Working with MAPPA: guidance for psychiatrists in England and Wales

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Introduction

Multi-agency public protection arrangements (MAPPA) were established in 2001 in England and Wales to oversee statutory arrangements for public protection by the identification, assessment and management of high-risk offenders. MAPPA were introduced with the aim of minimising the risk of sexual and violent offences to the general public posed by identified high-risk individuals living in the community.

The aim of this guidance is to assist psychiatrists in learning to work effectively with MAPPA and to provide clear and consistent advice regarding information-sharing with MAPPA, balancing our responsibility to maintain confidentiality for patients with the need to manage risk to others appropriately. MAPPA issues may be most commonly encountered in forensic settings, but psychiatric patients who are eligible may be encountered in all areas of mental health. To date, there have been inconsistencies in available guidance on how MAPPA applies to mental health services. This guidance aims to highlight areas of confusion and dispute, and to recommend practice that is consistent with current guidance from the Ministry of Justice (2012*a*), as well as existing professional guidelines on medical confidentiality and disclosure that are summarised in Appendix 1. Appendix 2 contains fictionalised cases illustrating likely scenarios that psychiatrists may encounter in working with MAPPA. Although many psychiatrists have, perhaps rightly, been wary of cooperating with MAPPA, working thoughtfully with MAPPA can assist psychiatrists in managing and sharing risk in the best interests of our patients.

Establishment of MAPPA, the responsible authority and the 'duty to cooperate'

Increasing social and political concern about violent and sexual offenders in the 1990s fostered closer working relationships between the police, probation and prison services, which were incorporated into legislation in the Criminal Justice and Court Services Act 2000. This legislation introduced MAPPA in each of the 42 criminal justice areas in England and Wales. The police, probation and prison services were established as the 'responsible authority' to oversee statutory arrangements for public protection by the identification of high-risk offenders, the assessment and management of their risk, and the sharing of relevant information among the agencies involved. These arrangements are regularly reviewed and monitored by strategic management boards in each of the 42 administrative areas of England and Wales. The boards also identify and plan the training and developmental needs of those working in the MAPPA, and offer a conduit to influence local practice. It is important to note that the implementation of MAPPA may vary in different parts of the country.

The duty to cooperate

The Criminal Justice Act 2003 further strengthened these arrangements by imposing on health and Social Service agencies a 'duty to cooperate' with MAPPA. The purpose of this clause was intended to enhance multi-agency work by the coordination of different agencies in assessing and managing risk, and to 'enable every agency, which has a legitimate interest, to contribute as fully as its existing statutory role and functions require, in a way that complements the work of other agencies' (Ministry of Justice, 2012*a*).

MAPPA is a set of arrangements, not a body in its own right, and therefore cannot direct other agencies to take action. The agencies that make up MAPPA retain their primary responsibilities independently of what they do under MAPPA. The police, probation and prison services, which together form the responsible authority, are responsible for establishing MAPPA in each MAPPA area. Other agencies, such as local authority youth offending teams, social care services (children and adults), housing (including registered social landlords), education, health (including mental health), Job Centre Plus and the UK Border Agency are known as the 'duty to cooperate agencies' and under law they have a duty to cooperate with

the responsible authority to ensure that MAPPA is working effectively to protect the public. In practice, this translates into an expectation that representatives from each agency will attend case conferences, share information about offenders and provide advice regarding management. MAPPA cannot make any agency do anything that is outside its usual responsibilities but there is an expectation that agencies will prioritise work and do all they possibly can to protect the public from serious harm. The strength of MAPPA comes from all agencies working well together.

The duty to cooperate agencies are listed in Section 325(6) of the Criminal Justice Act 2003, and 'health' is listed as:

- the health authority or strategic health authority
- the primary care trust or local health board
- the National Health Service (NHS) trust.

The duty to cooperate on health requires the provision of a suitably qualified senior member of staff to assist MAPPA in the risk assessment and management of mentally disordered offenders, and to provide a case manager for individual cases who should attend with any other colleagues to support the development of a MAPPA risk management plan where the case is to be managed at level 2 or level 3 (see pp. 9–10).

However, the duty to cooperate is imposed on an NHS trust and not on an individual mental health practitioner, who cannot alone determine what should be done by a trust in fulfilment of its obligations under the Criminal Justice Act. It is also important to note that the duty to cooperate is not something that applies only to forensic services and that all areas of a mental health trust must understand and comply with the duty to cooperate. All trusts and other health organisations should have policies that cover the role of psychiatrists and other members of the multidisciplinary team in the MAPPA process.

The MAPPA framework

The MAPPA framework is made up of four overlapping and complementary core functions, which the responsible authority must ensure are established across the agencies involved. These core functions are:

1 the identification of MAPPA offenders

2 the assessment of the risk that these offenders pose

3 the management of that risk

4 the safe and secure sharing of relevant information among the agencies involved in assessing and managing the risk of MAPPA offenders.

MAPPA CATEGORIES

Offenders who fall within the MAPPA remit are divided into three broad categories specified in Section 327 of the Criminal Justice Act 2003.

CATEGORY 1: REGISTERED SEXUAL OFFENDER

This category includes offenders required to comply with the notification requirements set out in Part 2 of the Sexual Offences Act 2003. These offenders are often referred to as being on the 'sexual offenders' register'.

CATEGORY 2: MURDERER OR SCHEDULE 15 OFFENDER

This category includes offenders who committed murder or an offender convicted of an offence under Schedule 15 of the Criminal Justice Act and:

- who has been sentenced to 12 months or more in custody, or
- who has been sentenced to 12 months or more in custody and is transferred to hospital under Section 47/49 of the Mental Health Act 1983, or
- who is detained in hospital under Section 37 of the Mental Health Act with or without a restriction order under Section 41 of the Act.

CATEGORY 3: OTHER DANGEROUS OFFENDER

This category includes a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for

an offence under Schedule 15 of the Criminal Justice Act 2003 (Ministry of Justice, 2010).

Category 3 is for offenders who do not fall into categories 1 or 2, but because of the severity of the offences committed by them are considered to pose a risk of serious harm to the public. 'Serious harm' is defined as 'Harm which is life threatening or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible' (Ministry of Justice, 2012*a*). Category 3 is intentionally broad, and most of the offenders in this category are those who have committed serious violent or sexual crimes prior to the introduction of MAPPA legislation, or have committed a more recent low-level offence and have other indicators of high risk.

The majority of MAPPA offenders will be released/discharged from prison or secure hospital. In March 2012 there were 55 002 MAPPA-eligible offenders. The majority of cases (96%) were managed at level 1, i.e. only 4% were assessed as requiring level 2 or 3 management (see below) (Ministry of Justice, 2012*b*).

Individuals referred to as 'potentially dangerous people', who are not offenders (i.e. have no conviction or court mental health disposal) but present with worrying behaviour, are not managed within the MAPPA process, but should be referred to the police in accordance with procedures for this group, which may vary in different areas of England and Wales.

MAPPA LEVELS

There are three tiers or levels to the MAPPA management system at which risk is assessed and managed. The level is determined by the nature and degree of resources required in order to manage the identified risk. Thus the level of management is associated with the level of risk but is not necessarily determined by it. The overriding principle is that cases should be managed at the lowest appropriate level, determined by defensible decision-making.

Level 1: Ordinary risk management

Level 1 is for offenders whose risk is classified as low or medium and can be managed by one lead agency, such as police, probation or mental health services. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 meeting. MAPPA considers it essential that information-sharing between MAPPA partner agencies takes place, disclosure (beyond or outside MAPPA agencies e.g. to an employer) is considered, and there are discussions between agencies as necessary. Many Section 37/41 cases, even with relatively serious offences, will be suitable for level 1 management, particularly where they are responding to treatment and are well engaged with mental health services. The extent of information-sharing to MAPPA will consist of basic leave and discharge details only, management will be solely by mental health services, and there will be MAPPA notification only, but no referral, multi-agency discussion or management plan.

The Tribunals Judiciary have issued a practice direction requiring details of MAPPA risk management plans to be included in social work reports for first-tier mental health review tribunals (MHRT) in order that MHRT panels can be informed of MAPPA issues before making decisions (Tribunals Judiciary, 2013).

Level 2: Active multi-agency management

Level 2 is for offenders whose management requires the active involvement of more than one agency. Here the work is coordinated at monthly multi-agency meetings where there is permanent representation of the core agencies of the police, probation and prison services, supplemented by representatives of other involved agencies where needed. Cases should be managed at level 2 where the offender:

- is assessed as posing a high or very high risk of serious harm, or
- the risk level is lower but the case requires active involvement and coordination of interventions from other agencies to manage the presenting risks of serious harm, or
- the case has been previously managed at level 3 but no longer meets the criteria for level 3, or
- multi-agency management adds value to the lead agency's management of the risk of serious harm posed.

Level 3: Active enhanced multi-agency management

Level 3 management should be used for a small number of cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the responsible authority and duty to cooperate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as high or very high risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that public confidence in the criminal justice system is maintained.

Level 3 offenders were originally referred to as 'the critical few' and this terminology persists in some areas, although it is no longer an official MAPPA term. It must be recognised that for level 3 cases, one of the concerns of the MAPPA responsible authority is the need to ensure that public confidence in the management by the criminal justice system of particularly high-risk and high-profile cases is maintained.

Working with MAPPA

Overall principles of medical confidentiality and disclosure

MAPPA draws a distinction between information-sharing between MAPPA partner agencies and disclosure beyond MAPPA agencies. The Ministry of Justice (2012*a*) MAPPA guidance (Section 10.2) defines information-sharing as the sharing of information between all the agencies involved in MAPPA. Disclosure, on the other hand, is the sharing of specific information about a MAPPA offender with a third party (not involved in MAPPA) for the purpose of protecting the public. The third party could be a member of the public such as a victim, an employer, a person forming a relationship with an offender, or a person acting in a professional capacity but not party to the multi-agency public protection arrangements.

Although psychiatrists have a duty to cooperate with MAPPA, this does not mean an obligation to share or disclose information. Any information-sharing or disclosure needs to be considered within the framework of the existing professional guidance on confidentiality and disclosure from the Royal College of Psychiatrists (2010), the General Medical Council (GMC; 2009), the British Medical Association (BMA; 2009) and the Department of Health (2003, 2010) (see Appendix 1). The duty placed on health services to cooperate with MAPPA does not extend to any statutory duty to disclose information to other agencies involved in these multi-agency arrangements. The same medical duties of confidentiality and information governance apply as in normal clinical practice and requests for information from MAPPA should be treated as all other requests, by informing the patient and seeking consent for disclosure, unless there are overriding considerations, which may include statutory obligations. Although legislation may create a 'statutory gateway' to allow information disclosure, this generally stops short of creating a requirement to disclose, and therefore the common law obligations of confidentiality must still be satisfied. This means that where psychiatrists are responsible for making information-sharing decisions it is still the decision of the doctor to determine, on a case-by-case basis, whether this is necessary to prevent serious harm. Given the centrality of informed consent in most guidance documents discussed above it would be good practice to seek informed consent from patients for MAPPA information sharing even if disclosure is likely to be required and justifiable in the absence of informed consent from the patient.

Moreover, if information-sharing is considered necessary, a decision will need to be made as to whether only minimum data are disclosed for risk management purposes (such as basic identification, nature of offence, commencement of unescorted leave, discharge address and contact details

of relevant mental health professional), or whether more detailed information is required to manage the risk (which might include some clinical information about relapse indicators or relevant risk or protective factors). Risk management information is likely to be more useful and relevant to MAPPA than biographical or historical information. In any event, information-sharing should be the minimum necessary to manage the risk and would not include handing over full psychiatric reports or medical records.

As the duty to cooperate is imposed on mental health trusts, some trusts are moving towards the implementation of procedures for the routine identification of eligible cases and notification to MAPPA. Whereas most decisions about MAPPA disclosure are made by consultant psychiatrists, particularly where they retain legal responsibility as responsible clinicians, anecdotal reports suggest that some decisions may be increasingly subject to other procedures, for example delegated to social workers without medical oversight or involvement. Where this is occurring, any complaint about information-sharing or disclosure by a patient would be dealt with in accordance with NHS complaints procedures and ultimately could result in civil court action. Psychiatrists need to be aware where these practices may result in disclosure of clinical documentation or reports without reference to them. Furthermore, a blurring of professional boundaries may occur at MAPPA meetings, where less experienced health representatives may be unprepared for the – often subtle – pressures placed upon them to disclose information on patients known to them, without having the opportunity to consider the requests in detail and discuss with the mental health team.

It is important that all psychiatrists, particularly those working in forensic settings, are familiar with their employer's MAPPA policy or the MAPPA policy of any hospital where they have admitting rights and where they have responsible clinician status for patients detained under the Mental Health Act 1983.

Identification of MAPPA-eligible offenders

There has been hitherto considerable confusion regarding the identification of MAPPA-eligible offenders who are psychiatric patients.

Schedule 15 of the Criminal Justice Act 2003 lists the convictions which would render a mentally disordered offender as MAPPA eligible. Schedule 15 is a list of 153 sexual and violent offences ranging from manslaughter and kidnapping to arson, affray, rape, causing prostitution of women or facilitating commission of a child sexual offence. This means that to qualify for management under MAPPA a patient must be convicted of a sexual or violent offence and sentenced to a hospital order under the Mental Health Act, Section 37 or 37/41, or be a prisoner whose detention in hospital was directed by the sentencing court (Section 45A of the Mental Health Act 1983) or by the Secretary of State (Section 47 of the Mental Health Act 1983).

Psychiatrists are advised to share information with MAPPA about restricted cases (Section 37/41 of the Mental Health Act 1983) where the hospital order must by definition have been made after a conviction or finding – under the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 – of insanity or unfitness to plead in the criminal courts (and sentencing in a Crown Court). The criterion of serious harm needed to justify information-sharing has been established by a Crown Court judge in the sentencing court and tested by written evidence of two psychiatrists and the

oral evidence of at least one psychiatrist. This provision is set out in Section 41(1) of the Mental Health Act (1983), which states:

> '[where] it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may [impose a] restriction order.'

Section 41(2) deals with the need for at least one registered medical practitioner to give evidence orally.

Serious harm has been defined further by case law, for example in *R v Paul Martin* (1998):

> 'where the patient poses a risk of serious harm from which the public needs protection. This is not the seriousness of the risk that the public may suffer some harm, but that the risk that the potential harm represented by the individual defendant would be serious.'

Other patients may qualify for MAPPA management if they are assessed by their clinical team as presenting a risk of serious harm to others and are detained under Section 3 or a 'notional' Section 37 of the Mental Health Act (e.g. having been assessed for detention, following a Mental Health Act assessment by a Section-12-approved doctor and an approved mental health practitioner).[1] MAPPA management also applies to patients with a past conviction for a violent or sexual offence and indicators of potential increase in risk of serious harm to others that requires management at MAPPA level 2 or 3.

This is the area that will be potentially the most ambiguous for psychiatrists. The principal issue in establishing the threshold for disclosure in the public interest is that of risk of serious harm. However, for non-restricted patients, the criterion of serious harm has not been established by a court and the Ministry of Justice may no longer be involved, even though some unrestricted cases in forensic units may be former sentenced prisoners (Mental Health Act Section 47/49 transfers whose sentences have expired) with substantial risk histories. In these cases it is recommended that a current structured risk assessment should be conducted, and depending on the risk level and original offence, the team should consider whether inter-agency discussion would benefit the risk management of the case and whether there is a potential risk of serious harm to justify MAPPA identification, notification and/or referral. An alternative would be to seek the patient's consent for disclosure to MAPPA, thus avoiding a breach of confidentiality (see Appendix 1).

It is important to emphasise that MAPPA is primarily concerned with convicted offenders who have contact with mental health services, most commonly in managing the individual's first return to the community from a custodial or hospital setting. Most health cases will be managed at MAPPA level 1, which is ordinary risk management, but this does not preclude information-sharing to appropriately manage the risks to the public. Mental

1 Other non-restricted patients may have been originally transferred from prison to hospital for treatment of a mental disorder while serving a determinate sentence of imprisonment imposed by a criminal court. If the period specified by the original sentence has elapsed and the expected date of release (EDR) has passed, then the restriction order attached to the original Section 47 transfer is deemed to have lapsed. Thus, a prisoner originally transferred under Section 47 and Section 49 of the Mental Health Act 1983 becomes a patient with the equivalent rights to a patient detained under an unrestricted hospital order (Section 37 of the Mental Health Act 1983), which is also known as a 'notional' Section 37 order.

health trusts should note that individuals admitted to hospital may already be MAPPA cases (e.g. a sexual offender subject to registration procedures), and checks should be made with the relevant MAPPA administrator. Police involvement/information-sharing by mental health services may be indicated in other situations, for example a detained patient absconding, child protection concerns, patient armed with a weapon, or assault on staff requiring police investigation, but this would not necessarily involve MAPPA.

All MAPPA-eligible offenders should be identified within 3 days of sentence or admission to hospital (note that Section 48 patients may become MAPPA qualifying on sentence). For mental health trusts it is recommended that procedures should be established to ensure identification within 3 days of a change in status. As a fail-safe procedure, at the first care programme approach (CPA) meeting or equivalent a designated member of the care team should be nominated as responsible for ensuring that the offender has been marked as MAPPA-eligible on the internal management/record-keeping system.

Notification and referral

Once a patient is identified as a MAPPA case a formal notification to the relevant MAPPA coordinator for the local area should be made (using the standard form from the MAPPA national guidance (Ministry of Justice, 2012*a*), but a full referral is not required. This is to ensure that all MAPPA-eligible offenders (MAPPA nominals) are identified even though they may be several years away from discharge. Additional information can be requested from MAPPA agencies such as the police, probation service, prisons. Psychiatrists are advised to identify potential MAPPA-eligible cases early in their admission so that subsequent decisions about information-sharing can be made in a timely fashion and with the most comprehensive information available.

Notification does not constitute a formal referral, but provides the opportunity to both share clinical information with the criminal justice agencies and request information from the police and probation services to inform risk assessment.

MAPPA guidance from the Ministry of Justice (2012*a*) advocates the routine notification and information-sharing on all MAPPA-eligible mentally disordered offenders at designated points in their care pathway. For detained patients on restricted hospital orders who are MAPPA-eligible offenders, the Ministry of Justice recommends that MAPPA be notified when there is any planned move of the patient outside the secure perimeter – such as leave or transfer to another hospital – and also at their first CPA meeting where a discharge is considered. However, confusion may arise when dealing with graduated leave and discharge from long-stay forensic mental health units. MAPPA guidance (Ministry of Justice, 2012*a*) recommends that notification (for level 1) and/or referral (for levels 2 or 3) should be made at the point of first (usually unescorted) leave, but most importantly, when discharge plans are being made, so that the MAPPA in the discharge locality area will be informed and can plan and contribute to risk management as necessary.

Leave and community discharge – notify MAPPA?

Psychiatrists are advised that if MAPPA notification is to be made, then first unescorted leave and final community discharge are appropriate time

points for notification. Standard notification and referral forms are available in the national MAPPA guidance (Ministry of Justice, 2012*a*). It is neither necessary nor practical to disclose each occasion of leave. Psychiatrists need to be aware that leave decisions remain the responsibility of the clinician signing the Mental Health Act Section 17 leave form; MAPPA cannot approve or decline leave for restricted cases, and neither should leave be withheld pending MAPPA notification in level 1 cases (single agency management).

As forensic patients may be in regional units away from their home area, initial leave may be in a different MAPPA locality from final discharge area; thus, two MAPPA panels may be involved. For example, a London patient convicted of manslaughter on Section 37/41 taking first community leave from a private sector hospital in the Cambridge area would need to be notified to the relevant London borough and to Cambridge MAPPA. Psychiatrists are advised that in cases where MAPPA notification is appropriate for out-of-area patients, both the home and host area MAPPA should be notified.

In addition, although the Mental Health Casework Section of the Ministry of Justice makes leave decisions for restricted cases, notification is the responsibility of the mental health team. Psychiatrists are advised that the Ministry of Justice does not routinely notify MAPPA panels about leave decisions and therefore it should not be assumed that one part of the criminal justice system will inform another part, although the Ministry of Justice may remind the responsible clinician of the need to consider MAPPA in written leave decisions. Where notification of first unescorted leave is deemed appropriate then this must be carried out by the mental health service, even for restricted cases.

From a mental health perspective, routine notifications about every single leave trip or variation in leave arrangements are unworkable and may also force the clinician into an unhelpful and counterproductive monitoring role, which may increase, rather than decrease, the patient's risk to self and others by interfering with a critical therapeutic alliance. For example, patients on planned escorted home leave may receive unexpected visits by the police, which may be experienced by the patient as intrusive and may disrupt the treatment process. There is no requirement in the Ministry of Justice MAPPA guidance to inform about single episodes of leave.

Making a referral to MAPPA

When planning discharge arrangements for a MAPPA-eligible offender, the CPA meeting should consider whether active multi-agency management is required. Referral into MAPPA for level 2 or level 3 management should be considered only once it is established in the CPA that additional resources are required to manage the risks identified. If level 2 or 3 management is required, a designated member of the care team should complete the referral form and send it to the relevant MAPPA coordinator in other areas to convene a level 2 or 3 meeting. Such a meeting will enable information-sharing, the preparation of an inter-agency risk management plan and access to specialist resources. Referral into MAPPA is not required if the case is to be managed at level 1 – notification alone is sufficient.

When cases are referred to MAPPA, they are recorded on the Violent and Sex Offender Register (ViSOR), a confidential and restricted database developed by the police and probation services in England and Wales which is

only accessible to the three responsible authority agencies (police, probation and prison services). All minutes of MAPPA meetings are put on ViSOR, as well as information about potentially dangerous people and registered sex offenders.

Liaison and attendance at MAPPA meetings

Each borough MAPPA (in London) or area MAPPA (outside London) should have a health representative who is a 'standing' MAPPA meeting member as required by the duty to cooperate. This person should have the authority to commit resources on behalf of the trust and possess relevant experience of risk/needs assessment, as well as analytical and team-working skills. There should be continuity of personnel in order to sustain good working relationships.

The standing member may or may not have direct knowledge of the MAPPA case under discussion. Therefore, a representative of the patient's clinical team should also be invited to attend, at levels 2 and 3, to contribute to the MAPPA discussion on individual cases. Attendance in person is the normal expectation but if this is not possible, video/telephone conferencing should be considered, or alternatively the provision of a written report or brief letter or email. Given the nature of MAPPA cases, it is recommended that any written communication with MAPPA be copied into the continuous clinical record of the patient.

Psychiatrists are advised that where they are attending MAPPA panels for level 2 or level 3 cases for which they are the responsible clinician, they should be mindful of the need to only share the minimum necessary information with other agencies. Equally, psychiatrists are entitled to assume that any limited clinical information shared with MAPPA agencies should not be disclosed by another MAPPA member without discussion or agreement by the MAPPA chair at the level 2 meeting.

Requests for information-sharing within MAPPA

The duty to cooperate may involve the sharing of information. Information shared should always be the minimum necessary to assist with risk assessment and management of individual cases. The question of where information might go after it is shared is also an important one and is relevant to decisions whether or not to share information in the first place. MAPPA members are therefore obliged to provide clear statements as to onward transmission before expecting others to share information with them.

Tensions may arise between trust policies on MAPPA and individual doctors' concerns regarding the information-sharing threshold. If there is any doubt whether information should be shared, trust staff should seek advice within the trust in line with trust procedures. Where there is disagreement within a multidisciplinary team as to whether or not information should be exchanged, the issue should then be peer reviewed by another consultant colleague, clinical director and/or the Caldicott Guardian. If members of the MAPPA seek information and an individual mental health professional refuses, MAPPA chairs may refer the matter to the NHS trust for review and final decision. The chief executive for the trust carries the legal duty and can be the final arbitrator in such decisions. Psychiatrists may also consider seeking advice from their medical defence organisation.

There is sometimes a concern among health professionals that it is a breach of confidence to request information about a patient from criminal justice agencies. However, a request for information does not constitute a breach of confidentiality. The agencies within MAPPA may hold information to support the risk assessment of patients, for instance the police have access to the Police National Computer (PNC, criminal record) and some limited intelligence. Should the team form the opinion that they do not already hold the necessary or complete information, a request can be made to the relevant MAPPA area administrator to process an information-sharing request among the MAPPA agencies. When a health professional requires information from MAPPA, in the first instance they should approach the MAPPA administrator for their area, who will discuss requests with their MAPPA chair and provide any information required.

Registered sexual offenders

Some patients may be subject to sexual offender register requirements. It is not the responsibility of mental health professionals to register such patients (this is initiated by the sentencing court), but when the patient's registration status is known, it is appropriate to check that appropriate registration has taken place. Where possible, this should always take place ahead of the first post-admission CPA. It is important for mental health professionals to be aware that failure to register as a sex offender constitutes an offence in itself and can attract a sentence of imprisonment. Registrants must inform the police of a change of address within 3 days and must notify when they are spending more than 7 nights away from home. Their bank details also need to be disclosed.

MAPPA-eligible offenders in prison

For patients who are remanded or sentenced prisoners but who are in contact with prison in-reach mental health teams, separate arrangements exist in relation to prison MAPPA procedures. It is the responsibility of the probation service to ensure that appropriate MAPPA notifications and referrals are made, but it may be appropriate for mental health professionals to contribute to this process.

Transferred prisoners

The lead agency within MAPPA for a transferred prisoner (Section 47 Mental Health Act) will be the probation service once the patient is in the community, but hospital-based staff need to consider the impact of their decisions and possible first-tier (mental health) tribunal decisions on the external agencies (e.g. offender manager, victim liaison officer, approved premises), and must ensure that MAPPA is informed of these decision-making processes. It is therefore important that mental health trusts prioritise attendance at MAPPA meetings in these cases. Since the decision-making of tribunals cannot be anticipated, it is essential that the mental health trust and the probation service have developed contingency plans and that MAPPA is fully informed of these arrangements.

Exit from MAPPA

It is important to identify when an offender is no longer eligible for MAPPA. The criteria for leaving MAPPA are different for each of the three categories of offenders:

1 Category 1 offenders (registered sexual offenders, RSOs): when their period of registration expires. In the most serious cases, registration is for life. Following a ruling in the Supreme Court in 2010, registered sexual offenders are now eligible to seek a review 15 years from the date of their first notification (if under 18 on the date of conviction or finding, this period is reduced to 8 years) (*R (on the application of F (by his litigation friend F)) and Thompson (FC) (Respondents) v Secretary of State for the Home Department (Appellant)* [2010]).

2 Category 2 offenders (violent and other sexual offenders): when the licence expires, the offender is discharged from the hospital order or guardianship order, or the disqualification order is revoked.

3 Category 3 offenders (other dangerous offenders): when a level 2 or 3 MAPPA meeting decides that the risk of harm has reduced sufficiently or the case no longer requires active multi-agency management.

Patients

In contrast with the common practice in mental health where the patient is routinely invited to attend his or her regular CPA meetings, MAPPA excludes patients or patient representatives from attending MAPPA meetings. The MAPPA offender has no legal representation at these meetings. He also has no right of appeal against the decisions of a MAPPA meeting, although there are formal complaint procedures within the police and probation services. The situation of the MAPPA offender is therefore much more restricted than that of the patient detained under the Mental Health Act with its inherent system of tribunals and appeals.

The Ministry of Justice (2012*a*) national MAPPA guidance recommends that patients should always be told of their MAPPA status. Patients may also be asked to consent to limited information-sharing with police and probation services to assist with their management. If a patient consents (and has capacity to understand what they are consenting to) then this avoids a breach of confidentiality and thus is a useful avenue, particularly for non-restricted cases. A patient leaflet has recently been drafted by the London MAPPA Strategic Management Board, and in Leicestershire and Rutland a standard pro-forma letter for MAPPA-eligible offenders and self-assessment form have been developed, but this is clearly an area in which more work needs to be done.

Appendix 1. Confidentiality and disclosure policies: NHS, BMA, GMC

The *NHS Code of Practice on Confidentiality* produced by the Department of Health (2003) provides guidelines for all NHS staff; *Supplementary Guidance on Public Interest Disclosures* was added to the *Code of Practice* in 2010. In addition to health-specific guidance, any decision by a public authority must also be compliant with Article 8 of the Human Rights Act 1998 ('right to privacy'). Although MAPPA is not explicitly mentioned in the *NHS Code of Practice* or the *Supplementary Guidance*, these documents make additional important points regarding confidentiality and disclosure that are potentially at odds with MAPPA guidance. The *NHS Code of Practice* highlights the centrality of seeking patient consent for the disclosure of confidential information, whereas in the MAPPA guidelines, although it is stated that: 'It is preferable that the offender is aware that disclosure is taking place, and, on occasion, they may make the disclosure themselves' (p. 70), the specific issue of consent is not mentioned. Furthermore, the *NHS Code of Practice* stresses the importance of balancing the need for disclosure against not only the duty of confidentiality of individual patients, but also the interest of public confidence in the NHS as a confidential service. In this respect, the disclosure of confidential information for one patient could indirectly damage the treatment of other patients whose confidence in the service may be undermined.

The position of the British Medical Association, as outlined in the *Confidentiality and Disclosure of Health Information Tool Kit* (2009), is that: 'In the absence of patient consent, a legal obligation or anonymisation, any decision as to whether identifiable information is to be shared with third parties must be made on a case by case basis and must be justifiable in the "public interest" […] where disclosure is essential to prevent a serious and imminent threat to […] the life of the individual or a third party or to prevent or detect serious crime' (p. 44). The BMA advises that the doctor should persuade the patient to disclose voluntarily, reveal only the minimum information necessary and be able to justify the decision. Regarding the definition of serious crime, this includes crimes such as murder, manslaughter, rape, treason, kidnapping and abuse of children or other vulnerable people.

The GMC advises that although confidentiality is central to the trust between doctors and patients, it is not absolute, and personal information may be breached without consent in the public interest if failure to disclose would expose others to a risk of serious harm (General Medical Council, 2009). The GMC advises that doctors should participate in procedures set up to protect the public from violent and sex offenders and should cooperate with requests for relevant information about patients who may pose a

risk of serious harm to others. However, the doctor should consider the assessment of risk posed by patients made by other professionals and by groups established for that purpose, but must make their own assessment and decision as to whether disclosure is justified. The doctor's assessment of risk is a matter of professional judgement in which an offender's past behaviour will be a factor. A case example is given on the GMC website of a psychiatrist making an appropriate disclosure to MAPPA in the case of a sex offender undergoing psychiatric treatment (www.gmc-uk.org/guidance/ethical_guidance/confidentiality_reporting_concerns.asp).

Appendix 2. Case examples

These cases are fictional but have been compiled to illustrate likely clinical scenarios involving MAPPA issues.

Case example 1: Level 1 MAPPA involvement

M is a 30-year-old man with a history of schizophrenia and five previous admissions for psychotic episodes. He has been in a medium secure unit for 26 months, having received a hospital order under Sections 37 and 41 of the Mental Health Act 1983, after a conviction for affray. In his developmental history he was severely neglected and emotionally abused by his single mother. During a psychotic relapse he had armed himself with a knife and entered a post office where he threatened staff who he believed were spying on him. He has responded well to clozapine therapy, completed a relapse prevention plan with a clinical psychologist and currently demonstrates good insight. He has had extensive community leave over a 12-month period and is being conditionally discharged to a 24-hour staffed hostel with follow-up from an assertive outreach team with forensic psychiatry co-working.

One week after sentencing he was logged on the hospital electronic record as being MAPPA eligible. At his first CPA meeting after sentencing, the local MAPPA coordination unit were informed of his name, address and date of birth, that he was an in-patient, and they were also notified when he began unescorted leave. After the discharge CPA meeting, the MAPPA coordination unit were notified of his discharge hostel address and the name and contact number of his responsible clinician and social supervisor. At no point was any information about his medication, abuse history or other personal details divulged to MAPPA. He was deemed to be appropriately managed by a single agency at level 1, and no further action was taken by the local MAPPA.

Nine months after discharge, the police were called to the hostel after a 999 call was made to deal with an incident where M was threatening staff with a kitchen knife. It transpired that this was in the context of him concealing non-adherence to clozapine over a 3-week period, which had resulted in a change to his mental state and an increased risk to himself and others. He was initially arrested and later recalled under Section 41 of the Mental Health Act. There was no need for MAPPA involvement to enhance, by inter-agency management, the standard police response to the circumstances of this recall, however, the MAPPA notification ensured that the police were aware of M's MAPPA status at the point of his arrest.

Case example 2: Level 2 MAPPA involvement

J is a 30-year-old man with a history of schizoaffective disorder who was convicted of rape, false imprisonment and wounding with intent of his partner after he had suffered a relapse of psychosis. In the context of cannabis misuse and non-adherence to oral antipsychotic medication he had developed delusions of jealousy and delusions of reference from the television. During the offence he subjected his partner to a prolonged assault and sexual offences while holding her captive in their flat. J inflicted stab wounds on his partner in response to abnormal experiences during the offence.

J has a history of childhood conduct disorder, with a pattern of street robberies as an adolescent while a member of an inner-city gang. He has a previous conviction for sexual intercourse with a 15-year-old girl. As well as a diagnosis of schizoaffective disorder, he has also been assessed as fulfilling DSM-IV criteria for a diagnosis of antisocial personality disorder, and his Hare Psychopathy Checklist (PCL-R) score has been measured as 27. Since J's hospital admission, his estranged partner has given birth to a child by a different father but has recently re-established contact with J and has been visiting and requesting that he be allowed to meet her new daughter as she wishes to resume a relationship with him after his discharge, despite the offence against her.

After stabilisation of his psychosis on depot antipsychotic medication, as well as extensive individual psychology and group sex-offender work, an application was made to the Ministry of Justice for unescorted community leave. The case was referred to MAPPA as a potential level 2 case and the in-patient social worker and responsible clinician were invited to a level 2 MAPPA meeting.

At the meeting, children and families Social Services made it clear that they would not sanction any unsupervised contact with the partner's young child. Local MAPPA made an entry on the police file relating to the partner's address in case of any 999 calls from that address and included relevant contact details. The partner was approached by a domestic violence voluntary agency after they had heard limited information at the level 2 MAPPA meeting.

Children and families Social Services requested a copy of the latest mental health review tribunal report about J from the in-patient responsible clinician. This request was declined and Social Services were advised to seek an independent psychiatric assessment through the family court proceedings, which would require the consent of J to undergo specific psychiatric assessment for this purpose.

The Ministry of Justice declined the unescorted community leave application on the grounds of risk concerns highlighted by a risk assessment of sexual and violent offending (e.g. the Risk for Sexual Violence Protocol; Hart *et al*, 2003). Level 2 MAPPA discussion of the case was adjourned pending further leave and/or discharge.

Case example 3: Level 3 MAPPA involvement

S is a 45-year-old man who was convicted of the manslaughter of a neighbour on the grounds of provocation after he had been racially abused. While serving a 9-year determinate sentence of imprisonment he developed

a psychotic illness and perpetrated a serious assault on a prison officer, who he thought was involved in a conspiracy to drug him and conduct medical experiments on him. He was transferred to a high-security hospital under Section 47/49 of the Mental Health Act, but following a decision by his responsible clinician that no effective treatment could be given, he was remitted back to prison, after which he received a short concurrent sentence for the new offence. It transpired that there was evidence of delusional disorder at the time of the original offence, which had not been picked up at his trial. However, subsequent treatment in hospital had not been effective as a result of disagreement about diagnosis.

Unfortunately, the psychotic episodes returned, resulting in S being transferred a second time to a secure hospital under Section 47/49. After his sentence expired and he became subject to a notional Section 37 order, a mental health review tribunal ordered discharge against medical advice. S planned to return to the borough where the offence was committed and where there had been significant press coverage of the original offence. The in-patient responsible clinician made a MAPPA referral requesting an emergency MAPPA meeting.

A level 3 meeting was called to discuss this specific case. The in-patient social worker from the high-security hospital attended, as did the MAPPA representative from the catchment area forensic service. There was a discussion regarding appropriate aftercare as S was still subject to a probation licence. Psychiatric aftercare was arranged by the local forensic service. The level 3 MAPPA was able to facilitate the fast-track provision of semi-supported accommodation in part of the borough distant from the victim's relatives, as this was thought to be a useful risk reduction strategy. The in-patient social worker was aware, as an experienced practitioner, of the subtle pressure to disclose extensive clinical information, but only disclosed the minimum necessary information. This did not include details of prescribed medication or aspects of S's developmental history, but did include relapse indicators and protective factors.

Relatives of the victim of the index offence of the homicide by S gave an interview to the local press expressing outrage at the discharge. Police liaison officers were able to speak to them about their concerns without disclosing confidential information other than that S would not be returning to the street where he lived next to the victim's family home. After S later defaulted from attending his out-patient psychiatric appointments and receiving depot antipsychotic medication, the MAPPA chair assisted with provision of police officers for a Mental Health Act assessment in the community. However, this assessment concluded that there were no current grounds for detention under the Act. S agreed to attend his out-patient appointments and later agreed to take an oral atypical antipsychotic as he had been unhappy with the side-effects of the depot antipsychotic. After a subsequently uneventful year of community supervision, the level of management changed to level 2 and was reviewed in line with MAPPA timescales.

Case example 4: Information-sharing *v.* disclosure

B is a registered sex offender with a history of contact offences against prepubescent female victims in a park area. He is residing in approved premises and subject to a licence. When he is discussed at a MAPPA level

2 meeting, information received from Job Centre Plus that he has applied for a job working for a company that runs trips on a local canal boat is shared by his supervising probation officer with MAPPA partners. Further enquiries reveal that the canal boat company regularly runs trips for local schoolchildren. It was decided that the probation officer needed to inform B that he must declare his offending history to his potential employers and that this would be checked to ensure it had been completed. B was informed that if he did not want to disclose he should consider seeking more suitable employment. B is visited by his probation officer and is warned that if he takes employment on a canal boat with schoolchildren having concealed his offending history, then a formal disclosure will have to be made and he will be in breach of his licence conditions. This action was agreed and noted in the MAPPA level 2 meeting. B elects to seek alternative employment and disclosure is not required to manage this particular risk.

Case example 5: Seeking information from MAPPA without sharing information

P is a man in his mid-twenties who is detained under a civil section, having been arrested and transferred to hospital under Section 136 for threatening a member of the public. He is dishevelled and appears to be responding to hallucinations, but is very guarded and gives limited information to mental health professionals. A subsequent request to the MAPPA coordination unit for his criminal record reveals a history of a previous hospital order following an offence of shoplifting in another area of the country, which facilitates a request to another mental health trust. A more complete background history is obtained as a result, including a previous positive response to a particular combination of antipsychotic medication, which enables more appropriate treatment to be offered. No information about P was required by MAPPA from his mental health team.

Case example 6: Assessing eligibility for MAPPA notification

P, as described in case example 5, is not a registered sexual offender and has no Schedule 15 (Criminal Justice Act 2003) qualifying offence, and is therefore not a category 1 or 2 MAPPA offender. An HCR-20 risk assessment is completed after P has responded to antipsychotic medication and it is decided that he does not pose a risk of serious harm to justify referral for category 3, level 2 MAPPA. He is therefore not a MAPPA-managed offender and no information is shared with MAPPA about subsequent leave and discharge arrangements.

Case example 7: Lack of information-sharing and potential for adverse outcome

W, a 26-year-old man, was treated over a 3-year period in a medium secure unit after being made subject to a restricted hospital order (Section 37/41) following a conviction for wounding, affray and possession of an offensive weapon. The offences were committed against a family member and were thought to have arisen from a first psychotic episode in the context of a diagnosis of schizophrenia. The response to in-patient treatment was generally good and a conditional discharge was made. W went to live in supported accommodation and attended appointments with the community psychiatrist and social supervisor. At the point of unescorted leave and discharge there was no notification to MAPPA and there was no information-sharing. The local mental health trust did not have a clear policy on whose responsibility it was to ensure MAPPA notification.

W stopped taking oral medication shortly after a monthly appointment with his psychiatrist, without informing him. There was a rapid re-emergence of psychotic symptoms with associated disturbed behaviour in the form of accusations by W to strangers that they were making derogatory comments. Police were called to a minor altercation at a bus stop; W was questioned and the police did an identity check. There was no information on the police database CRIMINT relating to the history of mental health problems and no record of any MAPPA notification. W calmed down and was cooperative with the police, who decided not to use their powers to remove him to a place of safety under Section 136 of the Mental Health Act. No information about the incident was passed to the mental health team, as the police were not aware of their involvement. W left the hostel that night and experienced a further deterioration in mental state. Three days later W assaulted a stranger in the street with a half brick in response to auditory hallucinations of derogatory comments. W was arrested and charged with a further offence of wounding. A subsequent serious incident review found that, had the police received a level 1 MAPPA notification at the point of discharge, the second wounding might have been avoided. The incident resulted in a review of MAPPA local policy. A MAPPA section was added to the CPA review section of the electronic medical records system at the mental health trust to prompt a discussion of MAPPA issues at CPA reviews in the future.

References

British Medical Association (2009) *Confidentiality and Disclosure of Health Information Tool Kit*. BMA (http://bma.org.uk/practical-support-at-work/ethics/confidentiality-tool-kit).

Department of Health (2003) *Confidentiality: NHS Code of Practice*. Department of Health.

Department of Health (2010) *Confidentiality: NHS Code of Practice. Supplementary Guidance: Public Interest Disclosures*. Department of Health.

General Medical Council (2009) *Confidentiality*. GMC.

Hart SD, Kropp R, Laws DR, *et al* (2003) *The Risk for Sexual Violence Protocol (RSVP) – Structured Professional Guideline for Assessing Risk of Sexual Violence*. Simon Fraser University, Mental Health, Law and Policy Institute.

Ministry of Justice (2010) *Guidance for Working with MAPPA and Mentally Disordered Offenders*. Ministry of Justice.

Ministry of Justice (2012*a*) *MAPPA Guidance 2012, Version 4*. Ministry of Justice.

Ministry of Justice (2012*b*) *Multi-Agency Public Protection Arrangements Annual Report 2011/12 (Ministry of Justice Statistics Bulletin)*. Ministry of Justice

Royal College of Psychiatrists (2010) *Good Psychiatric Practice: Confidentiality and Information Sharing (2nd edn)* (College Report CR160). Royal College of Psychiatrists.

Tribunals Judiciary (2013) *Practice Direction: First-Tier Tribunal Health Education and Social Care Chamber, Statements and Reports in Mental Health Cases*. Tribunals Judiciary (http://www.judiciary.gov.uk/Resources/JCO/Documents/Practice%20Directions/Tribunals/statements-in-mental-health-cases-hesc-28102013.pdf).

R v Paul Martin (1998) EWCA Crim 3166.

R (on the application of F (by his litigation friend F)) and Thompson (FC) (Respondents) v Secretary of State for the Home Department (Appellant) [2010] UKSC 17.