting company. At the time of assessment the MHSU was complaining of voices in his head – his 'own voice' telling him to kill himself. The MHSU was admitted to Ward 37 under the care of consultant psychiatrist 1 (CP1). At the time of admission he was taking 10mg temazepam at night and cannabis.
14 June 2002	The MHSU noted to be interacting well with other patients and staff. He had experienced no further suicidal thoughts. Staff observed no depressive symptoms in the MHSU. However problems with anger management were noted and also difficulties in relating to people. The MHSU was noted to isolate himself. With regards to his housing situation he was noted to have given up the Gipsil Project flat and had been living with his girlfriend.

Date	Contact
14 June 2002 continued	The clinical records note that the MHSU was offered a flat by the Carr-Gomm charity providing that he engaged with counselling. However he had not engaged once he had a girlfriend. It is noted that the MHSU reported that he had engaged with group counselling around Christmas 2001. It is also noted that both of his community social workers were concerned that if he returned to a hostel he would deteriorate - they felt he should be receiving help as he was asking for it. Support Worker R, it is noted, told the ward team that the MHSU always struggled when he experienced a relationship breakdown but usually coped OK when he felt safe and supported. He was noted to be an angry young man who felt let down by everyone. The support worker also advised the mental health team that he did not believe that the MHSU was suitable for hostels because he could not look after himself.
Date	**Contact**
15 June 2002	The MHSU showed evidence of manipulative behaviour following his break up with his girlfriend. He threatened to hang himself if she did not get in touch. He also asked staff to phone her and ask her to visit him – the staff did this on his behalf and his girlfriend said she would not visit. The MHSU's girlfriend was also noted to have told staff that she would take out an injunction if the MHSU came anywhere near her or her family. This was communicated to the MHSU but he asked another member of staff later the same day to also call his girlfriend. The MHSU was made aware that counselling was available to him via the Market Place (a free support and counselling service) if he made contact with them.

Date	Contact
17 June 2002	Ward 37 clinical records reveal no major concerns about the MHSU. There were some instances of unruly behaviour, threats of self harm, and verbal confrontation. It is noted that he said he was stressed all of the time. The MHSU remained preoccupied with his social problems, notably housing. He said he would like to be placed in shared accommodation. He felt he could not live alone. The MHSU was discussed with CP1. The staff were provided with clear guidance regarding offering appropriate services, and remembering that it was the MHSU's responsibility to engage with services and opportunities offered.
19 - 20 June 2002	The records note that the MHSU wanted to get an injunction against his girlfriend. He is reportedly angry that she has told everyone in the neighbourhood that he assaulted her (which he did). The MHSU received two occupational therapy (OT) assessments. As a result of the first, he was provided with a planned activity schedule to try and help him get balance in his life. The activities included woodwork, a creative workshop, and cookery. The second assessment looked at his suitability for living on his own when discharged. The records note that the MHSU was assessed as fully independent in all activities.

Date	Contact
23 - 28 June 2002	The MHSU's behaviour on the ward deteriorated between 23 and 25 June. However the records note that he was generally sociable and outgoing. He was seen by CP1 on 26 and 28 June. On 28 June it is noted that the MHSU was becoming abusive towards staff. It is also noted that the MHSU had not contacted the counselling agency (it was one of the agency's stipulations that a client made contact. Staff could not have done this for him.). The records also note that sorting out the MHSU's accommodation would take some time. The plan therefore was to refer him to the services for homeless people and to discharge him once a place was available for him.
2 July 2002	The MHSU was discharged from Ward 37. On discharge the MHSU was not on any prescribed medication. At the time of discharge it appears that the MHSU was developing a dependency on the ward and did not want to be discharged. He threatened to harm himself, and his behaviour deteriorated. To have maintained him as an inpatient would not have been in his best interests with regard to his recovery. There was a reasonably good quality discharge summary to the GP. He was seen by his consultant psychiatrist CP1 on the day before discharge. In fact he was seen by CP1 three times between 26 June and 1 July. Prior to this, consultant advice was sought from a consultant covering for CP1.

Date	Contact
8 July 2002	The MHSU was seen and assessed by the parasuicide team (PST) on the Clinical Decisions Unit (CDU) at St James's University Hospital. He had taken an overdose of six temazepam tablets which he said he had stolen. The noted antecedent to the overdose was heavy drinking the previous week. The MHSU had been discharged six days prior to this attendance at A&E. Enquiries by the PST revealed that the MHSU had gained little to no therapeutic benefit from his inpatient stay. He was reported not to engage in activities, refused counselling and was aggressive and abusive to staff. It is also noted that the MHSU had told a friend that he intended to hang himself, this was what prompted his friend to take him to A&E. The MHSU was discharged from the CDU back to Prospect House (an emergency hostel for 16-25 year-old males). It is noted that the MHSU was provided with the contact details of the Leeds Crisis Centre, alcohol services and homelessness services. He also had a key worker, the contact details of whom were stated in the discharge letter.
9 July 2002	The MHSU again presented in A&E. He received a thorough assessment by the SHO on duty in spite of his recent previous assessments. The MHSU was again admitted under the care of CP1 for assessment. He was seen and assessed by CP1 on the ward round. It is clearly documented that there was still no evidence of mental illness. Consequently a decision was made to discharge the MHSU from the ward. It is noted on the ward round that the MHSU said he wanted to learn how to cope in the community. CP1 also notes that on 8 July admission appeared to be the only option in view of the MHSU's threats of self-harm. However it is also noted that 'no benefit' was gained from the MHSU's previous admission. The overriding impression was that the MHSU 'wants to be cared for'.

Date	Contact
9 July 2002 continued	The MHSU was offered an outpatient appointment for four days' time. The records show that the consultant psychiatrist wanted the MHSU's care worker to attend.
15 July 2002	The MHSU did not attend his outpatient appointment. (The 13 July was a Saturday).
19 –23 July 2002	The MHSU re-attended at A&E at St James' Hospital. He reported an alleged overdose of five temazepam tablets and one pint of beer at 19.30 hours. He said he was feeling suicidal. The PST liaised with CP1 and a decision was made not to admit the MHSU to hospital. Subsequent to this the decision was reversed. The main precipitator to this appears to have been a low blood pressure reading. The MHSU's behaviour also deteriorated and his language towards staff became unacceptable with plentiful usage of the F word. The MHSU was also noted to be calling CP1 bad names. By about 22.30hrs this same day the MHSU was requesting to have overnight leave to go to 'his brother's' for the night.
24 July 2002	It looks as though the MHSU was assessed by an SHO on 24 July following what appeared to be excessive alcohol consumption. The MHSU was discharged from the Roundhay Wing.
26 July 2002	The MHSU was seen by CP1. It is noted that the MHSU was in the pub on the 25 July. CP1 also notes "again no evidence of mental illness" and that his clinical impression is that the MHSU has an emotionally unstable personality disorder - impulsive type.

Date	Contact
27 July – 1 August 2002	The MHSU made a number of superficial self harming attempts and tried to orchestrate admission to hospital. On 1 August, having been discharged from hospital, he again presented in A&E where he was assessed. He is noted to leave the interview when it is made clear to him that he will not be admitted.
4 July 2003	This was the next substantive contact between the MHSU and mental health services. The MHSU attended Leeds General Infirmary A&E department. He stated he had no fixed address after splitting up with his girlfriend. He said he was living on the streets and had no GP. He reported a history of hearing voices, and said he felt paranoid, for example he felt others were staring at him on the road. He also complained of hearing voices telling him to kill himself and to hit others. It is also noted that he could hear a baby crying ever since his baby died in January 2003. The clinical assessment undertaken revealed no evidence of formal thought disorder. He was admitted informally to Ward 3 at The Mount. Here he was commenced on chlorpromazine 50mg BD because of his persistent complaints about auditory hallucinations. Following his admission the MHSU initially settled quickly and frequently took his own leave. There was no evidence of thought disorder, clinical depression or psychosis. The overriding impression at the time was that he was frustrated that 'not more was being done to look after him'.

Date	Contact
5-31 July 2003	The MHSU's progress on the ward was remarkably similar to 2002. By 18 July it was noted that he was spending little time on the ward and on a number of occasions he returned intoxicated. On 23 July consultant psychiatrist 2 told the MHSU that he had been warned a number of times about returning to the ward drunk and that if it occurred again he would be discharged. The MHSU's behaviour improved as a consequence over the following week. By 31 July the clinical team came to the conclusion that inpatient care was of no therapeutic benefit to the MHSU, and a decision was made to discharge him. During his admission period there was no evidence of thought disorder, clinical depression or psychosis. At discharge the MHSU was on chlorpromazine only for sleep and agitation.
1 August 2003	The MHSU was transferred to Ward 5 at the Becklin Centre, run by Leeds Mental Health Teaching Trust, under the care of consultant psychiatrist 3 (CP3). On 4 August the MHSU was discharged completely from inpatient services. The records show that the MHSU was offered coping skills, confidence and communications groups. It is also noted that the referral to Community Links (a voluntary agency) would be chased up. The MHSU was also given Crisis Centre numbers.
1 September 2003 and 19 September 2003	The lead consultant in A&E wrote to CP3 on 1 September seeking advice on how best to manage the MHSU when he next presented. A response was sent back to A&E on 19 September cc'd to the consultant liaison psychiatrist. The correspondence advises that CP3 is very happy for his secretary to be contacted with a view to offering the MHSU outpatient follow up should he present again. The response notes that the MHSU has at this time been discharged from mental health services as he is unwilling to engage with treatments/help offered and therefore there is no current benefit to follow up. The response also says that if the A&E consultant could only get through to CP3's answer machine then he should leave a message with the MHSU's current contact details. CP3's team would follow up from there.

Date	Contact
THE MHSU HAD NO CONTACT WITH MENTAL HEALTH SERVICES BETWEEN AUGUST 2003 AND THE END OF JANUARY 2006.	
1 February 2006	The MHSU was referred to Sector 3 CMHT from his GP. He had registered as a new patient at the St GP Practice. It is noted that he has a history of depression and, for the last three to four months, a history of paranoia. The main impetus for the referral was that the MHSU had not been seen by mental health services for a number of years. During this time he had moved GP surgery approximately every six months.
15 and 20 February 2006	On 15 February, the MHSU was sent an outpatient appointment for 20 February. However he did not attend this appointment. No further appointment was sent but arrangements were made for the MHSU to be followed up by the CMHT. If their assessment suggested further follow up was required it would be offered.
28 March 2006	The CMHT assessment had occurred and a letter was sent to the GP advising that there was to be no further CMHT follow up offered to the MHSU.
3 May 2006 11.45am	The MHSU attended A&E and was assessed by a psychiatric SHO. The impression formed was of a young man with a two week history of persecutory thoughts. The SHO believed him to be suffering from 'acute psychotic illness'. A referral for further assessment by the Crisis and Home Treatment Team (CRHT) was therefore made. **Note:** During his time in A&E the MHSU was paranoid that someone was going to kill him. He also acted suspiciously in A&E, thinking a nurse was holding a knife when in fact she was holding a pen. He subsequently locked himself in a toilet and had superficial cuts to his throat when he came out. The MHSU was subsequently assessed by the CRHT. A decision was made to admit him in view of his potential risk to self and others. He was admitted to Ward 1 at the Becklin Centre.

Date	Contact
4 May 2006	The MHSU was assessed by the same SHO who met him in A&E when he was admitted to the ward. A mental state examination revealed no formal thought disorder. The MHSU had over valued ideas, for example that he was going to be stabbed. He described thoughts of wanting to harm self and others in terms of thought insertion. The MHSU also said he believed that others could read his mind. He denied any intention to act on self-harm thoughts. He complained of auditory hallucinations in the 2nd and 3rd person. It is noted that he had insight that he was unwell and needed help. The MHSU said that he took venlafaxine 125mg/day and Epilim ?30mg Nocte. It is also noted that the MHSU had threatened his girlfriend and their baby with a knife. Note: At the time of this admission the MHSU gave a history of: 1. no previous contact with mental health services; 2. no illicit drug use (current); 3. a blackout two weeks ago for which he was prescribed Epilim without any further tests by his GP(!). He said he had logged a complaint against his GP; 4. working for two years as a window fitter after leaving school but not working since; and 5. no trouble with the police. On admission the MHSU was initially on five-minute observations on Ward 1. After four days all auditory hallucinations and paranoid delusions had subsided. An EEG and a CT head scan were requested in view of the reported history of epilepsy, both were normal. Urine samples on admission tested positive for amphetamines and cannabinoids.

Date	Contact
4 May 2006 continued	**Risk assessment:** On admission the MHSU was graded as “significant” risk for suicide and a Grade 3, i.e. serious, risk for harm to others – most notably his girlfriend. The risk assessment clearly documents the MHSU’s thoughts of harm for others - a female voice telling him to harm his girlfriend and his daughter.
8 May 2008	The records note that many of the MHSU’s symptoms have receded and that he is planning to go to the job centre.
10 May 2006	It is noted that the MHSU wished to know what his mental health diagnosis was. The assessment notes a young man who was well kempt and showed no signs of self neglect. He is noted to have good rapport and eye contact. His speech was normal in rhythm and rate. With regards to mood, objectively he looked anxious, and was subjectively worried about what was wrong with him.
15 May 2006	There was a CPA meeting with a plan for discharge on 16 May. He was provided with two weeks medication of risperidone 2mg to be taken at night. The plan was: 1. seven-day follow up by his care coordinator (Sector 5 CMHT St May's House); and 2. follow up with the Sector 5 consultant - to be arranged by the MHSU’s care coordinator. The crisis plan was: 1. for the MHSU to contact his care coordinator or GP; or 2. to contact NHS Direct outside of office hours

Date	Contact
16 May 2006	The MHSU was arrested for an outstanding warrant on the ward. Cannabis was also found in his possession for which he was charged.
	THE MHSU WAS GIVEN A FOUR MONTH CUSTODIAL SENTENCE OF WHICH HE SERVED TWO MONTHS
19 July 2006	The MHSU presented to A&E. He was assessed by the same SHO who assessed him in May 2003. The MHSU was again complaining of hearing voices and feeling suicidal. He reported taking an overdose of 23 procyclidine tablets but later did not remember taking them. The antecedent to this action was an argument with his girlfriend. The SHO determined that further assessment and possibly admission was required for the MHSU. A CRHT referral was therefore made. A full assessment was carried out by a senior key worker for the CRHT. The outcome of this was a referral to Leeds Alcohol Unit (LAU). The MHSU was not considered to be in any immediate danger of harming self or others. It is noted that he was willing to engage with LAU for help and support.

APPENDIX 2 - Sources of information used to inform the investigation's findings

Persons interviewed:

- Consultant psychiatrist 1 (2002);
- Consultant psychiatrist 2 (2003, and 2006);
- Specialist registrar 1 (2006);
- Consultant psychiatrist 3 (in-patient services 2006);
- A&E consultant 2003;
- Consultant in psychiatric liaison;
- Lead nurse for psychiatric liaison;
- A community service manager;
- The CPN who undertook the MHSU's assessment in March 2006 ;
- A GP who cared for the MHSU;
- The practice manager from a GP practice;
- The director of psychological services;
- A service manager for Psychological Service – Working Age Adults;
- The CRHT member who assessed the MHSU in July 2006;
- The CRHT member who assessed the MHSU in May 2006;
- The SHO who assessed the MHSU in A&E in May and July 2006; and
- A service manager for two of the CMHTs

The interviews with staff constituted a mix of one-to-one interviews, telephone interviews and a round-the-table meeting of a group of ward staff grades 5 – 7.

The notes made of each interview were provided to each interviewee who had opportunity to review these and to confirm that they represented a fair and accurate presentation of what was discussed during interview. Where discrepancies were identified the interviewees were able to notate what it was they intended to convey at interview and/or correct any misinterpretation of what was said. Where interviews were recorded staff were provided with a digital copy of this for their personal records.

Documents reviewed

All of the MHSU's mental health records.
The trust internal investigation report.
The CPA policy document.
The probation records.
The prison electronic healthcare records.

APPENDIX 3 Personality disorder

There are at least ten different types of personality disorder with an overall estimated incidence of between 10-13% of the adult population in the community. Personality disorder is more common in younger age groups (25-44 years) and although equally distributed between the sexes, specific types of personality disorder such as anti-social personality disorder (ASPD) are more common among males. The incidence of people with personality disorders in psychiatric hospital populations ranges between 36% - 67%. In the prison population this may be as high as 78%.

Typically individuals with a personality disorder have poor impulse control. They often present when in crisis, threatening deliberate self-harm or aggression to others, and abusing drugs and/or alcohol.

Personality disordered individuals are more likely to have experienced adverse life events, such as relationship difficulties, housing problems and long-term unemployment.

Treatment

Government recommendations[22] emphasise treatment in the community for personality disorders as for other mental health disorders in order to remove access barriers. Given the range of escalating problems presented by this group of people, it is important that the range of services they are likely to need (health, social services, education/employment services, housing, probation, prison and police) are well organised and well coordinated in order to provide a "whole systems" approach. Good coordination is also important within the adult mental health services in order to provide clear and consistent treatment/management with clear boundaries. Commissioners should have an informed understanding of the treatment and management needs of individuals with personality disorder.

With regard to mental health, providing appropriate treatment for people with personality disorder requires clinicians to develop particular skills. Access to good systems for support and supervision for staff working with personality disordered clients is also essential. Specialist services which are not part of the general mental health service should be available, offering a range of different treatment options that are tailored to the needs of each individual. Such teams provide assessment and consultation to mainstream mental health service staff. Treatment options would include psychological approaches such as

[22] "Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder" Department of Health 2003. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009546

dynamic psychotherapy[23], cognitive analytical therapy, cognitive therapy, therapeutic community treatments and dialectical behaviour therapy (DBT). In all cases there should be a clear link between assessment and treatment with appropriate follow up and continuing care. Treatment should focus on the strengths of the individual and should be positive and optimistic. There should be access to peer networks and service users should be encouraged to engage with these.

Features of services which have been found to be unhelpful for people with a personality disorder include:

- "office hours" only;
- lack of continuity of staff;
- inappropriately trained staff;
- treatment decided by funding/availability/diagnosis;
- inability to fulfil promises made;
- dismissive or pessimistic attitudes;
- rigid adherence to a therapeutic model in cases where it is unhelpful;
- use of physical restraint;
- inappropriate use of medication;
- staff being critical of the expressed needs of the service user (such as crisis or respite),
- staff only responding to behaviour and not being interested in the causes of behaviour;
- passing on information to others without knowing the service user;
- withdrawal of a treatment contact as sanction; and
- long-term admissions to hospital.

People with a personality disorder often have other psychiatric conditions and their personality difficulties can not only complicate assessment and treatment but also adversely affect their recovery. Antipsychotic drugs, antidepressant drugs and mood stabilisers have been reported to have some beneficial effects in some cases.

Summary

To summarise, in general people with a personality disorder require multi-disciplinary and multi-agency input which is well structured and well coordinated. Services and service users should have access to a specialist team to undertake comprehensive assessment, delivery of treatment and coordination of care. This team should provide supervision and consultation for staff working in a range of settings including adult mental health, the wider trust and external agencies. The specialist team should also develop strong links with the local forensic service and facilitate the development of local peer networks.

[23] See glossary page xx for a brief definition of these therapies.

Note: It is important to remember that treatment for personality disorder cannot be enforced. The individual with the disorder needs to be willing to engage with therapists to help them achieve a more manageable life.

APPENDIX 4 Overview of mental health provision at HMP Leeds

Prior to 2001

Within HMP Leeds there was no identifiable mental health service although there were RMNs making up part of the healthcare complement of staff. Some prisoners were offered support via the GPs or wing nurses and at that time there were approximately 52 beds available in the “hospital”, which were used regularly for assessments. Not all of these assessments could be considered therapeutic at the time.

Prior to 2001 it was also a difficult and long process to get an inmate who was acutely ill out of prison and into an appropriate hospital. This often took weeks if not months. It was less than ideal.

The lack of coordinated mental healthcare was an identified short fall within prisons and this lead to the publication of “Changing the outlook a strategy for developing and modernising mental health services in prisons” by the Department of Health in December 2001. This gave a clear strategy for the development of mental health in reach teams.

2001 to 2007

HMP Leeds was one of the first prisons to benefit from the introduction of a mental health in reach team (IR team). The IR team has introduced the Care Programme Approach (CPA) to facilitate “seamless” care into and from prison.

The IR team has a commitment to Leeds Magistrate Courts (every weekday morning), weekly clinics at all four probation hostels and operates under CPA.

Within HMP Leeds, the RMNs continued to be part of the generic nursing team, due to the developments in substance misuse services and attempts to address dual diagnosis, co-morbidity and deaths in custody. This service was developed based on presenting patient need but did not attract additional funding. The service prioritised provision of substitute prescribing, stabilisation and preparation for discharge. Significant impact has been evidenced with there being no drug related deaths in Leeds involving individual released from custody.

The positive impact of the IR team was that it and the staff of the Acute Assessment Unit (prison hospital) were able to facilitate faster transfers to appropriate healthcare settings of those individuals identified as acutely ill.

The IR Team also introduced the “single point referral meeting”. This is a once a week meeting for all agencies with concerns about a prisoner to meet and pass on a referral or accept a referral. This reduced the duplication of services being involved with one prisoner. The idea was that the prisoner would be referred to the most appropriate service for their needs. Unfortunately the attendance of the RMNs at this meeting was ad hoc due to other work commitments.

During this time period healthcare within HMP Leeds moved from the prison service to Leeds West PCT and then to Leeds PCT, now known as NHS Leeds.

2007 to date.
NHS Leeds has been more proactive in its involvement in offender health than previously. Rather than each prison in the Leeds area working in isolation with one another, they are now managed under one head of healthcare and any developing service will hopefully be replicated in the other prisons. For example when the current developments in the primary care mental health service at HMP Leeds are established, they will be adopted at HMP Wealstun. The current developments are listed below.

- A mental health strategy has been written which proposes the introduction of the stepped care model recommended by NICE. This is being assessed by the NHS Leeds Clinical Governance Committee.
- All service designs and developments have been discussed involving the Prisoner Patient Involvement Forum (PPI). This is an ongoing process.
- A Patient Advice and Liaison Service has been introduced to good effect.
- The newly refurbished day hospital is now open and can offer two interview rooms and the potential for up to three group rooms. This is a real improvement.
- Mental health practitioners are offering clinics for common mental health problems, offering low intensity cognitive behavioural therapy (CBT) currently being used in the community as recommended by NICE under “Improving Access to Psychological Therapies” (IAPT).
- The RMNs in the in-patient unit as of the week commencing 25 January 09 will be gradually joining the primary care mental health team to help facilitate the designed service of crisis interventions, assertive outreach, planned interventions (via appointments) and initial assessments.
- All the RMNs are being encouraged to attend the low intensity CBT module at Huddersfield University to enhance their practice.
- There is a secondment opportunity for a senior mental health nurse to explore the needs of, (and service design for) those with a diagnosis of personality disorder who are located in the segregation unit. This is a fixed-term opportunity of 18 months.
- Services which will be available are yoga, relaxation and anxiety management, sleep management, inter-departmental shared care protocols to encourage social inclusion

(workshops, education and gym) as well more specific groups on topics such as coping with voices and self harms.

- The day hospital is developing as the hub of all mental health provision within HMP Leeds. All staff within the prison will know how to contact the service for advice and assistance. In addition the wider health community, and other agencies such the probation service and the voluntary sector, will know how to contact it to share information with regard to patient care and risks. It is the aspiration of the current safer custody/mental health lead that this will enable more reliable exchange of information between all relevant services and agencies.

GLOSSARY and FURTHER INFORMATION

CARE PROGRAMME APPROACH (1995 – 30 September 2008)

The Care Programme Approach (CPA) had four main elements as defined in "Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people". Department of Health 1995, London HMSO.

These elements are the following.

- Assessment: systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;
- A care plan: the formation of a care plan which addresses the identified health and social care needs;
- A key worker: The appointment of a key worker (now care co–ordinator) to keep in close touch with the patient and monitor care; and
- Regular review: regular review, and if need be, agreed changes to the care plan.

The cornerstones of the CPA

These four principles, of assessment, care plan, care coordination and review are the cornerstones of the CPA. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Modernising the CPA

In 1999, the Government undertook a review of the CPA which was considered timely for a number of reasons, including:

- the introduction of the National Service Framework for Mental Health, published in September 1999;
- the lessons learnt through research, reviews and inspections; and
- the need to listen to professionals' views about the CPA. The review resulted in the publication of 'Effective Care Coordination in Mental Health Services, Modernising the Care Programme Approach', published in October 1999.

Key changes

This confirmed the Government's commitment to the CPA for working age adults in contact with secondary mental health services and introduced changes to the CPA. The key changes are the following.

- Integration of the CPA and care management: the CPA is care management for people of working age in contact with specialist mental health services.
- Appointment of a lead officer: each health and social services provider is required to jointly identify a lead officer to work across both agencies.

- Levels of the CPA: two levels of the CPA must be introduced (standard and enhanced).
- Abolition of the supervision register: from April 2001, supervision registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place.
- Change of name: `key worker' to be referred to as `care co–ordinator'.
- Reviews of care plans: the requirement to review care plans six-monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set.
- Audit: regular audit is required looking at the quality of implementation of the CPA.
- Risk assessment/risk management: risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to include a crisis plan and contingency plan.

Standard CPA
Standard CPA is for people who require the support of only one agency. People on standard level will pose no danger to themselves or to others and will not be at high risk if they lose contact with services. The input of the full multidisciplinary community health team will not be required – service users on standard CPA will generally require the support of one or two members of the team.

Enhanced CPA
Enhanced CPA is for people with complex mental health needs who need the input of both health and social services. People on enhanced CPA generally need a range of community care services. This group of people may include those who have more than one clinical condition and also those who are hard to link with services and/or with whom it is difficult to maintain contact. Some people on enhanced CPA are thought to pose a risk if they lose contact with services. Generally speaking, enhanced CPA tends to apply to people with more severe mental health problems such as schizophrenia or manic depression. In some cases, enhanced CPA can ensure better access to services.

CPA from October 2008
New guidance has been issued regarding the Care Programme Approach (CPA). This guidance called "Refocusing the Care Programme Approach".

From 1st October 2008, the term CPA will describe the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex needs.

From October 2008 the term CPA will no longer apply to individuals in contact with a single professional.

Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan drawn up for the most serious offenders benefits from the information, skills and resources provided by the individual agencies being coordinated through MAPPA. MAPPA were introduced in 2001 and bring together the police, probation and prison services into what is known as the MAPPA Responsible Authority. Other agencies are under a duty to co-operate with the MAPPA Responsible Authority, including social care, health, housing and education services. Each MAPPA area produces an annual report which details performance, statistics, future developments and MAPPA team contact details.

How does MAPPA work?
There are four key features within MAPPA:

1. Identifying offenders to be supervised under MAPPA.
This is generally determined by the offender's offence and sentence, but is also by assessed risk.
There are three formal categories:

1. Category One: registered sex offenders (around 30,000 offenders in 2004/05)
2. Category Two: violent or other sex offenders (around 12,600 offenders in 2004/05)
3. Category Three: other offenders (around 3,000 offenders in 2004/05)

2. Sharing of information about offenders.
MAPPA promotes information sharing between all the agencies, resulting in more effective supervision and better public protection.
For example:

- police will share information with offender managers that they have gathered about an offender's behaviour from surveillance or intelligence gathering; and
- local authorities will help find offenders suitable accommodation where they can be effectively managed.

It is very important that victims' needs are represented in MAPPA, with the result that additional measures can be put into place to manage the risks posed to known victims.

3. Assessing the risks posed by offenders
Most MAPPA offenders do not present a risk of serious harm to the public: the MAPPA enable resources and attention to be focused on those who present the highest risks.

4. Managing the risk posed by individual offenders
MAPPA offenders should be managed at one of three levels.
While the assessed level of risk is an important factor, it is the degree of management intervention required which determines the level.

- Level One: this involves normal agency management.
  Generally offenders managed at this level will be assessed as presenting a low or medium risk of serious harm to others. In 2004/05 just more than 71% of MAPPA offenders were managed at this level.
- Level Two: this is often called local inter-risk agency management.
  Most offenders at this level are assessed as presenting a high or very high risk of harm. In 2004/05 just more than 25% of MAPPA offenders were managed at this level.
- Level Three: this involves Multi-Agency Public Protection Panels (or MAPPPs).
  This level is appropriate for those offenders who pose the highest risk of causing serious harm, or whose management is so problematic that multi-agency co-operation and oversight at a senior level is required with the authority to commit exceptional resources. In 2004/05 just more than 3% of MAPPA offenders were managed at this level.

Psychological Therapies
Psychological therapies is a term used to describe therapies based on psychological principles, often referred to as "talking therapies". Generally these therapies have evolved to help people with mental health problems and are structured interventions. A broad range of therapies can be described in this way, including a variety of behaviour therapies, cognitive therapy, psychotherapy, psychodynamic therapy and counselling.

Reference: “Treatment Choice in Psychological Therapies and Counselling, Evidence Based Practice Guideline”
DH 2001
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007323

Cognitive analytic therapy (CAT)
http://www.netdoctor.co.uk/diseases/depression/cognitiveanalytictherapy_000510.htm

Cognitive analytic therapy is a system of treatment in which the therapist helps the patient to understand why things have gone wrong in the past – and explores how to make sure that they don’t go wrong in the future.

In simple terms what it seeks to do is to apply the step-by-step

pragmatism of cognitive therapy to some of the ideas of the more analytical approach of psychodynamic therapy.

CAT was developed in the UK by Dr Anthony Ryle, who began his medical career as a GP but whose interest in neuroses and psychotherapy led to him becoming a consultant psychotherapist at St Thomas's hospital in London. He has been involved in the initiation and development of CAT since the late 1970s.

CAT first concentrates on discovering why a person's emotional or psychological problems have happened – including going back to childhood. Then it looks at the effectiveness (or otherwise) of the mechanisms which the sufferer has developed in order to cope with these problems. Finally, the therapist helps the client to see how he or she can improve their ways of coping.

As in cognitive behavioural therapy, the emphasis is on the client developing the tools to deal with his or her own psychological problems in the future.

Cognitive behavioural therapy (CBT)
CBT is a way of talking about:

- how you think about yourself, the world and other people; and
- how what you do affects your thoughts and feelings.

CBT can help a person change how they think ("cognition") and what they do ("behaviour)". These changes can help one to feel better. Unlike some of the other talking treatments, it focuses on "here and now" problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve your state of mind now.

It has been found to be helpful in the management of anxiety, depression, panic, agoraphobia and other phobias, social phobia, bulimia, obsessive-compulsive disorder, post-traumatic stress disorder and schizophrenia.

How does it work?
CBT helps make sense of overwhelming problems by breaking them down into smaller parts. This makes it easier to see how they are connected and how they affect you. These parts are:

- a problem, event or difficult situation; and

following on from this:

- thoughts;
- emotions;
- physical feelings; and
- actions.

Each of these areas can affect the others. How you think about a problem can affect how you feel physically and emotionally. It can also

alter what you do about it. There are helpful and unhelpful ways of reacting to most situations, depending on how you think about them.

Dialectical behaviour therapy (DBT)

The aim of DBT is to create a practical way of helping people who are otherwise very difficult to treat. DBT is a hybrid created out of a variety of disparate elements. It seems to have a number of intellectual roots.

Cognitive-behavioural therapy

One of DBT's elements is cognitive–behavioural therapy (CBT). DBT espouses the scientific ethos. It makes use of self-monitoring, there is an emphasis on the here and now and much of the therapeutic technique is borrowed from CBT, including the style of open and explicit collaboration between patient and therapist. The 'bible' of DBT is Marsha Linehan's "Cognitive Behavioural Treatment of Borderline Personality Disorder" (Guilford Press,1993).

Dialectical thinking

The 'dialectical' in DBT refers to a broad way of thinking that emphasises the limitations of linear ideas about causation. It substitutes 'both/and' for 'either/or' and sees truth as an evolving product of the opposition of different views. The use of dialectical ideas in DBT arises largely from clinical observation of the mixed and shifting nature of human emotion and experience in general, and in patients with borderline personality disorder in particular. Interaction with such a patient is unlikely to have the characteristics of a logical argument or even a orderly conversation. It is more likely to be akin to a dance to rapidly changing music in which clinician and patient each react to the other – sometimes to good effect, sometimes with much painful stamping on toes.

A touch of Zen

Dialectical thought emphasises the wholeness and interconnectedness of the world and the potential for the reconciliation of opposites. This emphasis is shared by the third element in DBT: the use of thinking and techniques drawn from Zen Buddhism. The key concept is that of mindfulness. The person with BPD is seen as having special difficulties in being at all detached from his or her experience and, indeed, as often being overwhelmed by it. Developing the capacity for being mindful and living in the moment allows a greater potential for feeling appropriately in charge of the self. Zen is full of paradox, and there is something paradoxical about seeking greater mastery through a kind of detachment. However, when the alternative is being engulfed, then the place of mindfulness becomes clear. A related concept is the balance between acceptance and change. The most difficult idea for some is that the world is as it is. But again there is some paradox in the notion that acceptance – for instance, of unchangeable traumatic events in the past – may be necessary for change to be possible.

TOUCHSTONE – THE HOSTEL

The Hostel is a mental health hostel. It is part of the registered charity Touchstone.

The work of the hostel is with 16-25 year olds and it has 11 rooms. The aim is to support the residents in moving to independent living. The Hostel is not a long term option. The staff look at education and training, and tailor this to individual needs. They also conduct outreach work in the community.

For example their `floating' clients live out in the community so the support workers often go to visit them at a place of their choosing. The support worker will also spend time with a young person in the community environment. Typical examples are in local cafes, post offices and job centres. Other parts of the Touchstone charity group do lots of different community-based work and outreach work.

Clients at The Hostel can be diagnosed or undiagnosed with regards to mental illness.

There was a time when The Hostel was more relaxed about its acceptance criteria and would take young adults who were homeless but with no definable mental health need, but where there had been psychological stressors such as family break-up. The pressures and demands on the service now mean that a more rigorous approach is required. Individuals who are depressed or suicidal but may not be diagnosed as such do meet the criteria for support from The Hostel.

Potential residents are prioritised and a range of criteria is used for this. Priority 1 individuals are:

- young people on enhanced care programme approach; or
- young people referred from mental health hospital wards.

Priority 2 individuals are:

- young people who are on care programme approach;
- young people who are referred by community mental health teams;
- young people who have dual diagnosis; or
- young people who are referred by the youth offending team.

There are also individuals who are eligible but who do not meet priority criteria. These are individuals who do not fulfil the priority categories, and they will be offered a place at the hostel on a first come, first served basis after allocation of the priority cases has occurred.