

Multi-Agency Risk Management: Safeguarding Public Safety and Individual Care

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Forward

The NHS is committed to evidence based practice and treatments. In mental health services, the National Service Framework and the National NHS Plan challenge us to provide an evidence based approach to risk assessment and management.

RAMAS (Risk Assessment, Management and Audit systems) is well known and regarded in the field of risk management, and provides an evidence based and systematic approach to identifying and managing risk in mental health. But it is more than a simple risk management tool: its chief value lies in the integration of risk assessment, management and audit into routine case management, such as the Care Programme Approach.

This report contains additional research and refinements to the approach validated in a range of clinical settings and services, and provides an invaluable addition to the growing body of literature in this area. It sets out criteria for successful implementation of the approach, based on a number of trials, including the need for visionary leadership, a sharp focus on results and staff training. The report also makes a helpful contribution to improving the delivery of mental health care through its emphasis on user empowerment, a common language for positive inter agency working, and practical guidance on issues such as confidentiality.

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CHAPTER 1: INTRODUCTION

1. General Background

This research and development project took place during a period of major change within the NHS. Indeed, the past 40 years has seen major changes in the patterns and deliver of treatment and care for people with mental disorders. These have been brought about by a number of factors including:-

- The advent of and developments in community care
- Developments in new drug treatments for major mental disorders
- A growing understanding and evidence base of psychological and other therapeutic approaches
- A growing recognition of the essential role of social support in effective mental health treatment and care
- Reduction in the number of psychiatric beds available
- A growing concern about the safe provision of mental health services in community as highlighted in a number of public inquiries into the treatment and care of people with mental disorder
- The NHS modernisation programme

The emphasis throughout the NHS has changed in the last decade, towards evidence based practice and treatments. The implications of this for mental health service provision are immense. The increasing trend and pressure is to provide only services, which are of proven therapeutic benefit. Clinical governance requires, as a minimum that NHS staff appraise and apply the research data available to them. Furthermore it requires that services are able to audit their own practice and to conduct research, which is appropriate to their practice. The NHS modernisation programme involves a willingness to adapt services to achieve better outcomes for service users and carers.

Mental health problems affect roughly one in three young people and adults in the U.K. For every person with mental health problems there are up to six other people, in the social network (family, partners, carers, friends) who are directly affected by the distress. Living with mental health problems can be a life shattering existence with profound effects on emotional, social and intellectual function.

People who pose a risk to themselves or others often have a wide range of problems including mental illness, substance misuse, legal or financial problems, housing difficulties, consequently they will require a spectrum of services. The range of services that people who pose risk may need, means that effective working between the different agencies responsible for the various aspects of care is essential.

Risk assessment and management does not fall exclusively within the domain of any single profession or discipline. No agency can operate in isolation when working with risk. The effective management of a person who presents as a risk to others, cannot just be the responsibility of mental health, social services, or probation or housing. As a public protection issue, it has to be the concern of all agencies, at all levels, and driven as such. Working together for public and community safety is widely recognized as an ideal to which all health, social care, criminal justice agencies and voluntary agencies should aspire. The potentially disastrous consequences of failure to do so are well known and documented. Failures in interagency communication and joint working continue to be cited in reports of inquiry into homicides and suicides in the community, the National Confidential Inquiry (NCI) and from in clinical practice.

1.2 Legislation and Policy Context

Major areas of legislation and policy on interagency collaboration now underpin services for people who pose a risk to themselves or others (Health Act 1999, Crime and Disorder Act 1998, Building Bridges, DOH 1995, The Spectrum of Care 1996; Criminal Justice and Court Services Act 2000). Public safety has become a major outcome for Mental Health, Social Care and Criminal Justice agencies.

The White Paper, *The New NHS: Modern, Dependable* (DoH, 1997) sets out the Government's strategy for modernising the health service. It covers a variety of issues relevant to mental health service provision, including the integration of services across health and social care, human resources, the more effective use of information technology and improving the quality of care. The quality strategy is described in the paper – *"A first Class Service: Quality in the New NHS"* (DOH, 1998), which describes the way in which national agencies (e.g. National Institute for Clinical Excellence (NICE) and the commission for Health Improvement (CHIMP), collate evidence on evidence based practice and inspect service while in parallel local agencies address effectiveness through clinical governance.

The National Service Framework (NSF) 1998, sets out the policy context, values, standards and implementation programme for "safe, sound and supportive" mental health services and identified seven priorities for development.

1. Strengthening comprehensive care
2. Providing 24 hour access to services
3. Developing, training and recruiting staff with the skills and motivation to modern services
4. Improving the planning and commissioning of services
5. Developing partnership working
6. Improving the use of information technology
7. Developing mental health promotion

The NSF is to be welcomed and sets a common agenda for local services to work to. The NSF will facilitate national and local progress through its comprehensive, flexible and positive direction. The NSF sets standards, milestones and outcome indicators over the ten-year period to 2009.

The NSF recognizes that 90% of mental health care is provided in primary settings (families, GP practices and community) and emphasises shared responsibility and partnerships across all agencies providing care. There are seven national standards for Mental Health. Box 1 summarises these standards.

Box 1 National Service Framework for Mental Health
NSF Standard
1. Equal opportunities to all in mental health promotion
2. Common Mental Disorders CMD (e.g. Depression, Anxiety) sufferers should have needs assessed and access to effective treatment
3. CMD sufferers should have 24 hours access to local care and NHS Direct
4. Effective Services for severe mental illness (SMI) e.g. written patient care plans which include advice on action to take in crises and on responding to special needs
5. SMI inpatients should have timely access to 'least restrictive' local bed and written aftercare plan
6. Carers of CPA patients should have their own care plan
7. Preventing suicides should be further helped by risk assessment training, suicide audits and support to local prison staff

The NSF standards will require risk managers to have at a minimum the following elements in place:-

Guidelines for standard practice state that the following are realized:-

- ⇒ Protocols for referral
- ⇒ Good information about the service
- ⇒ Access to service
- ⇒ Referral pathways
- ⇒ Evidence based care informed by research
- ⇒ Specify and match clients to treatment
- ⇒ Audit waiting times, access etc
- ⇒ Outcome monitoring, using standardised methods
- ⇒ Involve staff of all disciplines
- ⇒ Provide supervision and support

The Human Rights Act (1998) was enacted on October 2nd 2000. Key articles with implications for Mental health Services are outlined in box 2.

BOX 2: Human Rights Act 1998		
Article	Rights	May Affect
2	Rights to life	All
3	Freedom from Torture	Some Treatments (eg. ECT)
5	Freedom from Arbitrary Arrest and Detention	Risk Assessment Technology
6	Right to a Fair Trial	Risk Assessment Evidence
8	Right to respect of privacy and family life	Nearest relative issues Confidentiality, child visits etc.
9	Freedom of Thought, Conscience and Religion	All
10	Freedom of Expression	Appeal Options
12	Right to marry and found a family	Conjugal provisions in long-term and secure environments

The Criminal Justice and Court Services Act (2000) (sections 67 and 68) seeks to increase public protection by introducing a statutory duty on Police and Probation to make joint arrangements for the assessment and management of the risks posed by sexual, violent and other offenders who may cause serious harm to the public. This

duty commences on April 1st 2001, and strengthens arrangements under the Sex Offenders Act (1997).

The Crime Sentences Act (1997) introduced mandatory life sentences for second time serious sexual, violent offenders and the Crime and Disorder Act (1998) introduced extended sentences for the same category.

In December 2000, proposals for the management of dangerous offenders with severe personality disorder were published in the white paper '*Reforming the Mental Health Act*'. Part 1 deals with the new legal framework and part 2 concerns 'High Risk Patients'. New Mental Health legislation is set to provide a single framework for the application of compulsory powers for care and treatment for the small minority of those who pose a serious threat to the safety of others as a result of their mental disorder.

1.3 RAMAS and the NHS Plan

The Challenge of all this legislation together with the National Service Framework is to provide evidence based safe, sound and supportive risk management for NHS service users, staff, and the wider community. The ongoing research and development programme of the RAMAS is geared to developing the knowledge base, the professional skills and evidence based local policies to effectively manage and reduce risk. Our approach to the development of comprehensive evidence based risk management is founded on the principle that people with mental disorder (whatever the nature) should be treated in the same way as people with any other illnesses or medical conditions.

There is every reason to view risk primarily as behaviour(s) that respond to the same psychological principles that govern behaviour problems more generally. For example, outcome after specialist treatment for anger, depression or substance misuse problems is strongly driven by post adjustment factors such as social support, housing and environmental factors. Care and treatment needs should be properly assessed and wherever possible provided with full agreement and input of the patient and his/her significant other (family or carers). At the heart of this approach is the conviction that when staff are well trained on robust systems, adequately supported and contained by sensible and workable local policies and guidelines. Then they are able to work safely and therapeutically with our most difficult and challenging patients.

RAMAS (Risk Assessment, Management and Audit Systems) was developed by O'Rourke and Hammond (1996) in an effort to incorporate "lessons learned" from

public inquiries with “what works” principles in public safety, risk management, and clinical care. As such it attempts to provide a systematic approach to identifying and managing risk in mental health as an important element in community safety, identifying resources, building confidence and improving individual care through comprehensive consistent, collaborative information sharing and communication.

RAMAS aims to:-

- Ensure that people who pose a risk to themselves or to others do not “fall through the net” of treatment and care
- To provide a common language for inter-agency collaboration and communication on risk management, public safety and individual care
- Facilitate a flexible, user friendly integrated, co-coordinated and positive approach to risk by involving service users, their carers and families
- Facilitate case and workload management through a standardised method which provides evidence based care and good clinical practice

RAMAS is suitable for use with everyone who comes into contact with mental health, criminal justice, social service and other agencies. The system itself is more fully described in Chapter two.

1.4. The Scientific Background

The scientific background, the model and the conceptual frameworks have all been described in earlier reports of RAMAS developments (O’Rourke and Hammond 1998). In this section we will revisit this area briefly. The reader who wishes more detail is referred to documentation on the RAMAS website (www.ramas.co.uk). Here we will emphasise the need for risk measurement over risk prediction and we will take a cursory look at a number of commonly used systems that may be said to rival the RAMAS.

1.4.1. Risk Assessment: Measurement or Prediction

A problem facing those wishing to integrate the literature of risk assessment into their own practice is the discrepancy between the practitioner with an inherently idiographic problem and the researcher who typically approaches the problem from a normative perspective. Research in psychiatric risk assessment has largely concerned the building of statistical models for the prediction of a dangerous or problematic behaviour (Hassin 1986; Christiansen 1986; Monahan and Steadman 1994; Copas, Ditchfield and Marshall 1994; Harris and Rice 1997). These require analysis of substantial samples from which generalisations are to be drawn.

An assumption upon which these analyses are based is that the outcome, or dependent, variable, is reliably identified and measured. Unfortunately this assumption

is often difficult to justify. Putting aside problems in defining the outcome variable there are issues concerning the independence of the predictor variables with each other and also with the therapeutic context. Thus, for example, if a patient begins to show the precursors to self-harming behaviour, health care practitioners have a duty of care to act to minimise this occurrence.. In this way research within a clinical context is never likely to provide the background for the random effects that prediction/classification models often require.

Since Paul Meehl's seminal monograph in 1954 in the area of clinical decision making, there has been a clear divide between the procedures of clinically informed judgement and statistical prediction. It is generally found that statistical prediction is more accurate than pure clinical judgement and this has led to suggestions that risk assessment must be actuarially based and built around a transparent statistical model (Monahan 1981; Miller and Morris 1988; Klassen and O'Conner 1988; Monahan and Steadman 1994). The typical statistical approach is to build a linear or logistic regression model. However, a number of clinicians are uneasy about this trend since it relies very heavily on normative information and ignores valuable idiographic insights (Pollack 1990; Hammond 1995b). Thus, findings drawn from large scale statistical models, while of some general use, may not be directly applicable in a specific individual assessment. For example, Mullen (1984) has argued that dangerousness is a quality of an individual's actions rather than of the individual himself. The question to be posed in clinical practice is not "*is this person dangerous?*" but rather "*might this person in certain circumstances behave in a dangerous way?*" (Mullen 1984). Given that these circumstances are likely to be specific to the patient in question, it is important to recognise the value of the idiographic context in making an assessment of risk for a specific patient.

The dominance of the prediction/classification approach to risk assessment has led to a dearth of research exploring actuarial alternatives. It is perhaps not surprising, therefore, that there has been very little work on psychometric risk modeling. Under this approach the problem of risk assessment shifts from *the prediction or classification* of harmful behaviour to the *measurement* of underlying latencies. A psychometric latency is best viewed as a potential. Thus, a latent trait of dangerousness is a measurable construct indicating the potential for dangerous behaviour. The measurement is not direct but involves the modeling of a number of indicators to provide a reliable estimate of the trait.

Many existing risk assessment devices are simply lists of risk indicators or items, chosen for their perceived importance but not related to each other through any theoretically defensible structure. Risk scores are then commonly generated by a weighted or unweighted summation of the indicators (Nuffield 1989; Harris, Rice and Quinsey 1993; Copas, Ditchfield and Marshall 1994). Two serious limitations of this approach exist. First, this approach implies that the indicators conform to an additive measurement model and yet this assumption is rarely tested. Second, the underlying latent structure, defined by the relationships between the indicators, is rarely made explicit so the construct validity of the resulting scores is usually suspect.

One of the founding fathers of modern psychometrics, Louis Guttman (1941) stated that, in the absence of reliable criteria for validation, one has to look at the relationships between the items themselves. This is a widely supported position (Niemuller and van Schuur, 1983; De Jong and Molenaar 1987) and is the basic premise of all latent trait models of measurement. Fitting empirical data to an a-priori model of systematic relationships between risk indicators (items) allows the construct validation of a risk assessment device. In addition, such a model can be used empirically to evaluate any theoretically justified ordering of items.

Psychometric modeling of risk has a number of distinct advantages over the traditional statistical models of prediction and classification. First, it imposes a clear and transparent measurement model on the assessment procedure which may utilise a mixture of clinical judgement and actuarial data. Secondly, the relationships between the risk factors, or predictors, are explicitly modeled. This provides the means examining the structure and meaning of the risk behaviour under examination. Third, using appropriate item response theory models it is possible to generate a statistical estimate of the underlying latent trait of dangerousness that is sample independent. Based on this principle the assessor is able examine the degree to which an individual patient fits the model, thus, unpredictable or ill-fitting profiles can be readily identified. Finally, the reliability and validity of the risk assessment may be easily estimated using standard psychometric procedures.

The RAMAS proposes a cumulative model of risk for psychiatric risk assessment. This is the simplest and strictest psychometric model and comes in a variety of forms, all of which have the advantage of simplicity and ease of interpretation as well as enabling clear additive measurement. More detail is provided in chapter 3 where we test this model against accumulated data from the RAMAS checklist (RAC).

1.4.2. Alternative Systems

The RAMAS was originally devised by a clinician, M. O'Rourke, in order to meet the real practical needs she was confronted with in her community forensic work. A first step in meeting these needs, of course, is to search for systems already developed on the principle that there is little to be gained in reinventing the wheel. However, at this time there were no tools available that served the purpose. Since then a great many tools and systems have emerged with the generic form of risk assessment in mental health. In this section, we take a necessarily brief look at three such systems the PCL-R, the HCR-20 and the LSI-R. The latter two are consistent in their aims with the RAMAS although their focus and comprehensiveness varies. The PCL-R, is strictly speaking not a risk assessment instrument at all but it is so widely cited as one, especially in work with personality disordered offenders, that it was felt appropriate to mention it here.

We will not be comparing efficacy of these systems because to do so would imply that such a thing was possible. Instead, we wish to simply give a flavour of each tool and when it may be appropriate for use.

PCL-R

The Psychopathy Checklist – Revised (PCL-R) was published by Robert Hare in 1991. This is a 20-item checklist that purports to measure Psychopathy as originally conceptualized by Cleckley. As such, this psychometric device is not a risk assessment device at all but it is included here because it has become one of the standard tools for defining severe personality disorder (SPD), high risk personality disorder (HSPD) or dangerous severe personality disorder (DSPD). It requires the administration of a semi-structured interview that can last between 90 and 120 minutes. Hart, Hare and Forth (1994) stated that the full administration of the PCL-R requires intensive work and is time-consuming and they, therefore, devised an assessment measure that required less time and training. This measure is known as the Psychopathy Checklist: Screening Version (PCL:SV) and is used by clinicians and researchers as a screening instrument with limited time and case history information. Both the PCL-R and the PCL:SV assess a range of demographic, criminological, social and psychological information in a systematic manner.

The PCL-R has been shown to be a strong predictor of recidivism and violence in offenders and psychiatric patients, playing an important role in current risk assessment procedures and in many judicial decisions (Hare, 1998; Hemphill, Hare and Wong 1998; Monahan and Steadman 1998). It is indisputably an important tool in the

assessment and diagnosis of psychopathy and antisocial personality disorder. However, as a generalized tool to aid in the assessment and management of risk it has a number of drawbacks.

First, it is heavily oriented towards the forensic context and tells us nothing about risk to self, mental instability or vulnerability. Second, it is not sensitive to mental illness, being designed solely as a personality disorder device. Third, there are some disquieting signs that it is used naively and unethically, a situation exacerbated by its reliance on 'cut-off' scores for classification of 'high-risk' individuals. This latter point has been raised in a recent paper (Hammond 2001) who argues that the psychometric model upon which the PCL-R is based cannot support the use to which it is being put.

HCR-20

A tool with a wider applicability is the HCR-20 (Webster et al 1997). The name refers to Historical, Clinical, Risk Management and the number 20 refers to the number of items. Unlike the PCL-R this is a broad-band instrument with potential applicability to a variety of different settings. However, its focus upon violence appraisal weighs it heavily towards the forensic services.

The HCR-20 takes account of the patient/client's current mental, emotional, and behavioural functioning, and, like RAMAS, serves to integrate information from a number of sources such as face-to-face interviews, observation, clinical notes, ward notes, and psychological and neurological testing. The emphasis still rests upon historical rather than clinical constructs but the HCR-20 is fairly unique along with the RAMAS in that clinical aspects of the patient do receive concerted consideration. The HCR-20 also shares with the RAMAS a consideration of the issue of risk management with 5 of its 20 items dedicated to this issue.

In addition, the HCR-20 suggests ways of enhancing prediction accuracy, yields a summary risk statement, allows for the monitoring of current clinical status, and gives developing effective risk management strategies. The HCR-20 is a popular choice in the forensic field. It incorporates most of the lessons learned from the research literature in a relatively simple and accessible form. However, its emphasis upon brevity militates against a comprehensive multi-agency approach to risk assessment and management. In addition, there is no clearly formalized measurement model specified to explain the collation of the information collected.

LSI-R

The Level of Service Inventory-Revised (LSI-R) combines risk and needs information in a systematic format to inform offender treatment planning (Andrews and Bonta, 1995). It is presented as a 54-item '*quantitative survey of attributes of offenders and their situations relevant to level of service decisions*' (Andrews and Bonta 1995). Within its components are items that tap changeable (or dynamic) factors and these are used to evaluate change following intervention. Andrews and Robinson (1984) discovered that changes in LSI-R scores were related to changes in reconviction rates.

Interpretation of the LSI-R scores involves several steps. The first step is to examine the overall total score of the LSI-R. A profile sheet exists whereby the raw scores are converted to percentiles automatically and can indicate the level of risk for various situations (e.g., probation or institution settings). The second step is to examine the different subcomponents. Those subcomponents that have numerous endorsements are seen as problem areas.. Finally, the profile of the 54 individual item responses must also be carefully examined.

Another vital component of the LSI-R is the recognition that there may be a highly patient-specific situation or set of conditions that undermine the objective recommendation of the instrument. Thus the clinician can apply an override mechanism by calling upon information not reflected in the form. RAMAS has the same system although it is flexible enough to allow the team or the individual clinician the override.

The authors recommend using the LSI-R in numerous ways: to provide a record of factors to be reviewed prior to case classification; as a quantitative decision aid in case classification; and to assist in the appropriate allocation of resources both within and among offices. More specifically, the criteria are provided for: identifying treatment targets and for monitoring offender risk whilst under supervision and/or treatment services; making probation supervision decisions; making decisions with regard to placement into halfway houses; determining the appropriate security level with regard to classification within institutions; and for assessing the likelihood of recidivism. It is, however, important to note that the authors strongly recommend the use of this assessment tool by professionals who understand the basic principles of psychological testing and interpretation. However, as with the HCR-20 the actual measurement principles upon which it is based are rather naive and unsophisticated and may not withstand close scrutiny under Human Rights testing.

All of these devices, including RAMAS, require that the users should be properly trained before using them with patients. The PCL-R and LSI-R further stipulate that users should have an understanding of psychological testing and interpretation. This carries the implication that the assessor will be a psychologist. The HCR-20 and the RAMAS do not make this assumption and the RAMAS is specifically designed so that the language and presentation of the device is interpretable across professions and agencies. The public inquiries have taught us much about what is required for public safety and individual care (risk reduction and prevention). Each of the systems are now examined with regard to whether they meet the lessons learned in clinical, social and legal contexts. In table 1 a number of features taken from the inquiries are listed and each of the 3 systems and RAMAS is rated against each.

Table 1: Comparison of 3 Systems

Lessons from Inquiries	RAMAS	PCL-R	HCR-20	LSI-
A standardized approach	Y	Y	Y	Y
Comprehensive focus	Y	N	N	Y
Management planning built in	Y	N	Y	Y
Clinical needs Identified	Y	N	Y	Y
Social needs identified	Y	N	N	Y
Suitable for every level of service	Y	N	N	N
Goes beyond violence	Y	N	N	Y
Actuarial base	Y	Y	Y	Y
Reliable and valid for UK use	Y	?	?	?
Multi-Agency design and utility	Y	N	N	N
Acknowledges dynamic component	Y	N	Y	Y
Explicit measurement/statistical Model	Y	N	N	Y
Integrates Idiographic Information	Y	N	Y	Y
The Checklist a Guide Only	Y	N	Y	Y
Medication compliance monitored	Y	N	N	N
Audit and follow through	Y	N	N	Y
Safety-net provision explicit	Y	N	N	N
Crisis plan explicit	Y	N	N	N
Trained and supported staff	Y	Y	Y	Y

We do not wish to imply in table 1 that RAMAS is being held up as a gold-standard against which the other devices are found wanting. This would be to judge them against criteria that they were not designed for. However, it should demonstrate the conceptual distance between these tools and the RAMAS. Clearly, the PCL-R has the least in common with RAMAS and this is not surprising as we have already pointed out that it is not strictly speaking a risk tool at all. The closest to the RAMAS appears to be the LSI-R which differs on only 5 features. Particular is the fact that it is not specifically a multi-agency tool and it is designed for prison/probation use. None of these tools

was designed in the UK and, while this is not necessarily a problem, the more process or management oriented they try to be, the more difficult it is to integrate into a changing NHS context if the original conceptualization derives from the Canadian corrections system.

It is interesting to note that the underlying rhetoric of the HCR-20 and the LSI-R dovetails almost perfectly with that of the RAMAS. Each team is working with the same set of objectives and regard for clinical need. However, the notion that re-offending is the primary outcome means that both the HCR-20 and LSI-R are built around a prediction model. This limits their scope and makes them functionally single focus systems. Add to this the fact that they are also single agency tools and their general application with regard to the NSF, NHS, public safety and individual care needs becomes equivocal.

In the next section we will take a closer look at the 'rhetoric' of the RAMAS, its aims and objectives as well as its values and process.

1.5. Description of the RAMAS

The RAMAS (Risk Assessment, Management and Audit System) was developed by O'Rourke & Hammond, 1995 in an effort to incorporate "lessons learned" from public inquiry reports with "what works" principles in public safety, risk management, and individual care. RAMAS provides for the integration of risk assessment, management and audit into routine case management, for example Care Programme Approach (CPA) and other systems. It is suitable for use in hospital, institutional, community and research settings, in criminal justice systems in, and the health, social services, housing and probation practice and voluntary sector.

The design objectives for RAMAS were fixed by these needs and they are summarized in box 3.

At the centre of RAMAS is a risk assessment device that has been rigorously tested and fitted to a cumulative psychometric model (Hammond, 1995; O'Rourke & Hammond 2000; Maggi, 1998). This provides a sound basis for the measurement of four risk potentials, 1. Risk to others, 2. Mental Instability, 2. Self-Harm and Suicide risk., and 3. Vulnerability (O'Rourke and Hammond 2000).

Box 3: Design Objectives		
Content	Process	Utility
Short and user friendly	Unobtrusive/collaborative	Aids comprehensive, inclusive assessment
Pan-theoretical	Minimum Administration	Enhances multi-agency case management
Reliable and Valid	Easy to communicate	Provides baselines, monitoring, tracking and interservice comparison.
Detects Change	Supported by data and ‘intelligence’	Pool and maximize information
Responsivity	Easy to use in variety of Settings	Enhances Crisis Management, and fast-track access to services
Relates Client input to Service Output	Client Centred in process and protocols	Built around service users
Provides a Safety Net		Designed for integration
		Enhances purchasing, planning and development

In addition to this psychometric measure, the risk assessment procedure is designed to feed into risk management by recording the more case sensitive or client context data such as formalised crisis intervention “intelligence”, incident reporting and review and monitoring arrangements. As such it forces a clarification and agreement of roles and responsibilities across agencies as well as defining confidentiality limits and systems for information exchange.

The multiple needs and vulnerabilities of people at risk or who pose risk means that services need to work with a wide range of “partners in care”. RAMAS intends shared goals for agencies and improves the interface between agencies, by providing clarity and definition around common agendas. It allows shared training priorities to be agreed and it assists in clear communication in the planning and delivery of risk assessment management and audit. Successful interagency working is not easy to achieve but it is critical in enabling us to provide public safety and individual care.

RAMAS also attempts to focus on improving the user-professional interface in order to identify users not just as part of the problem but as part of the “solution” also.

RAMAS ensures that all agencies identify the user's profile of skills and natural competencies in order to provide a solution-focused approach to enhancing user engagement in the process of risk management and well-formed outcomes for health and social care. In using RAMAS, professionals from all agencies are not just assessing risk but they are also developing a plan of care and this means that the service user has to be a full member of the assessment and planning team.

1.5.1. Values and Principles

RAMAS values have been developed through clinical experience and are widely supported by service users, service providers and professionals in all agencies. They can be summarised as:-

- Safety
- Empowerment
- Autonomy and Respect
- User and Carer engagement
- Accessibility
- Effectiveness
- Accountability

RAMAS principles can best be summarised in the 12 points presented in box 4 below. For a fuller description of these principle, please refer to the 1998 – 2000 R & D report O'Rourke and Hammond (2000) entitled "Risk Management : Towards Safe, Sound and Supportive Services".

These principles also ensure adherence to the Department of Health's safe sound and supportive service principles to good practice and Human Rights and Natural Justice principles.

RAMAS is a decision support system to aid clinicians and practitioners in the assessment, management, follow through and follow up of risk to self and others. It is intended to support, not replace clinical judgement, clinical decisions or the Care Programme Approach (CPA). RAMAS is a tiered approach reflecting the complexity of individual needs, only one aspect of which will be risk. There are four forms which constitute the entire RAMAS:-

- 1 RAMAS MDS (minimum Data Set) for risk and needs identification
- 2 RAMAS Full Form: A comprehensive risk assessment, management and audit protocol.
- 3 RAMAS SR (Supervision Review), for use in reviewing ongoing case works and for CPA.
- 4 RAMAS BLIP (Blue Light Information Process) for use in crisis management

Box 4: Values and Principles of RAMAS

- Evidence based, scientifically researched systems
- A partnership, collaborative approach... A start safe, stay safe philosophy
- A holistic, whole-systems integrated process
- A common language, shared goals
- Client centre, Needs led, Capability Building... users and carers must be actively engaged in the process
- A solution-focused, relentlessly positive agenda
- A Systems Approach : family, carers and others included as appropriate
- People before paper! Respect for the individual and an emphasis on building positive relationships for safety and health. Empowering people and negotiating ways forward
- Credit when credit is due : history is important but it is not the full picture
- Clear and shared goals, RAMAS applies to all mental health service users
- Accurate, complete and communicable risk and care management
- A commitment to Audit, Review and life long learning for all: service users, staff and service systems

All forms are intended to be flexible and suitable for use in individual practices and for multidisciplinary and interagency work. The RAMAS also has four guides constructed for different levels of use. The first of these is the scientific and evidence base which details the actuarial prevention science approach of the RAMAS. The second is a more general factsheet containing basic information and instructions for use. Thirdly, there exists a more comprehensive Professional Manual available only after training and registration as a RAMAS user. Finally, there is a very general document addressing frequently asked questions (FAQ). These are all available on the RAMAS website www.ramas.co.uk.

1.5.2. Key components of RAMAS

It is helpful to think of the RAMAS as consisting of three major components. These are Assessment, Management and Audit. RAMAS provides the framework for agencies to develop a comprehensive assessment management and audit policy. With its emphasis on review and monitoring. RAMAS clearly implies that risk assessment and management are not one-off events but part of an on-going process of assessment, management review and re-assessment services.

Every professional who uses RAMAS must be trained and registered as a RAMAS user. All registered RAMAS users are responsible for monitoring and evaluating RAMAS against their professional standards. (National Standards are underway)
All registered RAMAS users have to sign an agreement, which states that they “will use RAMAS with clients/patients in a respectful, positive and constructive way in order to provide the best possible outcomes for public safety and individual care”.

1.5.3. Some Frequently Asked Questions

Who can complete the RAMAS?

Any Clinician, Practitioner or Project Worker trained in the process. There are four levels of training:

- | | |
|------------------|--|
| Level I | Risk Needs Awareness, Risk Identification. Allows use of RAMAS MDS, SR, BLIP |
| Level II | Risk Assessment, Management and Audit Systems. Allows use of all Level 1 plus Full RAMAS |
| Level III | Training as a Trainer. Allows use of all RAMAS Forms and delivery of Training Programme |
| Level IV | Training as a Auditor |

Who should be assessed?

RAMAS is designed for use with all Service Users of Primary care, Community Services and Adult Mental Health, Criminal Justice and Social Care Services. Screening for risk is inappropriate for on-going treatment and care in most of the above contexts but the MDS (Risk Identification) is helpful when starting the process of risk and care e.g. GP, Court Diversion, Section 136, Out of Housing or Crisis Intervention.

When is RAMAS Completed and Reviewed?

RAMAS MDS (Risk Identification) is suitable when an individual entering service either by referral or transfer. RAMAS should be reviewed for all service users who have previously reviewed a full risk, needs and care assessment or whenever there is new clinical cause for concern e.g. admission, intensive care, prior to discharge, on carers / family report of concern, crisis or prior to CPA or other Review.

How can RAMAS be used for interagency casework?

RAMAS promotes interagency casework by providing a common language and standardised “vehicle” for communication. All terminology is operationally and

behaviourally defined in order to provide a 'common' language. RAMAS is intended to provide a flexible approach to the following tasks:

- Accurate, complete and communicable information about Needs, Risks and responsivity of service users
- clarity regarding care roles and responsibility across agencies
- agreed confidentiality regarding transmission of RAMAS information
- clarity and agreement of documentation, eg. RAMAS forms and trained users
- agreed systems for review, monitoring and fail safety between reviews
- standardised, operationally defined training programme, RAMAS form and current manual
- formal RAMAS network for case and system updates, review and audit.

1.5.4. Partnerships In Risk Management

People who pose a risk to themselves or others often have a wide range of problems, including mental illness, substance misuse, housing, legal or financial problems, consequently they will require a spectrum of services. RAMAS enhances collaboration between agencies, thus allowing clients/patients more effective access to the matrix of services, which they may require. Clinical trials have concluded that the positive, solution focused RAMAS enhances co-operation, optimism and collaboration between patient, professionals and public. Clinical Case examples are provided in Chapter Four of this Report.

RAMAS continues to be researched, refined and developed. A number of UK health, social services, housing and probation services have now been trained or briefed on the system. The training programs are evaluated and written up in O'Rourke and Titley (2000) and the most recent research studies are summarised in the next chapter.

1.5.5. Confidentiality and Information Sharing

Professionals and services have a duty of care towards patients or clients and their families. Duty of care includes providing safe, sound and supportive service. Safe, sound and supportive service is defined by the Department of Health (1999) as follows:

Safe: to protect the public and provide effective care for those with mental illness when they need it

Sound: to ensure that patients and service users have access to the full range of services they need

Supportive: working with patients and service users, their families and carers, to build healthier communities.

Safety involves attitudes, values and behaviours and includes safe environments, safe services and safe practice.

Duty of care is also concerned with confidentiality. Patients have a legal right to confidentiality and thus any information exchange or information sharing should be on a “need to know” basis, most preferably with informed consent. Failure to share information can lead to disastrous results, as many inquiries have demonstrated. Information sharing can be negotiated with the individual but Public Interest (that is public safety) outweighs personal preference. One of the few defences for confidentiality breach is that of public interest. Professionals have a duty to take all practical steps to protect themselves, other staff, patients and others from risk. If confidentiality is broken the clinician or practitioner must:

- be able to explain the reason
- have evidence to support the action
- have consulted about the issues.

There are, in fact, many more complaints and problems generated by not passing on information. Nevertheless RAMAS requires professionals to treat all information about patients and their families with extreme care. In order to provide comprehensive safe, sound and support service, it is essential that information is shared as confidential and not in the public domain. The approach here is that any disclosures should be to specific individuals about specific risk and the level and range of disclosure should be clearly recorded and transparent.

If professionals are unclear or unsure about the appropriateness of sharing information, they should consult with senior colleagues and managers before divulging information.

1.5.6. Best Practice

Best Practice is to have open and collaborative communication with patients and their families, to consult with them about their needs and about issues of concern. Best practice requires the clinician or practitioner to:

- be able to explain their reasoning/decision making
- be able to “evidence” the decision(s)
- consult with colleagues about issues of concern
- show evidence of multi-disciplinary decision making

In addition, the clinician must provide service with attitudes, skills and behaviour consistent with retrospectively defensible practice i.e. ensuring practice today can be defensible at any point in the future! Succinctly put best practice for every patient every time!

CHAPTER 2: RESEARCH STUDIES

2.1. Outline of the Chapter

In this chapter we summarise the results of 6 small studies. These may be usefully grouped into two sections. Section 1 describes results from an ongoing psychometric evaluation of the Risk Assessment Checklist (RAC) that sits at the center of the RAMAS system. The first study reviews the fit of empirical data to the psychometric model. Excellent model fit is observed and the implications for identifying caution indices to supplement the risk scores are discussed. The second study explores the problem of test bias or differential item functioning. In particular an examination of the equivalence of model utility across agencies is undertaken. Again the results are encouraging although they do point to one or two concerns which highlight the need for systematic training and monitoring across agencies. The third study in this section examines the degree to which self-report is consistent with clinician ratings. Findings indicate that risk assessment is not best served by relying upon self-report. In addition, the consistency between clinicians was examined. The findings again emphasise the need for consistent and systematic training for tools such as the RAC. The final study in this section describes some of the correlates of the RAC scores. This is a descriptive study and is limited to a small number of assessments carried out in the community forensic service.

Section 2 contains the results for two implementation studies. The first is a small scale survey carried out in the States of Jersey where the RAMAS has been implemented across agencies. This study is the first of a planned programme of process evaluation and it concentrates upon the changes in practitioner attitude before and after implementation. Results are unequivocally positive at this stage although caution is advised due to the small size of the sample and the fact that implementation is in its early stages.

Section 2 is concluded with a qualitative study of senior managers and clinicians response to the challenge of a full multi-agency implementation in South West Surrey. The issues, pitfalls and challenges of such a process are described and comparisons are made between managers with a national or local remit and senior clinicians.

2.2. Psychometric Evaluation

2.2.1. Examining the Measurement Model

It must be constantly emphasized that the RAC is only one part of the entire RAMAS system and it serves primarily as a mnemonic for practitioners to ensure that all

relevant information has been considered. In an earlier study (Maggi 1999) it was seen that use of the checklist, irrespective of any scoring, had a significant effect upon the confidence in expressing a clinical judgement. In fact, the result suggests that confidence was lower following use of the checklist which is consistent with the argument that clinical judgement alone tends to focus on one or two salient issues and excludes the wider peripheral context which may be less immediate but also have a high relevance. When the complete context is considered the clinical or 'diagnostic' certainty may be compromised but a clearer understanding of patient needs regarding management is obtained. Thus, the use of a checklist is necessary for ensuring a comprehensive assessment irrespective of any measurement properties that it may have.

That said, the provision of a reliable and robust measurement model allows the clinician to inform decisions with greater confidence brought about by actuarial support. The fact that RAMAS is not a diagnostic tool but rather a case management tool means that less emphasis is placed upon the diagnosis or prediction of risk categories but rather provides a set of continua along which each patient may be placed. This is an analogue model

The original analysis used to identify the measurement model that sits at the centre of the RAMAS utilised a Mokken Scaling Model (Mokken 1971). This is a non-parametric model and may be seen as a probabilistic extension of the simpler cumulative model proposed by Guttman (1941) known as the Scalogram. However, this does not have the power of the parametric cumulative model known as the Rasch model (Rasch 1966). A clear advantage of the Rasch model is that it allows us to generate an index of person fit along with a highly accurate statistically derived person score. Due to the stricter assumptions concerning the item response function it is likely to be harder to fit the data to this than to the Mokken model. Thus, it proves to be a stricter test of the cumulative structure of the Risk Assessment Checklist.

Nevertheless, it was found that the fit to the Rasch model was very encouraging for all 4 scales of the RAC (O'Rourke and Hammond 2000). We review those findings here before utilising the advantages of the model to examine the measurement equivalence of the scale across agencies.

The following analyses were performed on data from 621 RAC protocols collected in a variety of contexts in mental health and forensic services. A majority of this data was collected under research conditions but 145 cases were taken from full RAMAS assessments in community mental health and probation.

The median age of the sample was 34 (Age range 17-78) and 41% were found to be on some form of psychiatric medication. Diagnostic status of the sample is reported in table 1. It is apparent that 30.11% of the sample had no specific diagnosis. Of the remaining the major categories are psychoses, personality disorder and depressive illness. This breakdown reflects the three major sources of data, Community Mental Health (including primary care), High Security Mental Health and Probation.

The marital and employment status of the sample is described in tables 2 and 3 respectively.

Table 1: Diagnostic Breakdown

Diagnoses	n	%
General problems not specified	187	30.11
Anxiety	43	6.92
Depression	103	16.58
OCD	5	0.80
Personality Disorder	114	18.36
Psychosis	147	23.67
Other	22	3.54

Table 2: Marital Status

Marital Status	n	%
Married	81	13.04
Single	252	40.57
Divorced/Separated	51	8.21
Unknown	237	38.16

Table 3: Employment Status

Employment	n	%
Missing	181	29.14
Professional	16	3.64
Blue Collar/Clerical	58	13.18
Manual/Unskilled	108	24.54
Unemployed	258	58.63

These results are only intended to give a general description of the total sample as there is much missing data. This is a result of the pooling of data from a variety of sources where some of these data were not routinely collected. However, the profile of

clients/patients is reasonably consistent with expectations. A relatively high proportion have mental health problems, are unemployed and are single.

The pooled data was subjected to a detailed psychometric analysis in order to test the model proposed in earlier reports on the development of the RAMAS (O'Rourke, Hammond and Davies 1996; O'Rourke and Hammond 2000). This involved the use of classical test analyses, Mokken scaling analyses and finally the fitting of the data to a cumulative Rasch Model. The results of the latter analysis are presented here as they serve to demonstrate most clearly the strength of the underlying psychometric tool.

Each subscale of the RAC was treated separately and was fitted to the Rasch Model using software written by the second researcher (Hammond 2001). This software was written specifically for the study and a WINDOWS version will be made freely available through the RAMAS website. The program fits the data using a conditional maximum likelihood estimation procedure. Multiple measures of fit are available.

The findings support the cumulative model. In each scale there was a statistically insignificant measure of misfit, indicating that the data fitted the model within standard statistical parameters. Analyses are presented in tables 4, 5, 6 and 7 for each scale respectively.

The fit of the Vulnerability scale is presented in table 4. There are, in fact, a number of ways to assess the fit of items to a Rasch model and for brevity we have chosen to present the fit index based upon the standardized residual of the model probabilities from the empirically generated proportions in the observed data (Wright and Masters 1982). This index of fit is normally distributed with a mean of 0 and a standard deviation of 1. Thus an index with an absolute value exceeding 1.96 is significant at the 5% level and if it exceeds 2.36 it is significant at 1%. A significant fit index indicates that the item in question *does not* fit the model. However, it is more typical to use the 1% criteria in interpreting fit to a Rasch model because of the inflated effects of chance with multiple items.

Indices of item fit are well within tolerable range except for *multiple problems* and *high levels of stress*. These may be less discriminating than the other items resulting in a poorer fit. For simplicity, our convention is to treat items with a fit greater than 2.57 as misfitting and to designate those items between 1.96 and 2.57 as weak. The overall fit of the model is good and the reliability of the scale is estimated at 0.87.

Table 4
Rasch Model Parameters for the Vulnerability Scale

Item	Difficulty	δ	S.E.	Fit
67. Trust of strangers	0.092	-1.511	0.332	-1.521
69. Naive	0.168	-0.716	0.264	-0.646
65. Susceptible	0.183	-0.592	0.256	-0.080
66. Over-disclosing	0.191	-0.533	0.252	-0.662
74. Recent Hosp. Admis.	0.229	-0.258	0.237	-0.260
76. No close relationships	0.237	-0.207	0.234	0.066
71. Unstable Environment	0.244	-0.156	0.232	-0.057
68. Needy/Isolated	0.298	0.170	0.219	-0.495
75. Multiple Problems	0.344	0.425	0.211	-2.260
83. History of vulnerability	0.382	0.625	0.206	-1.049
29. Emot. Control problem	0.412	0.780	0.203	0.029
72. Interpersonal Conflict	0.443	0.930	0.201	-0.100
70. High levels of stress	0.466	1.042	0.200	1.990

Overall fit =13.633 (ns)

Reliability Coefficient = 0.87

In table 5 the Self Harm scale is presented. Again there is a pretty good fit to this scale although one item, *Refuses Treatment*, appears to manifest a degree of misfit. It has been proposed that this item be excluded from the Self-Harm scale. When this is done the scale manifests a good fit to the cumulative Rasch model.

TABLE 5
Fitting Self Harm to the Rasch Model

Item	Difficulty	δ	S.E.	Fit
24. Risk to Self	0.590	-1.455	0.229	-1.757
10. History of Self harm	0.533	-1.173	0.228	-1.988
8. Parasuicide History	0.438	-0.700	0.232	-0.789
30. Refuses Treatment	0.362	-0.301	0.240	4.068
77. Feels Undervalued	0.314	-0.034	0.248	1.535
62. Hopelessness	0.305	0.021	0.249	-0.919
46. Suicidal Ideation	0.229	0.504	0.270	-1.056
73. Insomnia	0.171	0.935	0.296	-0.745
82. Evidence of Self harm	0.162	1.016	0.302	-0.555
35. Clinically Depressed	0.143	1.187	0.316	-1.109

Overall fit including item 30 = 28.87 p<0.01

Reliability = 0.85

Overall fit excluding item 30 = 12.38 ns

Reliability = 0.91

The reliability for the reduced scale is 0.91. Of course, removing the item, *Refuses Treatment*, from the self-harm scale does not imply that it is to be removed from the checklist. The refusal of treatment is clearly a vital piece of information in risk appraisal

and carries great weight when considering the management of the client/patient. However, it is not a feature specific to self-harming and does not provide useful information in generating a self-harm risk score.

In table 6 the Rasch fit for the Dangerousness scale is presented.

TABLE 6
Fitting Dangerousness to a Rasch Model

Item	Difficulty	δ	S.E.	Fit
1. History of Violence	0.870	-3.007	0.292	-1.065
2. Arrest for violence	0.610	-1.271	0.209	0.816
25. Risk to others (Unknown)	0.561	-1.024	0.206	-0.328
50. Impulsive	0.537	-0.904	0.205	-0.149
26. Risk to others (Known)	0.528	-0.864	0.204	0.327
29. Emotional Control	0.512	-0.784	0.204	-0.007
20. Use of force/weapons	0.496	-0.704	0.204	0.937
48. Substance misuse	0.496	-0.704	0.204	0.846
16. Threats to injure	0.480	-0.625	0.204	-1.541
22. Personality disorder	0.472	-0.585	0.204	0.307
49. Unpredictable	0.447	-0.465	0.204	-2.169
7. Childhood Conduct Disorder	0.398	-0.222	0.207	0.200
28. Risk to Family	0.374	-0.098	0.209	1.522
17. Threats to Kill	0.293	0.340	0.220	-0.840
27. Risk to Staff	0.293	0.340	0.220	-0.730
80. Evidence of Aggression	0.276	0.434	0.223	-0.735
19. Carries Weapons	0.268	0.482	0.225	0.272
31. Feels Threatened	0.252	0.581	0.229	0.442
60. Predatory Behaviour	0.220	0.791	0.239	-0.530
14. Menacing Phone Calls	0.163	1.214	0.265	-0.107
61. Criminal Lifestyle	0.163	1.214	0.265	0.227
3. Hostage Taking	0.106	1.765	0.313	-0.458
40. Likes Violent Material	0.106	1.765	0.313	0.310
15. Aggression Towards Animals	0.065	2.332	0.383	-0.106

Overall Fit = 15.73 (ns)

Reliability = 0.95

In this case a remarkably good fit is seen. Only one item, *unpredictable*, falls into the weak category. The overall fit of 15.73 is insignificant indicating a fit to the model and the reliability of 0.95 provides extra confidence if it were needed. It may be noted that a number of the features identified to belong to this scale are similar to the criteria identified by Hare (1991) as belonging to the Psychopathy domain. It has been argued elsewhere (Hammond 2001) that Hare's Checklist (PCL-R) would benefit from application of a Rasch Analysis and results have shown that similar measures of fit may be found. The broader implications for this is that the domain being variously described as *High Risk Personality Disorder*, *Severe Personality Disorder* or *Psychopathy* may be conceptualised along cumulative lines.

The Mental Instability scale is summarised in table 7. Again a pretty good fit is found and a reliability estimate of 0.94 is obtained. Clearly this patient group contains many who have been on some form of psychiatric medication but the more critical or specific features are those related to compliance and frequent hospital admissions.

TABLE 7
Fitting Mental Instability to the Rasch Model

Item	Difficulty	δ	S.E,	Fit
33. Psychiatric Medication	0.933	-4.328	0.762	1.972
5. History of Mental Illness	0.896	-2.061	0.379	0.939
34. Current Mental Illness	0.843	-1.403	0.323	-2.165
21. Paranoia	0.670	0.000	0.250	1.227
38. Hallucinations/Delusions	0.591	0.479	0.238	0.311
81. Evidence of Mental Instability	0.539	0.777	0.233	0.675
36. Unstable Mental Condition	0.496	1.019	0.231	-1.829
23. Treatment Unstable	0.400	1.543	0.231	-1.862
37. Frequent Admissions	0.357	1.785	0.233	1.697
39. Non Compliance w. med.	0.287	2.190	0.242	0.089

The Implications

The results reported here offer no surprises. The RAC clearly contains 4 robust scales which measure Vulnerability, Potential for Self-Harm, Potential for Harm of Others and Mental Instability. The fact that the empirical data fits a Rasch model has a number of important implications.

1. The Cumulative Nature of Risk

The model implies that a client/patient with a high score, reaches that point on the scale by accumulating characteristics and features in a relatively predictable order. Thus most people obtaining a high score will have a history of violent behaviour. However, only the most seriously high risk individuals will have a known history of cruelty towards animals. The model is probabilistic rather than deterministic so it is quite possible for a low scorer to have this feature. However, it is statistically improbable. The advantage of the cumulative property is that the general trend in a person's risk development may be mapped against a normative expectation. In light of earlier comments on the idiographic context of most clinical risk assessment this allows the user to examine individual 'misfit'.

2. Identifying Individual Misfit

It is possible to identify the degree to which an individual's profile fits the established model. It may be that a particular individual presents with a highly unusual profile. The score this individual manifests may be high or low but the very unpredictability of the profile may carry important clinical information. As an example consider the profiles for three clients (all drawn from the probation sample) that are presented in table 8.

Table 8: Self-Harm Profile from Three Cases

Risk Feature	A	B	C
Risk to Self	Y	N	Y
History of Self-Harm	Y	N	Y
Parasuicide History	N	N	Y
Feels Undervalued	Y	N	Y
Hopelessness	Y	N	Y
Suicidal Ideation	N	Y	Y
Insomnia	N	N	Y
Evidence of Self harm	N	N	Y
Clinically Depressed	N	Y	N
Raw Score	4	2	8
Derived Score	1.67	-0.11	4.82
Misfit	1.02	7.65	0.05

Client A manifests 4 features relevant to the Self-Harm Scales and so he obtains a simple raw score of 4. The Rasch model allows for a statistically derived score which turns out to have the value 1.67. This may be interpreted as a z-score with a mean of zero and a standard deviation of 1. Thus person A has a relatively high score but it is not statistically significant (ie. Greater than 1.96 for 5% significance). The misfit index may be interpreted in the same way and so it is apparent that the misfit index for this person (1.02) is not problematic. On the other hand person B has a low score close to the average but manifests a highly significant misfit. Person C has a very high score implying a high risk case and his profile conforms closely to the model.

The implication here is that person C should be considered closely as there is strong evidence that he represents a clear risk to himself. Person B reveals a pretty typical score and would probably be considered a low risk case. However, his misfit is extremely high and this should alert the clinician to look carefully at the profile as the predictability of this case is unclear. Indeed, this person may, in fact, manifest a high

self-harm risk because of the particular combination of the only two symptoms he manifests, *Suicidal Ideation* and *Clinical Depression*.

Thus the use of the cumulative measurement model goes beyond the simple identification of a score and provides in addition an index of misfit that we label the *Index of Concern*. This index serves as a warning to the clinician to look more closely at the profile presented. More often than not the mis-fitting individual, upon more detailed examination, will be assigned a low risk label (high misfit does not imply high risk) but the index is important in order to check the potential over-reliance upon a simple scale score.

Conclusion

We may conclude from these results that the four scales of the RAC have strong measurement properties. It must be reiterated that despite the strength of the scales they should not be treated as the primary focus of the risk assessment. Clearly a full comprehensive assessment takes account of *all* 83 items of the RAC as well as idiosyncratic and contextual information made available through the RAMAS process. Nevertheless, the scales do provide a solid actuarial basis to support clinical decision making, particularly in combination with the caution indices.

2.2.2. Multi-Agency Measurement Equivalence

One of the prime advantages of working with the Rasch Model is that it provides sample independent parameters. That is, the parameters derived from the above analyses should be applicable to all samples within this patient/client domain. Given the fact that RAMAS is flexible enough to be a multi agency tool it is important that the measurement model is shown to work in an equivalent fashion across agencies. This analysis considers three broad services from whom sufficient data on the RAC is available. These are community mental health, high security mental health and probation services.

It is entirely expected that the degree of risk as measured by the RAC will vary between agencies but what is not expected to vary is the meaning of the scores. In other words the quantity of risk may vary but the quality being assessed is assumed to be equivalent across client groups and context.

The problem of qualitative (or measurement) equivalence is widely known in the psychometric literature as Differential Item Functioning (DIF) and a range of procedures exist to address the issue. Work on DIF has been pioneered in educational assessments where the concern has been to ascertain that assessments are

measuring the same thing in different groups such as ethnic or gender groups. A number of procedures have been deployed in this area (Lord 1980; Swaminathan and Rogers 1990; Raju 1990; Hammond 1995). However, one of the principle procedures used in this context is the Mantel-Haenszel test (Holland and Thayer 1988) and this is particularly useful in the present context. The M-H test crosstabulates each item by each pair of groups and then compares response frequencies conditional upon each individual's scale score. In other words it provides an interaction effect that, if significant, indicates the item in question is functioning differently in the two groups.

The three groups represented in sufficient numbers for the analysis are Community Mental Health (201), High Security (122) and Probation (128). In table 9 a simple demographic breakdown for each group is presented. The probation sample has a higher proportion of females than the other two and this group is also younger. However, none of these differences are statistically significant.

Table 9: Demographic Breakdown of the 3 Agency Samples

	Community	High Security	Probation
N	201	122	128
Age	36.58 (11.44) 18-74	37.37 (11.80) 19-78	32.24 (11.41) 18-68
Sex	69% M 31% F	66.5% M 33.5% F	54% M 46% F

The conclusion here is that the three agencies are dealing with roughly equivalent samples regarding sex and age. When the agencies are compared on the RAC scores a number of interesting findings emerge. Results are presented in table 10.

Table 10: RAC Scale Score Variation Across Agencies

RAC Scale	Community			High Security			Probation		
	Mean	S.D.	Range	Mean	S.D.	Range	Mean	S.D.	Range
Mental Instability	3.94	2.92	0-10	3.39	3.01	0-10	0.92	1.45	0-7
Self-Harm	2.13	2.26	0-9	2.13	2.20	0-9	1.60	2.00	0-8
Dangerousness	2.90	3.48	0-17	4.14	4.01	0-16	3.19	3.38	0-13
Vulnerability	3.82	3.74	0-18	5.35	4.93	0-16	3.54	3.39	0-17

The immediate finding is that the raw scores for each scale do not manifest a simple normality of distribution. The standard deviations are large relative to the means and this is especially marked in the Self-Harm scale. In fact, this is entirely in accordance with expectations since it is quite unlikely that risk is distributed in a bell curve. Rather

we might expect a single sided asymptotic distribution with a majority of clients being rated as low risk and a smaller number manifesting extreme scores.

Statistical analyses of the differences between agencies were carried out using the rank order statistic known as the Kruskal-Wallis test. These are presented in table 11. From this it is clear that two of the RAC scales, *Mental Instability* and *Self-Harm* vary significantly between the three samples. By referring to table 10 it is quite apparent where these differences lie. Mental Instability is very low in the Probation group but significantly higher in the the Mental Health samples. This is entirely as expected and is almost a trivial result. Similarly, a lesser significant difference is found with regard to Self-Harm where, again, Probation manifests a lower degree of risk.

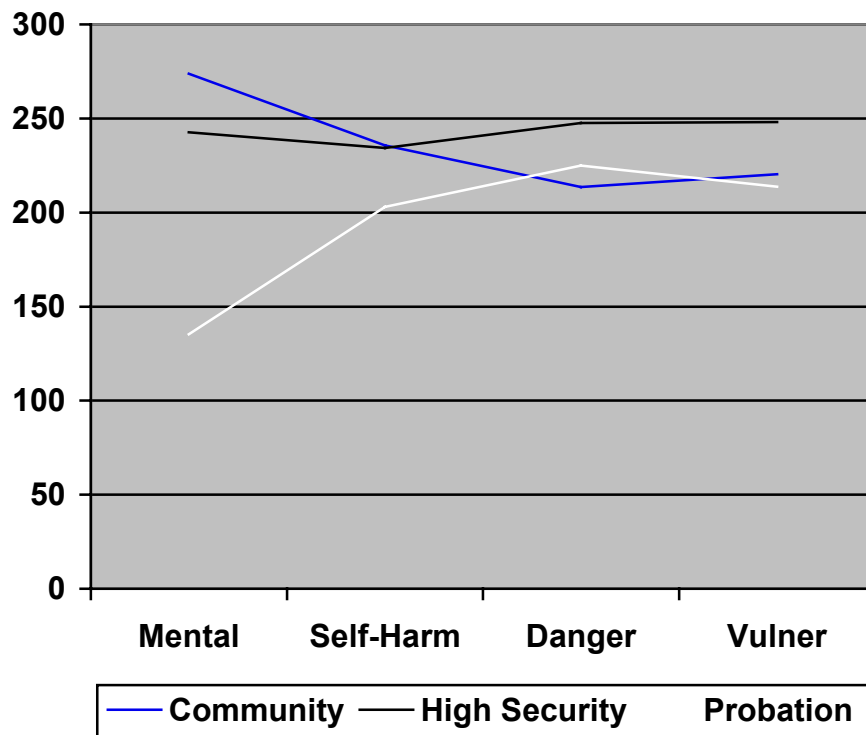
Table 11: Kruskal-Wallis Test Results Comparing Agencies

	Mental Instability	Self-Harm	Dangerousness	Vulnerability
X ²	94.52	6.12	5.41	5.12
p	<0.001	<0.05	ns	ns

A graphical representation of these analysis is presented in figure 5 where the mean ranks for each agency on each RAC scale are plotted. The pattern presented makes much sense with or without the statistical analyses. High Security patients are deemed to manifest greater dangerousness and vulnerability, while community mental health patients present a greater risk of mental instability. Given that the CMH sample is not essentially a forensic one it is not surprising that danger to others is deemed to be lower here than for the other two samples.

These analysis, of course, tell us little about the equivalence in meaning of the scales across the three agencies. It is not unreasonable to suggest that due to the widely different agendas, service objectives and referral processes that practitioners in the three agencies will interpret the RAMAS criteria very differently. Thus, these simple score comparisons may be no more that a comparison of apples and pears.

Figure 5
Mean Rank Scores Across Agency



To address this problem a DIF analyses were carried out using the Mantel-Haenzsel (M-H) procedure. The first analysis concerned a sex comparison in which males and females were compared. This was followed by a series of paired-comparison analyses in which each agency was compared to another. The results for the Dangerousness scale are presented in table 12.

The MH statistic is reported and where it reaches statistical significance it is entered in bold typeface. It is immediately apparent that there is very little DIF manifest in the dangerousness scale. The Item *Emotional Control* appears to be biased with regard to sex and also functions differently between Community and High Security groups.

Tables 13, 14 and 15 present the DIF analyses for Self-Harm, Mental Instability and Vulnerability respectively.

These results are very encouraging although they raise one or two areas for further scrutiny. Self-Harm is clearly a well understood construct with high degree of measurement equivalence between groups. However it may be that practitioners in the High Security area have a slightly different understanding of the factor *insomnia*.

Table 12: Mantel-Haenszel DIF Test: Dangerousness Scale

Item	Male vs Female	CMH vs Prob	CMH vs HSMH	HSMH vs Prob
History of Violence	1.35	0.98	1.01	0.87
Arrest for violence	1.82	1.34	0.92	1.77
Hostage Taking	0.09	0.54	0.66	0.82
Childhood Conduct Disorder	0.04	0.78	0.12	0.57
Menacing Phone Calls	0.02	0.11	0.45	0.09
Aggression Towards Animals	0.79	0.67	0.77	0.34
Threats to injure	0.28	0.57	0.22	1.07
Threats to Kill	1.17	1.33	1.88	2.02
Carries Weapons	0.00	0.82	0.78	0.76
Use of force/weapons	2.01	1.02	1.19	0.97
Personality disorder	2.39	0.98	1.98	2.10
Risk to others (Unknown)	0.10	0.06	0.12	0.63
Risk to others (Known)	1.07	0.88	0.92	1.22
Risk to Staff	1.58	1.99	2.10	1.00
Risk to Family	0.09	0.19	0.00	0.87
Emotional Control	6.05	1.33	4.62	1.88
Feels Threatened	0.05	0.10	0.87	0.50
Likes Violent Material	0.04	0.00	0.43	0.91
Substance misuse	0.36	0.36	0.07	0.26
Unpredictable	1.38	1.44	1.54	2.01
Impulsive	1.42	0.98	0.76	0.92
Predatory Behaviour	0.34	0.64	2.12	2.76
Criminal Lifestyle	0.18	0.66	0.62	0.69
Evidence of Aggression	2.65	0.44	0.51	1.60

Table 13: Mantel-Haenszel DIF Test: Self-Harm Scale

Item	Male vs Female	CMH vs Prob	CMH vs HSMH	HSMH vs Prob
Parasuicide History	0.01	-0.11	0.23	0.72
History of Self-Harm	0.12	-0.43	0.28	1.33
Risk to Self	0.11	-0.85	0.77	0.76
Clinically Depressed	0.89	0.92	0.82	1.34
Suicidal Ideation	0.42	0.62	0.69	0.79
Hopelessness	0.04	0.06	0.19	0.22
Insomnia	0.68	0.55	2.27	4.35
Feels Undervalued	0.28	-0.33	0.87	0.44
Evidence of Self harm	1.29	1.65	1.11	0.09

Table 14: Mantel-Haenszel DIF Test: Mental Instability Scale

Item	Male vs Female	CMH vs Prob	CMH vs HSMH	HSMH vs Prob
History of Mental Illness	1.02	1.78	1.27	0.93
Paranoia	0.09	0.32	0.25	1.42
Treatment Unstable	0.95	1.06	0.99	1.04
Psychiatric Medication	1.42	2.12	1.76	1.55
Current Mental Illness	0.25	0.67	2.34	2.02
Unstable Mental Condition	2.90	1.11	1.23	1.12
Frequent Admissions	1.03	1.00	0.87	1.19
Hallucinations/Delusions	7.25	0.42	0.34	0.41
Non Compliance w. med.	2.13	1.79	1.26	1.20
Evidence of Mental Instability	0.72	0.53	0.36	0.56

Equally, the Mental Instability scale reveals only one differentially functioning item and this is *Hallucinations/Delusions* which functions differently across sex. There is no obvious reason for this finding as it does not appear to have any relationship to known gender stereotypes. We are tempted to read this finding as a statistical ‘blip’ although clearly future scrutiny is advised.

Table 15: Mantel-Haenszel DIF Test: Vulnerability Scale

Item	Male vs Female	CMH vs Prob	CMH vs HSMH	HSMH vs Prob
Emot. Control problem	2.99	0.23	1.23	0.05
Susceptible	0.22	0.39	0.96	0.62
Over-disclosing	0.18	0.62	0.88	0.74
Trust of strangers	1.31	1.11	1.79	2.42
Needy/Isolated	0.93	0.83	0.22	0.92
Naive	0.01	0.41	0.36	1.73
High levels of stress	1.02	1.27	2.44	5.01
Unstable Environment	0.36	0.82	1.33	1.29
Interpersonal Conflict	0.06	0.54	0.59	0.55
Recent Hosp. Admis.	0.54	0.63	1.77	0.75
No close relationships	0.27	0.75	0.51	0.29
Multiple Problems	0.13	0.88	5.36	6.46
History of vulnerability	0.02	0.65	0.26	1.04

The Vulnerability scale is slightly more problematic with two items manifesting significant DIF. These are *High Levels of Stress* and *Multiple Problems*. Again the suggestion here is that the High Security practitioners view these items rather differently than those in the other agencies. It may be that something in the residential setting where input is heavily governed by a medical model serviced by multiple agencies, distorts the meaning of these items.

Overall, the DIF findings are very encouraging. One or two items appear to manifest a degree of DIF that demands some further scrutiny and monitoring. It is likely that training could mitigate, to a large measure, the apparent discrepancy in meaning for the items, *High Levels of Stress*, *Multiple Problems*, *Insomnia* and *Emotional Control* and this will need to be addressed in the training manual.

That said, the scales are almost devoid of obvious DIF using the M-H method. Of course, extreme care must be taken to avoid the problem of 'drift' where items begin to shift from their original meaning. The practice of ongoing review within agencies is vital for maintaining inter-rater consistency but it may not serve to minimize DIF. For this, it will be necessary for agencies to work together to review and compare the risk assessment process. This is a difficulty for all risk assessment and management systems although it is widely overlooked in the literature and in practice. The RAMAS system explicitly requires that such a process is put in place.

2.2.3 Consistency Between Self-Report And Clinician Rating

Previous work (O'Rourke and Hammond 2000) has shown that when trained raters assess common cases using the RAC reliability is high. However, an area not yet addressed is the viability of asking the patient/client themselves to complete the RAC.

The clinical importance of accessing patient's thoughts about their own risk has been highlighted in a number of places (Monahan 1993; Towl and Crighton, 1996; Roberts, et al., 1981). It has been suggested that asking patients about their violent behaviour is the easiest and quickest way of gaining clinical information, and having a substantial explanation of the events (see Pollock and Webster, 1990). Awareness of the difficulties with truthfulness of self-reports is important (Mulvey and Lidz, 1993) since violent patients tend to minimise and deny responsibility for their offences (Harris and Rice, 1994). Nevertheless, despite some patients distorting some of the information, they quite often are forthcoming about violence and questioning them about discrepancies provides useful insights. Others support this view on the grounds that the patient has a substantial explanation of the events (Pollock and Webster, 1990) and

their opinions add to 'specificity' (Mulvey and Lidz, 1993). Further, it has been suggested that assessing the reasons for discrepancy between patients and staff's views are of clinical importance as unwillingness or inability to evoke the intrapsychic experience concurrent with violent behaviour is an indicator of poor prognosis, indicating difficulties with organisation present in personality disordered offenders (Meloy, 1987). The opposite is also characteristic of false positives; that is, the ability to identify aggressive thoughts and affect in the absence of violent behaviour.

Most Risk assessment systems do not consider the patient's self-report but rely instead upon more 'objective' sources such as clinical notes and forensic record. The RAMAS is relatively unique in explicitly assuming that the patient and his/her family and important others will collude with, and have a role in, developing the risk assessment and management process. However, that is quite different from treating the RAC as a self-report instrument and this is not currently the practice in the RAMAS process.

In this study a small group of 16 patients in High Security were asked to complete the RAC for themselves. In addition, two clinicians also completed the checklist for that patient. The first clinician was the primary nurse and the second was a nurse on the patients ward but who was not directly associated with his care. It should be noted that the patient and the two raters had not received the full RAMAS training and received instead only the description of the features from the manual.

The RAC scales were computed for each patient in each of the three conditions, Self-Report, Rater A and Rater B. The scale scores were then correlated to examine the consistency between raters. Consistent with treating the scales as non-parametric, correlations of monotonic order were used (Kendall's Tau). Results are presented in table 16.

Table 16: Agreement Between Raters using Kendall's Tau

	Self vs Rater A	Rater A vs Rater B
Mental Instability	0.26	0.61
Self-Harm	0.59	0.60
Dangerousness	0.24	0.50
Vulnerability	0.44	0.57

The statistically significant coefficients are presented in bold typeface. It is apparent that the self-reports are not highly consistent with the ratings of the primary nurse especially with regard to Mental Instability and Dangerousness. The greatest agreement is with Self-Harm and Vulnerability both of which are statistically significant but are not by any means sufficiently high in agreement to be equivalent.

Interestingly, the two clinical raters agree more closely although again these coefficients do not convey the impression of high degrees of reliability. Previous work (O'Rourke and Hammond 2000) has shown that when trained raters assess common cases the reliability is high. Here we have raters who were not fully trained and one of each pair was not closely associated with the patient's case. Nevertheless, inter-rater agreement is consistently higher than the agreement between patient and primary nurse. This suggests that patient involvement, while necessary for the complete RAMAS formulation, should be treated with caution in completing the checklist.

Of course, it may be that the High Security context of this study introduces a bias into the results and this must be taken into account. However, our conclusion must be to urge extreme caution if practitioners wish to consider self-report use of the RAC.

3.2.4. Correlates With The RAC

The fact that self-report use of the RAC is not advised does not necessarily generalize to other self-report instruments that were designed specifically for that purpose. It is reasonable to maintain a degree of caution when using such measures especially in the forensic context where minimization, denial and malingering are suspected. However, much forensic and clinical assessment does rely heavily upon self report. In this section we are concerned to examine the correlation between some of these measures and the RAC scale scores.

Due to the multiple agency use of the RAMAS and the differing agendas that implies it has not been possible to identify a common set of assessments used by all practitioners. However, a number of measures are commonly used in the Forensic Clinical Psychology Unit (FCPU), which is a community based service. The FCPU jointly supervises patients and works closely with local Probation services and this has resulted in a sample of 77 clients from community and Probation with a common set of measures. These include the RAMAS Anger Assessment Profile (RAAP), The Emotional Control Questionnaire (ECQ), Ravens Matrices and, in the case of alcohol or drug problems, the SAD. Correlations with the RAMAS are presented in table 17.

Correlations with statistical significance levels of 5% or less are highlighted in a bold typeface. The immediate impression is that there are a large number of statistically significant correlations.

1. RAAP Scores

The anger scales of the RAAP are largely consistent with the Dangerousness scale of the RAC. This implies that cases viewed as dangerous will manifest greater numbers and range of anger problems. This is intuitively feasible and, given that the two measures were derived independently serves as validating evidence for both devices.

Table 17: Correlates with the RAC Scales

Scale	Mental Instability	Self-Harm	Danger	Vulnerability
RAAP				
Attitude	0.30	-0.15	0.20	0.09
Expression	0.26	0.31	0.05	0.26
Provocation	0.20	0.19	0.30	0.26
Somatic	0.32	0.22	0.55	0.32
Duration	0.38	0.32	0.35	0.54
Sensitivity	0.33	0.24	0.40	0.38
Victimisation	0.23	0.03	0.36	0.27
Assaultative	0.20	-0.03	0.47	0.14
Consequence	0.28	0.16	0.47	0.32
Control	0.02	0.09	0.20	0.17
ECQ				
Rehearsal	-0.17	0.08	0.14	-0.02
Inhibition	-0.18	0.07	0.00	-0.03
Benign	0.27	0.43	0.14	0.31
Aggression	-0.05	0.21	0.19	0.03
Raven's Matrices	0.10	0.18	0.11	0.08
Substance Dependence	0.13	0.25	0.25	0.38

Interestingly, it is not the Assaultative scale that has the highest correlation with dangerousness but rather, the largest correlation of 0.55 is between the somatic scale of the RAAP and Dangerousness. This scale taps the degree to which the patient experiences anger physically (eg. palpitations, trembling etc.). This scale also correlates significantly with Mental Instability and Vulnerability. The only scale to correlate with all RAC measures is Duration. This scale taps the degree to which a person is able to 'let go' of their anger and put it behind them. This is clearly a high risk factor.

The other correlations of the table are unsurprising. The correlation of Benign Emotional Control with Vulnerability and Self-Harm is consistent with the self-destructive behaviour implied by the Benign scale. Equally, worth noting is the finding that high dependency is associated with Vulnerability. The fact that the Raven's Matrices show no appreciable relationship to RAC measures is exactly as expected. This means that risk has little to do with cognitive functioning, rather the source of high risk may be found in social and personal functioning.

These correlations prove nothing in themselves but they are instructive of the manner in which high risk people may tend to present themselves. It is an open question as to whether their presentation unduly influences the risk rating they receive. However, these data were collected quite independently of the RAMAS assessments so the observed relationships carry a certain cache. Certainly the importance of anger and impulse control and the irrelevance of intellectual level are the salient findings here.

2.3. Implementation Studies

2.3.1. The Impact of RAMAS Implementation in the State Of Jersey

In this, the first of two studies examining RAMAS implementation, preliminary findings from an ongoing programme of service evaluation are presented. In 1999 the States of Jersey undertook to implement RAMAS as a multi-agency tool for case management. The initiative was originally from the probation service but all social and health-care agencies became involved and signed up to the system. As part of the arrangement with the RAMAS development team, it was agreed that an ongoing evaluation of service provision would be undertaken. The present study represents the first of a series of studies envisaged to span at least 5 years.

The Sample

Fifty-four people have completed the RAMAS training in the States of Jersey. There were four separate inter-agency training days. All practitioners/clinicians were chosen from various departments and agencies that are in direct contact with members of the community that may benefit from risk assessment and management. The following professionals were trained: Clinical Psychology; the States of Jersey Police; Psychiatry; Alcohol and Drug Services; Social Services (including the Child and Family Service); Jersey Probation Service; Social Work; the Prison Service and General Practice.

The first part of the present study involved sending out questionnaires (see Appendix A) to all 54 individuals who had completed the RAMAS training before and after the

implementation of RAMAS. From the 54 questionnaires, a total of 31 (57.4%) were completed and returned. Of the 31 replies, 22 were male and 9 were female. The professionals that did not respond to the questionnaire were contacted directly to ascertain their views. Non-respondents were followed up and it was revealed that factors such as retirement, people changing jobs or leaving the island, maternity leave and holidays prevented their input to the survey.

Of the 31 respondents a usable matching (before and after) was only possible on 21. This represents a complete response rate of 39%. Analyses need to be tailored to reflect the small sample and interpretation will inevitably be tentative.

That said it must also be acknowledged that this kind of service evaluation will typically be carried out on small samples as new programmes and initiatives tend to be introduced cautiously and in small pockets. The following analyses involve some traditional non-parametric methods as well as some slightly more experimental procedures in an attempt to address this problem.

The sample was broken down into 4 super-ordinate groups of service. These are Social Services, Health Services, Probation Services and the Police Service. Table 18 provides the breakdown of the sample into these groups.

Table 18
Group Membership

Group	n	%
Social Services	5	23.8
Health Service	8	38.1
Probation	5	23.8
Police	3	14.3

The Questionnaire

A questionnaire was used to obtain the data for this study (see Appendix A). The Questionnaire had previously been formulated by the Forensic Clinical Psychology Unit in Surrey, and was administered to one of the two training groups before the implementation of RAMAS in the States of Jersey. The Questionnaire was then administered to all the participants that had taken the training.

The first section of the Questionnaire consisted of 22 questions focusing on issues pertaining to risk assessment and risk management in the participants' service. The

questions were based on a 5-point rating scale, where 1 indicated that the participant was not at all satisfied with the specific feature (relating to either their services' risk assessment, risk management and multi-agency work) and 5 indicated that they were extremely satisfied. The second section of the Questionnaire listed nine other agencies and the participants were asked to rate the degree of satisfaction *vis-a-vis* their services' collaboration with the various other agencies. Once again, the 5-point scale was used.

Satisfaction Ratings

The questionnaire asked respondents to rate 22 features of their service according to the degree of satisfaction they felt for each. Ratings taken before RAMAS implementation were then compared with the same ratings after implementation. We are not concerned here with 'overall' satisfaction but rather with the differential impact that RAMAS may have upon these service features. To that end a Wilcoxon test was carried out for each of the 22 items in the questionnaire to assess the degree of change in ratings between the two time periods. The results are presented in table 19.

The Wilcoxon test itself is a rank test but rather than report the mean ranks, which tell us little about the actual ratings, the means and standard deviations of the ratings are also reported. Thus, it may be noted that satisfaction with psychometric testing was rated very low at time A while satisfaction with progress was rated favourably.

The results are pretty unequivocal. There was an improvement in satisfaction on every feature following RAMAS implementation. Furthermore this improvement was statistically significant in 17 out of the 22 features rated (15 with $p < 0.01$). (It should be noted that the negative value for the Wilcoxon statistic is a function of the order in which it compared the two time periods and actually reflects an improvement in satisfaction between times A and B).

Of course, it is always advisable to be wary of over interpreting statistical significance when carrying out multiple tests. However, the purpose here is to examine the profile of perceived change that has occurred. The fact that these changes are largely statistically significant is another point of interest from which we can draw confidence. Interestingly the RAMAS appears to have been most efficacious in promoting satisfaction with the actuarial nature of the service. This is one of the main aims in the RAMAS philosophy. However, there has been less movement in satisfaction over the management of Personality Disordered Patients.

TABLE 19
Changes in Item Ratings Pre and Post Implementation

Item	Time A		Time B		Wilcoxon z
	Mean	S.D.	Mean	S.D.	
Accurate	2.74	0.87	3.60	0.69	-3.49 **
Complete	2.36	0.89	3.00	1.05	-2.47 *
Clarity	2.16	0.89	3.10	0.73	-3.43 **
Actuarial	2.50	0.86	3.60	0.70	-3.82 **
Psymet	1.55	0.79	2.70	0.82	-3.82 **
Multi Agency	2.16	0.95	3.20	1.23	-3.06 **
Family	2.27	1.09	2.50	0.71	-1.16 ns
Needs Led	2.42	1.07	3.20	0.79	-2.57 **
Skills	2.22	0.94	3.10	0.99	-3.10 **
Person	2.22	0.80	3.20	1.13	-2.99 **
Noneng	2.55	0.93	3.30	0.67	-2.85 **
Chronic	2.82	1.13	3.33	1.00	-2.20 *
Complete	2.68	0.95	3.50	0.97	-3.72 **
Dual	2.53	0.72	3.22	1.09	-3.35 **
Ldis	2.58	1.12	3.00	0.92	-1.56 ns
PD	2.47	0.84	2.70	0.83	-0.92 ns
Mannl	2.50	1.03	2.90	0.99	-1.17 ns
Progress	3.17	1.20	3.20	1.03	-0.31 **
Intagent	2.84	0.96	3.60	0.69	-2.99 **
Assess	3.00	1.10	3.30	0.82	-1.56 ns
Sigothor	2.47	0.84	3.11	0.60	-2.92 **
Victim	2.17	0.98	2.25	0.71	-0.81 **

Having established a pretty robust time effect, we now turn to an exploration of group differences. This endeavour is severely handicapped by sample size restrictions as the typical approach would be to perform a split plot Analysis of Variance in order to identify a time by group interaction effect. However, the small sample size would be likely to severely distort the results of such analyses due to the assumption of normality. One option is to carry out a normal ANOVA upon the ranks of the data. In this way the non-normal distribution is transformed to be uniform. Although not ideal, this procedure has some precedent (Conover 1989) and may be useful as a descriptive summary. Results of these analyses for each rating are presented in table 20.

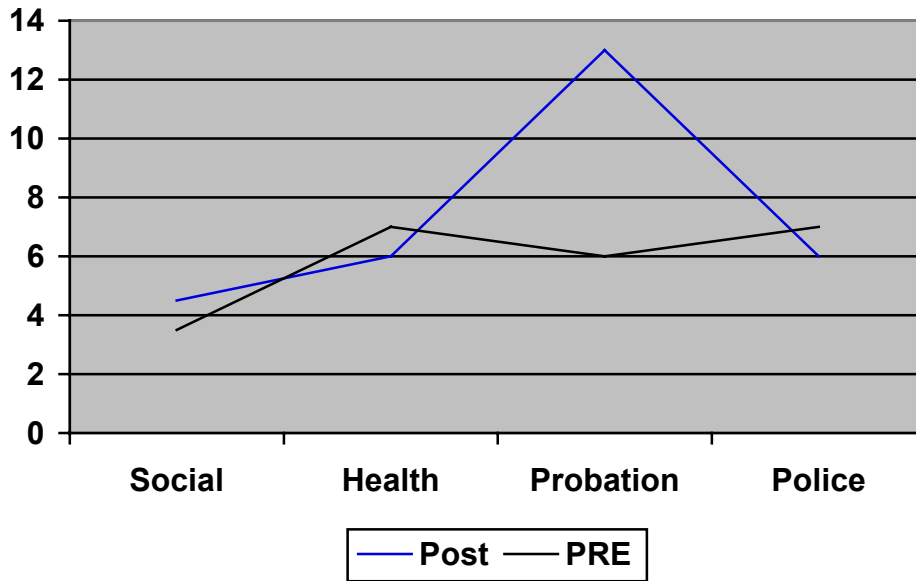
It is apparent from this table that the groups differ very little in their ratings of the features and only two features show any signs of significant group by time interactions. These are satisfaction with the actuarial nature of their work and multi-agency working. These interactions are summarised in figures 6 and 7 respectively.

Table 20
Main Group and Interaction Effects Split Plot ANOVA on Ranks

	Group Effect	Interaction Effect
Accurate	1.01	3.11
Complte	2.05	1.24
Clarity	0.81	1.89
Actuarial	0.66	13.66**
Psymet	0.82	1.89
Multi Agency	0.37	5.89 *
Family	0.56	2.85
Needs Led	0.89	0.95
Skills	4.95	3.75
Person	0.15	4.66
Noneng	1.20	2.74
Chronic	2.02	2.49
Complete	2,68	0.95
Dual	1.72	2.20
Ldis	1.60	2.83
PD =	0.53	0.81
Mannl	2.98	2.11
Progress	1.72	0.14
Intagent	1.98	1.27
Assess	3.00	1.10
Sigother	1.20	0.21
Victim	0.25	0.73

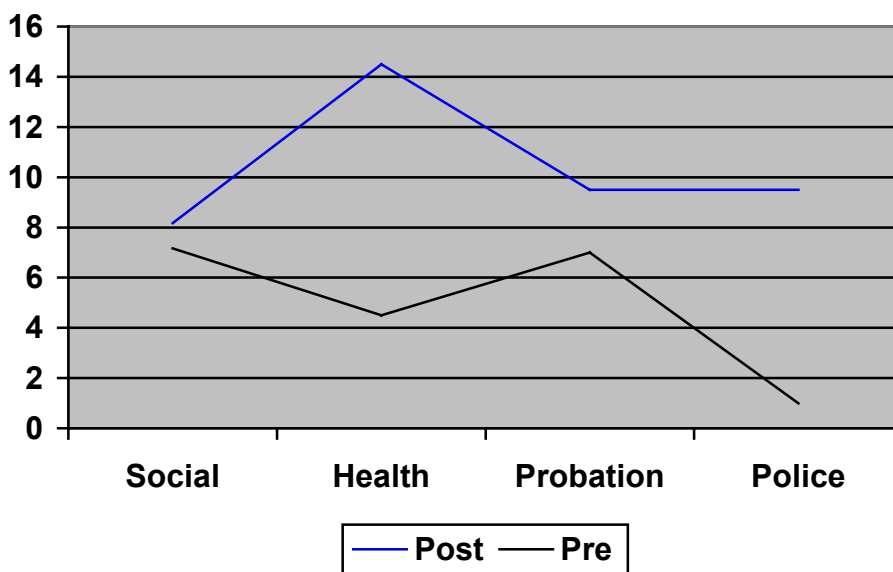
Clearly the interaction effect observed for the actuarial item is a function of a large change experienced in the probation service. All the other services appear to show little change, indeed social services show a small decrease in satisfaction. Thus, the large change in satisfaction for this feature expressed in table 1 may be attributed largely to the response of the probation service.

Figure 6
Time by Group Interaction (Mean Ranks)
Actuarial



The interaction with multiagency working shows a generalised improvement in satisfaction (again very much a central tenet in the RAMAS philosophy) but the significance of the interaction appears to be reflected in the huge change of those in the Health and Police Services.

Figure 7
Time by Group Interaction (Mean Ranks)
Multi-Agency



The fact that no other features manifest an interaction effect must not be over interpreted. The analysis these results were based upon is atypical and sample size is likely to inhibit the emergence of other effects. Nevertheless, these interactions do serve to highlight the issue of differential service impact of a system such as RAMAS. The manner in which it may pick up on areas of weakness in some services that are less problematic in others (eg actuarial methods in probation and multiagency working in health) is an issue that will be picked up again in the discussion.

Multi-Agency Use

In addition to asking practitioners about their satisfaction with aspects of their service the questionnaire also asked about the degree to which they used the services of other agencies. These data were analysed in the same manner as the satisfaction ratings by non-parametric Wilcoxon Rank tests. The results are presented in table 21.

Here we see that, although multi-agency working is perceived to have increased after RAMAS implementation, there are no statistically significant changes. Whether a larger sample would make a difference is an open question, but it is likely that the RAMAS implementation, if it does encourage more multi-agency working, will tend to show its effects gradually as trust and fuller integration of service goals grows. This is an issue that will need to be revisited in a subsequent evaluation.

Table 21
Mean Rating on MultiAgency Service Use

Service	Time 1		Time 2		Wilcoxon z
	Mean	S.D.	Mean	S.D.	
Health Service	2.05	0.93	3.20	0.83	-1.40
Social Services	3.00	0.94	3.25	0.71	-0.37
Voluntary Service	2.41	1.06	3.69	0.52	-1.34
Alcohol and Drug Service	3.27	0.75	3.28	0.75	-0.44
Local Community Service	2.53	0.99	4.36	0.70	-2.04
Probation Service	3.33	0.97	3.50	0.97	-0.18
Housing	2.47	1.21	3.77	0.97	-1.89
Police Service	3.23	0.75	3.00	1.12	0.00
Employment Service	3.47	0.94	3.50	0.98	-0.12

Individual Measures of Change

We conclude this section with another atypical analysis designed to explore the group differences. In this case we used a modified log-ratio index of change proposed by Agresti (1990) (see also Mellenbergh and van den Brink 1998) designed for

dichotomous data. This index works within each respondent and utilises a binomial error model. Briefly, the LR index for each person is estimated as:

$$LR = \ln\left(\frac{NI + 0.5}{ND + 0.5}\right)$$

Where:

NI = The number of items showing an increment over time

ND = The number of items showing a decrement over time

The numerator and denominator are both incremented by 0.5 to avoid division by zero problems. The standard error for the dichotomous case is easily derived, however, our data is in an ordered rating (Likert) form and, while this is not an intractable problem it is beyond the brief of this thesis to develop the necessary derivations and proofs. The LR index may be used as an idiographic measure of change for each individual as it stands although without the standard error it may not be treated as a statistical parameter.

Nevertheless, the LR index is more useful than the simple score difference on two major counts. First, the use of a total satisfaction score implies that the measure must be shown to be reliable, the sample size (indeed the population size of 54) is not sufficient to test this aspect of the questionnaire. Secondly, simple difference measures are problematic due to the fact that some pre-scores have more freedom to vary than others (the floor and ceiling effect).

Having estimated the LR index for each individual a test of group differences in overall movement towards greater satisfaction was carried out. The results are reported in table 22.

Table 22
Kruskal-Wallis Test of Log-ratio score between groups

Group	Mean	S.D.	Min	Max	Mean Rank
Social Service	0.79	1.08	0.00	2.61	13.50
Health Service	0.40	1.01	-0.24	2.83	9.44
Probation Service	0.37	0.69	0.00	1.61	11.10
Police Service	0.33	0.57	0.24	1.00	10.83
Chi-Squared ₃ = 1.62 ns					

The Kruskal-Wallis test showed no significant group difference although in keeping with the findings of table 1, it is worth noting that only one LR index was below zero, indicating a fall in satisfaction. This was found in a health service practitioner. All other respondents had zero (no change) or positive LR indices.

Conclusions

In summary, it is clear that there has been a positive movement in satisfaction in service provision following RAMAS implementation. Problems of sample size, however, must be borne in mind and the results should not be over-generalised. However, although the sample is small it does represent 39% of the population under scrutiny.

The interaction effects across practitioner groups are interesting in that both show a significant improvement in satisfaction for particular agencies. Thus probation appears to have benefited particularly from the greater actuarial emphasis that RAMAS brings to the service. On the other hand Health service workers and the police report significant improvement in multi-agency working. This highlights the reality that different agencies are likely to be sufficient and deficient in different areas of service provision. The RAMAS attempts to provide a basis for good practice across the board and so it is likely to impact differentially on services.

There may, of course be special conditions in Jersey that shape these results and it is entirely possible that these unequivocal results may not generalize. Nevertheless, this small scale study does, at least, convey the finding that RAMAS implementation does no harm to service provision from the perspectives of practitioners in a variety of agencies. Indeed, it appears to promote satisfaction in practice, clarity and multiagency aspects of service provision.

Of course, the current study only taps into practitioner perceptions and the ultimate test of RAMAS utility is in a longer-term evaluation of service provision using multiple performance and outcome measures. This study must simply stand as the initial pilot for this longer-term aim and the protocols for such a project have already been built into the implementation process in Jersey.

2.3.2. Interviews with Senior Managers and Policy Makers

The implementation of any new multi-agency system requires a great deal of negotiation and planning across the various professions. It is a common finding that, while the practitioners will quickly see the clinical benefit (or otherwise) of a new

system, planners and senior managers must juggle a variety of issues that may have little or nothing to do with clinical need.

In order to examine these other urgencies that often frustrate clinicians and practitioners directly involved in patient care a series of open ended interviews were carried out on 35 people whose roles involved implementation policy for service provision. Twenty-two direct questions taken from the Sainsbury Centre 'Taking your Partners' checklist were presented in relation to the possible implementation of RAMAS. An open-ended response was encouraged. Participants were ensured that their responses would be confidential. To further this, the interviews were carried out by an independent research consultant.

The sample consisted of 7 senior managers from Health, Home Office, Police, Probation and Housing, with a National remit, 15 senior managers with a local remit and 13 senior clinician/practitioners from the agencies involved. It was interesting to note that those with a National remit such as Home Office and Department of Health were extremely willing to offer their time for the survey as were the clinicians and practitioners from the various agencies (Health, Social Services, Probation etc.). This was not so true of all the senior managers with a local NHS remit and a number presented a rather suspicious and obstructive manner when approached to participate. Notably, one director of Mental Health refused to offer any input at all. This is worth noting in view of the fact that a multi-agency initiative may have all the support it needs from the National level but it will fail nevertheless if the local NHS manager's will is not behind it.

The richness of the information is hard to convey in anything other than a journalistic form. However, of the 22 questions put to the interviewees, it was possible to code 13 into a quantifiable response. These were coded as positive, equivocal or negative. In order to see whether the individual's position effected their response the proportion of positive responses to each question were compared. In addition the degree of agreement between individuals in each group was indexed by the proportion of modal responses. Where this is high a strong consistency exists. These proportions were transformed to percentages and are presented in table 23.

In table 23, modal responses accounting for less than 50% of the sample are highlighted in a bold typeface. This gives a rough estimate of the degree of consistency in the responses and the highlighted cases represent a more diffuse response across respondents. Clearly, the Professional with a national brief have a

more consistent view of the current status of the system while local managers and clinicians are less consistent. Interestingly, the issues that clinicians are less consensual on are the same as local managers. This is despite the fact that the modal categories are not necessarily the same. In other words clinicians and local managers are divided over the same issues but they do not necessarily agree with each other.

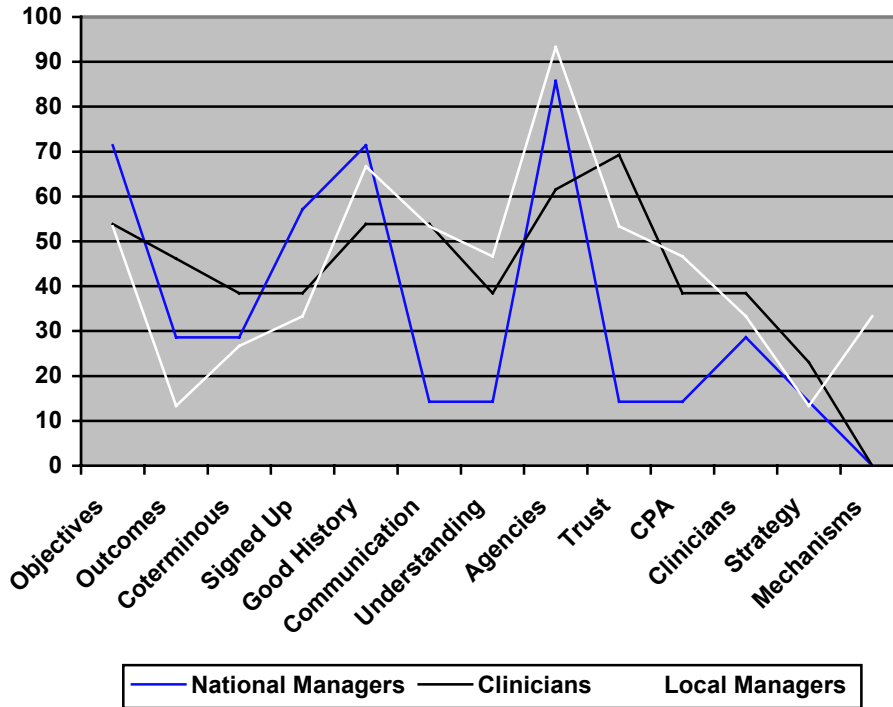
Table 23 : Responses to Quantifiable Questions Broken Down by Position

	National		Local		Clinician	
	+ve	Modal	+ve	Modal	+ve	
	Modal					
Objectives	71.42	P 71.42	53.33	P 53.33	53.84	P 53.84
Outcomes	28.57	E 57.14	13.33	N 46.67	46.15	P 46.15
Co-Terminous	28.57	E 42.85	26.67	E 40.00	38.46	N 46.15
Signed Up	57.14	P 57.14	33.33	P 33.33	38.46	P 38.46
Good History	71.42	P 71.42	66.67	P 66.67	53.84	P 53.84
Communication	14.28	E 57.14	53.33	P 53.33	53.84	P 53.84
Understanding	14.28	E 57.14	46.67	P 46.67	36.46	E 46.15
Agencies	85.71	P 85.71	93.33	P 93.33	61.54	P 61.54
Trust	14.28	E 57.14	53.33	P 53.33	69.23	P 69.23
CPA	14.28	N 57.14	46.67	P 46.67	38.46	E 46.15
Clinicians	28.57	E 71.42	33.33	E 40.00	38.46	P 38.46
Joint Strategy	14.28	N 85.71	13.33	N 60.00	23.07	N 53.84
Mechanisms	0.00	E 57.14	33.33	N 53.33	0.00	N 69.23

P = Positive Response, E = Equivocal Response, N = Negative Response

The graph in figure 5 shows the degree of agreement in terms of positive response. Here it is apparent that national managers are in less agreement than those working locally. However, clinicians and local managers also differ on a number of key issues. For example, local managers are more sanguine about mechanisms being in place for consulting and engaging with others. Interestingly, clinicians and professionals with a national brief unanimously view this issue in either negative or equivocal terms. It is also interesting to see that clinicians are more positive about agreed outcome measures than local managers.

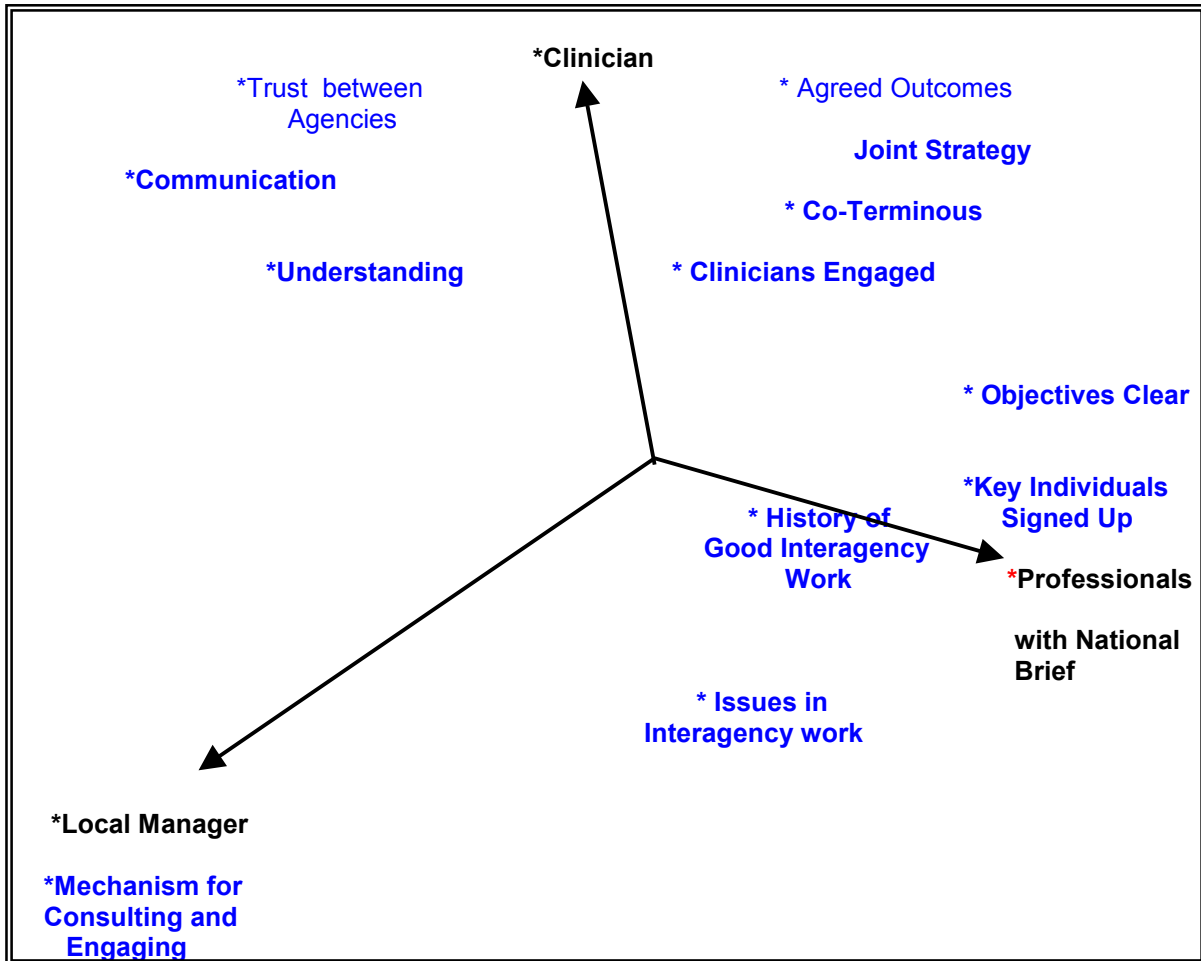
Figure 8:
Issues for which there is a positive view broken down by position



In order to represent these differences in a more conceptual way a Biplot analysis was carried out. This analysis projects the issues into a two dimensional space such that the proximity of two points indicates the degree of similarity of rating. In addition, it is then possible to project the groups into the same space. This analysis serves as a relatively simple discriminant analysis for categorical data that allows a qualitative interpretation.

The plot in figure 6 indicates that the three groups are separated quite widely by these implementation issues. Local managers are most discriminated from the other two groups by their belief in the presence of mechanisms for consulting and engaging with others. Clinicians are more positive about agreed outcomes and interagency trust than the managers while National managers are sanguine about the clarity of objectives and interagency cooperation.

**Figure 9:
Biplot Analysis of Implementation Issue by Job Position**



Of course, it is tempting to interpret this space from the perspective of the clinicians who are, after all, those who will be carrying out the task of risk and care management at the patient/client level. From this perspective the professionals with a national remit present a profile of confidence in the presence of clear objectives and the sense that everybody is 'pulling together' but also a sense that the agencies do not trust each other and have poor communication. On the other hand, local managers appear to have a perspective which placed more trust in the presence of locally organized mechanisms for consultation but less confidence in joint strategy and agreed outcomes.

The impression is that there is still considerable disarray and lack of clarity on the very basic features needed for successful implementation of a multi-agency patient/client management system for risk and care management. It is of some note that successful

implementation of the RAMAS in the States of Jersey was carried out with much less divisiveness than is apparent in the county of Surrey. Of course, comparisons of this sort are odious because the scale and diversity of the agencies involved is very different. Nevertheless, one cannot but feel a sense of disappointment that local senior NHS managers and clinicians are presenting such a dischordant pattern of responses.

It is perhaps worth noting that the Blue Light Initiative Programme (BLIP), a highly successful Surrey inter-agency initiative happened during a period when the NHS service provider was a single focus mental health trust, while current services are configured within a broader community and health service portfolio.

It has to be reiterated that these analysis simply show a small part of the richness of the data. A more descriptive list of the issues raised will be presented in a further report (Hammond, Buchnall and O'Rourke (In Preparation)).

2.4. Conclusions

The studies described in this report cover a variety of issues that have grown out of the last 5-years of experience with the RAMAS. Some of them may seem rather academic and narrowly focused, but they are needed to bring a broader understanding of a) the functionality of the RAC within the RAMAS process and b) to help identify the potential pratfalls and inconsistencies in the proper implementation of the full multi-agency system.

Broadly, the results provide support for the psychometric model at the heart of the RAMAS and with this support it is now possible to seriously consider the use of the statistical base for rational assessment not only of 'degree' of risk but also the 'unpredictability' of risk. This leads us closer to having a statistically robust system which allows the normative and idiographic needs of practitioners to be properly integrated rather than leaving these two approaches as extremes in an academic battleground.

The results from the implementation studies are less consistent. It is rewarding to see that the Jersey study is unequivocal in its support of the RAMAS implementation although it is important to realise that this is a small scale study in the very early stages of an ongoing evaluation. The interview survey conveys less encouraging news, although not surprising and not specifically problematic for the RAMAS. Clearly, the clinicians/practitioners do not share the same perspectives as the local managers or policy makers. It may be assumed that policy makers would be divorced from local

matters but what is slightly surprising is the distance that the local managers are from the practitioners. Of course, this may well simply reflect the state of affairs in South-West Surrey but such a sanguine view is not supported by data.

RAMAS and BLIP have had a number of small UK-based implementation trials. The lessons from our experiences in the various areas nationally seems to be that successful implementation relies on the following elements being in place:-

- A clear strategic purpose
- Leadership from visionary individuals
- A sharp focus upon results
- Common language and clear communication chains
- Investment in and support for people (service users, staff etc.)
- A shared training and support strategy
- Coordination at each level of service
- Audit and review

RAMAS is currently being implemented in a number of areas in the UK including Greater London, Berkshire, Devon, Cornwall, Sussex, Birmingham, Leeds, Glasgow and Lothian. The above elements are key features of the implementation process in these areas.

CHAPTER 3: APPLICATIONS: TRANSLATING RESEARCH INTO PRACTICE

In this chapter we intend to provide examples of a number of applications of the RAMAS. At the center of this are 3 case studies which are presented in a necessarily abbreviated form. The theme of the chapter is essentially the translation of research into practice

3.1. Working from an effective baseline

Clinical teams should seek to use the best available actuarial, statistical or predictive techniques to support clinical judgements about “Dangerousness” (Kirkman Report, 1991)

At the center of RAMAS is the Risk Assessment Checklist (RAC), a psychometric device that has been rigorously tested and fitted to a cumulative model. (See Chapters 1 and 2). The authors believe that the RAC is a robust risk assessment tool which, and can have the confidence of service users, carers, clinicians, practitioners and purchasers of service.

The RAC can claim equal status to the best available actuarial statistical or predictive tools. Table 1 has demonstrated how the RAC compares with other assessment tools.

We must be humble, however, about the RAC and about, other tools because the unreliability of psychiatric predictions of future dangerousness is by now an established fact within the professions. 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. (Barefoot Vs Estelle American, Psychiatric, Legal Case 463 U.S. 880. 1983p 896). Even the latest data of the world class studies by Monahan, Steadman, Webster and others confirm that continuing problems with high numbers of false positives and false negatives. A false positive may lead to a non-violent patient being detained, whereas a false negative may deprive someone of much needed help. The implications for service users are immense. The potential for Human Rights violations are very real.

The work of Munro and Rungay (2000) suggest a way forward. Munro and Rungay, analysed the findings of public inquiries between 1988-1997, in relation to predictability and preventability of the homicides. They wanted to examine the findings of public inquiries into homicides by people with mental illness to see if they support the claim that better risk assessment would have averted the tragedy of the homicides considered by the inquiry panels, 27.5% were judged to have been predictable, 65% preventable and 60% had long-term history, containing violence or substantial risk factors for violence. Munro and Rungay concluded that improved risk assessment has only a limited role in reducing homicides. More deaths could be prevented by improved mental health care, **irrespective of the risk of violence.**

Clinical Implications

If services become biased towards those assessed as high risk, then ethical concerns (threshold levels for intervention, Type I and II statistical errors, false negatives, false positives) arise about the care of both violent and non-violent patients.

Mental health, criminal justice and social care professionals have limited ability to predict rare incidents of violence. Human behaviour cannot be reduced to numbers or categories. Risk assessments are fallible. Targeting limited resources on those deemed potentially violence may lead to serious injustices to people who are seriously ill or who have multiple needs and vulnerabilities, but pose no danger.

Mental Health Professional has considerable skill in assessing, diagnosing and treating mental illness and personality disorder. The public would, it is argued, be better protected by having a good standard of care for all patients. Criminal justice, social services and social care agencies, similarly have considerable expertise in assessing and managing risk. Good risk management is the same as good practice. Good management follows for accurate complete and communicated assessments.

Reviews of the literature highlight the essential characteristics of good assessment. The characteristics of good assessment are as follows:

Firstly, good assessments are comprehensive and use multiple sources for information including: -

- Third part reports (Hospital Records, GP Reports, Psychiatric Reports, Case notes, Criminal Records, Police Reports, Victim Statements)
- Direct behavioural observation and clinical interview

- Self and Family Reports
- Psychometric testing
- Histories, Chronologies and Case notes

Secondly, good assessment should adopt a multifactorial model of risk and patients should be assessed in terms of clinical, dispositional and contextual factors in addition to the historical factors. Patients also need to be assessed for their specific risk and need features as well as for responsivity and previous response to treatment and/or care.

Thirdly, effective assessment recognises that the quality of self-report varies with internal motivation(s) with mood state, and with anticipated consequences of disclosure. Building positive, collaborative and reassuring relationships is an essential part of the assessment process.

Fourthly, Risk is dynamic, assessment should be ongoing and it should be appreciated that its quality improves over time. People with multiple needs and vulnerabilities have difficulties with trust and thus reveal things only when rapport has been well established.

Finally, good quality assessment is achieved through accurate, complete and communicated records, which are regularly, updated and reviewed. Good assessment (tools, records, systems) is the bridge to close the gap between problem identification, solution finding and effective outcomes.

RAMAS provides effective baselines through Robust Standardised Systems for all of the above elements. Our research has demonstrated that the assessment / measurement properties of RAMAS are consistent across patient groups regardless of service setting, that RAMAS is a Robust tool for standardised risk and care management. Our findings are consistent across services and across gender, race and mental health status of patients.

3.2 RAMAS IN ACTION: Public Safety

The Blue Light Information Process (BLIP) is a RAMAS multi-agency risk management, designed to enhance communication between services involved in high risk or immediate threats to public safety and individuals. Blip has been developed as an information sharing and support system to assist clinical, practitioners and police manage and audit risk (especially high risk) in community settings. BLIP is intended to

assist services and agencies develop common strategies to manage dangerous and at risk behaviours

In setting BLIP up, we examined the literature and it seemed that the information required for services to make the system to some degree fail-safe already existed. (Building Bridges 1995, The Spectrum of Care 1996). In discussions with organizations locally it became clear that a wide range of key agencies recognized that no single agency can either meet all the needs of those at risk of posing risk, or act alone to effectively manage public safety and individual care. We note that behaviours(s), which increase risk, can be displayed by other individual and organizations. We wanted to demonstrate that we have learned the lessons of recent public inquiries into homicides and suicides in the community (Sheppard 1996). We hoped to show that safe services are the product of agencies working together defining there shared goals and recognising that each provides only one element of the approach.

BLIP is a mechanism, operating 24 hours a day, 365 days a year, whereby agencies can quickly and effectively pass on information in circumstances where an individual is perceived as being either “a risk” or “at risk” in the community – and where co-ordinated support or management is not in place or unidentified.

The first pilot phase of Guildford’s BLIP initiative has proved to be an outstanding success since its inception in November 1997. It has demonstrated that it is possible for a wide range of agencies to work together on the common goals of public safety and individual care. A total of 43 BLIPS were issued between November 1997 and March 1999. 88% of BLIPS related to men, 12% to women.

The cause of concern which generated BLIP (warnings) detailed Drugs and/or Alcohol at 28.5%; Mental Disorder at 22.5%; Serious Violence at 18%; and Suicide (Deliberate Self Harm) at 14%; Other warnings arose from Weapons – 9%; Threats to Kill – 4.5%; Sex Offences – 2.5%; Homicide – 1%; and Arson (Endanger Life) 1%.

The development of effective working relationships between agencies working with people who pose a risk to themselves or others has, we believe had significant benefits including:-

- Improved information exchange about risk in the local areas
- Improvements in overall risk assessment and management of those presenting a risk of public harm, not just more comprehensive information but also making risk assessments more systematic, clear and communicable
- Increased objectivity and clarity and effective decision support with regard to risk
- Increased opportunities for early intervention, harm reduction and reduction of offending or people with alcohol, drug and mental health problems

The key to the success of the BLIP Project was probably, the fact that the agencies and particularly the individual involved in setting up BLIP had developed sufficient trust and respect for one another in their varying professional capacities, to be able to jointly resolve the more sensitive issues, such as confidentiality, which could have stood in the way of the project. As the BLIP Steering Group was drawn together, it became obvious that the managers of the various agencies involved were already accustomed to working together and welcomed the opportunity to jointly develop good working practice. The existence of this mature support network encompassing both the statutory and voluntary sectors was clearly a major factor in generating momentum as it goes under way. At the time of writing, we understand that BLIP is in the process of being replicated in a number of other key areas in Surrey, Berkshire, Hampshire and Oxfordshire.

3.3 RAMAS IN ACTION: Individual Care

RAMAS considers patients / clients not as passive recipients of care but as actively involved core contributors to high quality, outcome effective service(s).

“The New NHS: Modern, Dependable”, “A First Class Service” and “Modernising Mental Health” all set out a clear agenda for user involvement in the development of better quality mental health services.

Exciting the interest of, and engaging and empowering clients / patients through effective case management is central to RAMAS. Meeting the spectrum of needs is central to effective risk management, and RAMAS considers user involvement essential for driving up the quality of service provision. Of note, is the fact that service users regularly and consistently remark on the context of fairness and justice that RAMAS provides.

Engaging “Untreatable”, “Resistant” or “Non Engaging Clients

Research and clinical practice with RAMAS lends some credibility to the assertion that resistance and non-engagement is a two way process. The adage “past behaviour best predicts future behaviour” has, we believe led many patients to conclude that

there is little point in engaging with mental health services that hold this view, and who can blame them. If “you are finished before you’ve started” (as one patient reported) then why engage in the first place?

The Project Team has worked hard and continues to work at all levels (Staff Training, Research, Protocols and Policy Development) to break down barriers and open up possibilities for more optimistic solutions focused approaches to risk and case management generally.

The BLIP was set up to address issues relating to 24 hour crisis / support and communication.

The Needs Assessment process was designed to enable services to be more sensitive and responsive to the genuine broad-spectrum needs of Service Users. RAMAS enables Mental Health Services to collaborate and communicate clear and shared goals in partnership with other agencies and services. The past two years 1999 – 2001 have focused especially on multi-agency training, development and support , in order to enhance communication and good practice in this area.

The Skills Assessment Process has similarly been designed to enhance engagement and self-esteem in “difficult to manage” “difficult to engage” patients. The process actively seeks out the individual’s strengths, resources and supports, so that these can be built upon to achieve the best possible outcomes and health gains (responsivity principle). It is solution focused and provides for tailor-made, personally relevant assessment information together with acknowledgment and utilization of the individual’s own skills, strengths and opportunities for change. This increases the individual’s sense of control, thus making the Risk Management Process more collaborative, engaging and optimistic for all.

The CRUX of RAMAS is a six-page assessment and management, and review plan. The process is most vividly illustrated by means of the Clinical Case Studies presented in the next section.

The Clinical Case Examples:

Where cases have been quoted or presented by way of illustration, essential identifying data have been removed in order to preserve anonymity, in some cases composite presentations have been constructed. Cases that have been in the public domain are quoted without the above alterations.

Safeguards

Proper safeguards to ensure that individual service users and carers are treated fairly are crucial. The RAMAS Team have, together with Service Users and with the Mental Health Foundation drafted a RAMAS Service User Charter. (See website). A Factsheet: "Information for Service Users" (See website) is available for all service users, regardless of what service they use.

All RAMAS Forms are designed to enable scrutiny by third parties including service users and their carers and representatives as appropriate.

Three cases are presented in similar format. To the unfamiliar, Multi-axial Formulation Axes are as follows:-

Axis

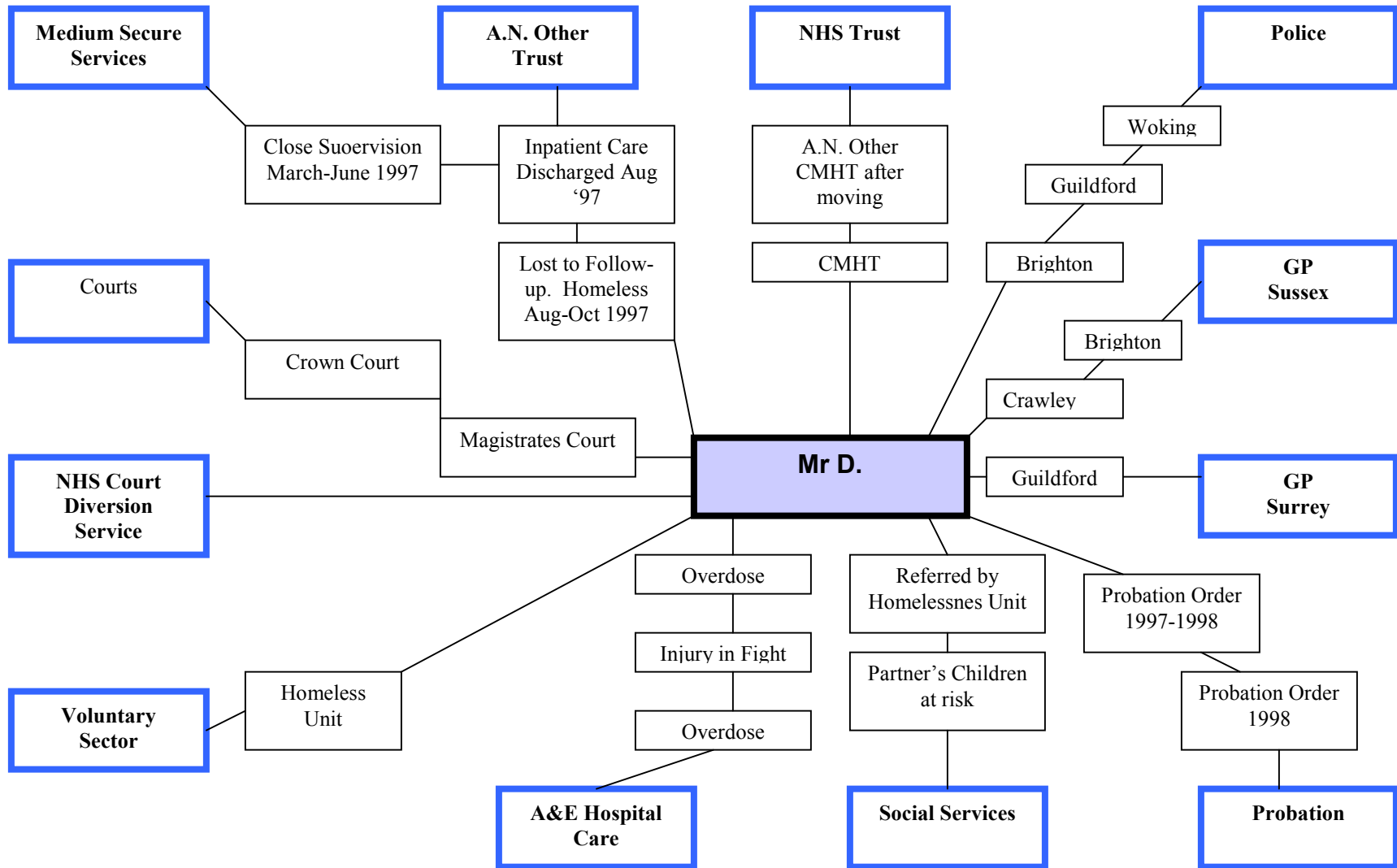
- I. Clinical Disorders(s)
- II. Personality Disorders
- III. General medical Conditions
- IV. Psycho-social and Environmental Problems
- V. Global Assessment of Functioning

CASE ONE: Mr P.D.

RAMAS Worked Example 1: A community example of Risk of Dangerousness

Patient:	Mr P.D. (32), single, unemployed, council Accom. Socially isolated, Fractured Family Relationships, Drug using, Alcohol Dependent. Peers, Similarly inclined.
Diagnosis	Personality Disorder
Multi-Axial Formulation	<ul style="list-style-type: none"> I. History of Depression and Paranoia co-morbid with II. PD, Drug and Alcohol Syndrome III. Foetal Alcohol Syndrome, borderline I.Q. soft neurological signs IV. Education problems, Housing Arrears, Financial and Legal Difficulties V. Poor self care, social problems
Cardinal Features:	<p>Multiple Needs and Vulnerabilities</p> <p>Mood disorder, addictions, regular overdoses with painkillers</p> <p>No close or confiding relationship</p> <p>Co-dependent on another patient, who lived in the same block and who suffered from borderline Personality Disorder and Substance Misuse</p>
Forensic History:	<p>Conduct disorder in childhood</p> <p>First contact Age 13, stealing</p> <p>Offences include, Theft, Burglary, Drug related offences, GBH and numerous ABH</p>
Index Offence:	Section 4 Violent Disorder Offence against neighbour male (38) Reduced from attempted murder. Breach of probation.
Comes to Notice:	Court Referral Pre-sentence Assessment
RAMAS Risk Assessment	<p>Risk to others: High</p> <p>Mental Instability: Medium</p> <p>Self Harm/Suicide Risk: Medium/High</p> <p>Vulnerability: High</p>
Outcome:	2 year Probation Order with a condition of Treatment and Programme Attendance
Risk Management:	Multi-agency through Care Programme Approach using RAMAS Supervision Review
After Care	An agreed point of contact, Key Worker named, Co-ordination through RAMAS Review

Agencies Involved in Mr D's care and Treatment 1997-1999



Points Worth Noting:

- The number of different agencies involved
- It is only a 2-year period! Mr. D. had been in contact with services for 15 years
- All involved, very little interagency communication, each agency knowing part, but not all important information
- Each agency measured risk differently. No baselines. No tracking
- Each agency was functioning inwardly, meeting service needs, but not involving Mr. D. not with him
- Service perceived as a series of disjointed starts and stops
- Mr. D. reported that all services wanted to do was highlight past problems, no credit given for progress or change

Getting Started using RAMAS MDS with Mr. P.D.

RAMAS Minimum Data Set (MDS) identifies key features of Mr. D's care path, after 15 years of service

- PD known to many services
- Banned from most services
- PD responding well to Probation Officer
- Index offence predicted, by several agencies including, GP, Housing and Police
- Services not communication
- Full and clear picture not available

MDS Triggered and RAMAS Supported

- Response from several agencies
- Shared information pooled by RAMAS
- Concerns flagged and tracked and followed through
- Maximised Information on problems and vulnerability identified
- Chronology patterns and "lessons" learned
- Identified GAPS, and Needs, skills and resources
- Solutions Generated with PD and Family
- Action, follow through and follow-up using full RAMAS and RAMAS SR

What RAMAS achieved with Mr. P.D.

- An up to date, standardised, effective baseline of Risk
- Accurate, complete and communicable information about risk, needs and care
- Timely Intervention(s)
- Support and follow through for Mr. D.
- Clear and shared goals with Mr. D
- A collaborative Process, not a series of Start and Stops
- Optimism and New Skills for Mr. D., which Mr. D. found supportive and motivating
- Real life relevant solutions for public and for Mr. D.

Mr P.D. response to the RAMAS Approach

This is probably best summarised by some Quotations from Mr. P.D.

“Who the fuck do you think you are, you useless shrink!”

(Time 1, objecting to questions)

“So you’ve convinced me that we need to talk to everyone involved in my care but no point contacting them, they’ll have nothing good to say about me”

(Time 2, Assessment)

“You’ve got me to a Tee, you seem to get it, I’m not a complete bastard. It’s a pity, I didn’t have these assessments before”

(Time 3, Feedback and Treatment Plan)

“How can I deal better with my mood? I wish I could get on better with people”

(Time 4, After 6 Treatment Sessions)

“I like coming here, once a fortnight is not enough”

(Time 5, At Interagency Review of Treatment Progress)

“At least you lot ask me what I think, here give me that Form I haven’t signed it yet”

(Time 6, 6 months Review)

Outcome:

Mr. D. reported improved mood, and mental health generally so much so that Amphetamine Sulphate use discontinued. Police reported substantial reduction in nuisance and aggressive acts in community by Mr. D. Hospital (A&E) reported substantial reduction in overdoses and hospital admissions. This was maintained over a 9-month follow-up period.

Case 2: Mr M.I.

RAMAS Worked Example 2 :A community example Mental Instability Risk

Patient:	Mr. M.I. (28) single, employed part-time, living with parents. Socially isolated. Difficult family dynamics as mother had mental illness and father was alcoholic dependent, no siblings. Non-compliant with medication
Diagnosis:	Mr. M.I. suffered from Schizophrenic illness first identified/diagnosed when he was 18 years
Multi-axial Formulation	Schizophrenic Illness Some Personality Difficulties Asthma Financial and Legal difficulties. Problems at work due to non-attendance through illness and alcohol misuse Poor self regulation and care
Forensic History:	First contact with Criminal Justice System at Age 21, for Drug Related Offence. Since then offences of GBH (including assault on Police Officer), ABH and numerous common assaults
Index Offence:	Assault on a Police Officer, threatening behaviour, being drunk and disorder
Comes to Notice:	Pleads Guilty Pre-sentence Report requested
RAMAS Risk Assessment	Referred to Clinical Psychologist through Probation Dangerousness: Medium/High associated only with Mental Instability Mental Instability: High/non-compliant with medication Self Harm/Suicide Risk: Medium/High Vulnerability: High/very distressed, marginalised at work
Outcome:	3 year Probation Order with Condition of Treatment
Risk Management:	Multi-agency through CPA and RAMAS (SR)

What RAMAS achieved for Mr. M.I.

- An up to date comprehensive, multi-disciplinary Review of Risk, needs and care
- A clear and recorded understanding of the mental illness, disease progression, effective treatments, residential problems, relapse process, medication and what worked
- A collaborative process whereby Mr. M.I. felt listened to regarding his concerns about medication and its effects
- A comprehensive, holistic, inclusive approach to treatment and care, where Mr. M.I. felt included and listened to as a person, a 28 year old man, and not just as “a schizophrenic”
- Medication change and improved compliance

- A relapse prevention programme for Mr. M.I. and his parents
- A support and education programme for Mr M.I.'s parents

Mr. M.I. response to the RAMAS Approach

Mr. M.I. reported that Schizophrenia was an illness that not only he, was frightened of but that his family, staff on the wards and professionals generally were wary of. He told us that he felt isolated and fearful most of the time. He told us that the medication had “horrible side-effects”, was only partially effective in getting rid of “voices” and that he used alcohol and cannabis (daily) “to calm things down”. Without alcohol or cannabis or both, he would feel irritable and hostile towards his family and people at his part-time job.

He told us that schizophrenic illness had traumatised him and devastated his life. This was fully explored with him and it was discovered that Mr. M.I. was suffering from residual Post Traumatic Stress Disorder Symptoms from his first episode of Schizophrenia. The P.T.S.D. was treated and changes in medication type and regime were negotiated.

Outcome:

Within 4 months Mr. M.I. reported that he was feeling well, he was taking medication as prescribed, he had cut down (not cut out) use of alcohol and cannabis and he was getting on better with family and people at work. Mr. M.I. reported that he felt more in control of things and that although he “had got Schizophrenia, Schizophrenia had not got him”.

The clinical team and Mr. I's family felt more optimistic about relapse prevention for the future. A more friendly, supportive, collaborative relationship was in evidence between Mr. I and his service providers.

Case 3: Ms S.H.
RAMAS Worked Example 3:A Community example of Risk of Suicide

Patient:	Ms.S.H. aged 42, married, lives with husband and two young children, aged 4 and 7
Diagnosis:	Depression and Anxiety
Multi-axial Formulation:	<ul style="list-style-type: none"> I. Clinical Depression, Reported Suicide Attempts II. Nil of note III. No medical problems IV. No close relationships, low self esteem, feelings of isolation and inadequacy, not employed outside home V. Good self care, socially competent
Cardinal Features:	History of Depression and Serious overdoses Marital and Sexual Difficulties Social isolation
Forensic History:	Nil
Comes to Notice:	Referred to CMHT via CPA and GP following discharge from hospital after overdose
RAMAS Risk Assessment	Risk to Others: Low, but safety steps taken for children Mental Instability: Low/Medium Self Harm/Suicide: High Vulnerability: Low - Supportive family
Outcome:	Cognitive Behavioural Therapy in conjunction with Anti-Depressant Medication Marital and Sexual therapy included
Risk Management:	Achieved through comprehensive package to include husband, family, psychiatrist, Clinical Psychologist and CPN.
After Care:	A named worker agreed and allocated as part of early intervention and Relapse Prevention Plan.

What the RAMAS Achieved for Ms S.H.

A RAMAS identified key features of Ms. S.H. case after 20 years of Mental Health Services.

- S.H. taken 25 overdoses, all following similar patterns
- History of sexual abuse in childhood, revealed for first time
- History of violent father and domestic violence between parent, revealed for first time
- Pre cursors / risk factors for Ms. S.H.'s depression and suicidal ideation
- Early intervention strategies, acceptable to Ms S.H.'s

RAMAS Supported

- Co-ordinated, supportive response, empowering Ms. S.H.'s to take control
- "Lessons Learned" from repeated hospital admission and overdoses
- Treatment targeted is relevant problems
- Follow up and Review
- Husband and Family intervention
- Ms. S.H. talent and skills in Art
- Employment and social inclusion
- Positive, Optimistic and Realistic goals

Ms. S.H.'s response to the RAMAS Approach

Ms. S.H.'s response is best captured by a letter she sent to the therapist after 16 sessions of Cognitive Behaviour Therapy. Some details of the letter are changed to protect the confidential details of Ms. S.H.

Letter from Ms S.H. to the Therapist

Dear

I am writing to you, to express my thanks to you and the other members of your team, who have over the past four months worked together with me to get to the bottom of why I get so depressed. I know you are all using a new system (RAMAS) for managing people who are at risk and I really think that it has helped me.

In the beginning I felt very annoyed at all the questions and at the fact that I had to discuss things with you all in the team, but I am glad I did because now I understand how I had tried to "bury" things in the past. I didn't tell anyone about the sexual stuff because no one ever really asked before or maybe it's fairer to say I made sure we avoided the subject.

I'm glad that the whole story is out! Although I still feel embarrassed and ashamed of what happened, but I am beginning (finally) to accept that it was not my fault. I don't feel so isolated now. I feel I can cope with my thoughts and feelings better. I know I may get setbacks. I will come to follow ups and I will make contact with.... If I have any problems. I feel confident enough to do that now.

I have all contact numbers on my Supervision Review paper! (So has my husband by the way).

Thanks again

S.H.

Comments on Case Studies

We hope that through these case studies, we have shown that RAMAS is concerned with managing risk and needs in a way that provides better opportunities for individuals, carers and organisations to deal with the consequences of mental, personal or family disorder. RAMAS is patient focused and client centred in practice, protocols and processes. Rather than regarding the person as a passive object of treatment / management that has to be planned and implemented by an “expert” (psychiatrist, nurse, clinical psychologist, social worker, probation officer etc) a collaborative approach is advocated as both ethically desirable and more outcome effective.

Professionals can not work together with their clients to devise appropriate interventions unless they have the will and the skill(s) to listen carefully to clients or service users’ own accounts and perspectives, to understand the unique impact that medical, social and mental health problems are having on the person’s life and harness that person’s goals, skills and resources.

3.4. The importance of Communication

“All tragedy is the failure of communication”, John Wilson, Commentator on English Literature, 1974, (cited in Prins 2000). The year 1994 saw the setting up of mandatory independent inquiries into all cases, where homicides had been committed by those in contact with mental Health Services. The seven years since then have seen over 70 reports of inquiry, very many of which have catalogued failures in communication on a very large scale, (Prins, 1999).

Our research and Clinical Practice has indicated that several aspects of communication are important in order to achieve effective risk and care management, some of these include:

1. Listening to all concerned... a full and clear picture is essential
2. Asking the Questions... the quality of the assessment is dependent on the demand characteristics
3. Good written records... if information is not recorded it will not be remembered/discussed or acted on
4. Regularly consult the records... monitoring and recording change
5. A strategy for Action Points... a communication chain, clear and shared goals
6. Confidentiality... Any information sharing should be confidentiality on a ‘need to know’ basis and not in the public domain.
7. Regular Review... An active learning, changing process

The potentially disasterous consequences of failure to communicate are well known and documented in many of the public inquiries. The following is a direct quotation

from a report of inquire into the treatment and care of a mental health patient, Paul Smith,

“We realized as each new piece of evidence cam together that we were looking at a familiar picture. Here was a young man with a history of mental disorder about whom there was a great deal of information – about his family history, his criminal background, his home environment, and most importantly his mental illness – but this wealth of information was never pulled together, was never known in its entirety by any one person or professional team. Potentially vital information was not shared between the many professionals who were involved at one time or another with Paul, and therefore we believe that no one responsible for the treatment and care of Paul could have had a full and clear picture of the nature and extent of his illness. We got the information because it was there for the asking and we asked for it. However it had all been there for the asking for anyone involved with Paul who chose to find out more about him, and we wish they had. We feel that the last of a full and clear picture of Paul’s illness created a serious impediment to the ability to carry out a proper assessment of risk to himself or others or to formulate a clear care plan for him”. **Report of Inquiry into the Treatment and Care of Paul Smith, July 1997.**

Failure to share information can lead to disastrous results. Good systems of communication are vital if risk management is to be effective. Missing information can lead to underestimation of risk, and a consequently a failure to act when action is required.

The lesson here then is that agencies working together really can make the difference. RAMAS enables agencies to make that difference. This is what our surveys and our clinical experience has demonstrated.

When forms are standardised and safe systems implemented, it is important to supply regular updates. This is achieved, through RAMAS (SR) – the supervision Review. Our Surveys reveal that RAMAS (SR) is used routinely in practice in Surrey. RAMAS (SR) meets the National Standards set by Probation Services.

Sound safety information and communication systems are a precondition for systematic learning from failures and successes. It is important for services and individual practitioners/clinicians to take account of the fact that low-level incidents or “near misses” can provide a useful barometer of more serious risk. (‘An Organisation with a Memory’, Department of Health, 2000)

Using RAMAS across agencies is an effective way to build up close relationships and networks at the practice (grass-roots) level, our service user and practitioners surveys continue to demonstrate this. Our multi-agency training and support programme together with the standardised, common language RAMAS Forms has increased opportunities for early intervention harm reduction and reduction of offending for people with alcohol, drug and mental health problems. Accurate, complete, and timely communication has been the cornerstone to partnership working on risk.

3.5 Enhancing Good Practice

The link between adverse life conditions and poor mental health, is well established and well illustrated through the case studies above. People who pose a risk to themselves or others often have a wide range of problems including mental health problems, substance misuse, social, legal, financial, housing or family problems.

Consequently they will require a spectrum of services. The range of services often needed, means that effective working between the different agencies responsible for the various aspects of care is essential. No individual professional or agency can operate in isolation when working with risk. We need more than good will and regular communication if real progress is to be made in risk management. All those working together must see their input as part of the wider context and as part of the overall effort. Perhaps the most useful metaphor is to consider each individual contribution as one part of a jigsaw, each part is necessary (but not sufficient) and inescapably part of and interdependent with the work of others.

People who pose a risk to themselves or others often have difficulties continually or intermittently, and at several points through the lifespan. Roughly on third of people with mental health problems who have multiple needs, and vulnerabilities will require mental health and social care throughout adulthood. High Risk is most often, (but not exclusively) associated with long-term need. It is argued therefore that the earlier we can get into collaborative and supportive relationships with service users the better the planning, the progress and the outcomes.

RAMAS has demonstrated, through research and clinical practice, that it is:

- **Ethically Desirable** It is robust and evidence based, it adheres to Human Rights and most importantly, it is well received by service users and their families.
- **Outcome Effective** Staff and service users feel supported by the process. RAMAS provides better opportunities and well formed outcomes by addressing risk, need and responsivity.

RAMAS:

- Highlights needs and vulnerabilities
- Provides baselines against which to measuring and monitor progress
- Provides a common language to communicate and collaboration on risk
- Clarifies roles and responsibilities across professionals and agencies
- Ensures follow-up and follow through
- Ensures safety-nets and after care arrangements are in place
- Trains and supports staff in the delivery of confidential evidence based high quality risk and care management
- Ensures well-formed, positive outcomes.

Ridgely et al (1998), have demonstrated that developing a collaborative approach to service provision is not just outcome effective, but cost effective also. The development of effective Multi-agency Risk and Care Management has, we believe significant mutual benefits including:

- Improvements in overall risk assessment and management of those presenting a risk, not just more comprehensive information but also making risk assessments more systematic, clear and communicable
- Increase objectivity, clarity and effective decision support with regard to risk
- Increased opportunity for early intervention, harm reduction and reduction of offending for people with alcohol, drug and mental health problems
- Enhanced communication and collaboration with service users and carers
- Health gain for victims of crime through earlier and more systematic comprehensive responses
- Reduced fear of risk and its impact on the health of the public
- Enhanced public safety and individual care
- Increased public confidence in the ability of services to provide safe services in the community
- Increased access to additional sources of funding, resources, and support

Training and support programmes are very popular and their success is described in O'Rourke and Titley (2000) and on the website (www.ramas.co.uk).

Work thus, far suggests that risk management and care co-ordination is enhanced when the process is facilitated by well-trained supported RAMAS co-ordinators at every level service. Trained RAMAS users are available in the following services across the UK and States of Jersey. Their role, training and support networks are being strengthened through pilots over the next 18 months.

CHAPTER 4: THE WAY FORWARD

The purpose of this report has been to provide an account of work completed between 1998-2001. However it must be emphasised that there is still much to do.

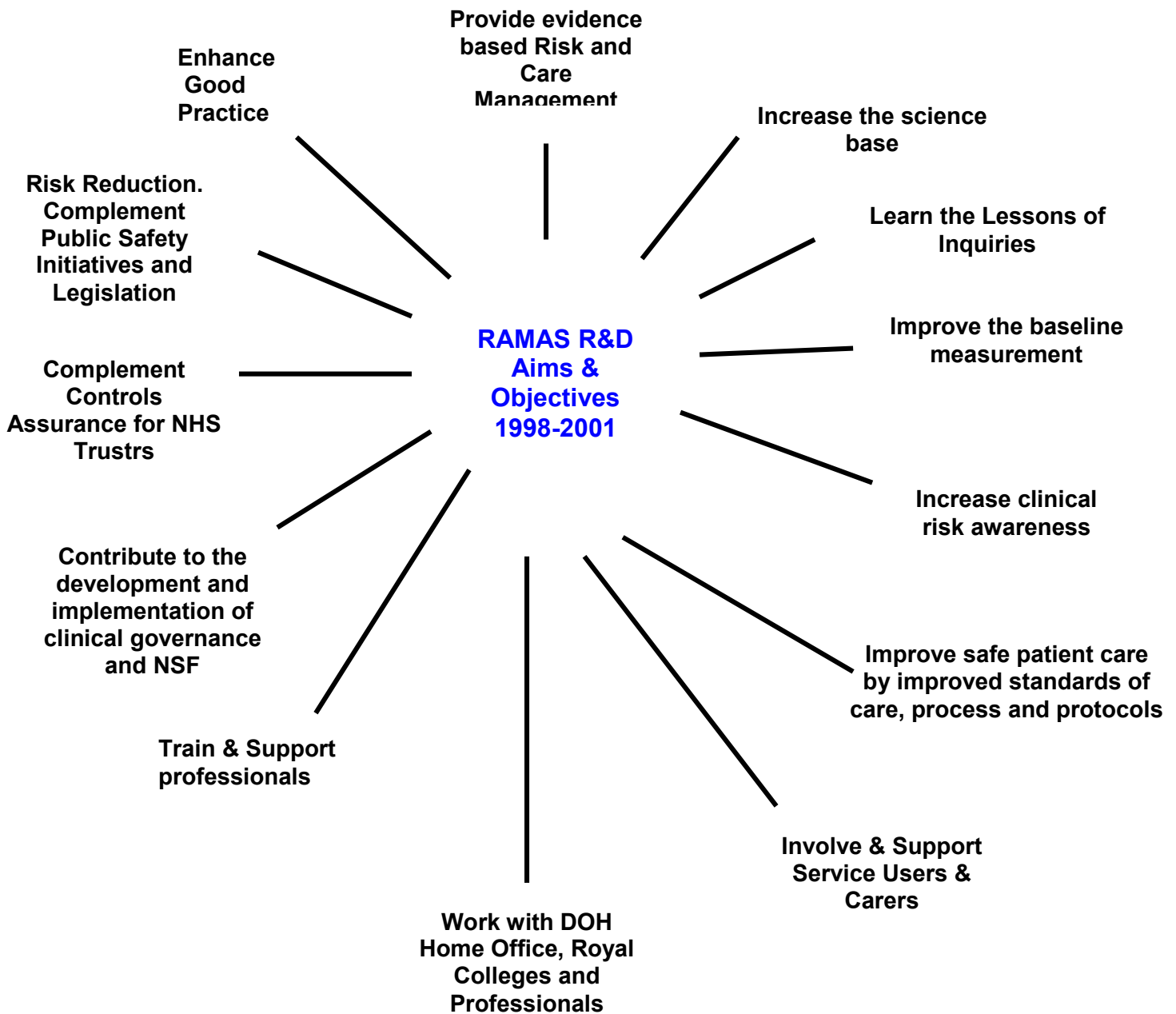
To date, we have developed and introduced in conjunction with other agencies, a standardised form of risk and needs assessment, monitoring, management and review, using a common language and standardised forms. We have through RAMAS found solutions to challenges within existing resources. Very little new “stuff” has been required but new thinking and new energy has been critical.

The Department of Health funding has enabled us to test the science and evidence base of RAMAS and to train and support staff of all disciplines, across all agencies to strengthen the shared agenda of public safety and high quality care.

We believe that we have enhanced Good Practice through:-

- Improved information exchange about risk in general and about individuals in particular.
- Improvements in overall risk assessment and management of those presenting a risk of self and public harm, not just more comprehensive information but also making assessments more systematic, clear and communicable.
- Increased objectivity and clarity and effective decision support with regard to risk, need and responsivity in individual case management.
- Increased opportunities for early intervention, harm reduction and reduction of offending of people with alcohol, drug and mental health problems.
- Increased opportunities for more optimistic, solution focused, high quality care.
- Increased confidence and trust between agencies.

The following figure outlines what we believe we have achieved in the past 3-5 years.



Using RAMAS across agencies is an effective way to build up close relationships and networks at the practice level.

RAMAS is not intended to be a stand alone process, it is part of integral to good practice. It is designed to assist clinicians and practitioners work smarter not harder. Good Risk Management is the same as good case management. One does not come without the other.

RAMAS takes a partnership approach to risk and care because it is self-evident that partnership has the potential to result in better services for users. However, it is useful to be explicit with service users, clinicians and practitioners about the reasons why partnerships should deliver better outcomes. Some major reasons include:

- It has the potential to improve efficacy and outcomes
- Maximises integration for clients and staff
- Reduces duplication, minimizes bureaucracy
- Maximises information, data and “intelligence”
- Improves communication and care planning
- Fast track solutions to complex cases and crises
- Allows long term planning, avoids the stop-start approach to care
- Patients/clients feel engaged in the process
- Allows services to be more responsive to the user, both as a player in partnership and a source of information about service gaps
- Avoids organizational defensive routines
- Allows organizations to look at service users and external factors when planning and acting.... Working towards co-terminosity

Our Research and Development Project and clinical trials have demonstrated that RAMAS can deliver successful partnerships.

We have demonstrated this in a number of areas in the UK and in Jersey. A number of factors that underpin effective partnership and which represent preconditions for success have been identified through the RAMAS R&D and audit programme. These include:

- Creating networks which form part of everyday functioning of organisations (e.g. BLIP, RAMAS MDS and RAMAS SR for entry to service and ongoing review).
- Having a clear strategic purpose for the partnership e.g. BLIP
- Developing a supportive training programme
- Developing a supportive infrastructure e.g. RAMAS Support Network
- Taking account of National and Local success factors
- User focus, RAMAS works with the patients to negotiate and plan safety and treatment successes
- “Learning the lessons” about service users needs, service gaps and interagency communication
- Looking at National and Local factors e.g. New Mental Health Act, National Service Frameworks, Evidence Based Practice, Crime and Disorder Act, Human Rights Act
- A willingness to learn from past mistakes and new approaches
- Seeing joint working and service to patients and the public as a priority
- Integrated training and supervision of RAMAS Users
- Monitoring progress
- A commitment to removing obstacles, openness and full information exchange
- A commitment to audit, peer reviewed publications and external scrutiny
- Joint projects e.g. Life Matters a project with supported housing
- Joint working as a means, not an end

Box 5 below provides a summary of the key negative characteristics of community risk assessment and management prior to this project and juxtaposes the positive characteristics we believe RAMAS can help develop in the future.

Towards National Standards

RAMAS has been freely available to the NHS, South East Region Risk Assessment Group (SERO) and to Surrey Local Implementation Team (L.I.T.) to facilitate the progress of the National Service Frameworks for Mental Health.

RAMAS has been made freely available to Surrey Social Services, Surrey Probation, Surrey Police, Housing, Surrey English Churches Housing, and voluntary Agencies in Surrey. We have trained over 200, clinicians, practitioners and other professionals in Surrey. We have trained over 500 people nationally. A number of clinical trials are in place and feedback is very encouraging.

BOX 5	
RAMAS: A New approach to responding to risk and need in Mental Health, Probation, Social Services, Housing and Voluntary Services	
Past	Future
Lack of Standardised Approach	RAMAS provides common language and vehicle for multi-agency approach
Absence of documentation and procedures	RAMAS provides robust, evidence based, valid and reliable measures and standardised forms
Absence of consistent implementations	Standardised procedures, clinical guidelines procedures and reporting possible
Absence of strategic approach to care planning	Multi-agency collaboration as baseline and standard
Absence of training	Multi-agency and team based training
Absence of staff developed and support	RAMAS Support Network
Focus on risk prediction, served to elevate this facet above clinical/social input(s)	RAMAS model provides a framework for modern prevention science and outcome effective treatment options
Short-term fixing of problems	Emphasis on sustaining risk reduction prevention and high quality care
Defensive practice	Retrospectively Defensible Practice
Passive Responding to events, learning by default	Active Learning

We suggest that RAMAS is a leading edge approach to promoting an integrated interagency response to public safety and individual care.

The project team are delighted that RAMAS is cited as an example of good practice in the recent White Paper “**Reforming the Mental Health Act**” Dept. of Health, **December 2000**. We are delighted with the massive interest and support we have received nationally and locally.

The input and support from service users in general and The Friends of Oaktree (A Mental Health Charity) has been particularly encouraging. The Friends of Oaktree have donated the sum of £25,000 for future work on developing **RAMAS Personal Support Plans** for Mental Health Patients in South West Surrey. English Churches Housing Group and others are already in the process of piloting Personal Support Plans Nationally and we have jointly produced “*Life matters*” O’Rourke, Stone-Pearn & McGeachy, (1999) to assist this process. We will continue to work towards high quality care and National Standards for Risk Management.

To this end we have formed a Strategic Partnership with Mental Health Foundation in order to put RAMAS on a national platform and achieve national reach, for work on National Risk Management standards.

A Vision for the Future

It is hoped that the year 2001 will see the launch of a charitable organisation known, as **The RAMAS Foundation**. The RAMAS Foundation will seek to continue the work on Risk but also to develop other RAMAS treatment and care programmes such as the ‘*Keep Your Cool*’ anger management programme, the ‘*Tough Love*’, ‘*Home Improvements*’, ‘*Triumph over Trauma*’ and Life Skills programmes already underway.

The authors of this report can be contacted through the RAMAS Foundation (*address below*) or through e-mail at the RAMAS Website www.ramas.co.uk.

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Annexe A

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INFORMATION FOR SERVICE USERS

Start safe....stay safe.

What is RAMAS?

- It is a system of assessing, managing and reviewing risk and care.
- It addresses risk to self and others.
- It helps you and us in developing a plan of action to reduce risk of harm
- It is achieved through discussion with yourself, your buddy, your keyworker and other professionals.
- RAMAS is designed to positively assist you in reducing risk, and in increasing progress in your needs and goals
- RAMAS also stands for Realistic Achievable Measurable and Appropriate Services

What does it require of me?

- In order for your RAMAS to be as complete and accurate as possible it requires input and information from you regarding your past & present, behaviours & feelings
- It enables you to let us know your opinions about your level of risk, and how best it can be managed.
- Your level of risk may change with time or circumstances and therefore your RAMAS will be regularly reviewed. This provides an opportunity for positive changes to be registered by everyone involved – in other words you get proper credit for progress that you make.
- It also ensures that past mistakes are not forgotten but that they are not held against you and that your skills and assets are strengthened.

Who will the information go to?

- In order for your care, and public safety, to be best co-ordinated, it is essential that professionals involved have a full and accurate understanding of you, your situation and your needs....
- ...therefore the person/s collecting information for your RAMAS form(s) will also be receiving information from, and discussing your case with, other professionals involved in your care. These people have a duty to share information with other professionals when your safety, or the safety of another person, is at stake.

Why should I be involved?

- You, and we, want a clear and organised system of care that is fair to you, and one which highlights your skills and strengths as well as your difficulties, problems, or needs.
- RAMAS gives you the clear chance to put across your point of view and to feel involved in decisions about your care.
- RAMAS analyse the past, but with your input, it helps design a safe, supportive future.

- THANK YOU FOR TAKING THE TIME TO READ THIS -

I have read this / had this explained to me, and I agree to co-operate with the RAMAS process. I would like RAMAS to help me with:

Name: My "buddy" is:

Signed: Contact him/her at.....

Date:

RAMAS CLIENT'S CHARTER

Safeguards for Service Users

- ⇒ Service users have a right to confidentiality

- ⇒ Have a right to be cared for by those who can maintain a sense of hopefulness, however changing this may be

- ⇒ Have a right to participate in decisions concerning my case

- ⇒ Have a right to have my questions answered honestly

- ⇒ Have a right to retain my dignity and not be judged for past errors or dangerous behaviours

- ⇒ A right to be listened to and not judged for my decisions which may be contrary to the beliefs of others

- ⇒ I have a right to have potential for change taken into account at all times

- ⇒ Not to be offered therapies which are impossible to provide in resource terms

Control of risk is not the central message of RAMAS, but maximising citizenship, pro-social behaviour and capability building is!!

Twelve Important Points About Risk

- **Risk can not be eliminated, there is no such thing as zero risk**
- **Risk is dynamic, it fluctuates and changes over time**
- **Risk may be general or specific or both**
- **Good risk assessment, management or audit can not be performed in isolation**
- **Having identified risk, there is an absolute duty of care to manage it, effective identification and management of risk can achieve risk minimisation**
- **Comprehensive risk management multi-featured, multi-sourced and multi-agency**
- **Some interventions can be harmful, not just physically as in the case of some medication, but also psychologically, socially or emotionally**
- **People with mental illness risk factors are in general a much higher risk to themselves than others**
- **Patients presenting risk to others are highly likely to face other forms of risk, most notably deliberate self-harm and suicide.**
- **Rigorous Assessment and good practice can reduce risk**
- **Good Practice and effective risk management are the same.**
- **RAMAS provides multi-agency, high quality, nationally recognized risk and care systems.**

RAMAS training is accredited by the Royal College of Psychiatrists and, in principle, by the Royal College of Nursing. It provides competency based multi-agency training.

For details of training, research and practice contact:-

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