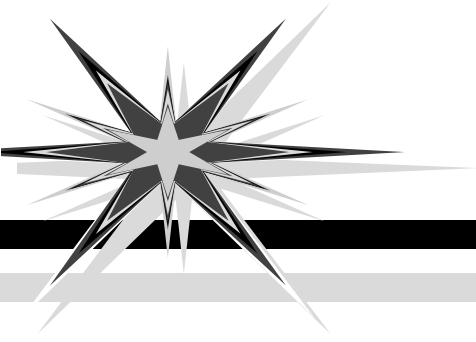


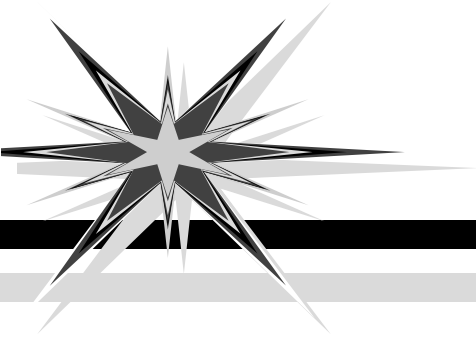
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A New Approach to
Individual Care and
Public Safety



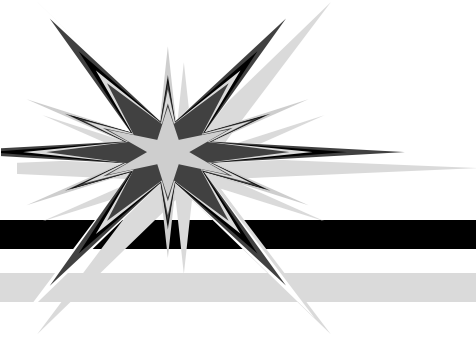
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An Integrated Approach
to Individual Care
and Public Safety



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- ◆ The Content
- ◆ The Lessons
- ◆ The Challenge
- ◆ The Principles
- ◆ The System
- ◆ Next Steps ...



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LESSONS LEARNED

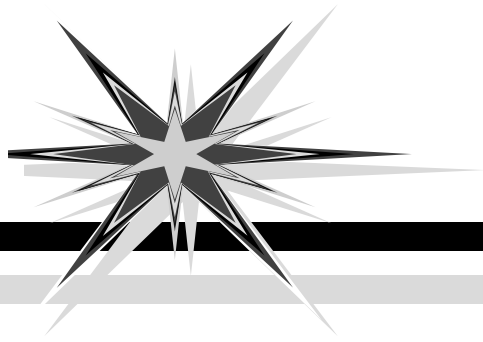
- ◆ Revolving doors
- ◆ Comprehensive assessment
- ◆ Needs led risk management
- ◆ Transfer of care
- ◆ Inter-agency co-operation
- ◆ Mending the net
- ◆ Integration
- ◆ After care follow up
- ◆ Training and support
- ◆ Audit



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CONTEXT

- ◆ Process of Normalisation
- ◆ Care in the Community
- ◆ Availability of beds



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LANDMARKS

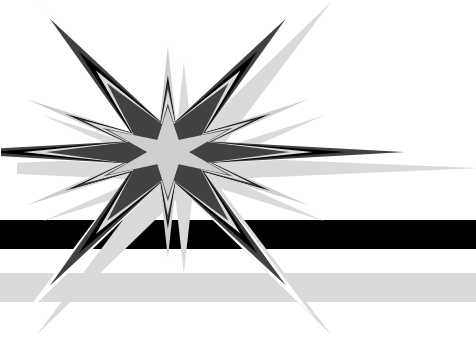
- ◆ The Care Programme Approach
(Legislation) 1990
- ◆ “Provision for Mentally Disordered Offenders”
HC 66/90 (Guidance) 1990
- ◆ “Custody, care and justice”
DOH/HO (Guidance) 1991
- ◆ “Review of Services for MDO’s and Patients
with Similar Needs” - Reed Report 1992
- ◆ Introduction of Supervision Registers
(Legislation) 1994
- ◆ High Profile Public Inquiries (Five) 1994
- ◆ High Profile Public Inquiries (Seven) 1995
- ◆ Seven Public Inquiries
24 in the pipeline! 1996



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*“Yesterday’s scandals of the institution
have already been replaced by today’s
scandals of the community”*

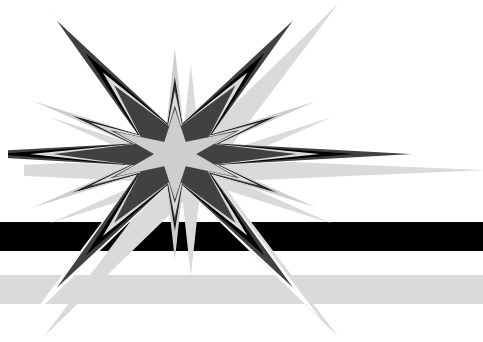
Rose 1986



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“Each inquiry sets out to ‘learn the lessons’... This worthy ambition has a hollow ring about it now. It seems that every authority in the country would need to have its homicide, perhaps more than one... before there is any chance of any lesson being learned at local level.”

Adapted from Learning the Lessons 1996

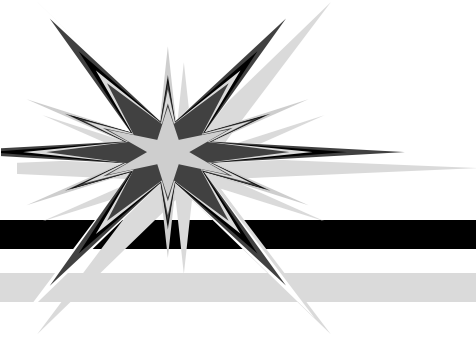


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“Inquiries are not set up only to prevent recurrences. They also provide explanations and insight for bereaved relatives and, in the case of homicides, also for the family of the mentally ill person who often feel abandoned and let down by the services. As public servants, surely managers and clinicians must be ready to have their practice scrutinized and should demonstrate a positive willingness to be criticized when criticism is justified.”

Elaine Murphy

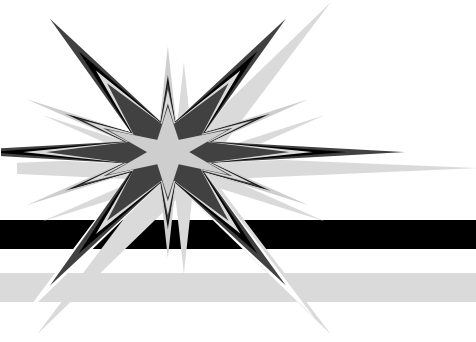
Former Vice Chair, Mental Health Act Commission



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“The irony is that an alarming number of published enquiry reports reveal that, had the family and/or those close to the family been listened to by professionals the first place, there is every chance the homicide would not have taken place.”

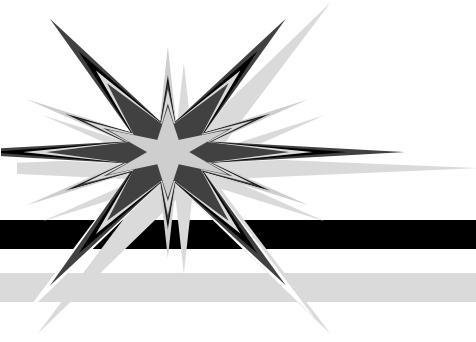
Learning the Lessons 1996



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The great challenge of what remains of the 1990's is to integrate the almost separate worlds of research, clinical practice, individual care and public safety.

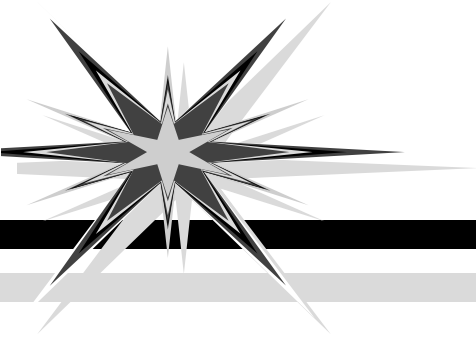
O'Rourke 1996



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“..the unreliability of psychiatric predictions of future dangerousness is by now established fact within the profession... the large body of research in this area indicates that, even under the best conditions, psychiatric predictions of long term future dangerousness are wrong in at least two out of every three cases.”

American Psychiatric Association 1983
Barefoot vs Estelle. Legal 463,US880



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GOALS

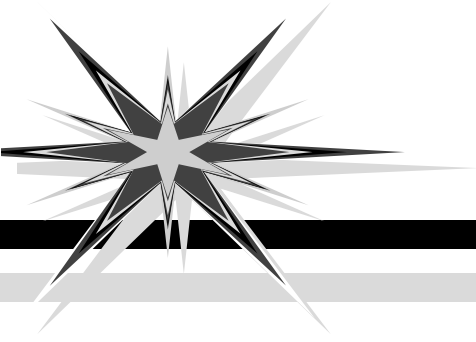
- ◆ Shared Goals
- ◆ Shared Training
- ◆ Enhanced Communication
- ◆ Enhanced Good Practice



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GENERAL PRINCIPLES

- ◆ Risk cannot be eliminated
- ◆ Risk is dynamic
- ◆ Risk may be general or specific
- ◆ Rigorous assessment and good practice can reduce risk
- ◆ Good risk assessment can not be done in isolation
- ◆ Having identified risk there is an absolute duty of care to manage it
- ◆ Comprehensive risk management is multi-featured
- ◆ Some interventions can be harmful
- ◆ Patients presenting risk to others are likely to be vulnerable to other forms of risk



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CONFIDENTIALITY

We have learned the lessons.....

about revolving doors

about comprehensive assessment

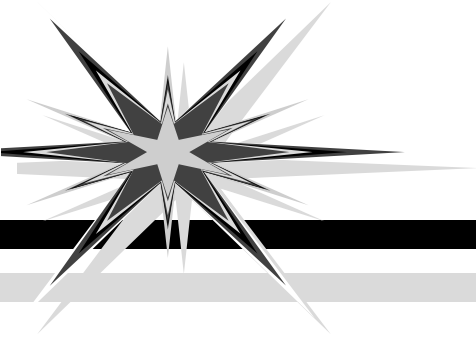
about needs led risk assessment and risk

about inter-agency co-operation and
communication

about transfer of care

about mending the net

about after-care, follow up, review, safety nets

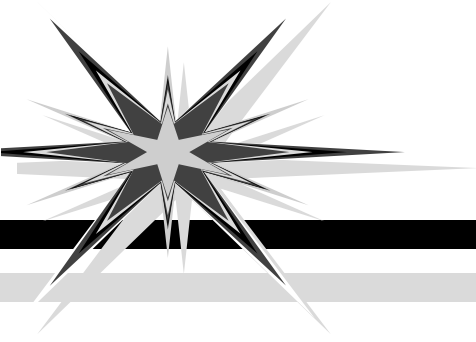


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Information about the patient may be passed on to someone else:

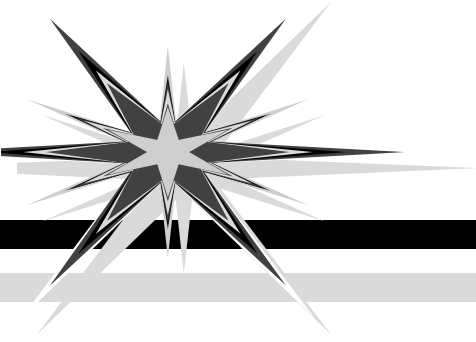
- ◆ with the patient's explicit consent; or
- ◆ on a 'need to know' basis
recipient needs information for therapy and care
- ◆ need to protect the public in general
- ◆ need to protect victim(s)



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“It has been noticeable how little routine attention appears to have been paid by anybody to quality or outcome measures of the community management of mentally ill people. The same is true of performance of staff, either as individuals or teams. There seem to have been no consequences whether the work was done well or badly. Those who planned procedures or made policies do not appear to have checked or to know whether they were being followed.”

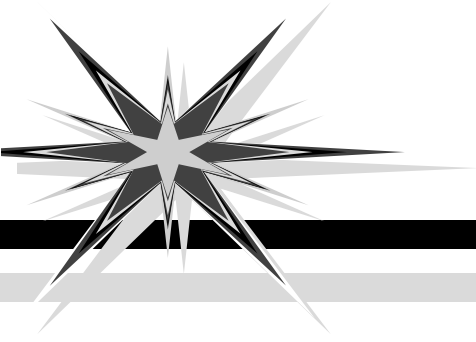
The Clunis Report 1994



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PRINCIPLES

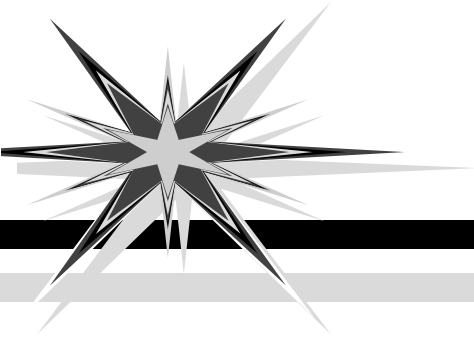
- ◆ Patient Centered
- ◆ Needs Led
- ◆ Inter-agency Driven
- ◆ Decisions Must Be Supported
- ◆ Carers Must Be Consulted
- ◆ Quality Focused



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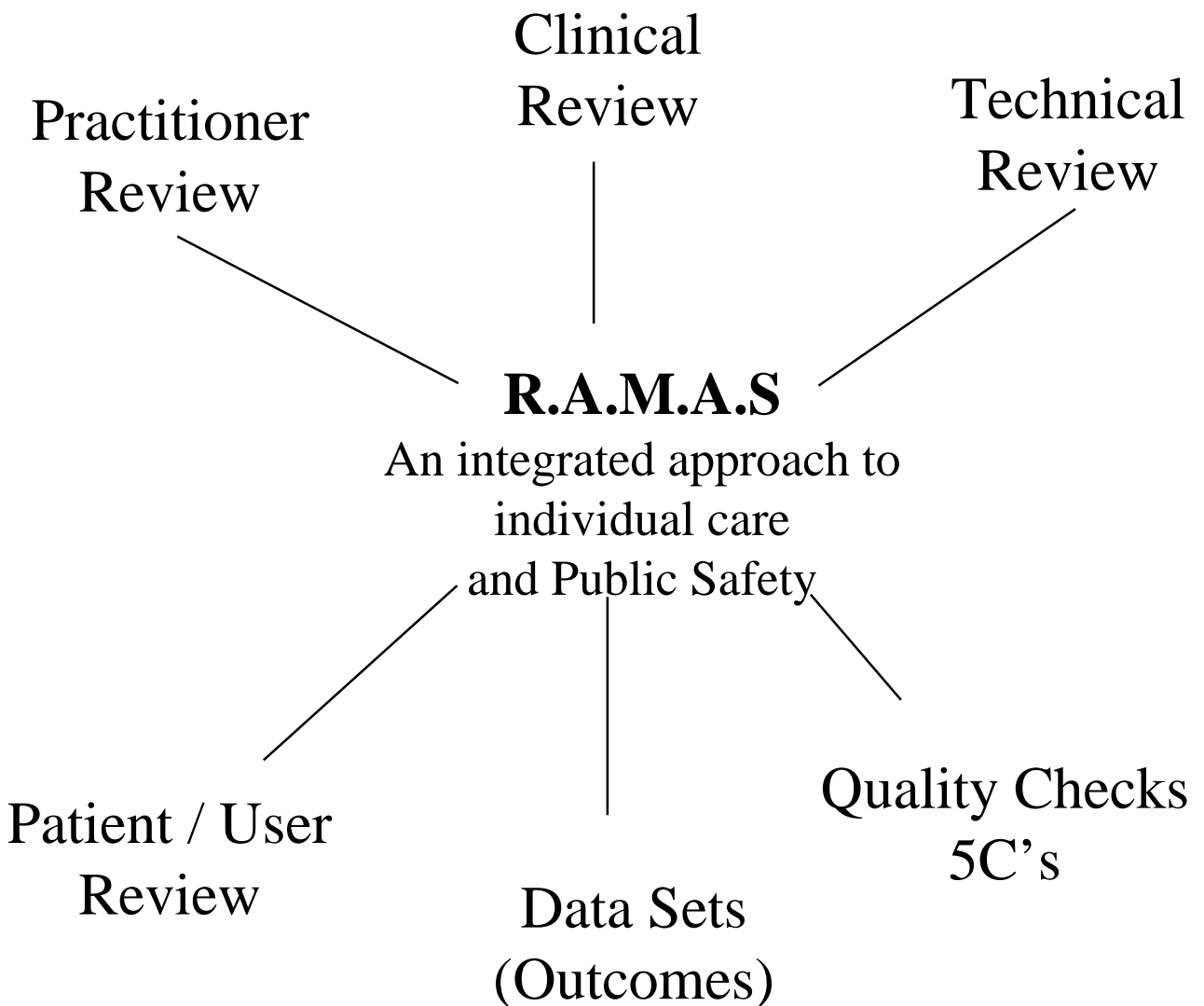
THE MANAGEMENT

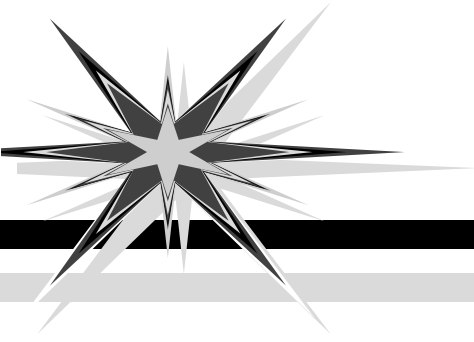
- ◆ Risk Assessment Profile
- ◆ Needs Assessment Action
- ◆ Patient Assets
- ◆ Safety
- ◆ Supports
- ◆ Strategies
- ◆ Supervision / Review
- ◆ Integration



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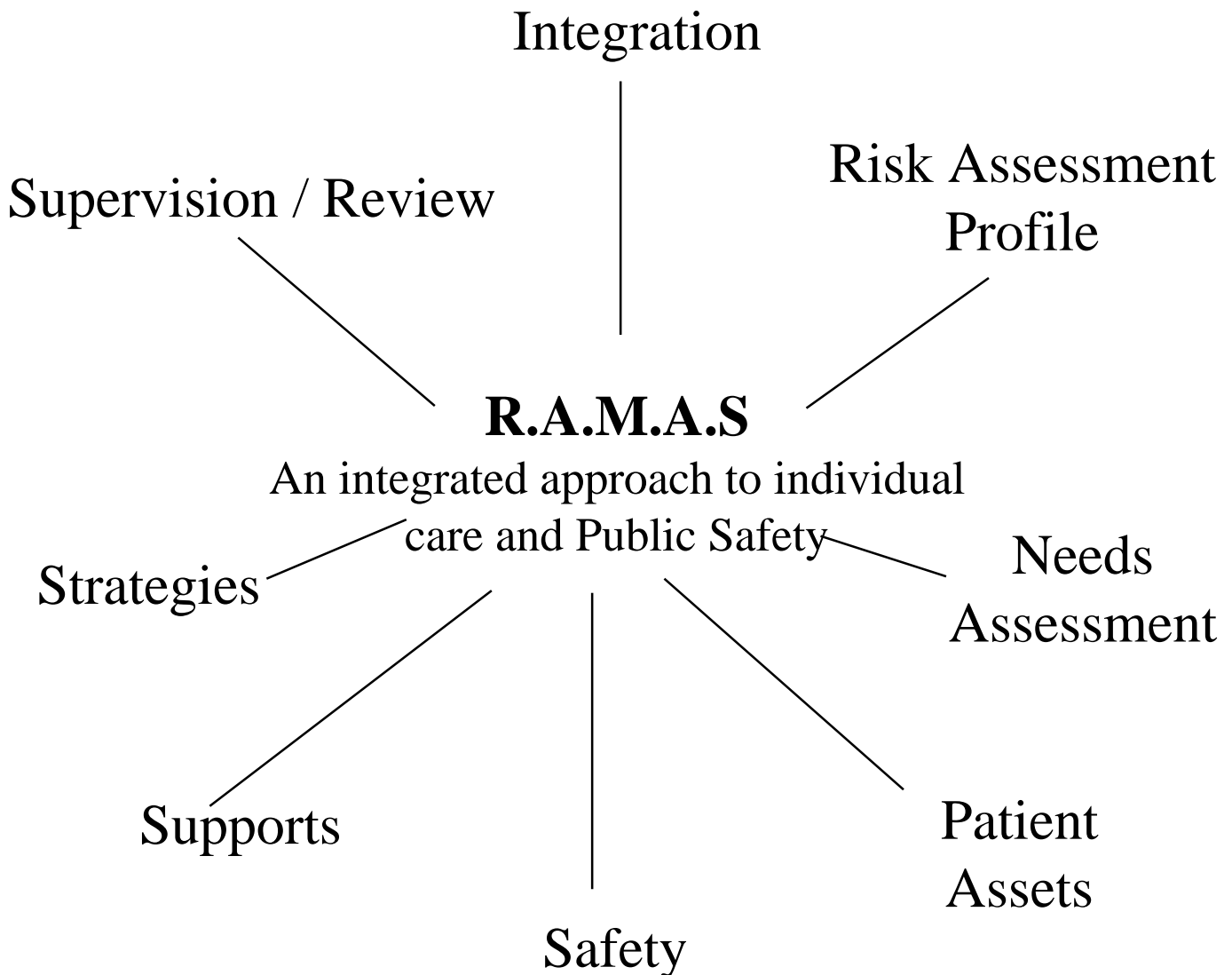
THE AUDIT

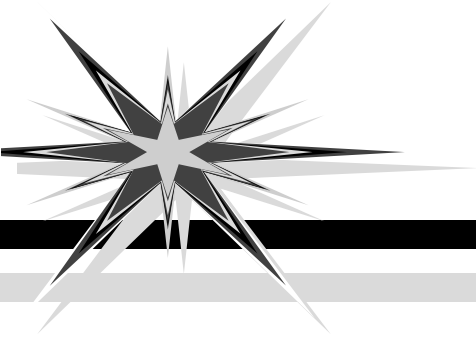




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THE MANAGEMENT

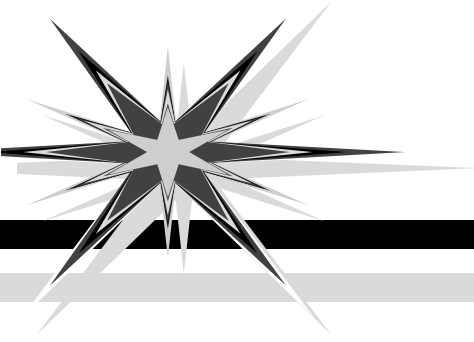




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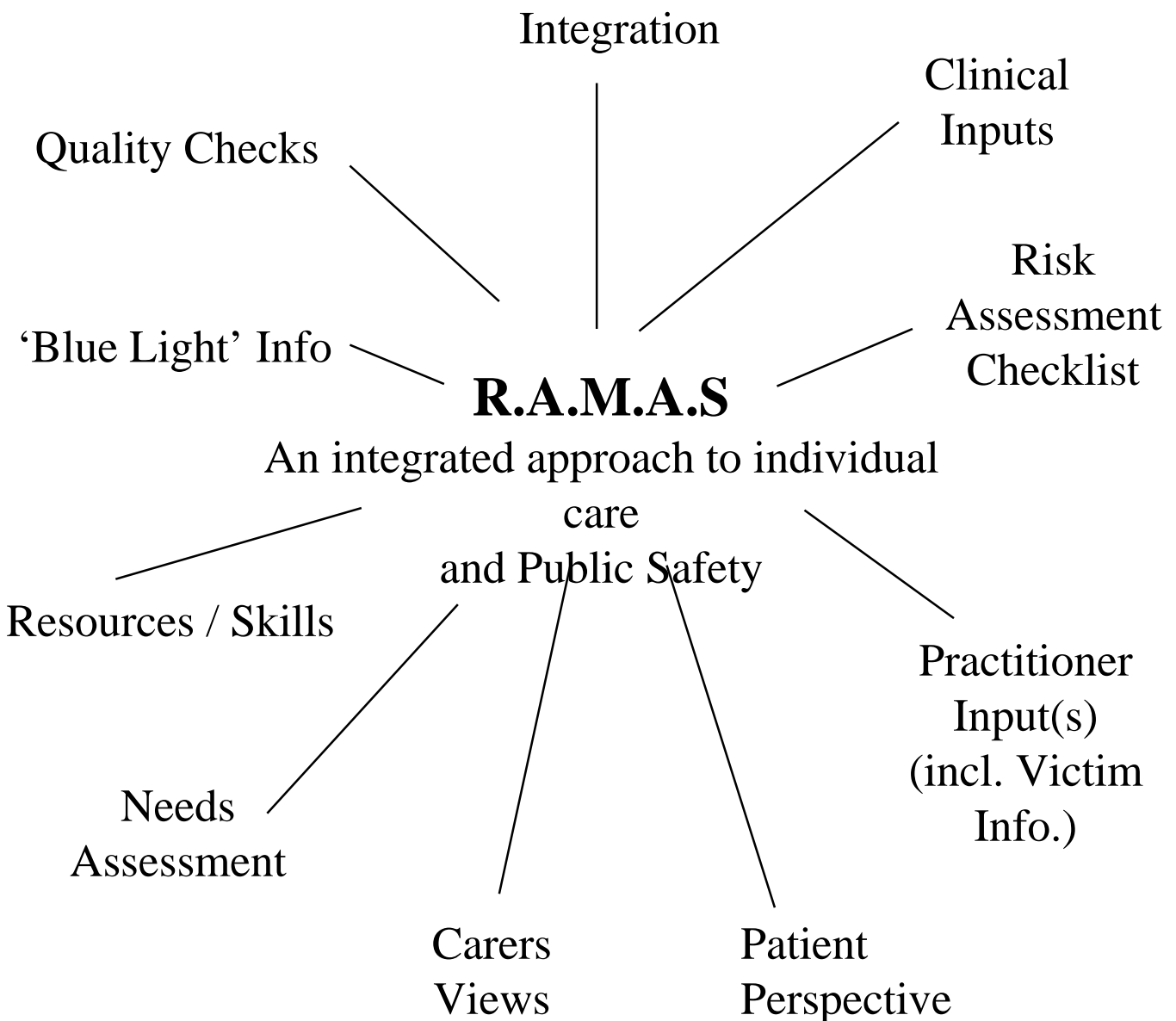
THE ASSESSMENT

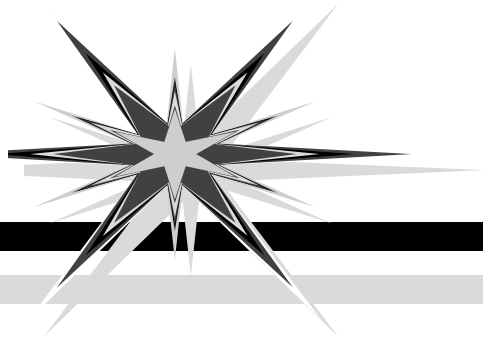
- ◆ Clinical Inputs
- ◆ Risk Assessment Checklist
- ◆ Practitioner Inputs (including Victim Data)
- ◆ Patient Perspective
- ◆ Carers Views
- ◆ Needs Assessment
- ◆ Resources, Skills
- ◆ ‘Blue Light’ Information
- ◆ Quality Checks
- ◆ Integration



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THE ASSESSMENT

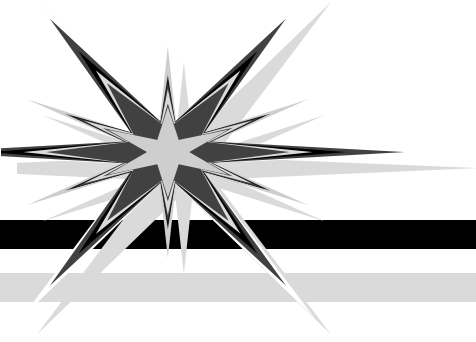




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“The history of the care of the mentally ill people is that, without external scrutiny, standards always drop, whether they are to be found within hospital or outside.”

Clunis Report 1994



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NEXT STEPS ...

- ◆ ‘Blue Light’ System
- ◆ Community Maps I, II, III
- ◆ ‘Safety Net’ Programme
- ◆ Ongoing Research & Development
- ◆ Training the Trainees
- ◆ Audit