

Consultation Document

Human Rights Joint Risk Assessment & Management Plan (*HR-JRAMP*)

A Human Rights Based Approach
Last revised 15/8/08

Beth Greenhill
Richard Whitehead
Melonie Grannell
Ged Carney
Jim Williams
Alex Cookson
Frank Chapman
Emma Ward
Amy Lee

Consultation Version

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For further information and training opportunities contact:-

beth.greenhill@merseycare.nhs.uk
richard.whitehead@merseycare.nhs.uk

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Authors' Preface

"We are disappointed that, at the start of the 21st century, almost ten years after the introduction of the Human Rights Act...the evidence convinces us that we need to emphasise that adults with learning disabilities have the same human rights as everyone else"

(Joint Committee on Human Rights, 2008)

This quotation from the recent report 'A Life Like Any Other?' gives some indication of just how far away the realities of many services for people with learning disabilities are from lawful, let alone aspirational, practice. Making human rights real for people with complex needs and learning disabilities might seem to be starting with the 'hard part' but is perhaps also about starting where the need for change is greatest (Bush, 2007). The human rights paradigm provides an overarching framework, a robust process, and clarifies the concepts needed for positive risk taking. This, it is hoped, will ensure balanced decision making and proportionality regarding human rights, risk assessment and risk management plans. These guidance notes attempt to integrate human rights for people with learning disabilities with the complex care framework outlined by the Joint Risk Assessment and Management Plan (J-RAMP; Williams et. al., 1999).

The J-RAMP was first developed in 1999 by Jim Williams, Chris Ferns and Tim Riding. The primary aim of the document was to set out how Social Workers and Clinicians should go about a formal joint assessment of the risks associated with the relatively small group of adults with a learning disability who present a likely and serious risk of harm to either themselves or others. The J-RAMP was based on recognised research and good practice in this field (Webster & Eaves, 1994; Pollock et. al., 1990; Prins, 1996; Turner, 1998). In doing this a numerical quantification of risk was adopted, whilst avoiding the 'figure to trigger' approach of some assessment schemes.

The J-RAMP has been used many times over the years and has proved to be a useful tool. However, a number of difficulties have arisen. One of the major problems identified has been the use of the J-RAMP in isolation from other person-centred assessments. This has led to staff and agencies providing direct support to Service Users becoming increasingly preoccupied with risk issues, without adopting a balanced, holistic, approach to interventions and support.

The Human Rights in Healthcare project seemed to offer a useful paradigm, allowing us to resolve some of these difficulties. The Human Rights in Healthcare project is a joint initiative between the Department of Health and the British Institute of Human Rights, aiming to encourage NHS Trusts to adopt and develop their use of an explicitly 'Human Rights Based Approach' in their practice. The Learning Disabilities Directorate of Mersey Care NHS Trust was offered the opportunity to participate as one of five pilot sites in this project. One of the areas we chose to focus on was on integrating human rights with our risk assessment processes and tools. Our previous approach to supporting people with

learning disabilities who have difficult or challenging behaviours aimed to integrate principles of person-centred care with risk assessment and management frameworks. Within these frameworks there was little explicit reference to Service User's human rights. In this document we are suggesting a different approach. We hope to shift our focus and understanding so that the key outcome is an assessment and management framework which balances the human rights of Service Users, their supporters and their communities. It is through this process of balancing rights that risk too can meaningfully be balanced.

Put simply, we hope that we can positively manage and balance risk if we can support Service Users, their carers and their communities to access their rights.

A reflective practice approach has also been incorporated into the revised Human Rights Joint Risk Assessment and Management Plan (*HR-JRAMP*). It has been evident when reading J-RAMPs that a person's professional background or beliefs have influenced the way it has been written. This can have quite serious consequences as the use of emotive language and an unbalanced approach can influence whether a person is considered to be appropriate for living in the community.

The *HR-JRAMP* document has also been revised in line with 'Valuing People Now' (2007), new legislation, including the Mental Capacity Act (2005), new Mental Health Act (2007) and recent research evidence. We have tried to take account of pending legislation, for example the Deprivation of Liberty Safeguards (2009).

Finally, numerous people have been involved with the revision of the text so a big 'thank you' to: Lucy Matthews, Hannah Clayton, Lindsey Dyer, Kulvinder Kaur, Michelle Montrose, Janet Shelmerdine, Julie Blakely, Bill Hiley, 'The Liverpool Team' and "People First, Liverpool".

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Beth Greenhill (Clinical Psychologist, Learning Disability Directorate)

Richard Whitehead (Head of Psychology, Learning Disability Directorate)

Melonie Grannell (Clinical Psychologist)

Ged Carney (Community Nurse, Learning Disability Directorate)

Jim Williams (Clinical Director, Liverpool D. Clin. Psychol. Training Programme)

Alex Cookson (Clinical Psychologist, Learning Disability Directorate)

Frank Chapman (Clinical Psychologist, Learning Disability Directorate)

Emma Ward (Assistant Clinical Psychologist)

Amy Lee (Assistant Clinical Psychologist)

Authors 27th July, 1999

Jim Williams (Clinical Psychologist, Learning Disability Directorate)

Chris Ferns (Learning Disability Social Work Team Manager, Social Services)

Tim Riding (Specialist Nurse Consultant, Learning Disability Directorate)

1 A Human Rights Based Approach to Complex Care & Risk Management

“He who forgets his history is destined to repeat it”

(George Santayana)

On a plaque in block four of the Auschwitz barracks, George Santayana’s words act as a powerful reminder that the memory of our social, cultural and personal journeys is vital to our ability to progress and transcend our history. For Service Users with complex needs, understanding a person’s journey is the key to potential development and growth. The Joint Risk Assessment and Management Plan (*HR-JRAMP*) attempts to understand the risky behaviours of people with a learning disability in the context of their personal history.

The desire to effect change through understanding our histories, but on an international scale, also precipitated the first attempts to enshrine in international law rights for all. The United Nation’s Universal Declaration of Human Rights (UDHR) formed part of the international community’s response to the horror of the Holocaust. Some of the rights listed in the UDHR were adopted in 1950 by the Council of Europe and have been brought into UK law by the Human Rights Act (1998).

Services for people with learning disabilities have long been concerned with the underlying values central to our practice (O’Brien, 1987; Wolfensberger, 1972). The core human rights principles underpinning the Human Rights Act, those of **Fairness, Respect, Equality, Dignity and Autonomy (FREDA)** give these values a powerful contemporary expression, meaningful in the day-to-day lives of the people we serve, and in our own lives.

This introductory section presents an overview of a ‘human rights based approach’ (HRBA) to complex care. It explains how human rights principles (FREDA) apply to risk assessment and management planning. It also explains how human rights processes apply in ensuring that our risk management practice is lawful, balances the interests of all those involved in a package of care and is proportionate in terms of the risk management strategies we advise.

1.1 What is a Human Rights Based Approach (HRBA)?

Key to making human rights real in risk management is a ‘human rights based approach’ built on the following:

- Putting **human rights** & human rights principles **at the heart of policy and planning**.
- **Empowering staff and Service Users** with knowledge, skills and the organisational leadership and commitment to achieve human rights based approaches.
- Enabling meaningful **involvement & participation** of all key people.

- Ensuring clear **accountability**.
- **Non-discrimination** & attention to vulnerable groups.

(Human Rights in Health Care, DoH & BIHR, 2007)

In essence, employing a HRBA approach promotes a shared sense of entitlement, encourages personal responsibility and upholds respects for the rights of others; whilst promoting equality and diversity.

1.2 Policy Summary

This joint policy statement briefly summarises the most relevant elements of Mersey Care NHS Trust and Social Services' policies regarding the assessment and management of risk and human rights. It forms the framework within which Mersey Care and Social Services staff enable people to live lives which respect their rights and choices, balancing these with the rights of their supporters and the communities to which they belong, through the process of meaningfully assessing and managing risk. The policy describes the standard to which this should be done.

As public authorities, the NHS or Health Trusts and Social Services have a '*positive obligation*' to take proactive steps to protect human rights if we are aware, or should be aware that someone is at risk. We have a responsibility to assess and manage all risks arising from and associated with the services we provide. We are also responsible for doing this in a way that ensures Service User's human rights are upheld.

Each agency has to discharge its duty of care towards their Service Users to an appropriate standard. This entails being able to demonstrate that as staff we have acted and made decisions in a manner which is comparable to that of another competent body of responsible co-professionals, acting in the same circumstances.

In exercising professional judgement all staff will act within the law and in accordance with the policies and procedures of Liverpool Social Services Directorate, Mersey Care NHS Trust and Liverpool Health Authority.

Staff can expect to be supported in action which they have taken provided they have adhered to their agency's policies and procedures in regard to the assessment and management of risk and demonstrated an acceptable standard of care in the discharge of their responsibilities. At times this will mean supporting a Service User to receive services or to remain in a situation in which there are significant risks. Decisions regarding risk situations should only be made following a full evaluation of all the relevant information in accordance with the guidance herein. The decision taken will be on the basis of the informed consent of the Service User (or their representative), subject to their legal capacity, age and understanding.

1.3 Human Rights Aims & Principles in Complex Care Pathways

Overall, Mersey Care NHS Trust, Liverpool and Sefton Social Services aim to:

- Use a **human rights based approach** to risk assessment and management.
- **Involve the person** as much as possible in the process of planning their own care and management of their own risk.
- Apply a holistic, **person centred approach to assessment** in which the individual's rights to non-discrimination on the basis of their religion or spirituality, their race or culture, their gender, sexual preference, disability or mental health are considered.
- Assist in finding a suitable placement for the individual. Its aim would be to achieve a **supported living placement within the city** (Mansell, 2007). Where possible, the placement will be in a community that recognises and promotes the individual's cultural, religious and other diversity needs, allowing them the potential to make a positive contribution to that community.
- **Promote access and quality in generic health and social care services** and contribute to the planning and development of comprehensive services.
- Provide sufficient skilled support to enable, wherever possible, individuals with a disability to remain within their community, benefit from being a member of and **make a positive contribution to their community** (Mansell, 2007).

The way in which we assess and manage rights and risk should be consistent with the overall aims of the Human Rights Act and should be based on the FREDA principles. The table below shows some examples of how the FREDA principles may be relevant to risk management. The table identifies which of the FREDA principles are most relevant to each particular risk management example, but note that often more than one of the principles will be relevant to a particular situation or example.

Human Rights Principle	Risk Management Example
Fairness	Risk decisions always involve balancing health and safety issues, for the service user and others (including the general public) with Service User's quality of life, personal growth, rights and choice.
	Risk assessments and judgements should be founded on the application of explicit criteria and form part of an overall assessment process.
	Service Users and carers should be able to access information held about them regarding risk and know in advance on what basis information may be shared with others.
Respect	Decisions which flow from risk assessments should be communicated effectively with relevant individuals.
Equality	Any risk assessment should take into account and respond to a person's age, race, religion, spirituality, culture, gender, sexual orientation, disability and communication needs.
Dignity	Adults who lack capacity in law should, wherever possible, be protected from significant harm.
	Service Users and carers should have the opportunity to live as safely and free from harm as possible.
	Interventions implemented following risk assessments should be the least restrictive possible in the circumstances.
Autonomy	Risk is an important aspect of learning; it is also an unavoidable part of life. It is not possible or desirable to remove all aspects of risk from the experience of Service Users.
	Encouragement and information should be given to maximise the freedom of choice of users and carers and to encourage independence (considering their capacity in law, age and understanding).
	Service Users and carers should be supported to judge the potential benefits as well as the potential harms of any situation
	Services aim not only to reduce the risk of harm, but to manage and promote risk-taking in a planned, controlled way.

1.4 Human Rights Act Summary

The Human Rights Act (1998) incorporated into UK law most of the rights detailed in the European Convention on Human Rights. The European Convention is the main source of our legal human rights protection in the UK. Although its focus is on civil and political rights, because the rights it contains are defined broadly, it has strong significance within the context of health services.

The Human Rights Act imposes a direct legal obligation on NHS Trusts to ensure that we respect European Convention rights in all we do. The articles of the Human Rights Act are described below.

The rights contained in the Human Rights Act are:

- The right to life
- The right not to be tortured or treated in an inhuman or degrading way
- The right to be free from slavery or forced labour
- The right to liberty
- The right to a fair trial
- The right to no punishment without law
- The right to respect for private and family life, home and correspondence
- The right to freedom of thought, conscience and religion
- The right to freedom of expression
- The right to freedom of assembly and association
- The right to marry and found a family
- The right not to be discriminated against in relation to any of the rights contained in the European Convention.
- The right to peaceful enjoyment of possessions
- The right to education
- The right to free elections

1.5 Human Rights Processes in Complex Care

Different Types of Human Rights

Human rights can be most simply classified as **absolute rights** and **non-absolute rights**. These are described more fully below. The right to liberty (Article 5) is described separately.

- **Absolute rights**

These rights can never be interfered with, in any way by NHS Trusts, Social Services or any other public authorities. They are

- The right to life
- The right not to be tortured or treated in an inhuman or degrading way
- The right to be free from slavery

- **Non-absolute rights**

Most rights in the HRA are not absolute but have some degree of qualification. They can be interfered with by NHS Trusts and Social services if the decisions we make are:

- **Lawful** – completed with reference to the appropriate legal frameworks.
- Have a **legitimate aim** – *“to protect the rights of others or for the wider good”*
- **Proportionate** – *“appropriate and not excessive in the circumstances”* or *“not using a sledgehammer to crack a nut”*
- **Balanced** – take into account the rights of the Service User, their staff and the rights and general interests (e.g. national security and economic well-being) of the wider community of which both are a part.

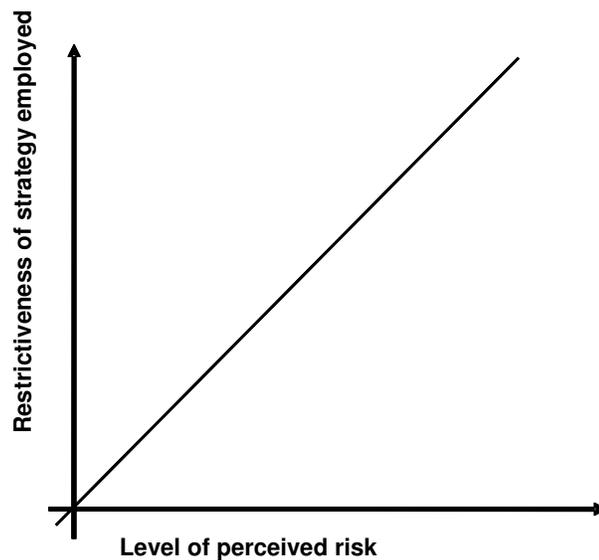
An example of a non-absolute right is the right to respect for private and family life, home and correspondence.

- **The Right to Liberty (Article 5)**

Article 5 can be *‘limited in specific and finite circumstances’* which are described within the HRA. For example, the right to liberty may be restricted to allow the legal detention of someone with mental health problems.

1.6 Proportionality

Proportionality is fundamental to assessing risk. In essence, a proportionate strategy is one that is *'appropriate and not excessive in the circumstances'* (DoH, 2007). In practice, proportionality ensures that the infringement of a person's human rights is kept to a minimum. It is probable that as the level of perceived risk increases, so too would the reasonable restrictiveness of any strategy employed (see below). However, the principle of proportionality should ensure that this is always the **least restrictive strategy**.



When considering if a strategy is proportionate the assessor should ask:

- What will be left of the person's rights if the strategy is employed?
- Is there an alternative strategy that would be less drastic?

Proportionality: Case Example

Calvin is a young man with Cornelia de Lange Syndrome. Calvin began to display self-injurious behaviours including pulling his own hair out, and attempting to bite his hands. These incidents occurred roughly once a week and could last for an entire morning or afternoon. The management team at Calvin's day centre decided to introduce straight arm restrictive devices (splints) to avoid Calvin seriously hurting himself. Over a five year period, the time Calvin spent wearing the splints increased until he spent most days in them. This risked violating Calvin's right to respect for his private life, and in extreme circumstances, his right not to be treated in an inhuman or degrading way. In particular, the period of intervention (i.e. the amount of time Calvin spent wearing the splints) was not proportionate to the self-injurious behaviours displayed (they occurred at most for one morning or afternoon per week). However, if the intervention raised Calvin's right not to be treated in an inhuman or degrading way (an absolute right) then proportionality would not apply and the intervention would be unlawful.

The intervention was reviewed; using a human rights based approach, to see if it was proportionate to the risk. As a result, staff systematically faded down the amount of time Calvin wore the splints. The splints are now only used when Calvin's self-injurious behaviour poses significant risk to his own well-being.

1.7 Proactive and Reactive Strategies

The principle of proportionality means that, in risk management, an emphasis on **proactive** rather than **reactive** strategies is more likely to be consistent with a human rights based approach.

Proactive Strategies aim to reduce the frequency of risk/challenging behaviours or prevent them from occurring in the first place.

They might include:

- Sex education and sexual health awareness to support a person who takes sexual risks.
- Increasing social activities identified as relevant to the person to reduce boredom and therefore reduce the risks of fire-setting.
- Working through a desensitisation programme with a person for their needle-phobia.
- Providing someone with psychological therapy to help them understand why they are angry and upset after one of their parents has died.

Reactive strategies are an immediate or emergency response to the risk/challenging behaviour which aim to minimise its severity

They might include:

- Physical restraint to stop a distressed person assaulting their staff
- Mechanical restraint to prevent a person from serious self harm
- Pro Ra Nate (PRN) Medication to help a person calm down when they are angry

A human rights based approach will mean carefully analysing the person's history and the context in which their difficult behaviours occur to try and identify the cause of the difficulty. Functional analysis of the person's behaviour and a comprehensive life history or 'critical event history' will be essential to identifying 'causes'. Once the cause has been identified the least restrictive option will often be to develop proactive strategies to address the cause of the person's behaviour.

It may take time for proactive strategies (e.g. psychological therapies) to have an impact on the person's behaviour. It may also take time for clinicians to understand the meaning of and communication in the person's behaviour. In this context, where reactive strategies are not being exclusively relied upon but have been developed as a short term measure or in conjunction with proactive strategies, they are more likely to be human rights compliant.

Reactive strategies should always;

- Be reviewed at regular specified intervals
- Be the least restrictive possible intervention
- Use approved & accredited techniques
- Follow best practice and professional guidelines
- Be explained to the person in an accessible format where possible.

Proactive & Reactive Strategies: Case Example

Shaun is a young man with autism. Shaun was reported by care staff to be trying to hit and bite them. This usually happened in the mornings. Staff were trying to manage Shaun's aggression reactively by using physical intervention techniques for extended periods of time. This risked violating Shaun's right not to be treated in an inhuman or degrading way.

After looking at when and why incidents occurred, staff realised Shaun would become aggressive when they were trying to assist him to get washed. After speaking to Shaun's mum, staff realised that to wash him as a child Shaun's Mum had developed a highly structured shower routine which he was used to following every day. They proactively adopted this routine and the physical aggression they were experiencing from Shaun reduced dramatically.

1.8 Balanced Decision Making

The principle of proportionality leads to an additional concept of risk assessment – '**balanced decision making**.' There are two important dimensions across which rights need to be balanced:

The assessor should balance the potentially competing rights associated with:

- **the risk posed (for the person or other people)**
- **and the strategy employed (for the person or the other people)**

In practice, this may mean that you are trying to balance the Service User's different rights. You may be trying to balance the rights involved in the person's risky behaviour against the rights involved in any management strategy proposed. The following example illustrates this point.

Balancing the Rights in the Risk & the Rights in the Strategy: Case Example

Melissa is a Service User with a learning disability who seriously self harms and leaves her package of care without support. When she leaves her carers, Melissa engages in unprotected sex with strangers. She has tried to take her own life on previous occasions when alone in the community. Melissa is on a section of the Mental Health Act.

Staff have placed restrictors on a Melissa's window to prevent her from leaving her package of care. This interferes with Melissa's right to liberty, a limited right, to protect her absolute right to life which would be compromised by not employing a strategy. In this instance, staff are attempting to balance Melissa's right to life against her right to liberty. As Melissa is under a section of Mental Health Act her right to liberty can legally be restricted.

You may also be involved in trying to balance the Service User's rights against those of other people in their life, as illustrated below.

Balancing the *Service User's* Rights against those of Others: Case Example

Lorna is 25 and lives in a shared house for people with learning disabilities. George also lives in the house, is of the same age, and has become attracted to Lorna. George has begun to express his feelings to Lorna and on occasion has tried to kiss her when they are alone. George has also tried to enter Lorna's bedroom and when asked by the staff team has explained that he 'just wants to watch TV with her'. Staff are concerned about these events, but are reluctant to intervene as they do not want to breach George's right to a private life. However, staff are aware that Laura's anxiety over George's behaviour and that this raises her right to a private life and their duty to protect this.

Staff realised a balanced decision needed to be made, and any intervention would need to balance the rights of George and Laura.

2 Research and Practice

2.1 Introduction

This section examines the current state of research into risk assessment and its links to current practice. The material presented is part of an analysis of literature that has informed our work.

2.2 Current Difficulties

One of the main difficulties in this area is that much of the research related to risk assessment has been carried out with violent or other criminal offenders and people with mental health problems. These findings cannot therefore automatically be transposed to the field of learning disability.

Johnson's (2002) review identified that there was no research evidence to support the assumption that existing learning disability assessment and management frameworks provide adequate information when determining future re-offending and devising risk management plans. He also stated that adaptations to theoretical models in non-learning disabled populations have been applied but not validated for those with learning disabilities. It was highlighted that the published evidence for existing clinical practice in forensic risk assessment of offenders with learning disabilities is small (Johnson, 2002).

Three serious deficits in the field of risk assessment have been identified.

- Firstly, research and practice were unconnected. Webster and Eaves (1995) stated that research on the prediction of violence needed to be integrated into clinical assessment. Rice *et al.* (1991) reported how only a small sample of clinicians were using standardised assessment tools. The reasons for this were multiple, including that many instruments were designed for research rather than clinical work, required expensive training, did not inform clinical decision-making, were time-consuming to administer, and could be used as part of routine clinical practice.
- Secondly, assessment validation research was almost exclusively concerned with psychiatric offenders or patients, and not with those with learning disabilities. Mossman (1994) added that there was evidence that clinical judgement was a poor predictor of future offending, with no obvious advantages over actuarial methods or assessments by non-clinical care staff.
- Thirdly, the accuracy of any systematic method of risk assessment for those with learning disabilities, whether short or long term, in inpatient or community settings, or for particular categories of prisoners or Service Users, had not yet been established.

Reporting of Risk

Each stage of risk assessment is influenced by each individual's interpretation of events, their perspectives on the individual involved, and the role they fulfil. Identical incidents may be interpreted differently by different professionals and by those with varying degrees of knowledge, experience and skills. Studies by Kiernan and Alborz (1991), Lyall *et al.* (1995) and Clare and Murphy (1998) identified that where there is contact between an alleged offender and learning disability services, offending behaviour is underreported, even for offences as serious as rape. Staff attitudes towards offending, and therefore its prevalence may vary according to service setting (Wilson *et al.*, 1996). It has been suggested that people who work with those with a learning disability have a different body of knowledge and experience compared to those who work with offenders or offenders with mental health difficulties (Johnson, 2002).

Assessment of risk must be informed by evidence relating to the prevalence and nature of the risks being considered. This is particularly difficult when the person has a learning disability (Turner, 2000). Maden (1996) stated that the process of risk assessment and management was that of data collection, recording, interpretation, communication and implementation of a risk reduction plan. This is not always carried out.

Prediction of Risk

Turner (1996) identified that it is extremely difficult to predict the future violent acts of individuals with mental health difficulties. Despite our inability to make these predictions well, such predictions are made routinely, regardless of the evidence. Also, a variety of justice and mental health system are required to make these predictions. In 2000, Turner reviewed the learning disability literature and suggested that much of the evidence relating to the prevalence and pattern of offending by individuals with a learning disability is thwarted with methodological weaknesses. Turner concluded that assessors should be aware that *"the knowledge base for risk assessment is at best partial and at worst misleading [which] should underpin the process of assessment, management and review"* (Turner, 2000).

Therefore, processes in which judgements about risk can be made more effectively and efficiently remain necessary. Department of Health (DoH) guidance (1994) on the assessment of offenders with mental health difficulties suggests that assessment should be based on:

- evidence and clinical opinion on the past history of the patient;
- self-reporting of the patient at interview;
- observation of her or his behaviour and mental state;
- discrepancies between reports and observation;

- and statistics derived from studies of related cases and prediction indicators derived from research.

2.3 Clinical Versus Actuarial Judgements

Following deinstitutionalisation there has been a general perception that more people with a learning disability are at a greater risk of offending (Turner, 2000). This has increased forensic interest into researching the clinical and actuarial data for this population. In his review, Turner (2000) noted assessment tools often combine actuarial and clinical data; increasingly they also include the dynamic nature of risk, and situational and accidental triggers. Whilst the actuarial approach compares individuals statistically with characteristics of groups with a known negative outcome, the clinical approach considers the individual's medical condition, symptoms and treatment. The actuarial approach is rooted in probability theory borrowed from the field of insurance risk assessment. It has recently been applied in the field of social welfare. Actuarial predictors developed from prison or psychiatric population studies may also be invalid for learning disabled populations. It is important to note that of the research available, little or account is taken of participants' gender, sexuality, ethnicity or cultural background.

The lack of actuarial data for the learning disabled population has allowed for the predominance of clinical models of assessment to become the norm, although, as Johnson (2002) documented, few have been described in the public domain. The clinical approach is a process in which decisions are reliant on the subjective state and experience of the clinician/professional, each stage is subject to their bias, which may confound the interpretation of each incident (Johnson, 2002). Clinical judgement has previously been shown to be extremely poor in relation to risk prediction (Lindsay & Beail, 2004). McNiel *et al.* (2000) highlighted that when there was agreement between professionals regarding the prediction of risk, the accuracy of that prediction was significantly increased.

Clinical assessment in forensic psychiatry attempts to answer the legal, public and administrators' question "*Will s/he do it again?*" (Prins, 1990). Pollock and Webster (1990) argued that it was impossible to give a definitive answer since it is based on the assumption that dangerousness is a stable and consistent quality existing within the individual. Litwack (1993) noted it is preferable to ask what are the psychological, social and biological factors influencing behaviour, and thus the implications for future behaviour and for change. They note that different actuarial factors are relevant for different types of risk of outcome behaviours. They say that situational factors (e.g. heavy drinking or non compliance with medication) need to be recognised as potential modifiers of risk, and be incorporated into assessment reports. Such factors may be wholly unpredictable, while others (e.g. family stress) may be open to intervention.

In general, researchers agree that importance should be ascribed to actuarial considerations. It has been argued (Webster and Eaves, 1995; Litwack *et al.*, 1993; Johnson, 2002) that the prediction of risk should consist of two parts;

- An actuarial approach in which pertinent information is extracted from historical records, however clinicians should remain aware of the biases within these
- A clinical component which would, in some cases, allow for variation from the statistically-derived probabilities. Risk assessment should combine actuarial and clinical approaches in a structured approach to clinical judgement (Lindsay & Beail, 2004).

2.4 What's Important in Risk Assessment?

Involving the Person in the Process

Risk assessment should not be a process which is '*done to*' a person. Rather, professionals should strive to ensure that the process adopts a collaborative (i.e. a non-didactic) approach; collaborative in the sense that the professionals work, whenever possible, *in collaboration* with the individual with whom the assessment is concerned. In other words, where possible, any perceived risk is in fact 'openly and explicitly acknowledged and managed' (Alaszewski & Alaszewski, 2005). Furthermore, where possible, risk assessment should be framed within a person-centred model of practice, incorporating the underlying human rights principles of Fairness, Respect, Equality, Dignity, and Autonomy (FREDA).

In achieving this aim, organisational support systems need to adopt a person-centred approach to risk assessment which emphasises an individual's gender, sexuality, ethnicity, and cultural background and attends to health inequalities. Moreover, psychological, social and biological factors also require consideration and implementation into any risk assessment programme. Indeed, judgements of risk 'need to be about values, and [in person-centred risk assessment] primacy should be given to the person at the centre of the planning system' (Alaszewski and Alaszewski, 2005).

Consequently, the principal objective of a Human Rights-based approach for risk assessment is to enable decisions to be collaboratively arrived upon at each stage, where the individual is as thoroughly immersed and involved in the decision tree as possible. To enable facilitation of this process, where possible, teams should consider aspects such as ethics, and employ ethical decision-making team meetings regularly. Such bodies should embrace the process of decision-making and examine how the quality of decision-making can be improved upon.

Guidance on how to make information easier for the individual for whom the risk assessment concerns needs to be employed throughout the process, such as up-to-date literature on accessible information (see Rogers and Namaganda, 2005; Ward & Townsley, 2005). Moreover, such accessible information needs to be accessible not only at the level of 'easy-info', but also be produced with issues of diversity in mind.

In keeping with the recommendations regarding collaborative approaches, organisational systems should endeavour to produce (accessible) step-by-step guides to each (human rights-driven) risk assessment for the person the assessment concerns. This could be achieved, for example, by producing a 'Your Guide to Your Risk Assessment – What We Will Do' document. Such a guide would explain what the person can expect at each stage of the process, and how they can contribute in partnership with the stakeholders, in order to produce as person-centred an assessment as is possible.

People with Learning Disabilities are believed to have low levels of awareness of their own human rights (JCHR Report, 2007). As part of the process of assessment clinicians should ensure that Service Users have accessible information about their human rights. A number of 'easy read' human rights guides are included in the reference and further resources section of this document.

Reflective Practice

It is important in the process of risk assessment for organisations to avoid becoming iatrogenic systems, where problems are exacerbated *within* the system *by* the system itself. In not being reflective, we build a system that feeds into and confirms the identity of the person who challenges as a person who ultimately is powerless, unworthy of a voice, and dangerous. Clearly, such an outcome is unlikely to be a moral, fair or just reflection of that individual.

To avoid such an outcome, systems can be 'broken down' and considered at different levels. For example, staff characteristics should be reflected upon at multiple stages when collating a complex case care pathway and a top-down, bottom-up approach should be taken. Clinicians completing the care pathway should be reflective of the position and stance they take when collating the information, whilst staff on the coalface should be reflective of their position and their feelings when completing incident forms, particularly with regards to, for example, discrimination (or risk of discriminatory practices). At every point in the process there should be a space for reflection, in which people ask themselves:

1. How could I have done things differently?
2. Have I acted in a fair and just manner (incorporating the FREDA principles outlined above)?, and
3. Is this a true reflection of the person being written about?

Clinicians must at all times ensure that they work with teams in a non-judgemental, non-blaming manner. Systemic models of reflective practice are important here, both for the members of the team to adopt, but, in addition, also for the clinicians working and supporting those teams. Indeed, it is vital that clinicians monitor their own working practice throughout the process, to ensure that they deliver a service to the team concerned that is in no way judgemental, nor in any way blaming.

At the organisational level, it is vital that Learning Disability services continue to strive to meet the needs of those whose behaviour presents challenges to those services themselves. Indeed, recent reports at national level (see Mansell, 2007) suggest that it is the services for people who display 'challenging behaviours' that are often most at risk of breaking down. Such outcomes present further financial costs to services, as often when such service provision breaks down at the local level, expensive out-of-area placements are commissioned. Such an outcome not only places financial burden on NHS providers, but, more importantly, can be seen to violate the person's human rights. People placed out-of-area become excluded from mainstream community services, are at risk of experiencing reduced (or indeed cessation) of contact with family and friendship networks, and possibly therefore serve to exacerbate behaviours deemed 'challenging' to those services *originally*.

In line with 'Valuing People' (2001) and 'Valuing People Now' (2007), the Mansell Reports (Mansell, 1993; Mansell, 2007) go on to outline ways in which people with learning disabilities can continue to have their rights, independence, inclusion and choices recognised by the services at local level to avoid such outcomes. Consequently, in aiming to implement such recommendations, the creation of ethical decision making teams should be employed, with organisational support systems mapped-out and provided-for to ensure such models are adhered to. Again, such models should be based on recommendations made by Mansell (2007) for both the commissioning and implementation of such services.

Mediator Analysis

The principle of non-discrimination is one of the key areas of concern within a human rights based approach and it is vital that staff are aware of how their own biases may, however unwittingly, lay the basis for discrimination.

When analysing documents written by another person, the perspective of the person who has made the inscription must be considered. We must have an understanding of the staff member's characteristics in order to begin to recognise the meaning they may have attributed to any given situation. For example, an experienced staff member may trivialise an incident that an inexperienced staff member may have deemed serious, or the staff member and the individual may clash on an interpersonal level, and therefore the incident may be documented in a way that reflects this. The knowledge, meanings and language different people use affect their observations and narratives of events. Consequently, how these events are interpreted and documented will affect intervention, and moreover affect any decisions that will concern the person's reputation and future choices.

How staff respond to episodes of challenging behaviour is dependent on their beliefs and the strategies that they employ when attempting to assign understanding to such behaviour. For example, a study by Grey, McClean and Barnes-Holme (2002) identified the potential for staff responses to intensify the situation. These authors highlighted how the power and knowledge of professionals served them in their role. For example, staff

may implement chemical or behavioural strategies to change an individual's behaviour, yet in some cases this may be done in the absence of a thorough understanding for the reasons for such behaviours.

How staff teams respond to a person's challenges, and the support strategies that they subsequently employ to remediate them, may act as barriers for those in their care, because those Service Users might not be accepted by the wider society, which in turn will likely limit these persons' opportunities to integrate into the society (LaVigna and Willis, 1995). Moreover, studies such as Jones and Stanfert-Kroese (2006) have also highlighted Service Users views on 'controlling' techniques such as restraint procedures, and how such procedures can violate personal space (Topping-Morris, 1995), can threaten injury to both Service Users and staff (Hill and Spreat, 1987), and can result in devalued images of the Service User (Middlewick, 2000). Furthermore, research has also found that in some instances Service Users have questioned whether restraint techniques do indeed achieve the 'desired' effect (i.e. to 'calm' a person down), and moreover whether staff actually enjoy performing restraint (Jones and Stanfert-Kroese, 2006). Consequently, in a human rights-driven approach, it is essential to consider whether such physical intervention techniques have a legitimate aim, are lawful, necessary, and proportionate.

LaVigna and Willis (1995) suggested that staff teams' support strategies need to be evaluated not only in terms of the durability and generalization of their effects, but also with regards to their social, clinical and educational validity, whilst being mindful of any 'side-effects' produced. In short, LaVigna and Willis (1995) suggest that the focus of such interventions should *not* simply be the elimination of target events, but more importantly should strive to 'contribute to the overall quality of the person's life'. To achieve such a goal, therefore, and consequently to support individuals to have increased access, opportunity, competency, choice, control, and to develop nurturing and mutually gratifying relationships, multidisciplinary (and multiagency) teams need to work in constantly collaborative ways with each other.

LaVigna and Willis (1995) argue that achieving such a 'complex array of...outcomes' means it is often not possible to adopt any one sole strategy, and that desired outcomes often require '*multi-element support plans...whose components...address the full range of outcome requirements.*' These authors, therefore, have provided a model, "Breaking the Barrier", which was set out in an attempt to overcome these obstacles. Their model places heavy emphasis on multidisciplinary teamwork when attempting to overcome any barriers to social and community integration, and identify mediator analyses as crucial to any success in achieving these aims. Such a model, where possible they argue, should involve a collaborative, pro-active approach to individual care planning, incorporating both proactive strategies (e.g. ecological changes; positive programming; focussed support) alongside agreed, legitimate, lawful, proportionate reactive strategies. Furthermore, LaVigna and Willis (1995) stress the importance of teamwork in producing desired outcomes for any support plan, in that all team members should implement plans collaboratively with the Service User, in as full and consistent a manner as possible.

Staff Characteristics

Roy (2000) described the key attributes of a good care coordinator; these are also applicable to clinicians completing a comprehensive risk plan. Attributes include;

- A good understanding of the mental health needs of individuals with learning disabilities
- Knowledge of the Service User and his/her family
- An awareness of the individual's race, gender, social and cultural context, etc.
- Knowledge of and communication with all agencies and teams who have a role in the individual's life

Additionally, recent guidelines from the Department of Health (DoH, 2007) with regards to best practice in risk management suggest the following essentials for staff when working with Service Users and carers:

1. That all staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in ethnicity, faith, age, gender, disability and sexual orientation, and
2. That risk management must always be based on awareness of the capacity for the Service User's risk level to change over time, and recognition that each Service User requires a consistent and individualised approach.

Factors in Risk Assessment

Department of Health guidance (Department of Health, HSG\94\27, 1994) on the discharge of offenders suggests the following issues and sources were important in risk assessment:

- Past history of the person.
- Self-reporting of the person at interview.
- Observation of the behaviour and mental state of the person.
- Discrepancies between what is reported and what is observed.
- Statistics derived from studies of related cases.
- Prediction indicators derived from research pertinent to those with learning disabilities.

Risk assessment with people with learning disability has much the same purpose and content, as Clare (1993) highlighted, the aim of assessment was to clarify the factors contributing to the aetiology and maintenance of the individual's offending. All of the above issues and attributes are important when completing a comprehensive risk assessment.

Recent guidelines developed by the Department of Health (2007; see above) have suggested that:

- Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual Service User and their social context, knowledge of the Service User's own experience, and clinical judgment.

Moreover, the guidelines state that such practice incorporates the following key fundamental requirements;

- That positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.
- That risk management should be conducted in a spirit of collaboration and based on a relationship between the Service User and their carers that is as trusting as possible.
- That risk management must be built on a recognition of the Service User's strengths, and
- That risk management requires an organisational strategy as well as efforts by the individual practitioner.

The guidelines go on to suggest the following basic ideas in risk management:

- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
- Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
- Knowledge and understanding of legislation (e.g. mental health legislation) is an important component of risk management.
- The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the Service User in response to crisis.

Finally, the guidelines offer the following points as examples of best practice in managing risk:

- That where suitable tools are available, risk management should be based on assessment using the structured clinical judgment approach, and
- That risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a Service User.

Webster and Eaves (1995) identified that the circumstances in which an assessment occurred should also be considered. They argue that although most authorities agree that assessing dangerousness and risk of violence is a difficult task, they have not attended to the basic task of ensuring that conditions for evaluation are made as near ideal as possible. This includes ensuring that assessors have sufficient time and resources to complete the assessment.

Risk assessments must be thorough and systematic. Assessors should acquaint themselves fully with the relevant aspects of a file before rendering opinion. Predictions about risk should be in specific terms for specific periods. They should not be framed in terms of yes/no, but in terms of the probability of certain behaviours in certain circumstances.

Webster and Eaves (1995) break down the process of risk assessment into three phases:

- **Phase 1**
This is concerned with the orderly and detailed review and cross-checking of historical and statistical variables. We would add that systemic issues and context are cross referenced with the appropriate documents and clinicians.
- **Phase 2**
This is taken up with a consideration of present clinical issues, including estimating how particular kinds of symptomatology might be related to potential for violent conduct.
- **Phase 3**
This centres on forecasting how the individual might respond, given the existence of a comprehensive plan, and suitable physical, social, and vocational support. This part of the evaluation is influenced not so much by files or characteristics of the individual, but on the orchestration of social support systems.

Recently, the Department of Health (DoH, 2007) have recommended the following requirements for both individual and team working practice when considering risk assessment and management:

- Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.
- That all staff involved in risk management should receive relevant training, which should be updated at least every three years, and
- That a risk management plan is only as good as the time and effort put into communicating its findings to others.

Positive Risk Management

Moreover, the Department of Health (2007) guidelines emphasise Positive Risk Management, which is defined as:

“Being aware that risk can never be completely eliminated and aware that management plans inevitably have to include decisions that carry some risk”.

And that:

“This should be explicit in the decision-making process, and should be discussed openly with the Service User”

Positive risk management therefore includes:

- Working with the Service User to identify what is likely to work;
- Paying attention to the views of carers and others around the service user when deciding a plan of action;
- Weighing up the potential benefits and harms of choosing one action over another;
- Being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- Being clear to all involved about the potential benefits and the potential risks;
- Developing plans and actions that support the positive potentials and priorities stated by the Service User, and minimise the risks to the Service User or others;
- Ensuring that the Service User, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans;

And

- Using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome.

2.5 The Service Context of Assessment

Assessing a person with a learning disability may present unique difficulties. Clare (1993) lists these potential problems as:

- Poor memory.
- Acquiescence and suggestibility.
- Reading problems.
- Poor understanding of complex language and concepts.
- Responding inappropriately to questions due to poor understanding.

Such problems may be minimised by use of open, general questions, and back-up checks using audio tapes. Standard measures may be adaptable to pictorial form, and response scales simplified. Responses to fictionalised vignettes are another method. Service Users may need training in order to understand the significance of such cues, particularly when used with physiological measures. The effect of medication may also mask responses and make assessment more difficult.

Clare and Murphy (1993) also point out that consent is required unless the patient is under a Mental Health Act (2007) detention order. However the Mental Capacity Act (2005) provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this. The Mental Capacity Act is underpinned by the following five key principles;

- **A presumption of capacity** - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- **The right for individuals to be supported to make their own decisions** - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the **right to make what might be seen as eccentric or unwise decisions**;
- **Best interests** – anything done for or on behalf of people without capacity must be in their best interests; and

- Least restrictive intervention – anything done for or on behalf of people without capacity should be the **least restrictive of their basic rights and freedoms**

Issues may arise with regards to confidentiality. However, through the development of the Mental Capacity Act it is now possible to identify a framework for minimising risk and service response if re-offending occurs is possible. Clare and Murphy (1993) go on to list the preliminary requirements of assessment;

- Clarify agency roles.
- Clarify the nature of the behaviour and action planned or taken as a result.
- Collation of evidence.
- Confidentiality issues discussed.
- Non-threatening but safe interview setting.
- Safeguards regarding repetition during interview.
- Named contact in each agency established.
- Case manager identified.
- Key worker's involvement.
- Progress meetings arranged.

Clare and Murphy (1993) state that while mainstream forensic assessment is cognitive-behavioural, there is a lack of evidence for the efficacy of this approach for people with learning disabilities. Therefore, broad based assessment is needed, using self-report, reports from others, behavioural observations, and archival material. Given the predominance of mild disabilities among offenders, self-report should be possible, but may require additional resources (e.g. pictorial aids). Self-report measures developed in mainstream forensic work are generally unsuitable because they demand reading skills and/or use concepts, rating scales etc., which are inaccessible.

2.6 The Importance of Life Events

The importance of understanding the meaning of aspects of behaviour, or their *function*, particularly with regards to behaviours which ultimately become labelled 'challenging', is well documented within the literature pertaining to individuals with learning disabilities (see Emerson, 2001). Moreover, understanding these behaviours as means of communication has also often been addressed within the literature (Emerson and Bromley, 1995). As previously discussed, such behaviours have often evolved over many years, and those who display such behaviours have lives often bereft of meaningful relationships, power, a sense of safety and well-being, or value and worth, relevant skills and knowledge, and things to look forward to. Minimising or ignoring such needs in human services settings, therefore, can result in persons becoming depressed, isolated, helpless, insecure, and sometimes persistent 'rule'-breakers (Pitonyak, 2001).

It is important therefore to view evolved behaviours within this context; as such an approach can foster and encourage the development of sound relationships with these

persons, and encourage team members to concentrate more fully on working with the person, as opposed to focussing solely on those behaviours considered problematic. Moreover, authors have suggested that such behaviours derive initially from the persons' attempts to problem-solve or sort a problem out; in other words their best attempt at finding a solution to a problem (Pitonyak, 2001). Over time, therefore, such an initial attempt at solution ultimately evolves and becomes labelled a 'challenging' behaviour.

By employing such a model to our practice, the importance of a person's life events inevitably become more salient to all aspects when assessing for any level of risk. Researchers generally agree on the importance of studying a person's records thoroughly and constructing an accurate history. Monahan (1981) reminds us that;

"If there is one finding that overshadows all others in the area of prediction, it is that the probability of future crime increases with each prior criminal act"

As with offenders who have mental health difficulties, there is a consensus in the literature that previous offending is a powerful predictor of future offending with people who have a learning disability. Payne *et al.* (1974) found that offenders with a conviction prior to the offence that led to the current hospital order were twice as likely to be convicted again during the 2 years after discharge than those with no such previous offence. Those with six or more previous convictions were four times more likely to be re-convicted than those with no previous offence. In support of this, Day (1993) found that the risk of recidivism within the learning disabled population is highest during the year immediately following discharge. Gibbens and Robertson (1983) carried out a multiple-regression analysis of the factors predisposing to subsequent offences in their cohort and found that for all categories the best single predictor of reconviction was the number of previous court appearances; however it is not clear whether age, gender, sexuality, race, etc was controlled for. Both Payne *et al.* and Gibbens and Robertson identified that learning disabled and offenders with psychopathic symptoms were more likely to be re-convicted than individuals with mental health difficulties.

Day (1990) suggests the following pattern. Firstly, while one offence is not necessarily predictive of future offending behaviour, a history of previous convictions is strongly predictive of future failure. Secondly, that the chance of re-offending and reconviction among those under hospital orders is high, and increases in proportion to length of follow-up. Thirdly, very few re-offenders commit serious offences. Fourthly, that longer institutional care is associated with lower re-offending rates, perhaps showing that prolonged socialisation is effective, although it may be that there is an age effect operating.

2.7 Actuarial Characteristics of People with Learning Disabilities who Offend

Logan (2007), in her contribution to the debate on "Implementing best practice in managing risk in England" highlighted that no risk assessment should be based solely on actuarial assessment. Rather any such assessment should combine both clinical and

actuarial assessment, and we would add, should be underpinned by a human rights based approach. Thus, when undertaking an analysis of the actuarial characteristics, the person's human rights should be considered at all times.

Whilst there has been much work in the area of offenders in general, and those with mental health difficulties in particular, there is not a great deal in the area of learning disability. This is partly because learning disability tends to be administratively defined and biased to those with moderate to profound disabilities. The propensity to offending behaviour however is more likely to be higher among those with mild or borderline disabilities.

Clare and Murphy (1998) have highlighted that the term offender is often used in relation to people diagnosed with a learning disability, specifically when considering challenging behaviour, which could constitute a criminal act. In English law, a behaviour or an act and its consequences (the 'actus reus') are not considered to be criminal act unless combined with 'guilty state of mind' ('mens rea'). 'Mens rea' refers to the mental element of the offence and comprises of four classes: intention; knowledge; recklessness; negligence, along with the presence or absence of foresight. Holland *et al.* (2002) acknowledge that this area is blurred in terms of what constitutes a challenging behaviour and what is an offence.

Evidence of challenging behaviour provided by Emerson *et al.* (2001) identified that;

- Challenging behaviours were demonstrated by between 10-15% of individuals with a learning disability who were in contact with educational, health and/or social services.
- The most common forms of challenging behaviours were described as "other" (recorded by 9-12% of all people questioned), aggression (7%), destructive behaviour (4-5%) and self-injurious behaviour (4%).
- The majority of people identified as having challenging behaviour demonstrated two or more of the above behaviours.
- Approximately two thirds of those identified were male
- Almost two thirds of those identified were adolescents or young adults
- Approximately half of those identified as illustrating more demanding challenging behaviours lived with their families
- Those who demonstrated more demanding challenging behaviour tended to need more assistance in self care and have restricted expressive and receptive communication.

Quinsey (2004) has highlighted the now considerable research into the actuarial assessment of long-term risk in offending populations. However, little of this research has been used to explore offenders who have a learning disability. In recent years, research has begun to explore both the characteristics and prevalence of offenders with a learning disability.

Holland *et al.*'s (2002) review suggests that there are two distinct groups of people with learning disability who offend; the first is described as a broad group of people who are intellectually and socially disadvantaged who may not be known or included in learning disability services. This group is characterised by; a higher ratio of males to females, mental illness and substance misuse and history of risk taking, impulsivity and social exclusion. The second group is usually known to services and comprises of people who exhibit challenging behaviour, which may be perceived as offending. The following characteristics have been identified (Simpson & Hogg, 2001, Holland *et al.*, 2002) that indicate if an individual is at greater risk of offending, many of which overlap the evidence provided by Emerson *et al.* (2001) for those displaying challenging behaviours.

Simpson and Hogg (2001) and Holland *et al.* (2002) reviewed the evidence for people with learning disabilities who offended. They identified the following characteristics that indicated if an individual was at a greater risk of offending, many of which overlap the evidence provided by Emerson *et al.* (2001) for those who display challenging behaviours.

- Men
- Younger age groups
- Less severe learning disability
- Mental health difficulties
- Previous offending
- Behavioural problems since childhood
- Psychosocial disadvantage
- Lower social class
- Unemployment

Demetral (1994) concluded that the degree of social isolation perceived by the offender was highly correlated with the probability of offending and re-offending. He reported that 87% of sex offenders with had a learning disability, who had been referred to an outpatient treatment program run by a non-profit organisation were not in any day care or employment programme. Adding that 84% of these individuals had been physically abused and 66% sexually abused in the past.

In West and Farrington's (1977) longitudinal study of boys growing up in South London, both low intelligence and educational failure were predictive of offending. It is not surprising that offender populations tend to score lower on intelligence tests than the general population. Whilst there may be important educational needs in many offenders, significant learning disability (that which needs special services) is much less common.

Studies based in courts and hospitals have shown that learning disabilities have a specific association with sexual offending. Possible explanations include lack of sexual knowledge, deficiencies in social skills, and general disinhibition associated with some individuals with a learning disability. Rejection, and the denial of ordinary sexual outlets, may also play a part. It is important to disentangle these factors when attempting treatment and risk management.

Arson has also been associated with learning disability. This offence may be seen as a form of violence or criminal damage which is adopted by those who are otherwise powerless, in that a small action can cause enormous damage. Arson is also more common in female offenders, probably for similar reasons.

Most offending by those with learning disabilities is theft, as is the case with offenders from the general population. Due to their learning disabilities these individuals may be caught more easily. Management is often concerned with circumstantial factors, including accommodation, substance misuse and protection from exploitation. The latter is a particular problem within prison, and is a powerful argument for diversion.

Problems of definition and with the limitations of statistical evidence mean that it is difficult to predict which behaviours individuals with learning disabilities are at risk of taking. Riding Swann & Swann (2005) identified that studies over the past 20 years suggested that sexual misconduct may be more common (however less serious), alcohol and drug related problems less common and physical violence offences are less common, at least among men, compared with the general population. The most common offences are petty theft, burglary and vandalism. Some studies suggest that arson is over-represented among males with learning disabilities. However the use of different definitions of offending and learning disability in many studies has made interpretation difficult. Simpson and Hogg (2001) concluded that there was no convincing evidence to suggest that individuals with learning disabilities were more likely to commit any particular offence than anyone else.

Historical factors are of particular importance as several studies have identified that previous behaviour is a good indicator of future behaviour rates (Riding *et al.*, 2005). Different offences have different recidivism rates. Holland *et al.* (2002) suggested that there may be some similarities in predictors of offending amongst those with learning disabilities and those with mental health difficulties. They went on to add that the level and nature of offending amongst women has largely been neglected, but there is some evidence that service and legal responses to offending may be different for women than for men, i.e. the 'gender lens'.

Women with a Learning Disability & Offending

The evidence base relating to female offenders with a learning disability is sparse (Kendall 2004). Much of the research (Lindsay *et al.*, 2004; Holland, Clare & Mukhopadhyay, 2002) that has been carried out focuses specifically on the characteristics of female offenders in comparison to their male counterparts. Authors such as Lindsay *et*

al. (2004) recognise the paucity of research and have attempted to provide a “reasonable picture” (Lindsay *et al.*, 2004) of women with learning disabilities who offend.

Within their study, Lindsay *et al.* (2004) identified that the female offenders within their study showed similar characteristics to their male counterparts. However, they noted higher levels of sexual abuse, higher levels of mental illness and lower levels of re-offending. More specifically Lindsay *et al.* (2004) noted that mental illness appeared to be an intervening variable in the female’s offending behaviour, and posit that such behaviour should reduce if the mental illness is placed at the focus of intervention. These findings have been replicated by Hayes (2007).

One explanation for the increased rates of psychiatric disorder may relate to the tendency to pathologise the experiences of female offenders in general since they have violated both the law and challenged what is culturally expected of them as a female (Kendall, 2004). Hence females who have offended are perceived as ‘doubly deviant’.

Crawford has highlighted that women with learning disabilities in secure services are considered to be an “especially challenging group” (Crawford, 2002) when compared to non disabled women in secure services. Kendall (2004), has stated that female offenders with a learning disability are perceived to be ‘triply deviant’ by virtue of the diagnosis of learning disability.

Holland *et al.* (2002) also highlighted that whilst those from different ethnic minorities may be over represented among defendants and prisoners with learning disabilities in studies from other countries; there is little evidence for this issue in the UK.

2.8 Actuarial / Background Factors Related to Violence

Webster and Eaves (1995) identify a number of factors relating to the background of violent offenders in general. Many of these overlap with the research summarised by Clare and Murphy. Webster and Eaves also identify what may be ‘protective characteristics’ and go into more detail about how background factors may operate to increase or decrease risk. Some of the factors they examine are:

Relationship Stability

It is generally found that social support works to protect against violent crime. Marriage, civil partnership or stability in some form of close relationship in particular seems to serve as a “protective factor”. It is worth considering how these factors may affect a person with a learning disability:

Employment Stability

General statistics on criminal recidivism show a link between income level and conduct on parole.

Alcohol or Drug Abuse

Clinicians have little difficulty recognising, on the basis of experience, the link between alcohol and drug abuse and violent conduct. Swanson (1994) has recently reported that, in his large-scale, multi-sided Epidemiological Catchment Area (ECA) project, having a substance abuse diagnosed yielded much stronger associations with violence than did having a mental disorder

Mental Health Difficulties

It can be expected that, relative to the general population, individuals experiencing psychosis, or at least certain symptoms of it in particular stages, would have raised potential for violence

Early Childhood Experiences (at Home and School)

This variable includes consideration of both academic ability and accomplishments as well as classroom conduct and general adjustment to school. Assessors will be interested in progress through the grades, marks obtained, reasons for leaving school, truancy and the like. These authors found that being separated from parents before age 16 also yielded a significant correlation with later violent outcome.

2.9 Actuarial / Research Data on Suicide

There have been a large number of studies on the background characteristics of those who commit suicide. These have resulted in a well defined list of factors associated with a higher risk of suicide. Strathdee (1998) summarises this data as follows.

The suicide rate in men is twice that among women, and in both sexes the rate rises with age. In recent years, suicide rates among men have risen in the U.K., especially young men. From this, some researchers have concluded that as there has been no increase in mental health difficulties, (the most common aetiology for suicide), it follows that unemployment is a significant factor.

Depression is the most common mental health difficulty associated with suicide (Strathdee, 1998). The Health of the Nation handbook delineates the order of risk for the three other groups which carry high mortality rates;

- affective disorder 15%
- "personality disorder" 15%
- alcohol dependent 15%
- psychosis 10%

Previous deliberate self-harm or suicidal behaviour is a constant predictor of future attempts. Research shows a suicide rate of 1% per annum following suicide attempts. After 10 years, 11% of 484 attempted suicides in one study had died by suicide, the period of risk being highest immediately after the first attempt.

Most people who take their own lives have had contact with their doctor within weeks or even days of their death. In a study of 47 suicides, 16 failed suicides and 24 attempted suicides of people who jumped from a high bridge over 15 years, Cantor *et al.*, (1989) found that one-third of all incidents occurred while the individuals were in-patients and another one-third as outpatients. Another study likewise found that 91% of deaths by overdose and 71% of suicides by other means had been under the care of a doctor in the previous 6 months. Patients who discharge themselves against medical advice are also at particular risk.

2.10 Clinical Variables

In the Historical Clinical Risk-20 Scheme (HCR-20), Webster and Eaves identify a number of clinical variables that have an effect on risk. These are:

Insight

This is defined as reasonable understanding and evaluation of one's own mental processes, reactions, abilities; and self knowledge. There should be ample scope in an assessment to determine the extent to which the individual perceives himself or herself to be dangerous, angry, or out-of-control.

It may be useful to think of insight in terms of levels. A person presenting with serious psychotic symptoms may follow direction and accept medication largely because of respect or liking for the clinician. But there may be little self-understanding or self-appreciation of his or her condition. At another level, there may be recognition of some problems but this "insight" may be accompanied by a belief that the problems do not apply fully to him or her. The individual may conform to a treatment program more to escape notice than to achieve recovery. At yet another level, the individual may recognise that he or she has a serious mental disorder and, for example, it is the voices which are giving instructions. But the same person may feel that the delusions are to be taken seriously and be unable to provide distance from this material. Moving to a yet higher level, the person may recognise quite well the fact that she or he has an illness and that it gives rise to false sensations and perceptions.

Within a human rights approach it would be positive to identify processes that enable insight to be achieved. An example of this is the "*Understanding Voices and Disturbing Beliefs*" guide produced by Newcastle, North Tyneside and Northumberland Mental Health Trust. This shows how people can identify and develop positive responses to hearing voices. Materials specifically aimed at People with a Learning Disability have been produced by Mersey Care NHS trust to enable people understand aspects of mental health and taking medication '*Getting Better: Keeping your Mind Healthy*' and '*Getting Better; Taking My Medicines*' (Whitehead & Toker-Lester, 2002). It would also be appropriate to identify any service barriers to achieving insight. For example, are there educational materials produced in a number of languages or are there easy read versions

of the materials? Throughout this process the clinician can work alongside the person to identify the level of insight and also look at the external barriers to achieving insight.

Attitude

This is defined as an enduring, learned predisposition to behave in a consistent way toward a given class of objects; a persistent mental and / or neural state of readiness to react to a certain object or class of objects, not as they are but as they are conceived to be. Attitude is one of many terms that refer to an aspect of personality inferred to account for persistent and consistent behaviour toward a family of related situations or objects (English & English, 1958).

It is important in the assessment to determine the extent to which the individual's pervasive attitudes are pro or anti-social. There needs to be some exploration of the person's current attitudes towards other people and to agencies and institutions. Attitude toward the law and other authority is obviously important. It is also useful to gain some general idea of the person's overall state of optimism or pessimism about his or her future.

The clinician should be attentive to the Service User's attitude toward their own risk behaviour. Some individuals will be genuinely sorrowful and regretful about their behaviour, others may minimise and deny. The assessor must be at pains to discern remorselessness, callousness, lack of empathy and the extent to which these apply to the Service User's current experience.

From a human rights perspective it is important that the source of a person's attitude is explored. This can be done by speaking with the person about their life history and what kind of experiences have led to the person's current attitude towards other people and organisations. It is important to ascertain how the person perceives other agencies and institutions. It may also include their perception of professionals and what the professional's role is likely to be.

For People with a Learning Disability there has been an historical perception of abuse and mistreatment by professionals and institutions. This perception may make it difficult for the person to engage in the risk assessment process and may require addressing whilst formulating the risk assessment plan. Particular attention is required to enable a partnership rather than paternal approach to risk management.

Symptoms

A symptom is any event or appearance that occurs with something else and indicates its existence or occurrence. This includes something that indicates presence of a pathological condition. It is well to guard against allowing symptoms to claim a disproportionate influence in some assessments. Factors other than existing frank symptoms may be much more crucial in determining risk.

Stability

Stability is a characteristic of a person not given to swings in mood or marked changes in emotional attitude. It is surely the case that the actions of emotionally stable persons are easier to predict than those of unstable people.

Treatability

Treatment is any measure to ameliorate an undesirable condition; an endeavour to help a person attain better health or better adjustment by whatever means. It is of great interest to the assessor whether an individual has responded to past and present attempts at remediation or treatment. Some knowledge is also needed about the amount of effort the person has applied to therapy, education or vocational advance.

There would also be a requirement to establish the suitability of a previous treatment plan for a person i.e. was the Sex Offenders Treatment Programme (Murphy, Powells, Guzman & Hays, 2007) adapted specifically for people with a learning disability? There may be further knowledge to be gained from identifying environments in which the person engaged with treatment plans. It would be positive to identify with which approaches the person feels supported therapeutically, educationally or vocationally. Overall, when considering treatability assessors should consider how receptive both the person and their environment are to treatment, in equal measure.

Although an area fraught with difficulties and debate (Moreland, Hendy & Brown, 2008) it is no longer the case that a diagnosis of 'personality disorder' should automatically exclude People with a Learning Disability from treatment or services (NIHME, 2003; NICE, 2008).

3 Procedure

3.1 Introduction

Each local area is likely to have different mechanisms for deciding funding arrangements for individuals with complex needs. In the following section we will describe the current mechanism in place in Merseyside, The JIMG (Joint Investment and Management Group). This group of senior Social Workers, Team Managers, Clinicians, and Commissioners meet monthly in Liverpool to discuss the packages of care and funding for the most complex clients. This forum decides whether a HRJRAMP should be completed.

3.2 Human Rights Joint Risk Assessment

Risk assessments should always be carried out in the context of a general Community Care Assessment by Social Services or of the Care Programme Approach (CPA) by the Learning Disability Directorate.

3.3 Criteria for a Level 3/ Human Rights joint risk assessment

The criteria for a Human Rights joint risk assessment are that:

- The Service User fulfils the criteria at CPA or its equivalent for Community Care/Social Work
- And**
- Presents a **significant** (i.e. likely and serious) risk of harm to either themselves or others.
- And**
- The Social Worker's and CPA Line Manager, MDT and the JIMG agree that a HR - JRAMP is necessary in the circumstances.

The meaning of **significant risk** in this context may include;

- Suicide.
- Self-harm.
- Abuse.
- Violence to others.
- Criminal offending.
- Neglect.

It is important to note that for most Service Users the assessment of risk can be done in collaboration with other professionals as part of the normal assessment process without the need to implement the full joint procedure. The benefits derived from a full joint assessment should be weighed against the staff resources used in the process and whether or not this is justified by the risks involved.

A typical joint assessment might be conducted on a person who;

- Is detained, or at risk of being detained, in a medium secure unit.
- Has committed offences for which a court may make a disposal under section (37) of the Mental Health Act (2007) or the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.
- Is subject to a Home Office Restriction Order.

3.4 Applying to Complete a HR-JRAMP/Keeping Me Safe and Well Plan

Joint risk assessments can be proposed either by a Service User's Social Worker, Care co-ordinator, Clinical Lead or Commissioner. In the first instance, such proposals must be discussed with the respective line manager in order to determine;

- Whether or not the person fulfils the criteria for a joint assessment,
And
- Whether, taking into account all the relevant circumstances, a joint assessment is necessary,
And
- Whether the proposed lead and co-assessor have the capacity within their caseload to carry out the assessment.

Any other person, including an agency providing direct support, who thinks that a joint risk assessment is necessary, should firstly discuss this with either the person's Social Worker or CPA Co-ordinator or Clinical lead. Ultimately the decision whether to proceed needs to be determined following discussions between the multidisciplinary team, including Social workers, and a Clinical lead. An overview should be written for presentation to the JIMG highlighting the reasons for The *HR-JRAMP*.

The JIMG should then discuss the proposal at the next available opportunity. It is essential a member of the Commissioning team is at this meeting. The Care co-ordinator and clinical lead will present the information to the JIMG. The JIMG will state whether the proposed joint risk assessment should proceed, and confirm the names of the lead and co-assessors.

If the application to proceed with a joint risk assessment is refused the JIMG should briefly outline the reasons for this.

3.5 Time Allowed for Completion of Assessment/Plan

This procedure is not intended to be used in short term crises or emergency situations. A joint risk assessment should normally be completed between three to six months following the lead assessor being notified of the approval. The JIMG will schedule a discussion of

the completed form at their regular meeting 4 months after the meeting at which the application was approved to assess progress.

3.6 Circulation of Completed Assessment/Plan

Once approved, copies of the completed risk assessment and management plan should be held;

- With the commissioners.
- Within the service user's social work file.
- Within the CPA file.
- Within the Consultant Psychiatrist's file.

Copies of the risk assessment and/or the management plan may also be circulated to others as appropriate. This should only be done within the normal bounds of confidentiality and access to records (see Guidance-Section 4.19). Such circulation might include the;

- Service User.
- Service provider agency.
- Family and / or carers.

3.7 Roles of Assessors

It is important that the assessment is completed by two clinicians, in co-ordination with other professionals, prominent team members, family members and Service User to the maximum of their ability to participate. The clinicians completing the assessment should work closely together and use their different skills to produce the best possible assessment and management plan. Any problems in this regard should be reported to the JIMG. Parts of the assessment can be delegated to other members of the team for completion e.g. a critical events history can be completed by a Trainee Clinical Psychologist or Assistant Psychologist. It is important that the quality of this information is monitored closely by the lead or co-assessor.

The **Lead assessor (Care co-ordinator)** is responsible for:

- Co-ordinating and ensuring the overall completion of the risk assessment and management plan in accordance with this policy and procedure.
- Delegating particular tasks to the co-assessor and other relevant professionals.
- Dissemination of the approved risk assessment / plan to all the relevant professionals, user and carers.
- Revisions of the plan in the light of subsequent reviews.
- Notifying the JIMG if they think the persons risk level status has changed.

The **Co-assessor (Clinical Lead)** is responsible for:

- Supporting the lead assessor in fulfilling their responsibilities.
- Carrying out such tasks as the lead assessor reasonably delegates to them in accordance with this policy and procedure.

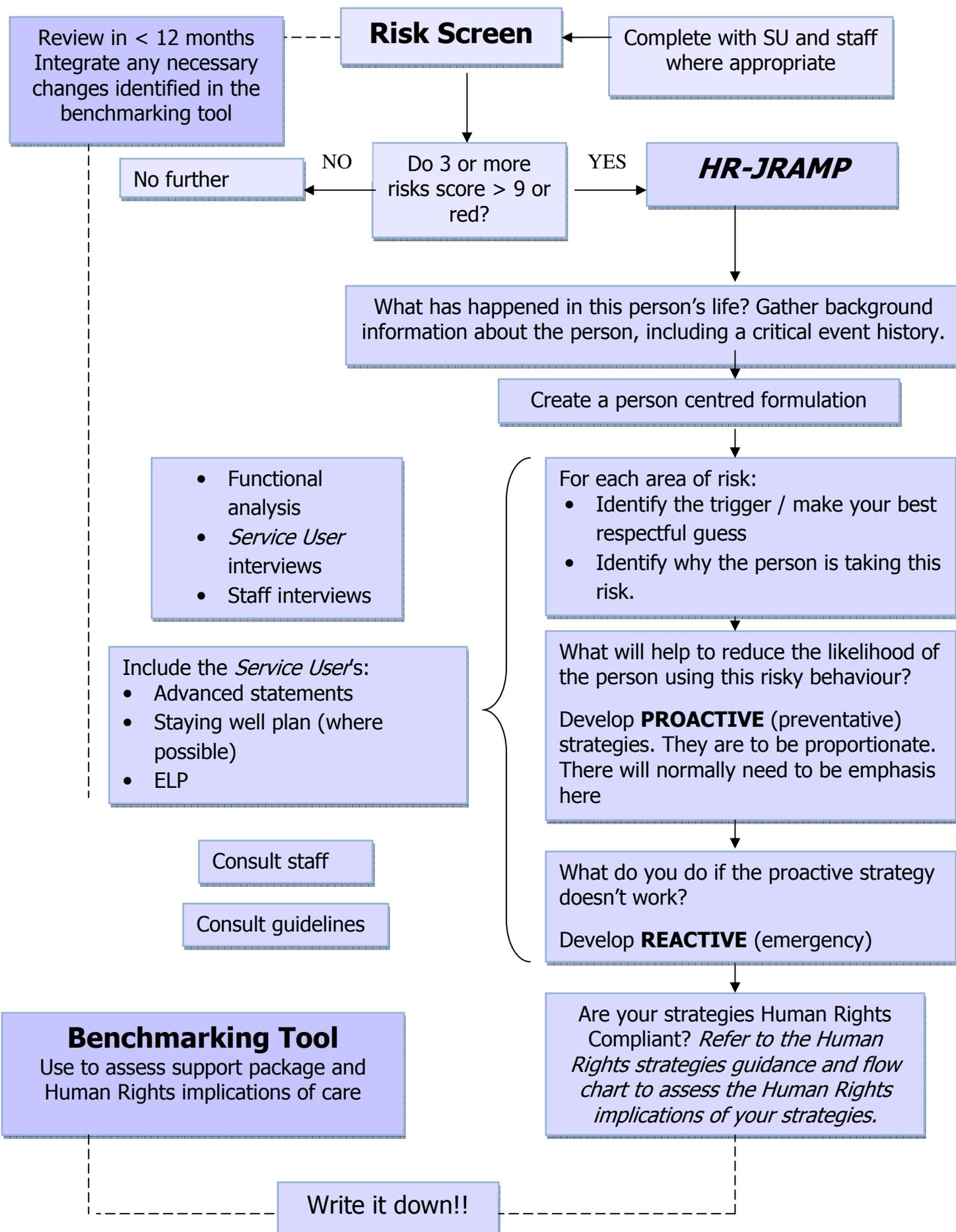
4 Guidance Notes

Introduction

This section contains detailed guidance on the process of completing a risk assessment and constructing a risk management plan. It also defines out how this should be recorded, to ensure a thorough and rigorous analysis of risk and a robust plan for its management is completed.

For each item below there is a corresponding section in the recording form. The form however is only a skeleton document. It has been laid out for the convenience of recording the assessment prior to completion. Assessors should not be constrained by the space available or think they are required to fill it. There should not be any blank spaces in the final assessment document. Assessments and plans should be written in good, understandable, plain English, or in the language of the Service User and relevant staff. All documentation should be available in an accessible format, e.g. easy read, without using jargon.

The following flow chart presents and overview of the whole risk assessment and management planning process.



4.1 About Me

Please state the Service User's full name, date of birth (in date/month/year format) and current location. Please also state the Service User's demographic information.

4.2 'Who Is Filling This In?' (Assessors)

Details of the lead and co-assessor should be provided here, as should details of all staff who have contributed to each section of the plan (where available). The demographic characteristics of staff (i.e. gender, ethnicity etc.) that documented critical incidents and completed interviews should be included. This is to encourage reflective practice through staff acknowledging their own position and possible biases relative to the Service User.

The Service User should be always be included as a co-assessor, and involved as actively as possible. This may be through their 'Essential Lifestyle Plan' (ELP), 'Staying Well Plan' or 'Advanced Statement'.

If a service user is unable to participate fully, you should consider involving a Service User consultant, familiar with a human rights based approach.

4.3 Where Did This Information Come From?

In collecting information for a risk assessment it is vital to consult all possible sources of information that may be useful. Where possible, sources should be cross-referenced to provide corroboration of particular critical events. Assessors should also comment on the reliability and comprehensiveness of the information they have obtained, and state where caution needs to be exercised in its interpretation.

A qualitative analysis must be completed; comparing critical incidents over the years, medication use, staff turn-over, the number of times the person has moved from place to place, etc.

When interviewing service users, a more accessible format of the *HR-JRAMP* should be applied, this may be in the form of easy read or may need to be adjusted for those who have sensory impairments.

The following, although not an exhaustive list, may provide a useful checklist of sources of information:

- Interviewing the service user
- Parents / Relatives.
- Partners/spouse
- Carers / Friends.
- Previous / current care staff.

- Incident report records of care placements.
- The multi-disciplinary team responsible for the person.
- Psychiatric reports.
- Educational services.
- Social Worker / Social Work File.
- Named Health Worker / Health services file.
- Probation services.
- Police services.
- Court reports and depositions.

Having collated all relevant information you should then record the sources you have consulted in the space provided. Please note the date that applies to each particular source (e.g. social work file 1973 to 1998). Where appropriate, list any person's name, role and relationship to the Service User. The type of environment the individual was living in or experiencing at the time should also be clearly documented; for example, was a punitive regime in operation at that time. How the individual reacts to certain events should also be considered. The individual's past history should be considered to then take into account any protective strategies or behaviours they have developed over time, for example, if the individual had been abused, they may feel safe when they self-injure. Any protective strategies should be documented, stating what they are and when they are used. If there are any significant omissions (i.e. potentially useful sources that you could not consult) you should clearly state the reasons for this.

4.4 Why is The Assessment Being Carried Out Now?

Before carrying out the assessment you should have a clear idea about why it is being done. Usually, this will be because the 'Keeping me Safe and Well Screen' (risk screen) has identified three or more areas of risk scoring over '9' or identified as a 'red' area by the staff and Service User. The need should already have been stated, in part at least, on the submission to the JIMG requesting approval for the *HR-JRAMP* to be undertaken. In thinking about 'why now', you should ask:

- Does the person know and understand that a risk assessment is being completed?
- Is there a specific decision to be made, or are you using the assessment to review current risks / management plan?
- Have circumstances changed, or are they about to change?
- Has there been a recent incident?
- Has anything happened to raise concerns about the degree of risk presented by this person? Or concerns about the person's degree of vulnerability?
- What are the consequences of inaction?
- Should the decision be described as a 'risk' or a 'dilemma'? (A dilemma is a situation in which the available options could be considered to present similar risks of harm).
- How does this risk assessment relate to other health or social services assessments or plans that are being or have been undertaken? (E.g. Essential Lifestyle Plan or CPA Assessment).

The risk assessment should be a part of the holistic approach to the person and not a separate element.

4.5 When Will We Look At My Risk Plan Again? (Period Covered By Risk Assessment)

In this section assessors should state the future time period for which the risk assessment and management plan will apply. Risk assessments should always be carried out with a specific time period in mind. We recommend that all assessments are reviewed every 6 months as this reflects a better approach to the person, where this is not possible, a review should occur within a twelve month period. Research indicates that predicting behaviour over short periods is much more accurate than over long periods (Logan, 2007).

A person's *HR-JRAMP* is an evolving document and in line with best practice and human right principles (particularly Article 6, the right to a fair trial) should be reviewed on a minimum six monthly basis.

It is therefore important to consider and record considerations relating to the time period e.g.:

- What period of time will elapse before the risk is reviewed?
- What mechanisms are in place for intervening earlier if things go wrong? (E.g. applying the Essential Lifestyle Plan or Care Programme Approach).
- What are the practical implications of having a shorter risk period?
- How will you know if the decision has been 'successful'? (E.g. by measuring outcomes such as staff turn over, number of critical incidents, types of intervention applied, i.e. medication use, control and restraint.)
- For how long will the risk last (i.e. for how long afterwards is the team responsible for the consequences)?
- Is the Service User able and supported to ask for a review?

4.6 My Wishes

Service User involvement and participation is a key strand of a human rights based approach. This section is about looking at how the service user perceives the risks they present, or are presented to them, in the context of how they would like to live their lives. The knowledge and experience of those with learning disabilities has largely been ignored, this assessment aims to involve service users at multiple levels to gain their insight into incidents and environments.

Useful information about this may already be contained in;

- the risk screen

- The person's essential lifestyle plan or other person centred plan. By incorporating the risk assessment into the essential lifestyle plan the individual can be involved in the risk assessment plan, allowing them the opportunity to describe how they perceive the risk they present or their perspective on the risks that others present to them.

The assessors should describe how the service user perceives the risks they pose or are subject to. If there are communication difficulties in assessing this, they should be clearly described, together with the efforts made to overcome them, for example the risk plan should be completed in any appropriate accessible format, e.g. another language, easy read, large print, Braille, recorded onto a CD or DVD. In most cases the lead or co-assessors should determine the service user's perceptions by means of face-to-face contact. If this is not possible and the observations and opinions of the Service User's wishes have been sought from other sources (such as the current service providers) this should be made clear. If this information is collated from other sources their relationship to that person should be clearly documented, as should the assessor's demographics, how the information was collated and in what environment.

4.7 'About My Life' - Critical Event History

This should be a chronological list of all events that have happened in service user's life that may be relevant to the assessment of risk. It should be laid out in the pre-defined format explained below. The critical event history should take into account the service user's culture, beliefs, protective factors, early childhood experiences etc. in context to the behaviours illustrated. The demographics of the staff who documented the incidents should be reflected upon;

- All significant dangerous and potentially dangerous events that have occurred. The opportunities in the environment, staff involvement and characteristics and the behaviours the service user engaged in should all be clearly documented.
- Significant changes in living arrangements.
- Significant changes in care support.
- Involvement with the criminal justice system. This should include the reasons for involvement and the ways in which they were treated.
- Periods of detention under the Mental Health Act. Once again reasons for their detainment and where they were detained should be clearly documented.
- Occurrence of significant physical or mental health problems.
- Changes in schooling.
- Changes in family / carer circumstances (e.g. birth, marriage, death).
- Employment / unemployment.
- Disclosures/allegations

It is particularly important to accurately date and record the first of a history of dangerous or criminal events. E.g. If there has been a history of violence against people it is important to accurately date (to the year at least) when the first incident happened.

Assessors should cross check these dates with carers or professionals who can corroborate them. If the risk assessment is completed with essential lifestyle plans and as a part of the Care Programme Approach, this process should be relatively straight forward.

Assessors should seek to explore particular settings, and times in the service user's life when dangerous, or potentially dangerous events occurred. In the process of the assessment these will need to be compared with times when such events did not happen.

Questions you may wish to consider when deciding on the relevance of particular incidents include;

- What happened before the behaviour?
- What exactly did it look like?
- What happened afterwards?
- What interventions were implemented?
- What factors are associated with the non-occurrence of the behaviour?
- Staff characteristics, their reflections upon the incident
- Environmental characteristics
- What was the service user's perspective and what are their reflections of the incident?
- Were any human rights issues involved?

The Critical Event History is meant to be a brief, easily readable chronological list. It should be recorded in the pre-defined format on the form, i.e.:

- **Date**

The date should be written in the format of Day/Month/Year, e.g. 25/6/98. Oldest events should be placed first.

- **Event**

The event should be described as briefly and accurately as possible. Descriptions should be as factual as possible and avoid terms which are vague or ambiguous e.g.: "Violently attacked support worker who needed some minor hospital treatment" could mean many things whereas: "Stabbed male support worker in arm with fork necessitating two stitches" is a more accurate factual description.

- **Context / Comment**

It is imperative that, where possible, a brief description of the context in which the event described took place and / or any relevant comment on the events significance and severity. It may include

- a description of any possible 'triggers' to the event, it should also
- include environmental and staff characteristics to encourage a non-blaming culture,
- the service user's and staff's reactions, and

- The potential an event may have had for more serious negative outcomes (i.e. near misses). Where this is not possible, an explanation should be given as to why it is not documented.

Assessors should establish whether the events listed have been corroborated or not. All reported events should be included but assessors should note, where relevant, if reports are first or second hand or if the evidence for a particular event is circumstantial or direct. The critical event history can be correlated and verified by other clinicians who are involved in the essential lifestyle plan and care programme approach, thus providing a holistic approach to person centred planning.

4.8 Things I or Other People Are Worried About (Risk Factors)

Risk factors are individual or social characteristics or circumstances, which may affect the probability of a dangerous event occurring, either to themselves or others. In this section assessors should explicitly analyse the risk factors associated with the service user. This is perhaps the most difficult part of the assessment process and will entail the assessors sifting all the information they have collected in order to look for patterns of behaviour and predictive factors. Research has shown that this can be done effectively by examining information in four areas. These are;

- Historical Factors.
- Clinical Factors.
- Social Factors.
- Actuarial Factors.

Listed below under each of these main headings is an explanation of what they should include. Each of these four main areas is divided into a number of sub-headings. These should be used as the assessors think appropriate. They are neither entirely prescriptive nor exhaustive. Assessors may add other sub-headings as they think suit the particular person they are assessing. However, assessors should bear in mind that the sub-headings given have been shown by research to be relevant to the prediction of risk.

It is important to hold the Service User at the centre of this assessment to ensure a person centred approach which takes into consideration the individual's values and human rights.

a) Historical Factors

This section should contain an analysis of the significance of dangerous events that have previously occurred which are listed in the "Critical Event History". Assessors should look for patterns in the person's previous behaviour. The individual's behaviour should be put into context by considering their belief systems and culture. This should be analysed firstly in terms of the frequency and severity of different types of dangerous events and secondly in relation to the context in which these events took place.

The Frequency and Severity of Different Types of Dangerous Events:

This section should analyse previous dangerous events by seeing if they can be classified into different groups e.g. how many times has the person been involved in events such as:

- Sexual assault.
- Arson.
- Violence.
- Other Criminal Activity.
- Damage to property.
- Self-harm.
- Verbal Abuse and Threats (by self or others).
- Exploitation.
- Victim of Abuse.

Categories may be further broken down as assessors think appropriate, e.g. violence could be sub-divided into violence against support staff, other service users and family members. Only relevant categories should be used. Assessors do not need to comment on categories of event that the service user has not been involved in.

For each category of dangerous event assessors should analyse their frequency (i.e. how a particular number / sort of event has been spread out over time) and severity. This includes whether a particular category of event represents a continuing trend or has only occurred at some specific time in the past, together with analysing whether particular events are increasing or decreasing in severity.

Context of Events

For each category of dangerous event assessors should analyse if there are any similarities in the context in which they occurred. Assessors should analyse whether any particular type of supervision or lack of it appears to be connected with potentially dangerous events. In cases of violence or abuse on others, assessors should analyse any similarity in the characteristics of victims (e.g. age, race, gender, impairment or relationship to service user). The personal demographics of the instigator, the victim and the individual recording the incident should all be recorded. The risk screen may also highlight any particular risks relating to or from the person relating to equality and diversity.

b) Clinical Factors

This section should contain an analysis of clinical factors that may affect the risks posed by or to the service user. Under this heading, the assessors may include the following:

Mental Health Diagnosis and Treatment

Assessors should clearly state any previous or present clinical symptoms and mental health diagnosis. This is particularly important in the case of psychopathy, psychosis or 'personality disorder'.

In recent years there has been a move away from purely focusing on the diagnosis someone is given. Such authors as Bentall (2003) have advocated the adoption of an approach that is symptom/complaint focused and takes into account such factors as the person's social environment and life experiences (see next section). Furthermore, there is a growing evidence base to suggest that the person's subjective experience and understanding of the symptoms, specifically in psychosis, is paramount in informing treatment and intervention. (Campbell & Morrison, 2007; Pitt, Kilbride, Nothard, Welford, and Morrison, 2007; Morrison, Renton, Dunn, Williams & Bentall, 2003) Thus, assessors should explore the individual symptoms associated with any diagnosis and how the Service User makes sense of and understands their experiences.

Both past and current research findings suggest that ethnic minority groups, specifically black Caribbean, black African and other black groups, are over represented in psychiatric hospitals; these groups being two-three times more likely than the general population to be admitted (MIND, 2006). Furthermore, Afro Caribbean people are between two-eight times more likely to be given a diagnosis of schizophrenia (MIND, 2006). One explanation for this may relate to the way in which the person's experiences are interpreted, suggesting a possible bias amongst those who are responsible for diagnosis and treatment (MIND, 2006).

Under the Human Rights Act (1998), Article 14 protects the individual against discrimination and states that an individual should not be discriminated against on any grounds such as ethnic background, sex, colour and language. Thus, assessors should take into consideration such factors as the person's ethnic background, religion, language and other socio-cultural factors when assessing the Service User's mental health, past and present

The degree of learning disability and any specific clinical factors associated with this should also be described in detail. It should be acknowledged that both learning disability and certain diagnostic categories such as schizophrenia are believed to confound the detection of the other (Smiley, 2005). Smiley (2005) has highlighted that people who are diagnosed with what is considered to be a severe mental illness, such as schizophrenia, often perform poorly on tests of intelligence. Consequently the person may be diagnosed with having a learning disability. Furthermore, a person who is functioning at a low level and experiencing psychotic symptoms may have the low level of functioning attributed to the presence of psychotic symptoms rather than an underlying learning disability. Smiley (2005) and Whittaker and Read (2006) also suggested that there are further difficulties with dual diagnosis in relation to diagnostic overshadowing, whereby mental health difficulties are ascribed to a learning disability.

It is important for assessors to consider that labels of Learning Disability or mental health diagnoses might significantly negatively impact on the person's self-esteem, identity, opportunities and therefore on their risky behaviours.

Current clinical intervention

For current clinical treatment being received, and that given in the past, assessors should explore how the Service User has engaged with intervention and treatment plans. It may also be useful to explore whether treatment options were discussed in collaboration with the Service User and what information they were provided with to help inform their decision.

Assessors should consider balancing the Service User's autonomy to decline treatment rather than viewing any such action as non-compliance. Assessment should explore whether the intervention/ treatment plans hold the person at the centre of the intervention and take into consideration their human rights.

Interpersonal style

This section should look at how the Service User's interpersonal and relational style may affect the perceived level of risk to themselves or others. For example such personality traits as impulsiveness, anger and hostility may, either generally or in particular circumstances, increase risk. Reference should also be made to the person's ability to exercise self control. Such factors should be put in the context of events that have either previously taken place or may take place in the future. In assessing the Service User's interpersonal and relational style it may be helpful to consider early and current attachments, trauma and family circumstances.

Insight

Assessors should analyse the degree to which the Service User is aware of the dangers they pose to others or themselves, this can be assessed by their inclusion in the process. It is also important to look at the Service User's understanding of what has happened and their awareness of the consequences of their actions on both themselves and others. The degree to which such awareness may influence their behaviour should also be explored. It is important to continue to assess the Service User's degree of insight as this may change over time depending on the individual's psychological well being.

Acquiescence

It is well documented that people with learning disabilities are prone to acquiescence, suggestibility and confabulation (Proser & Bromley, 1998; Kebbell, Hatton, Johnson & O'Kelly, 2001; Finlay & Lyons, 2002). People with Learning Disabilities in general often have had contact with services from an early age, recognise those in charge of their care as authority figures, and are dependent upon staff for their physical and emotional wellbeing and friendship (Goble, 1999). Thus, Service Users engaging in this assessment process may be more likely to agree and 'passively comply' with the assessors to ensure their ongoing 'friendships' with staff.

Finlay and Lyons (2002) have explored the most likely causes of acquiescence and suggested that it may be the result of multiple factors including; difficulty understanding the question, not knowing the answer and interactional demands placed on the individual during the interview. Thus, assessors should, when including the Service User in this assessment process, ensure full consideration of the relationship between the Service

User and staff members, the Service User and the assessor(s), the way in which the information is presented in the assessment. Furthermore, when including the Service User in this process, the assessors should use reflection, allow the expression of uncertainty and check answers (Finlay & Lyons, 2002).

Attitudes

This section should look at the Service User's attitude towards their own behaviour or their attitude towards others that may engender risk, e.g. does the person usually show remorse? Whilst this may be related to their interpersonal style and degree of insight it is important to distinguish between these elements as they may all contribute in different ways towards risk. Where there are clear links between these elements assessors should analyse these in detail and explain how they are linked.

The attitudes of all staff and clinicians involved in the risk plan should be clearly documented to ensure a comprehensive, unbiased perspective of the risk history and future plan.

Physical Health Diagnosis and Treatment

Assessors should detail any physical health problems that may impact upon the person's risk behaviour, paying particular attention to conditions such as epilepsy or diabetes. Any relationship between the person's physical and mental health should also be considered.

Inequalities in health for people with learning difficulties should also be highlighted. Once a day (DoH, 1995), Signposts for Success (DoH, 1996) and Death by Indifference (Mencap, 2007) illustrate the differing patterns of health needs for people with learning difficulties. Each person should have a developed Health Action Plan, as identified in the Valuing People white paper (DoH, 2001). The assessor may wish to identify, amend, create or analyse the Health Action Plan in relation to the person's risk behaviour. In order to propose an intervention the physical Health needs of the person should be considered e.g. if physical restraint is to be proposed for a person with Down's syndrome then a screen for atlanto-axial instability should be undertaken. The assessor may wish to reflect on the impact of such an intervention plan.

If the person travels through the criminal justice system, there is a role for the health care professional. Police within local custody suites are striving for the safer handling and detention of prisoners. If a person has specific health needs or requirements then these can be written down and given to the desk sergeant as part of the risk management plan. If a person is to be detained in prison, it would be the role of the health care professional to inform the relevant parties of any physical health risks. If a person is to be assessed within prison, there is a toolkit currently available developed by Marshall, Simpson & Stevens (2000). This is known as the toolkit for health care needs in prison.

Overall, the role of the assessor is:

- to identify any physical health needs and their impact on a person's previous risk behaviour

- To identify components of a Health Action Plan.
- to screen the person for any possible adverse physical effects of proposed interventions and
- To raise awareness or put in place signposts for members of the criminal justice system to identify the specific health needs of the person.

c) Social Factors

This section should contain information from the assessment of the service user's social situation that may affect their risk behaviour. Of particular interest here are not only previous social factors (such as childhood abuse) which may be giving rise to current risks, but also current circumstances which may ameliorate or exacerbate risks. It is important that, wherever possible, a collaborative approach to assessment is employed. Moreover, previous and current contexts should be evaluated by incorporating person-centred, human rights-driven strategies, as discussed in previous sections of this document.

Childhood Adversity

Adverse events in childhood have been linked to behavioural and other difficulties in adulthood. Where possible, and appropriate, assessors should thoroughly examine and evaluate the circumstances of the service user's childhood. Assessors should be well versed in the relevant literature surrounding the possible antecedent/historical events known to increase the risk of identified presenting behaviours. Of particular relevance here are whether violations of an individual's human rights have occurred in the past, and how these circumstances have possibly triggered or exacerbated current behaviours. Of particular importance is how specific patterns of current behaviour that may have started in childhood may or may not be linked to certain adverse circumstances. Whilst assessors should not indulge in idle speculation about such links, they should point out that links may exist and the evidence for them. For example, there is wide ranging literature base for adverse events and circumstances and their relationship to current behaviours in those with learning disabilities. These include:

- Impact of institutionalised care (DoH, 2001; Emerson, 2005)
- Impact of negative historical relationships with staff (Flynn and Brown, 2005)
- Importance of role models (Russell, 1998) and their impact e.g. guidance in conflict resolution. (see McConkey, 2005)
- Impact of gender, culture, ethnicity, sexuality, and reactions in those without a learning disability (Grant & Whittell, 2000)
- Bullying
- Poorly supported transitions and the impact of them
- Dispersed community housing and over reliance of 1 or 2 people in the absence of adequate social networks (Srivastava, 2001; McConkey, 2005) social stability, social support or social interactions (see Newton *et al.*, 1994)
- Social and economic deprivation

Situational Factors

This part should look at types of social or family situations and interactions that affect the person's risk behaviour. It must, however, be mindful of diversity within families, such as can be found in cultural, religious, sexual, and/or ethnic backgrounds, and assessors should strive to move their practice away from a 'Euro-centric' approach when it is necessary to do so. This may be particularly salient when assessing, for example, individuals from minority backgrounds living in majority-white British supported accommodation (where person- and human rights-centred practices risk being overlooked due to the prevailing and dominant culture of the organisation). Moreover, consideration should be given to the interpersonal skills and communication abilities of others towards the person being assessed (importantly both the carers family, friends etc *and* those undertaking the assessment; see also the literature on family communication styles, high vs. low Expressed Emotion, (Camberwell,)). This again may also be information worthy of collection from individuals who previously (but no longer) work with that person, alongside role models and/or important others.

Environmental Factors

This would encompass a wide range of factors to do with the service user's physical environment that may engender risk. This might include the layout of the care environment; its proximity to sources of danger (e.g. main roads) or the proximity of other environments where the person might indulge in risk behaviours.

From the clinical examination, it will have become clear whether or not the individual sees weapons, including his or her own body, as a means of solving problems and whether the person has fantasies involving weapons. The question so far as risk management is concerned has to do with the extent to which such weapons are available and can be controlled. Assessors should examine access to possible victims, weapons, and other potential risk situations. Risk increases when individuals are discharged to situations similar to those involved in the index offence. Again, where possible the person assessed should be involved in this process as much as is possible, and this approach should again be collaborative. Risk management presents challenges in terms of working with people with Learning Disabilities because the promotion of independence and choice necessarily will include an element of risk (Styring and Grant, 2005). The challenge, however, is to achieve this balance under the guidance of the person's human rights, whilst also protecting the public; in other words, achieving risk management versus public protection.

Relationship Stability

This section should look at nature and stability of relationships formed with family, friends and paid carers. The presence of patient, tolerant, and encouraging relatives can, of course, be of enormous assistance in maintaining a plan. The same obviously holds true of mental health and other professionals able to lend assistance. A great deal depends on being able to supply a clean, comfortable and safe environment. It is generally found that social support works to protect against violent crime. As cited above, a large body of

evidence concerns the importance of interpersonal relationships and their stability in the protection against adverse behaviours. Assessment should again be sensitive, respectful, and person-centred where undertaken, preferably by an assessor who is (at least to some degree) aware of Personal Relationships and Sexuality issues.

Substance Misuse

Research suggests that alcohol and drug abuse amongst people with Learning Disabilities is generally at low levels (Lund, 1985) although in more independent living circumstances the use of alcohol may be higher (see Hatton and Taylor, 2005). However, it is important for any usage to be explored, assessed, and reported and in doing so the assessors need to describe the nature of any drug or alcohol problem the service user has and how this is related to any identifiable risks. Such assessments should be undertaken sensitively, enquiring for example how often the person drinks, how much they drink, when they drink and what the consequences of this may be.

Where possible, assessors should attempt to apply recommended techniques which are utilised in Drug and Alcohol services (such as Motivational Interviewing, etc.). A human rights based approach needs to acknowledge that limiting access to such substances is possibly in violation of an individual's freedom of choice, and thus a collaborative approach, adopted by specialised agencies alongside the person being assessed, where possible allows for clear and realistic agreements to be reached between all parties regarding both the use and monitoring of substances. Again, where possible, such an approach needs to be undertaken in a systematic, evidence-based manner, where collaborative, non-didactic, empathy-based supervisory approaches are employed by stakeholders.

Collaboration with Services

In this part assessors need to outline the way in which the service user is able to or prepared to collaborate with services which are provided for them, and the implications this may have for any risks identified. Exploration should be undertaken if poor collaboration is identified (e.g. as this may be due to inappropriateness of previous interventions, breakdown in communication and understanding; staff difficulties etc.). It is paramount that, for example, staff teams' willingness and/or their ability to collaborate both with the individual and with the outlined plans are also documented at every stage; such information can also be informed by previous successes / deemed 'failures' in collaborative enterprise. Whether current or past plans have been person-centred, whether the individual has participated in (or been offered meaningful choice etc) should also be considered and reported.

Stress

Stress-coping models (e.g. Lazarus and Folkman, 1984; Orr *et al.*, 1991) can also be employed as frameworks for understanding how individuals and others respond to such stressors, and how such situations may affect others around the individual; reactions which might become crucial antecedents to exacerbating stress in the person being assessed. Moreover, identifying and supporting the self-understanding of individuals within these systems can lead to 'explanatory or organising frameworks for individuals

which evolve over time' (Grant, 2005). Such understanding additionally could promote more functional, person-centred coping strategies over the life course.

This part of the assessment entails trying to forecast what sources of stress the individual is likely to encounter. Stresses can range from things that are difficult to predict such as deaths of close relatives, financial losses, and environmental catastrophes and everyday occurrences that may be stressful to that particular individual, such as changes in activities or routines, environmental, staff or day centre changes. Particular vulnerabilities need to be isolated and considered. You may therefore need to take account of;

- How the person responds to stress or pressure.
- What helps the person to deal with stress?
- How stressful situations may affect other family members or carers.

By completing the risk management plan as part of the essential lifestyle plan or care programme approach these factors will be covered therefore reducing the amount of overlap between the different items.

d) Actuarial Factors

As has been documented in the research and practice chapter of this document, it is uncertain, as the evidence base is narrow, how well the evidence base reflects the learning disability population. Although some research data shows that certain behaviours are more likely in people with particular traits, the research is particularly limited in describing the personal characteristics such as culture, race, sexuality, therefore may not fit particular traits of people. These are listed under particular dangerous behaviours below. In this section the assessors should highlight whether or not, and if so how, the service user "fits" the data regarding particular dangerous behaviours. Assessors should specify, for each particular danger listed that is thought to be a risk for the service user, the degree of "fit" with the list of characteristics shown for that danger. This can be done in a number of different ways to suit the circumstances of the assessment. Assessors should generally point out how many factors for a particular danger are listed and how many of these apply to the person being assessed. It may be useful to include a list of those that apply or the entire list with an indication of those that apply.

Actuarial data is not available for all dangers, and what is available cannot be regarded as comprehensive. Nor is it possible to automatically assume that because there is a good 'fit' with actuarial data the person will necessarily indulge in a particular dangerous behaviour. A good 'fit' means that the person should be regarded as being at a significantly greater risk of engaging in the dangerous behaviour than a person who is not.

Data is given here which relates to both learning disability specifically, people who have committed suicide, people with mental health problems and the general population. The data given is only a guide and not a definitive answer.

General Criminal Offending and Learning Disability

For People with a Learning Disability those at a higher risk of all types of criminal offences are more likely to have a mild learning disability (Leonard *et al.*, 2005) and;

- Be younger.
- Be male.
- Be Unemployed,
- Have a history of social disadvantage
- Have self-reported behavioural problems dating back to childhood,
- Have limited academic achievement at school,
- A history of hyperactivity/impulsivity/risk-taking behaviours,
- Have substance misuse problems,
- To experience social exclusion in adolescence and adulthood.

(Holland *et al.*, 2002)

Within the above more ***persistent or serious*** offenders with learning disabilities tend to;

- Have difficult early life experiences and backgrounds.
- Have interpersonal difficulties/"personality disorder".
- Commit offences other than the index offence.
- Experience under-socialisation.
- Have poor internal controls.

There is some evidence that offenders against the person have a better prognosis than property offenders, in terms of re-offending. Female offenders are reported to be mostly involved in property offences and \ or sexual offences (soliciting, prostitution and incest). Compared with males, the female offender with a learning disability has much more in common with the non-disabled offender.

Arson and Learning Disability

People with a Learning Disability who have committed arson have been shown to be more likely to have;

- Previously self-harmed
- Difficulties with sexual relationships, sexual feelings or their sexuality.
- Long term behaviour problems.
- Been separated from their parents early in life.
- Engaged in some form of damage to property.
- Have a chromosomal disorder, for example Klinefelter`s syndrome, epilepsy.

Sexual Offending and Learning Disability

People with a Learning Disability who have been involved in sexual offences are more likely to;

- Be male.
- Be socially isolated (i.e. the degree of isolation perceived by the offender).
- Not be in any day care or employment programme.
- Have been physically abused.
- Have been sexually abused.

As there is evidence that there is a link between sexual offending and having been physically/sexually abused, assessors need to consider the implications of this for the rest of their assessment.

Suicide and the General Population

People who commit **suicide** have been shown to be more likely to have the following characteristics.

Be:

- Male.
- Older-Younger.
- Unemployed.
- Single\widowed\divorced.
- At the onset of an acute phase of a mental health difficulty

Have:

- Previously or recently attempted suicide.
- A history of mental health difficulties, particularly;
 - Affective disorder.
 - Psychosis.
 - Interpersonal difficulties/"Personality disorder".
- Alcohol dependence.
- Be an In- or Out-patient.
- Discharge oneself from hospital against medical advice.
- Have been discharged between 1 week and 3 months.
- Had recent GP contact.

It should also be borne in mind that suicide is more likely in spring/early summer. Also about two thirds of women take overdoses of paracetamol, whilst a third of men die from the effects of car exhaust fumes.

Mental Health Difficulties and Violence

For people suffering from mental health difficulties the following factors appear to be linked with an increased risk of **violence** to others;

- Having a history of violent behaviour.
- Being younger when committed the first offence.
- Being separated from parents before 16 years old.
- Having high levels of anger/hostility.
- Having a clinical diagnosis and active symptoms.

- Non compliance with treatment and/or failing to attend appointments.
- Concurrent substance misuse.
- Homelessness.
- Unemployment.
- The presence of situational factors, particularly those that have been associated with past violence.
- Lack of close relationships.
- Difficult early life experiences at home and school.

Violence and Aggression in the General Population

In general, looking at the whole population, people who commit acts of violence and aggression tend to be;

- Youths.
- Male.
- Of low socio-economic status.
- Of low educational level.

4.9 What Does All This Mean? (Analysis and Summary)

This is the part of the assessment where you attempt to pull all the risk factor information together. Assessors should present a formulation for the picture as a whole, i.e.

- An analysis of whether the historical, social, clinical and actuarial risk factors tend to point to the same indication of likely risk or not.
- How the various categories might be linked;
- How patterns have developed, and
- What the psychological, social, or physical “pay off” or benefits might be, e.g. ‘whilst the episodes of aggression have reduced over time, they seem to have been replaced by more frequent fire setting, which could be a more effective strategy for getting admitted to a more secure and predictable environment’.

For each category of dangerous behaviour described assessors should identify any patterns or trends associated with that behaviour. This should include, for each category of behaviour:

- A summary of the significant events over time; general trends e.g. whether they are increasing or decreasing in frequency or severity.
- Any circumstances that make the behaviour more, or less likely e.g. “more often than not this has happened after he has been drinking alcohol”; “these problems

- rarely occur when given one-to-one support”; “tends to happen more often soon after visits home to parents”
- Who is usually the target of the behaviour e.g. “can be anyone in the wrong place at the wrong time” or “only targets vulnerable people who cannot defend themselves”
- The person’s typical reaction to the events e.g. “is generally showing some remorse or empathy for the victim”; “is showing signs of exercising more self control over this behaviour”.
- A description of any evidence of “build up” or “early warning signs” in mood or behaviour, e.g. ‘usually only follows a period of prolonged low mood lasting more than three days’; or whether dangerous acts tend to come “out of the blue” or are preceded by a pattern of less dangerous behaviours, e.g. ‘usually starts off by shouting and screaming, building up to damage to property, and culminating in violent attacks’.

The formulation could also include ideas as to why behaviours may have been absent for certain periods e.g. “*There was a period of 3 or 4 years when no sexual offending took place, and this also coincided with a time when he was in a stable relationship with a girlfriend.*”

4.10 Looking At My Risks, What Options Have I Got? (Significance of Risk)

The previously completed risk screen (‘Keeping Me Safe and Well Screen’) will have identified areas of risk. In addition to informing the formulation, identified risk factors and human rights will also inform choice of placement. For each housing/placement option available, assessors should consider how each area of risk is likely to impact on the sustainability and viability of the placement. Please see ‘Risk Screen Guidance Notes’ (Appendix 2) to identify relevant humans rights involved in the risk and document these in the third column.

Whilst there will inevitably be a degree of subjectivity involved in estimating the significance of risk, decision making concerning risk can be enhanced by attempts to quantify such elements as **likelihood** and **severity**. In this part of the assessment, assessors should therefore explicitly quantify the significance of the risks presented by the service user in relation to each of the options seriously considered for managing the risks identified. This exercise should also be completed for each area of risk (e.g. arson, absconding, and violence to others) identified.

There are two fundamental factors to consider when calculating the significance of a particular risk. These are the:

- **Likelihood** of the risk occurring in the period covered by the risk assessment
- And
- **Severity** of its consequences

When arriving at likelihood estimation there are several important considerations which you will have already looked at in your assessment:-

- Is there any known history to this particular risk?
- How often has it occurred in the past and with what frequency?
- Are there any known triggers and are they likely to occur within the risk period?

The assessment of likelihood can only be made with reference to a set of assumptions, e.g.

- Where the person will live.
- The expected level of support.

These form the context in which the estimate applies. Assumptions about this context should be clearly stated.

Likelihood should then be scored either 1, 2 or 3, according to the following criteria:

1 = Unlikely to happen in the next six months.

2 = Evens (50%) chance of happening in the next six months.

3 = More than 50 % chance of happening in the next six months.

Severity should also be scored 1, 2 or 3, according to the following criteria:-

1 = Minor

- The risks that the service user or others are exposed to are no greater than for the general population,
Or
- Where any harm that results (physical or psychological) would not require professional support (e.g. medical, clinical, on-call etc)

2 = Serious

- Physical injury to the service user or others which would require medical attention (e.g. GP, AED, etc) Psychological trauma which impinges on the service user's or others' quality of life and sense of well being, and would require professional support
Or
- Behaviour which may lead to breakdown of current placement

3 = Major

- Physical injury (including death) to the service user or others which would require their admission to hospital
Or
- Psychological trauma to the service user or others which would require their admission to hospital
Or
- Behaviour which would result in criminal prosecution and imprisonment or sectioning under the Mental Health Act (2007).

Significance is then calculated quite simply by multiplying one number by the other i.e.:

Significance = likelihood x Severity

Obviously the higher the number the more significant the risk, with 9 representing the most significant and 1 representing the least significant (N.B. Total scores of only 1, 2, 3, 4, 6 or 9 can be obtained).

4.11 Where's the Best Place for Me to Live?

Where more than one placement option has been considered in section 10, the relative balance of risk and benefit associated with each housing option should be presented in this section, along with the assessors' comments and recommendations associated with each option. For the preferred option, a management plan which seeks to further enhance benefit and reduce risk needs to be described in the next section.

4.12 What Legal Documents Are Important In My Risk Plan?

This section should consider in general how legal powers, such as those under the Mental Health Act (2007) have been used in the past and may be used in the future as part of the overall risk management plan. Particular attention and consideration should be paid to:-

- The Service User's capacity relevant to any decisions being made
- The Service User's current legal status.
- Supervised Discharge.
- Guardianship.
- Court of Protection.
- Section 117 After-Care.
- Probation Order.
- Bail Order.
- Criminal Procedure (Insanity and Unfitness to plead) Act (1991).
- Deprivation of Liberty Guidelines (2009)

It may be relevant to discuss in general terms whether the service user has a mental disorder within the meaning of the Mental Health Act even if none of the Act's powers are to be used. If it is proposed that some legal measure be taken, there needs to be an explanation of specifically how this might contribute to the overall risk management plan. The issue of the service user's capacity to give their legal (i.e. informed) consent both in general and to particular issues relevant to them may also need to be considered. The Mental Capacity Act (2005) may also be relevant here.

In using a human rights based approach, it will also be important, under the right to a fair hearing, to share with the Service User their rights to challenge any decisions made about them under the MHA. These discussions should be documented. It may also be relevant to review the outcome of any previous Mental Health Review Tribunals when considering detaining a person under the Mental Health Act (including guardianship).

4.13 My Risk Management Plan

In formulating the Risk Management Plan it is good practice to consult with and involve those people who will be expected to deliver and monitor it. In particular it is imperative that, where there is a Responsible Clinician (RC) involved, the Risk Management Plan is drawn up with their full consultation and agreement. Consultation should also take place with actual or potential service providers and carers / family members. However, the final contents of the plan remain the responsibility of the assessors.

The risk management plan should detail the practical arrangements that the assessors deem necessary to manage the risks identified in the previous sections. We advocate that the Risk Management Plan should be integrated with other support plans such as the person's Essential Lifestyle Plan as a process of best practice.

Within the Risk Management Plan the following areas should be considered:

a) Support Levels

This should include a consideration of the number of hours of support the service user receives and the level of support (i.e. 1:1, 2:1, etc), including:

- Usual support levels and whether this is constant throughout the day, week or month.
- Provision for increasing support levels to manage short term crises, including additional support that may be deployed via the on-call service (agency or directorate).
- Consider whether or not it is appropriate to draw on the support of family or friends.
- The importance of the continuity, consistency and quality of support.
- Characteristics of staff employed

b) Triggers

Any reliably occurring triggers for particular behaviours should be documented. Challenging behaviours are often the Service User's best attempts to solve a problem and by examining the critical event history and looking at your formulation you should be able create hypotheses or to make 'respectful guesses' about the triggers to behaviour even where you are not certain. Clinical judgement should be exercised here.

c) Proactive Strategies

These are actions or interventions that seek to reduce or minimise the occurrence of risk behaviours, including:

- Avoiding triggers and high risk situations.
- Therapeutic input, such as cognitive-behavioural therapy, counselling and contingency management.
- Skills teaching, such as anger and stress management.
- Scheduling routines.

- Medication.
- Managing the environment e.g. avoidance of crowds, reduction of noise.
- Provision for monitoring the person's behaviour/mental health (e.g. using scatter plots, ABC charts, relapse scales and standardised tools).
- Effective communication and teamwork.
- Support given to staff teams (e.g. training, de-briefing and staff supervision).

d) Reactive Strategies

These are actions or interventions that may be employed in response to the occurrence of a risk behaviour, including:

- Use of low arousal diffusion and distraction techniques.
- Use of recognised restraint techniques (e.g. MVA).
- On-call services, including the Learning Disabilities Directorate, the Emergency Duty Team and agency specific on-call services.
- Input and support from family and friends (where appropriate).
- Emergency admission to health or social services facility.
- Use of agreed protocols (for example, accessing GP or accident and emergency departments, and monitoring physical health).
- Consider the point at which police may need to become involved.

e) Human Rights considerations

First, document the human rights involved in the risk itself ('Keeping Me Safe and Well' screen guidelines, Appendix 2) so that you are aware of the human rights you are trying to protect. The aim of your management strategies is to protect the human rights which are at risk if no management strategy is put in place.

Secondly, the management strategies you have developed also need to be considered to see which rights are being raised. Human rights issues which may be involved in common management strategies can be found in the 'Human Rights in Risk Management Strategies Guidance' in Appendix 3.

You will need to document:

- Will the strategy raise any human rights?
- If the strategy will result in the restriction of a right, whose right will this be?
- What type of right will be involved in the strategy i.e. absolute, non-absolute or Article 5?
- If the strategy **will** breach an absolute right, then it **shouldn't** be implemented.
- If the strategy has the **potential** to breach an absolute right, you need to be very careful about the way you implement it
- If it's a limited right will the strategy be compliant with limitations set out in the convention
- If it's a non-absolute right, will the restriction be lawful, necessary and proportionate?
- Does the strategy require a balanced decision process?

The 'Summary of Human Rights in Strategies Flowchart' in Appendix 4 will help you to consider:

- a) If a management strategy has human rights implications
- b) Which human rights are implicated?
- c) Whether those rights are absolute, non-absolute or Article 5.

For each strategy you will need to show that you have balanced:

- 1) The Service User's competing rights i.e. those involved in the risk itself vs. those involved in the proposed management plan
- 2) The rights of the Service User with their staff or carers and the wider community.

You may wish to use the 'Human Rights Decision Making Form' in Appendix 5 to help you think about how to document your decision making process.

If for whatever reason you are unable to mitigate the trigger or to identify individualised proactive strategies, you are at a higher risk of breaching the person's human rights. You should identify particular areas where rights may be most at risk.

If you are putting in place protective measures as part of your positive duty to protect the Service User e.g. to prevent suspected sexual abuse, you should be aware that you may be infringing the human rights of family carers or others but these should be balanced against each other.

f) Legal Powers

Assessors should detail the relevant sections of the Mental Health Act, Mental Capacity Act (including the Deprivation of Liberty Safeguards) or other legal powers that will or may be utilised to assist in managing the degree of risk presented by the service user. This should describe what specific power, in which way and in what circumstance is to be used, including:

- Guardianship (e.g. requiring the service user to reside in a specified place).
- Supervised discharge (e.g. details of appointments the service user must attend and where the service user would be conveyed to if necessary).
- Details of section 17 leave (Mental Health Act).
- Use of detention under sections (2) or (3) in an emergency situation.
- Supervision and Treatment Order (Criminal Procedure Act, 1991).

Fundamentally, this should be underpinned by the Human Rights Act (1998) and the principles contained within the articles. Assessors should give consideration to the fact that all public bodies have a *positive obligation* to *protect* the rights of Service Users; in addition to a duty to refrain from taking action that may infringe a Service User's human rights (DoH, 2007).

g) Networking and Communication

A number of enquiries have highlighted the potentially fatal mistakes that can arise out of poor communication between different agencies. The management of risk requires a collaborative, multi-agency approach that details the roles and responsibilities of all those involved in delivering the plan, including the following:

- Carers and family members.
- Voluntary and private sector organisations.
- Service commissioners / purchasers.
- Probation services.
- Court diversion schemes.
- Police.
- Forensic services (for example, Low, Medium or High-secure Units).
- On-call services (Learning Disabilities Directorate, Emergency Duty Team, and Agency-specific in-house on-call).
- Multi-agency Public Protection Arrangements (MAPPA)

Assessors should detail what sort of information needs to be given to whom, and in what time scale, e.g. if a person is thought to have absconded, what length of time should elapse before the police are informed. It may be beneficial to have one main point of contact for most information, together with a back up plan for when that person is not available.

h) Training Implications

By their very nature, many of the interventions employed within the risk management plan may require additional training for those involved in delivering direct care to the service user, including the following:

- Studio III Management of Violence and Aggression.
- Recording and monitoring methods.
- Health surveillance.
- Offending behaviour.
- Sexual abuse.
- Self-injurious behaviour.
- Psycho-social interventions.
- Understanding formulations
- Basic behavioural teaching

4.14 Will the Risk Decision help me? (Benefits of Risk Decision to the Service User)

It is recognised that in any consideration of the options available to manage the risks that an individual presents, some options carry more risks of harm than others. However, in many cases, a riskier option will also entail an increased benefit to the service user. It is important, therefore, when more than one option is being considered to state the positive benefits that are likely to result from each option. For example to:-

- Learn from mistakes and accept the natural consequences of behaviour.

- Improve self-control and learn to take responsibility.
- Enhance the quality of the service user's decision making.
- Gain independence and reduce the support required from others.
- Minimise the negative effects of overprotection.
- Broaden one's experience.
- Promote the dignity of risk.
- Increase opportunities for community presence, participation and choice.
- Improve quality of life.

Be explicit and reflective, however, regarding whose 'values' you are considering (i.e. is this really what the service user wants or are you 'imposing' the values of your service?). It is also necessary to consider the likelihood of realising each of the potential benefits.

4.15 How Will My Plan Be Put Into Place, How Will My Plan Be Monitored and When Will My Plan Be Looked At Again? (Implementation, Benchmarking and Review)

This section should contain details of how the risk management plan is to be implemented, monitored and reviewed.

Implementation

This is the process by which the necessary resources or services are secured in order to put the plan into operation. It may be dependent on a number of factors including;

- Negotiations with service providers.
- Further care management processes that need to be completed (i.e. Service Specifications, Funding Applications, and Care Planning Meetings).
- Legal matters which may be outstanding (e.g. court appearances, Mental Health Review Tribunals, Guardianship applications)

Monitoring

This is the process by which the delivery of the risk management plan is supported and controlled on a continuing basis. The type and level of monitoring should relate to the scale of intervention and the complexity of the service user's needs. Information gathered during this process can then be used at formal review meetings. Plans for monitoring should detail both how information about the on-going effectiveness of the plan is to be collected and how minor adjustments to the plan may be made, including;

- Contacts between the clinician, service user and service providers.
- Contacts between Social Worker, service user and service providers.
- Contacts between Consultant, service user and service providers.
- Care management meetings other than formal reviews (e.g. section 117 meetings).
- Clear recording procedures (e.g. behaviour charts, recording of medication use, physical restraint, staff turn-over, etc.).

Benchmarking

This process evaluates the extent to which a human rights based approach is implemented by services and incorporated into the Service User's life. The benchmarking

tool should be completed annually. Year one, two and three standards have been developed against which, the delivery of complex care will be assessed. Thus an acceptable level of human rights based care provision and Service User involvement at year one would not be acceptable at year three. In addition, the tool contains certain 'trigger' questions, where a score of zero would necessitate immediate action by the service, i.e. unacceptable practice (regardless of the overall score for that section). The results should be fed back to the MDT and commissioners.

The tool can be completed by

- CPA co-ordinators,
- Clinicians,
- Social workers,
- Allied mental health professionals,
- Commissioners.

Reviewing

This is the process by which changing needs are identified and services adapted accordingly. The risk management plan should be designed to last for a specific period after which both the assessment and plan are reviewed in the light information gathered during the monitoring process. This section should detail;

- Who will be the principle Care Manager?
- Who is responsible for organising reviews?
- How often formal reviews will be.
- Who will go to reviews?
- Who will Chair review meetings.
- Who is responsible for updating the JIMG?

4.16 What Do I Think Of My Plan? (HRBA)

This should record the service user's views on the proposed risk management plan, particularly the balance to be struck between the risks and benefits involved. If the Service User expresses dissent or an attitude of non-compliance any alternative suggestions they have should be recorded. Where any such suggestions have been incorporated into the plan they should be clearly indicated here.

If there are problems in getting the Service User's views due to communication difficulties, this should be clearly described, together with the efforts made to overcome them (e.g. the use of an advocate). Where possible the lead or co-assessors should ascertain these by means of face-to-face contact. If this is not possible and the observations and opinions of the Service User's views have been sought from other sources (such as the current service providers) this should be made clear.

4.17 What Do The People Who Care For Me Think Of My Plan? (HRBA)

Carer in this context means:

- Any person who is defined as a carer under the Carers Act.

- Next of kin who have significant contact with the Service User.
- Any other informal carer the assessors feel it is necessary to consult with.

This should record the carer's views on the proposed risk management plan, particularly the balance to be struck between the risks and benefits involved. Any areas of disagreement should be noted. Any suggestions from carers that have been incorporated in the final plan should also be noted.

4.18 What Do My Staff Think Of My Plan? (HRBA)

This section should record the perspectives of the agencies and staff that support the individual on a daily basis. This should record staffs views on the proposed risk management plan, particularly the balance to be struck between the risks and benefits involved. Any areas of disagreement should be noted. Any suggestions from staff that have been incorporated in the final plan should also be noted.

4.19 Who Is Allowed To See My Plan?

The assessors should complete a list of people / agencies that are to receive a copy of the assessment and / or risk management plan. In considering who should be circulated with a copy of the document assessors should bear in mind that it will contain sensitive and confidential information. The normal rules regarding confidentiality and access that apply to health and social service work in general and records in particular also apply to the risk assessment and management plan.

This is potentially a complex area of law and policy which assessors may need to discuss with their line managers. Assessors should ensure they are aware of, and where appropriate to refer to;

- The Liverpool and Sefton Interagency Agreement on Confidentiality and the Sharing of Information for People in Contact with Mental Health Services (December 1998).
- Department of Health Circular NO. LAC (88)17: Personal Social Services: Confidentiality of Personal Information.
- Access to Personal File Act 1987.
- Data Protection Act 1984.
- Access to Health Records Act 1990.

In light of the above it may be possible and appropriate to share parts of the assessment / plan with other agencies / individuals and not others. The risk management plan section of the document, for example, may be easily reproduced as a separate document for circulation.

Issues of confidentiality and what is circulated to whom should all be noted in this section.

4.20 Signatures of Assessors

All the assessors should sign and date the document to signify their agreement with its contents.

4.21 Plan Approvers / Recommendations

Having considered the assessment and plan the designated people on the JIMG should tick the box indicating if the Risk Assessment and management plan has been approved or not. They should sign in the space provided on behalf of Liverpool Social Services and Liverpool Health Authority. The assessment and plan should only be signed as approved if no significant changes are necessary in order for it to be put into operation.

If the assessment / plan is not approved, the comments section should be used to indicate, in as much detail as possible, what further work needs to be done to facilitate its approval.

If the assessment / plan is agreed, the comments section should not generally be used. However, it may be used in exceptional circumstances to recommend minor adjustments to the assessment / plan. Signatories should bear in mind that such comments on an approved plan are only advisory, and will not be binding on the assessors and/or those responsible for putting the plan into operation. If any changes are necessary before any plan is put into operation, then the assessment / plan should not be approved.

THE KEEPING ME SAFE AND WELL PLAN (HR-JRAMP)

My name:

Insert photograph here

1. ABOUT ME

My Birthday:	
Where I live now:	
My Religion:	
My Gender:	
My Ethnicity:	
My Sexual Orientation:	

Mersey Care 
NHS Trust



2. WHO IS FILLING THIS IN?

Name	Position	Location	Line Manager	Lead assessor / co assessor
	Service User			

3. WHERE DID THIS INFORMATION COME FROM?

4. WHY IS THE ASSESSMENT
BEING CARRIED OUT NOW?

5. WHEN WILL MY RISK PLAN BE
LOOKED AT AGAIN?

6. MY WISHES

Include any information that has been completed with the Service User to highlight their wishes (such as the 'listen to me' workbook or an ELP)

7. ABOUT MY LIFE (CRITICAL
EVENT HISTORY)

The *Service User* has the right to apply and view what
has been written.

7. ABOUT MY LIFE (CRITICAL
EVENT HISTORY)

Date	Event	Comment

**8. THINGS ME OR OTHER PEOPLE
ARE WORRIED ABOUT**

a. Historical Factors

b. Clinical Factors

c. Social Factors

If a negative staff attitude is noticed in the critical event history, this should be documented here. It should also be noted if it seems like the staff do not treat the person with FREDA when they respond to incidents.

d. Actuarial Factors

9. WHAT DOES ALL THIS MEAN?
(ANALYSIS AND SUMMARY)

10. AFTER LOOKING AT MY 'RISKS,'
WHAT OPTIONS HAVE I GOT?

OPTION 1:				
RISK AREA	Likelihood	Severity	Significance	Relevant human rights involved in risk (see risk screen guidelines for prompts)
				
				
				
				

OPTION 2:				
RISK AREA	Likelihood	Severity	Significance	Relevant human rights involved in risk (see risk screen guidelines for prompts)
				
				
				
				

OPTION 3:				
-----------	--	--	--	--

RISK AREA		Likelihood	Severity	Significance	Relevant human rights involved in risk (see risk screen guidelines for prompts)
					
					
					
					

OPTION 4:		Likelihood	Severity	Significance	Relevant human rights involved in risk (see risk screen guidelines for prompts)
					
					
					
					

11. LOOKING AT MY OPTIONS

12. WHAT LEGAL DOCUMENTS ARE IMPORTANT IN MY RISK PLAN?

E.g. the Human Rights Act, The Mental Capacity Act (including the deprivation of liberty guidelines), the Mental Health Act.

13. MY RISK MANAGEMENT PLAN

The *Service User's* wishes regarding how their risks are managed should be incorporated into this section: This can be achieved in a variety of ways, e.g:

- The 'listen to me' workbook
- Information from an Essential Lifestyle Plan
- A staying well plan
- An advanced statement
- Information from the risk screen (role plays etc)

The management plan should document which human rights are relevant to the area of risk and to the management of that risk.

14. - HOW WILL MY PLAN BE PUT INTO PLACE?

- HOW WILL MY PLAN BE MONITORED?

- WHEN WILL MY PLAN BE LOOKED AT AGAIN?

15. WILL THE RISK DECISION HELP ME?

(BENEFIT OF RISK DECISION TO THE *SERVICE USER*)

16. WHAT DO I THINK OF MY PLAN?

17. WHAT DO THE PEOPLE WHO CARE
FOR ME THINK OF MY PLAN?

18. WHAT DO MY STAFF THINK OF MY PLAN?

19. WHO IS ALLOWED TO SEE MY PLAN?

Article 8: right to private and family life - who is this information available to?

21. PLAN APPROVAL / COMMENTS BY
JOINT INVESTMENT AND
MANAGEMENT GROUP

20. Assessors signatures to agree document's contents	Lead Assessor	Co-Assessor
Name: (print)		
Signed:		
Date:		

Tick	Approved	Not Approved
Comments		
	Liverpool / Sefton Health Authority	Liverpool / Sefton Social Services Authority
Name: (Print)		
Position:		
Signed:		
Date:		

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7 Appendices

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Appendix 1: Learning Disability Directorate Care Programme Approach (CPA)

The Care Programme Approach (CPA) is the system which has been used to coordinate the care of people under the specialist mental health services since it was introduced in England in 1993. It should include:

- A full assessment of the person's needs
- A care plan intended to meet these needs
- A care co-ordinator who should monitor how the plan is delivered
- Regular reviews to check progress
- Collaboration between health and social services
- Involvement of service users and carers.

CRITERIA FOR DETERMINING C.P.A. / NON C.P.A.

C.P.A. Not Required

Clients who require a specific, short / medium term piece of work that does not need to be co-ordinated with other professionals / agencies. For example Psychological Assessment relating to legal proceedings.

Clients who require short / medium term health input where there is no need for formal co-ordination across agencies i.e.:-

- Where clients are settled in care packages with no major concerns and where identified risk issues are being addressed.
- Where they may be ongoing social care issues but the health input can be delivered without formal co-ordination.

Clients who are Non – C.P.A. will have a statement of care which will be an identified care plan.

C.P.A.

A) Clients Involved with the In Patient Services

- Clients who are subject to 117 aftercare:- these can be re-designated Non-C.P.A. following review.
- Clients admitted to inpatient units who are formally detained under the Mental Health Act.
- Clients who are not formally detained but who are not known or not had previous contact with L.D. Services.
- Clients who are known to the service who are admitted but not formally detained will remain on current status.

- B)** Clients who are diagnosed as having significant mental health problems in addition to their learning disabilities and who require C.P.A. (including robust crisis / contingency plans) for any of the following reasons.
- Clients who present a significant degree of risk either to themselves or others.
 - Clients who are at risk of serious self neglect and / or vulnerability including financial / sexual exploitation.
 - Clients who are prone to rapid relapse and who require close monitoring.
 - Clients who are likely to disengage from services with potential serious consequences.
 - Clients who require frequent and intensive health interventions perhaps including frequent changes in medication.
 - Clients who have significant health and social care needs that require formal inter-agency co-ordination.
- C)** Community
- Clients who continue to present a significant degree of risk to others due to severe challenging behaviour and / or offending behaviour.
 - Clients who are at risk of serious self neglect and / or vulnerability including financial / sexual exploitation.
 - Clients who have significant health and social care needs that require formal inter agency co-ordination.
 - Clients who are at significant risk of breakdown of their care package.

Please note that the final decision of who should be placed on C.P.A. will be made by the team manager due to resource implications.

The documentation used in the Learning Disabilities Directorate for the CPA is as follows:

- The initial care assessment (single assessment document used across all teams and services)
- The Risk Screen
- The C.P.A care plan
- An IRAMP or a JRAMP are optional
- C.P.A. risk assessment

Appendix 2: Risk Screen Guidance

Guidelines for completing the human rights based 'Keeping me Safe and Well' screen.

Contains:

- **General guidelines for using the 'Keeping me Safe and Well' screen**
- **Guidelines for personalising the 'Keeping me Safe and Well' Screen to person Service Users.**
- **Information about human rights articles that may be relevant to each risk**

Section 1

Guidelines for completing the 'Keeping me Safe and Well' screen.

The 'keeping me safe and well' screen is the first stage of assessing somebody's risk. If risks are identified at this stage, a management plan (see human rights risk management guidance) should be completed.

- Any scores of 9 should be discussed immediately with your line manager
- A J-RAMP (Joint Risk Assessment and Management Plan) should be completed if 3 or more risk areas have a score of 9.
- An I-RAMP (Intermediate Risk Assessment and Management Plan) should be completed if 1 risk area has a score of 9, or 3 risk areas have a score of 6

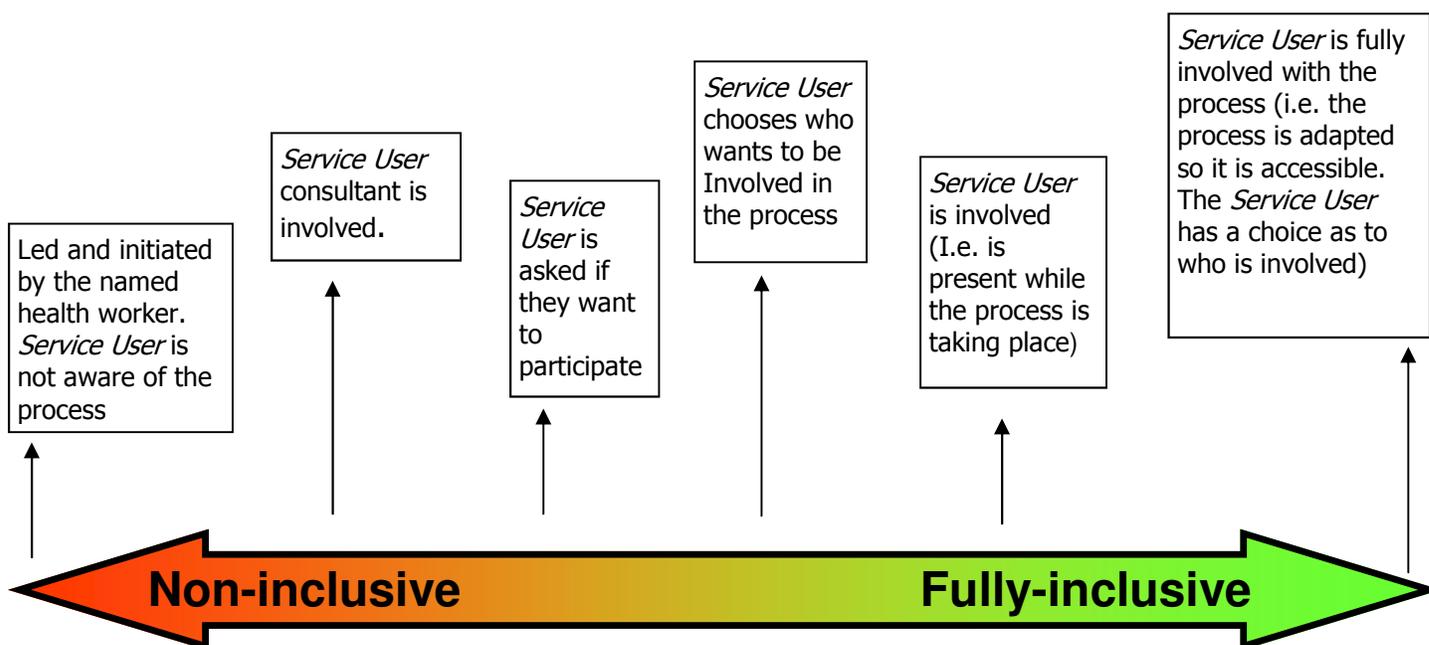
The screen is set out as follows:

- A section of easy read information about how you assess risk. This is to help Service User understand what they are doing.
- The screen contains four sections that outline: potential risks to the Service User, risks to others, risks to the Service User from others and property.
- Under each item is a list of articles of the Human Rights Act that need to be looked at if the risk is highlighted. Underline the relevant rights as you are going through to document to demonstrate that you have thought about this.
- The third section of this guide includes more information about how the human rights articles that are relevant.
- The last page of the screen contains information about how to score potential risks and about the review process.
- If ways to manage the risk have been identified, these should be put on the last page.

In line with the human rights based principles, (Framework for Human Rights in Healthcare, the Department of Health) it is important to try and achieve maximum Service User involvement in their own risk assessment. However, this is not always possible. Perhaps the Service User is very upset or unwell. They also might decide not to engage with the assessment. If this is the case, then initially the health worker would be expected to work through the risk assessment either on the Service User's behalf or with the help of family members or chosen support staff. As the Service User's situation improves, they should become actively involved.

It is very important to speak to the Service User before hand to try to establish who they would like to be involved. They might be happy to complete the screen with just the health worker, though they might want (or indeed choose not to have) input from family members or chosen support staff. If Service User Consultants are available they should be used.

Below is a diagram showing the different ways the Service User could be involved in relation to their risk assessment. The gold standard is for the Service User to lead and be fully involved with the whole process. Although this is the aim, it is likely that the process may sway back and forth along the continuum depending on how the Service User is.



It is important that the screen is also completed independently by people who know the Service User well. There may be differences between what the Service User and other

people see as a risk n (e.g. some staff may be risk averse and highlight difficulties that do not exist.)

Any differences should be discussed with the Service User before a consensus is agreed upon and a combined assessment written. An advocate or someone independent should be brought in at this stage to help resolve any differences. If the Service User and staff cannot agree on certain areas this should be highlighted on the screen as disputed areas.

Section 2

Guidelines for personalising the 'Keeping me Safe and Well' screen

The keeping me safe and well screen should be personalised to the Service User as much as possible. Involving the Service User in their risk screen will increase accessibility, engagement and ultimately, ownership of the Service User's care.

When is a person ready be become actively involved?

A number of things need to be considered before the risk screen is personalised for a Service User. For example, how is the person's:

- **Psychological state** (e.g. is depression or anxiety going to prevent the person from engaging with the assessment?)
- **Attention span** (e.g. how long will they sit down and be able to concentrate?)
- **Engagement** (e.g. will the person join in with the assessment?)
- **Insight** (e.g. if they have problems with physical violence, do they realise they could be causing risk to themselves or others?)
- **Remorse** (e.g. if they have hurt somebody, do they say sorry and mean it?)
- **Suggestibility** (e.g. is the person able to say 'no' and expect this to be heard or do they feel as though they have to agree and say 'yes'?)

Is there anything else that might have an impact on completing the assessment alongside the Service User?

Timing is key when deciding at what level the Service User can be involved in the risk assessment and requires good clinical judgement about what the Service User can tolerate.

Improving accessibility of the risk screen can be improved by looking at each Service User personally and assessing their skills. For example:

- Do they have verbal communication?
- Do they speak English?
- Can they read?
- Do they understand spoken language?
- If the Service User does not communicate verbally, do they have any other ways of communicating?
 - Picture cards
 - Sounds
 - Behaviours
 - Signs

Top Tip

Use coloured pens. Have a red, orange and green pen and let the *Service User* colour the relevant traffic light in depending on the risk.

Personalising the ‘keeping me safe and well’ screen

After assessing the Service User’s skills, look at ways to make the risk screen meaningful for them. Below is a non exclusive list of examples:

- Wording

Although the words in the risk assessment are simplified, it might be the case that the Service User needs more of an explanation. Alternatively they might need it displayed in a way that is more meaningful to them. For example, if in the ‘*Transport*’ section the risk is related to refusing to wear a seatbelt, make sure you highlight this. Use the person’s words and language because this is likely to make the process more meaningful. You might need to negotiate this with the person.

- Pictures

If the Service User cannot read or has difficulty reading, pictures provide a greater understanding. Depending on the ability of the Service User, this can be implemented in different ways.

- Use enlarged pictures to represent each item and have them on the page with no words. If the Service User understands spoken language, you could then explain the pictures simply using the screening tool for reference.
- For some Service Users, it might be more meaningful to draw their own pictures. Explain each item in very simple terms and then ask the person to draw a picture to match. For example: in ‘*Issues concerning physical health*’ if the Service User has a risk relating to asthma, they might draw a picture of an inhaler. This might help the person think of the risks that are important for them.
- With some Service Users, taking photographs to illustrate the most important risks might be beneficial. In the item ‘*Self-neglect*’ for example, you could support them to take a photograph of their soap or clean clothes.

- Role Plays

A role play can be beneficial in a number of ways. It can help the Service User remember the event, it can make the task more fun and increase the likelihood of engagement and it is also good if there is an issue of insight. If the Service User doesn’t see a risk and does not understand why other people might worry about them, a role play can help the person see it from other perspectives.

- Tapes or DVDs
- Translations

Top Tip

When you are involving the *Service User*, have a printed out copy of the traffic light system to put in between you.

This will aid understanding and make the process

Good Practice Example

At the beginning I never used to come to the meetings because it was very stressful and I was upset. It was scary, the way I was, really it got me. I didn't want to go to the meetings; I was quite high and destructive. I felt worried [not being there] because things might have gone wrong without me.

We looked at the problems I had first, the violence and stuff because I wasn't very well. My Health Worker wrote the stuff on the board, cutting myself, hanging myself and having a shower; that was a problem, falling wasn't a problem (*pointing to the risk screen pictures*). I can't read so I drew the pictures, I'm good at drawing. The pictures helped me understand. My Health Worker went through everything from the beginning and explained it.

We then looked at each problem to see if it was something to worry about. Green meant that you are ok; you are not worried about that. Red was something to worry about and orange was in between the two. We scribbled the colours underneath each problem together.

My Health Worker had done the role play first and then I did it after. She was trying to buy a scarf but she didn't have enough money. She was kicking off because she wanted the scarf. She came over to me and said I want it now, I said you can't, you have to put it back because you don't have any money. She got very angry and I said we had to ring whoever is on-call. On call said I had to talk to her and let her cool off. I had to find out why she had said that stuff and try to calm her down. It was funny acting like being on telly, Eastenders and that. I wanted to do it.

I wanted to be able to do it; it helped me achieve and made me feel good.

Any problems or ideas of how to improve the 'keeping me safe and well' plan should be given to Beth Greenhill: beth.greenhill@merseycare.nhs.uk

Section 3 Human Rights

Under each section in the risk screen are lists of the human rights articles that are relevant to that risk. If there is a significant risk, you should look at the relevant section below for more information. As a statutory agency, we have a positive obligation to protect the human rights of the people we support.

The human rights articles that are applicable to the *management* of the risk can be found in the J-RAMP guidelines.

Risks to self

1-1) Issues concerning physical health

Article 2: Right to life-

Does the person have access to appropriate health care services?

Has the person been refused any treatment for physical health on grounds of their disability?

Is the person supported to make informed choices around medical treatment (e.g. attending the doctors)?

Is the person supported to access medical checks / clinics? In extreme cases, a denial of any of these things could lead to death.

Article 3: Prohibition of torture, inhuman and degrading treatment- e.g. Are facilities available to enable persons with physical health needs to be cared for effectively? (e.g. hoists or changing facilities).

Are there enough staff available to ensure aspects of the person's physical health needs are met with dignity? (E.g. if incontinent, is the person changed on a regular basis so they do not have to sit in wet clothing?). If not, this could be classed as inhuman or degrading treatment.

Article 8: Right to respect for private and family life, home and correspondence- A physical health problem could have an impact on the person's physical and psychological well-being – an important aspect of their private life.

Article 14: Prohibition of discrimination – e.g. does the person have access to medical treatment they need regardless of their learning disability?

1-2) Attempted suicide

Article 2: Right to life – if the person is successful in their attempt of suicide, their right to life will be taken away.

Article 8: Right to respect for private and family life, home and correspondence– e.g. is confidential information about potential suicide just shared on a 'need-to-know' basis?

1-3) Para Suicide

Article 2: Right to life – e.g. The person could lose their life in their attempt of para suicide.

Article 8: Right to respect for private and family life, home and correspondence– e.g. is confidential information about para suicide just shared on a 'need-to-know' basis'?

FREDA – Is the person treated seriously and with dignity in the event of para suicide?

1-4) Issues around Medication

Article 2: Right to life – e.g. Does the person have access to any regular medication (e.g. is diabetes / epilepsy medication given at the correct time with the correct doses etc).

Does the person have access to appropriate mainstream health services?

Article 8: Right to respect for private and family life, home and correspondence– e.g. is information about the person's medication shared only on a 'need-to-know' basis?

Does the person have any input into their medication?

Have they been involved in discussions of these areas? (Do they have capacity?)

Is the person given respect and privacy while taking their medication?

Are they given information as to why they are on any medication, and to what side effects may occur?

Is medication easily available if the person has a head ache or an upset stomach etc?

Is medication used as a form of restraint for the person, and if so, have they consented and if not, is the restraint proportionate to the person's difficulty?

FREDA – Is the person treated with dignity and respect with regard to their medication? e.g. are they able to take it in private?

1-5) Self-neglect (including nutrition and hygiene)

Article 2: Right to life – If self neglect becomes extreme, this could potentially lead to death.

Article 8: Right to respect for private and family life, home and correspondence– e.g. does the person have the opportunity to make or get a drink / food when they want?

Does the person have access to his / her own money?

Are they able to spend their money on whatever they decide?

Is the person given respect and privacy (by both staff and other Service Users) whilst undertaking personal care?

If the person refuses to do personal care, is this right respected?

Is the person encouraged to eat refused food?

FREDA – e.g. is the person treated with equality and dignity regardless of their presentation? Is their autonomy respected with regards to personal care?

1-6) Deliberate self harm / injury.

Article 2: Right to life – in extreme cases deliberate self harm or injury could result in a loss of life.

Does the person have access to suitable healthcare services to get help?

Article 8: Right to respect for private and family life, home and correspondence- e.g. is all information about the person's behaviour kept confidential?

If not, is it just shared on a 'need-to-know' basis?

Does the person have any say in which staff members intervene when they are self harming?

Also, is the person given dignity when they are self-harming and privacy where applicable?

If the person is not causing serious harm, are their rights to make informed choices respected?

FREDA – Is the person treated with dignity and respect in the event of self harm? E.g. are they given the opportunity to speak with staff after an incident?

- Self harm is sometimes linked to a history of sexual abuse. If this is suspected then steps need to be taken to reduce further exposure to this.

1-7) Transport

Article 8: Right to respect for private and family life, home and correspondence- Is the person able to make their own choices with regards to transport? If not this could potentially impact upon their psychological well being. E.g. are the doors to the property locked because of the person's lack of road safety?

FREDA: If it is the person's wish not to get into a vehicle, is this wish respected?

1-8) Mobility

Article 2: Right to life – If the person is likely to fall and seriously hurt themselves and no one is available to help, then in extreme cases this could lead to death

Article 3: Prohibition of torture, inhuman and degrading treatment- e.g. are there enough staff available to ensure the person does not suffer 'degrading' treatment? (e.g. if the person needs help changing or eating).

Article 8: Right to respect for private and family life, home and correspondence– e.g. is personal care undertaken with respect, dignity and privacy?

Is the place the person resides fully equipped for any mobility difficulties they may have? (E.g. disabled access, room calls, kitchen equipment that is suitable for disabled persons etc).

Is there appropriate disabled access to the property?

Is the person free to leave the property when they want to?

Are there enough staff available to ensure the person gets out as frequently as they require?

FREDA – Is the person treated with fairness, dignity and respect despite any mobility problems? E.g. are facilities available to ensure persons are cared for effectively (e.g. hoists or changing facilities). Do any mobility needs have an impact on their autonomy – i.e. does it prevent from making choices about where to go and what to do? Are they supported to make these choices as far as is possible?

1-9) Risk of being stranded

Article 8: Right to respect for private and family life, home and correspondence– The risk of being stranded could have implications towards the person's psychological well being. e.g. Are staff available to go out with the person if they so wish?

FREDA- Is the person treated with fairness and autonomy despite a risk of being stranded? Is the person able to leave the property when they wish (e.g. are there enough staff available to take the person out if they are not capable of going out alone?).

1-10) Domestic Hazard

Article 2: Right to life – There is potential for the person to seriously harm or kill themselves due to a domestic hazard.

Article 8: Right to respect for private and family life, home and correspondence– If the hazard may result in the person hurting themselves (for example by cutting themselves with a sharp knife), then this could affect their physical wellbeing.

In shared accommodation, could the risk impede on the quality of life of other Service Users?

FREDA - Is the person treated with fairness, dignity and respect with regard to their issues around domestic hazard? (for example with staff attitude towards the Service User as a consequence of the risk).

1-11) Risks related to leaving the package of care without support.

Article 2: Right to Life - If the person leaves the package of care without support and places themselves in danger, this could in extreme cases lead to death (e.g. if the person crosses the road without looking, or places themselves in vulnerable positions).

Article 8: Right to respect for private and family life, home and correspondence- the person's physical and psychological wellbeing could potentially be breached if they place themselves in vulnerable situations while they are out unsupported (e.g. engaging in sexually risky or drug taking behaviour.)

If the person is likely to assault others / be assaulted by others while out unsupported, then again, physical or psychological integrity could potentially be breached (this includes any potential risks to children).

1-12) Deterioration in mental health

Article 14: Protection against discrimination – e.g. does the person have access to appropriate healthcare services? If not, is this because the person also has a learning disability?

Article 5: Right to liberty and security– e.g. is the person able to leave the property whenever they wish? Is the person sectioned? If so, have they been given information as to why, and do they receive regular reviews/tribunals?

Article 8: Right to respect for private and family life, home and correspondence– This risk could obviously have implications towards the person's psychological well being if help is not available.

FREDA – Is the person treated with respect and dignity with regard to their mental health problems. This includes treatment by staff, family and other Service Users.

1-13) Alcohol / substance abuse

Article 8: Right to respect for private and family life- e.g. is the person able to drink in his own home? If so, does this impede on the human rights of any other Service Users / carers living in the same place? Is the person supported in making informed choices regarding his or her drinking?

Does alcohol or substance misuse affect the person's physical health or mental health? Does it contribute to other risk areas such as self harm or self neglect? This could potentially affect the person's physical and psychological well being.

Article 2: Right to life – e.g. are mainstream services available for the person to help with his or her problems? (E.g. alcohol services?)

FREDA – is the person treated with respect and autonomy for making their own decisions about drinking habits? Are they treated with dignity in relation to alcohol / substance misuse problems?

Risks to others

2-1) Verbal aggression / intimidation

Human rights issues related to the potential victim

Article 3: Prohibition of torture, inhuman and degrading treatment– e.g. is the person's behaviour compromising a carer /relative / or the general public's right not to be treated in an inhuman or degrading way?

Article 8: Right to respect for private and family life, home and correspondence– e.g. if the person is focussing the verbal aggression on staff, family or other Service Users living at the same address, is this impacting on their private life and/or their psychological well-being?

Human rights issues related to the person being assessed

FREDA - Is the person treated with respect and autonomy by staff despite any verbal aggression or intimidation they may display?

2-2) & 2-3) Physical violence (including and excluding premeditated use of weapons)

Human rights issues related to the potential victim

Article 3: Prohibition of torture, inhuman and degrading treatment– e.g. is the person likely to focus this aggression towards carers / family / Service Users or the general public? If so their right not to be treated in an inhuman or degrading way maybe compromised.

Article 8: Right to respect for private and family life, home and correspondence– e.g. if the person is focussing the physical aggression on staff, family or other Service Users living at the same address, will this impact on their private life, and/or their physical/psychological well-being?

Article 2: Right to life– If the physical violence becomes so extreme that it could result in a loss of life, then the victim's 'right to life' may become compromised.

Human rights issues related to the person being assessed

FREDA – Is the person treated with fairness and respect with regard to any potential violence? E.g. If the person has a complaint made against them because of their aggression, will it be investigated fully? Will they be supported? Also, are there consequences with regard to violent outbursts? Removal of privileges etc may affect the person's equality or respect.

2-4) Sexual offending

Human rights issues related to the potential victim

Article 3: Prohibition of torture, inhuman and degrading treatment– By sexually abusing someone, the person is treating them in an inhuman and degrading way.

Article 8: Right to respect for private and family – By sexually abusing somebody, the person is effecting the person’s psychological and/or physical well being.

Human rights issues related to the person being assessed

FREDA – In the event of a sexual offence, will the person be treated as an equal and with dignity, fairness and respect?

2-5) Stealing

Human rights issues related to the potential victim

Article 1 of Protocol 1: Protection of property – e.g. If the person takes property that belongs to somebody else, they are compromising the right of this person.

Article 8: Right to respect for private and family life, home and correspondence– By stealing, the person might affect the victim’s psychological well being. This includes family, carers and other Service Users.

Human rights issues related to the person being assessed

FREDA – Is the person treated with dignity and respect despite potential stealing behaviour?

Do they have a reputation of being a thief? If so, does this reputation cause the person to be treated differently or in a degrading way?

2-6) Arson

Human rights issues related to the potential victim

Article 1 of Protocol 1: Protection of property - By setting fire to somebody’s property, the person is impeding on the victim’s right to have their property protected

Article 2: Right to life - If the fire is severe enough, it could cause death to the victim.

Human rights issues related to the person being assessed

Article 2: Right to life - If the fire is severe enough, it could cause death to the person.

FREDA – Is the person treated with dignity and respect despite the risk of arson?

Are they treated as an equal? E.g. do they have a reputation relating to this risk? Does this affect the care they receive, or how they are treated by either staff members or other Service Users?

2-7) Other criminal or antisocial acts (eg hoax calls etc)

FREDA - Is the person treated with dignity and respect despite the potential for any other criminal or antisocial acts?

Do they have a reputation around this risk? Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users?

2-8) Exploitation/manipulation/intimidation

Human rights issues related to the potential victim

Article 8: Right to respect for private and family life, home and correspondence– This risk might affect the victim's psychological or physical well being. This includes family, carers and other Service Users.

Human rights issues related to the person being assessed

FREDA - Is the person treated with dignity and respect despite the potential for exploitation, manipulation or intimidation?

Do they have a reputation around this risk? Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users?

2-9) Fabrication

FREDA - Is the person treated with dignity and respect despite the potential for fabrication? Do they have a reputation around this risk?

Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users? For example, have they got a reputation for making 'allegations' of sexual abuse?

Does this result in any allegations they make not to be taken seriously? Any allegation should be treated as serious and acted upon.

2-10) Any particular risks to children

Human rights issues related to the potential victim

Article 8: Right to respect for private and family life, home and correspondence– This risk might affect the child's psychological or physical well being. Steps should be put in place to prevent this from happening.

Article 3: Prohibition of torture, inhuman and degrading treatment- Child abuse could be construed as torture of the child – or inhuman or degrading treatment.

Article 2: Right to life – If the risk is severe enough, the risk could possibly endanger the child's life.

Human rights issues related to the person being assessed

FREDA – Is the person treated with dignity and respect despite the potential risk to children? Do they have a reputation around this risk?

Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users?

If any allegations have been made against the person, are they still treated as an equal by staff? And are they aware of their rights around allegations against them?

2-11) Any particular risks to dependants

Human rights issues related to the potential victim

Article 2: Right to Life – Neglect of a dependent could potentially lead to death. Steps should be in place to prevent this from happening. E.g. support should be available for the person in regard to their child.

Article 2 of Protocol 1: Right to education – A risk to a dependent could potentially affect a child's education. E.g. if the person finds it difficult to take the child to school.

Article 3: Prohibition of torture, inhuman and degrading treatment– Neglect or degrading treatment of the child could be construed as torture.

Human rights issues related to the person being assessed

Article 8: Right to respect for private and family life, home and correspondence– e.g. is the person supported or given the opportunity to have a family life with their child? If the child does not live with the person, do they have visiting rights to see the child? Are steps in place to support the person to have a safe and productive family life with the child?

FREDA – Is the person's family life respected? Are they treated differently in terms of access to their children because of their learning disability?

2-12 to 2-16. Equality and Diversity issues. This includes:

- **Race, culture and skin colour**
- **Gender**
- **Religion**
- **Language**
- **Sexuality**
- **Disability**

Human rights issues related to the potential victim

Article 3: Prohibition of torture, inhuman and degrading treatment- e.g. Do the person's beliefs cause behaviour towards another person which may compromise this right? Extreme abuse that is discriminatory e.g. extreme racial abuse may be considered to be inhuman or degrading treatment.

Article 14: Prohibition of Discrimination – Does the person express discriminatory views? Is the person treating anyone differently because of who they are (e.g. because of their race, gender, religion etc). Have any steps been taken to explain why this behaviour is wrong?

Article 8: Right to respect for private and family life, home and correspondence– This risk has the potential to impede on the victim's psychological or physical wellbeing, and other aspects of their private life.

Human rights issues related to the person being assessed

Article 8: Right to respect for private and family life, home and correspondence– are the person's views and beliefs being respected? Are they allowed to express their own views, as long as they are not impacting on the rights of others?

FREDA - Is the person treated with dignity, respect and equality despite any beliefs they may hold against others? E.g. if a complaint is made against the person regarding how they treat another person, will they be informed about why it has happened, and will they be made aware of the process and of the outcome?

Risks from others

3-1) Physical abuse by others

Article 2: Right to life – If the person is subjected to extreme physical abuse by others, this could result in a loss of their life.

Article 8: Right to respect for private and family life, home and correspondence– Physical abuse will affect the person's physical integrity and their psychological well being. If another Service User is abusing the person or if the person is vulnerable to abuse when out on their own this could also impact their physical and psychological integrity.

Article 3: Prohibition of torture, inhuman and degrading treatment- In extreme cases of physical abuse, it could be construed as torture or inhuman and degrading treatment. Additionally, is there a policy of restraint around the person? Could this be seen as physical abuse?

FREDA - Is the person treated as an equal and with respect? e.g. if the person makes a complaint about physical abuse, is it investigated fully and taken seriously?

3-2) Sexual abuse by others

Article 3: Prohibition of torture, inhuman and degrading treatment- If the person has been sexually abused, this right is likely to have been compromised. If sexual abuse has been suspected then steps may need to be taken to prevent further exposure to the risk.

Article 8: Right to respect for private and family life, home and correspondence– e.g. Is the person supported or given the opportunity to make relationships? If the client wishes to engage in sexual relationships, is this supported? Has the person had help and advice about sex and been empowered to know their rights, therefore limiting the chance of sexual abuse?

- Self harm is sometimes linked to a history of sexual abuse. If this is suspected then steps need to be taken to reduce further exposure to this.

FREDA – Is the person treated as an equal and with respect? e.g. if the person makes a complaint about sexual abuse, is it investigated fully and taken seriously?

3-3) Financial abuse by others

Article 4: Prohibition of slavery and forced labour – e.g. does the person undertake any kind of work, and if they do, do they receive suitable payment for the work? (e.g. the same as any other employee).

Article 8: Right to respect for private and family life, home and correspondence– e.g. who handles the person's money? Are they informed about this and do they understand why? Does the person have access to their own money? Are they able to spend their money on whatever they decide? Is confidential data regarding the person's money kept locked away and only shared on a 'need-to-know' basis?

FREDA – Is the person treated as an equal and with respect? – e.g. if the person makes a complaint regarding their financial situation, is it taken seriously and is it investigated fully? Does the person have autonomy in terms of managing their own finances?

3-4) Emotional abuse by others

Article 3: Prohibition of torture, inhuman and degrading treatment- Extreme emotional abuse could be construed as inhuman or degrading treatment. Strategies should be in place to prevent this from happening. Staff need to be aware of potential emotional abuse as it could be more difficult to identify,

Article 8: Right to respect for private and family life, home and correspondence– e.g. does the person feel respected in his / her home? Does the person have any involvement in choosing their staff / housemates? This is especially true if they feel they are being emotionally abused by somebody they live with.

FREDA – Is the person treated as an equal and with respect? – E.g. if the person makes a complaint regarding any emotional abuse, is it taken seriously and is it investigated fully?

3-5) Family: vulnerability of carers

Article 8: Right to respect for private and family life, home and correspondence– e.g. if the person's carer's vulnerability is affecting the Service Users quality of life, are there strategies in place to help the situation? (e.g. outside carers to give extra support). Alternatively, if by looking after the person the carer's right is compromised, then again, are there interventions in place to help?

3-6 to 3-12) Risks relating to equality and diversity. This includes:

- **Race, culture and skin colour**
- **Gender**
- **Religion**
- **Language**
- **Trans-gender**

- **Sexuality**
- **Disability**

Article 3: Prohibition of torture, inhuman and degrading treatment—e.g. is the person treated in a way that might be construed as inhuman or degrading as a result of any issues relating to equality and diversity? Extreme abuse that is discriminatory e.g. extreme racial abuse may be considered to be inhuman or degrading treatment.

Article 9: Freedom of thought, conscience and religion – e.g. does the person feel able to express their beliefs and practice activities regarding equality and diversity? Is the person supported to attend meetings / events etc? If so, are clients attending things when they don't want to?

Article 8: – Right to respect for private and family life - Does the person feel able to express themselves? Is the person given the opportunity to express their identity by making choices about their clothes/hair/food/activities etc.?

Is the person supported to attend groups should they wish? Do they feel pressurised to attend groups when they would prefer not to? Does the person have the opportunity to meet and socialise with other persons of the same sexuality/ethnic group/any other group should they wish to? (E.g. Does the person have access to a group for gay people with a learning disability if they wish to?).

Article 14: Prohibition of discrimination – Are there particular reasons why the person may be vulnerable to discrimination, from staff or other Service Users?

Is the person treated differently from others in a way that cannot be reasonably justified, because, for example, of their sexuality or religion? For example is a person in a same sex relationship not given the same level of support as a person in a heterosexual relationship?

Or, is the person treated the same as others despite having very different needs? For example if a person is not able to access certain activities without support because of their disability, and is not provided with that support, this may be discriminatory.

FREDA – Is the person treated as an equal and with respect? – e.g. if the person makes a complaint about how they are being treated, is it taken seriously and investigated fully?

Risks relating to property

4-1) Arson

Article 1 of Protocol 1: Protection of property – Setting fire to somebody's property will compromise their right to have their property protected.

Article 2: Right to Life – If the person sets fire to a house with somebody still in it, it might compromise the person's or the victim's right to life

Article 8: Right to respect for private and family life, home and correspondence – e.g. If the person damages somebody else's property, they may be compromising the owner's right to respect for their private life and home.

FREDA - Is the person treated with dignity and respect despite the potential for arson or damage to property?

Does the person have a reputation around this risk? Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users?

4-2) Damage to own property

FREDA - Is the person treated with dignity and respect despite the potential for arson or damage their property? Are functional necessities replaced if they have been damaged (e.g. television)?

Does the person have a reputation around this risk? Does this then impede on the care they receive, or how they are treated by either staff members or other Service Users?

4-3) Damage to others property

Article 1 of Protocol 1: Protection of property – If the person damages somebody else's property, then they are compromising their right to have their property protected.

Article 8: Right to respect for private and family life, home and correspondence– e.g. If the person damages somebody else's property, they may be compromising the owner's right to respect for their private life and/or home.

Appendix 3:

Human Rights in Risk Management Strategies Guidance

Human rights are inherent in many of the risks posed by or to Service Users. Different rights are *also* raised when various *strategies* are employed to *manage* these risks.

When developing strategies, useful questions to ask include:

- Which rights are raised?
- What type of right is it? (i.e. absolute, non-absolute or Article 5: Right to liberty)
- Whose rights are they?
- Do I have a duty to protect the rights?
- How do I make sure I'm not breaching them?

If the right is **non-absolute**, for **all** strategies employed, you must ensure that:

- There is a **legitimate aim** (e.g. To protect other people's rights)
- The strategy is **necessary** (e.g. Is it really needed to achieve that aim?)
- The strategy is **lawful** (e.g. Is it in line with the Mental Capacity Act, Mental Health Act?)
- The strategy is **proportionate** (i.e. The least restrictive alternative?)

Some **key considerations** include:

- Is the strategy appropriate and not excessive to the risk posed?
- Is the interference with the Service Users rights kept to a minimum?
- Is the least restrictive strategy being used?
- What will be left of the Service User's rights if you employ the strategy?
- Is there an alternative, less drastic strategy?

The diversity of and creativity involved in developing strategies means that it is not possible to provide an exhaustive list of their potential human rights implications. These guidelines are intended as an *overview* of the rights that *may* be raised by strategies employed to manage risks identified in the 'Keeping Me Safe and Well Screen.'

The rights that are most often relevant to healthcare in general, and risk management in particular, are likely to be:

- Article 3: The right not to be tortured or treated in an inhuman or degrading way Article 3 applies in ‘*extreme*’ cases. It may be useful to think of a ‘spectrum’ between Article 3 and Article 8. For example, restraining somebody to a chair for hours each day may constitute inhuman treatment, but the use of physical restraint to manage *specific* behaviours would be more likely to raise Article 8.
- Article 8: The right to respect for private and family life, home and correspondence
- Article 14: The right not to be discriminated against in relation to any of the rights contained in the European Convention; A strategy cannot restrict a Service User’s enjoyment of their rights based on their learning disability, gender, sexuality, religion or any other aspect of their diversity. All strategies have the potential to raise Article 14, and you should ensure that you account for equality and diversity issues when developing your strategies.

However, a number of other human rights may be relevant and each strategy should be considered *individually*.

Article 5: The right to liberty; there are very strict guidelines as to when a Service User’s right to liberty can be restricted. To be a lawful restriction, the Service User would need to be under a section of the Mental Health Act.

Article 7: The right to punishment without law; Article 7 is strictly limited to punishment linked to criminal law and so does not refer to strategies (e.g. removal of an afternoon activity following an incident) which act as a form of punishment. Any strategy which may be construed as a punishment is likely to have human rights implications. Often these may be under Article 8 (The right to respect for private and family life).

Management Strategies likely to have Human Rights Implications

Any risk management strategy (whether pro or reactive) has the potential to restrict a Service User’s rights. In general, proactive strategies are more likely to be human rights compliant. Proactive strategies should be integral to and the main focus of any management plan. Where it is not possible (for reasons of the person’s safety) the *least restrictive* reactive strategies should be used. These guidelines are intended to assist your decision making process when developing strategies rather than being a definitive or ‘literal’ checklist. It is important to keep a record of this process.

Pro Re Nate (PRN) medication

Article 3: The right not to be tortured or treated in an inhuman or degrading way The use of PRN medication to keep somebody sedated would not be acceptable practice and may constitute inhuman and degrading treatment. Rapid tranquilisation may only be used in extreme circumstances and it is essential that Trust guidelines are followed.

- Have direct support staff been trained in the use of PRN?

Article 8: The right to respect for private and family life, home and correspondence

PRN medication has the potential to impact on a person's physical and/or psychological well-being, which is an important aspect of the right to respect for private life. Therefore, it is essential that the use of PRN medication has a legitimate aim, is lawful, necessary and proportionate.

- Does the Service User know what PRN medication is used for?
- Have they been given accessible information about the particular medication being administered?
- Does the Service User have any input into decisions relating to PRN medication?
- Is the Service User aware of any side-effects of PRN medication?
- Is the PRN medication administered in the least invasive way?
- Has the Service User consented to the use of PRN? If not, is the strategy a proportionate and balanced decision?

FREDA

- Is the person treated with dignity and respect when receiving PRN medication?
- Is there a PRN protocol and is this followed?

Physical and Mechanical restraint

Article 2: The Right to life

In extreme cases, the use of physical restraint has resulted in death. This has been due to the use of excessive force or unsuitable restraint technique being employed. You should ensure that the Service User has regular physical examinations to determine whether restraint is appropriate.

Article 3: The right not to be tortured or treated in an inhuman or degrading way

If restraint is very severe and used with excessive force (i.e. not proportionate to the risk); it could potentially be considered inhuman or degrading treatment. If this is suspected, action should cease immediately as Article 3 is an absolute right that should not be compromised.

- Are the restraints approved by a recognised/accredited body e.g. Mersey Care Managing Violence and Aggression (MVA) or British Institute of Learning Disabilities?
- Do the techniques emphasise use of de-escalation prior to use of physical intervention?
- Do techniques use the minimum force necessary to ensure the safety of the person and/or others? E.g. tying somebody to a chair to prevent them moving would be inhuman and degrading treatment.
- Is any mechanical restraint (e.g. splints) used appropriately and not for prolonged periods unless absolutely necessary (would removal of the restraint result in immediate, extreme harm to the Service User and/or others)?

Article 8: The right to respect for private and family life, home and correspondence

Physical or mechanical restraint may impact on a person's physical and or psychological well-being, which is an important aspect of the right to respect for private life. If this is the case, it is essential that any physical and/or mechanical restraint has a legitimate aim, is lawful, necessary and proportionate.

- Is the use of physical restraint regularly reviewed to make sure it is still necessary and the least restrictive option?
- Does the Service User have an Advanced Statement which includes information about preferred restraints, effective verbal de-escalation techniques?

FREDA

- Is the Service User treated with dignity and respect before, during and after the physical intervention?
- Does the Service User understand the reasons for the physical restraint and are they debriefed following this?
- Does the person have a say in how they are restrained or who restrains them? (e.g. gender, relationship to the person)

1-6) Self-harm/injury (see also section on sexual abuse)

(For the purpose of this booklet, this does not refer to parasuicidal behaviours)

Article 2: The Right to life

- Any strategy e.g. harm reduction, that supports the person to continue self-harming is likely to involve their right to life. However, a harm reduction approach may jeopardise a person's right to life less than 'unsupported' self-injury.

Article 8: The right to respect for private and family life, home and correspondence

- Where family contact is identified as a trigger to self harm **and** restrictions are placed on this, the person's right to a family life should be considered.
- Is the Service User's room or clothing searched for items with which they may self-injure?
- Is the Service User able to access appropriate and non-judgemental medical treatment (if needed) following self-harm or self injury? Or, is the Service User able to care for their injuries effectively?
- Are proactive, person-centred strategies in place to reduce the likelihood/severity of self harm/self injury?
- Have these strategies considered the person's reasons and motivations to self harm?
- Have the staff team considered what role self harm/injury fulfils?
- Is the Service User's right to make informed decisions and choices respected?
- Does the Service User have a say in the strategies that are used e.g. Dialectical Behaviour Therapy (DBT) techniques of marking skin with a red pen, flicking elastic bands against your wrist?
- Does the person have the opportunity to talk to somebody following the self harm/injury?

FREDA

- Do staff/carers respect the Service User's autonomy by supporting them to use their proactive strategies? e.g. DBT.
- Does the Service User have any say in which staff members intervene when they are self-harming?

1-10) Strategies for domestic hazard

Article 8: The right to respect for private and family life, home and correspondence

- Does the strategy prevent a Service User from making hot drink/snacks for themselves? If so are they regularly offered these by staff?
- Does the strategy restrict the person's access to the kitchen or cupboards within the kitchen? (In extreme cases, this could raise Article 3)
- Can the Service User receive snacks/drinks when they ask for them?
- Are safety gates in place?

- If safety gates are used do they restrict the person's access to bathroom/toilet etc.? (In extreme cases, this could raise Article 3)
- Are certain things locked away to prevent the Service User from using them?
- In shared accommodation, do any strategies impede the quality of life of other Service Users who are not at risk of domestic hazard?

FREDA

- Does any intervention consider fairness, dignity and respect?
- Are interventions within the home (e.g. safety gates) age appropriate?

Article 1 of protocol 1: The right to peaceful enjoyment of property

- Do any restrictions in place limit the Service User's access to their property or rooms that contain their property? Is this a necessary, proportionate restriction?

1-11) Leaving package of care without support

Article 5: Right to liberty and security

- Are doors to the person's home locked, restrictors/alarms placed on windows or doors or is the Service User supervised for lengthy periods of the day? If so, unless the person is detained under a relevant section of the Mental Health Act their detention is likely to be unlawful.
- Any restriction placed on liberty and security must be considered in light of the **potential** for harm to the Service User, staff and the community (including property) if the strategy was **not** in place. If the restriction protects other, competing rights of the Service User (e.g. the right to life) or the rights of others (e.g. The right not to be tortured or treated in an inhuman or degrading way) it must be a proportionate response and the balanced decision evidenced.
- Is the person able to request to leave the property?

Article 8: The right to respect for private and family life, home and correspondence

- Is the Service User aware of their rights relating to leaving the property?
- Is the Service User aware of their rights under the Mental Health Act?
- Consider the impact any restriction can have on psychological integrity.
- Are the reasons for any restrictions explained to the Service User?

FREDA

- Is the Service User's autonomy respected?

Supervision

Article 8: The right to respect for private and family life, home and correspondence

- If the Service User requires intensive support, is their independence preserved as far as possible? This may be by using the minimum number of staff, or having periods in the day with reduced ratios/time for the person to be alone.
- If the Service User shares their home with staff or other residents, is the home respected as their own?
- Are there any restrictions on visits to or visits from family/friends?
- Are all visits supervised or is this decided on an individual basis?
- Is there a restriction on the ability for the Service User to develop personal and sexual relationships?

FREDA

- Is the Service User treated with dignity and respect when being supported?

1-12) Deterioration in mental health

Article 5: Right to Liberty and security

- Is the Service User sectioned under the Mental Health Act?

Article 8: The right to respect for private and family life, home and correspondence

- Does the person have any input into how their mental health problems are managed?
- Has the Service User made an Advanced Statement? Is this used?
- Is the Service User aware of people they can talk to if they have any concerns relating to their mental health?
- Does the Service User have access to medical and psychological treatments if their mental health deteriorates?
- Are proactive strategies in place? E.g. Symptom maintenance, awareness of early warning signs, Staying Well Plan?
- Does the Service User have accessible information on any diagnosed mental health problem?

If the Service User takes medication for their mental health problem:

- Has the Service User consented to take medication?
- How is medication administered (orally, depot injection etc.)?
- Is the Service User involved in decisions regarding their medication?
- Does the Service User know how to raise any concerns relating to their medication?
- Does the Service User have accessible information about the reasons for being on medication and their possible side effects?
- Is the medication regularly reviewed?

FREDA

- Is the Service User treated with dignity and respect with regard to their mental health problems? This includes the attitudes of and treatment by the staff team, family and other Service Users. If they take medication, is the Service User able to do so in private?

1-13) Alcohol and substance abuse

Article 2: Right to Life

- Can mainstream services be accessed by the Service User (e.g. alcohol services)? If not, this could potentially raise their right to life

Article 5: Right to liberty and security

- Are there restrictions placed on the Service User leaving their home (e.g. restrictors, locked doors)?
- Has the Service User been issued a treatment order?

Article 8: The right to respect for private and family life, home and correspondence

- Has the Service User consented to any intervention?
- Is the Service User offered psycho-education to promote their understanding of the effects of alcohol/substance misuse?
- Is the Service User's access to money restricted?
- Is the Service User supported to maintain nutrition and personal hygiene? Lack of support could potentially lead to inhuman or degrading treatment.
- Does the strategy place any restriction on access to family/friends or children

FREDA

Is the Service User's autonomy for making decisions about their drinking habits (for example) respected?

Psychological therapies

Although not a 'risk management' strategy per se, many Service Users may have ongoing or short-term psychological therapy for a variety of reasons. This can include indirect psychological interventions with family and staff teams.

Article 8: The right to respect for private and family life, home and correspondence

- Has the Service User provided informed consent for direct and indirect interventions?
- Is the Service User aware of confidentiality and implications of any disclosures they make?
- Is any information about the Service User shared on a need to know basis?
- Is psychological therapy being used to locate the problem in the person and not in the system of support? E.g. Is anger management being used to 'treat' someone when they are angry about their rights being denied?
- Is information shared on a 'need to know' basis?

Restrictions on access to the community

Restrictions on access to the community may be based on protecting the community or possibly, specific groups within the community (including adult males, adult females or a specific ethnic minority group). This may be pertinent where a Service User poses a risk of verbal aggression/intimidation or physical violence.

Any restriction should:

- Be applied only to specific areas, places or times that would trigger the risk behaviour
- Be regularly reviewed – is a 'permanent' restriction justified?
- Be mindful of the benefits if positive risk taking etc.

Article 5: Right to liberty and security

- Does the strategy impose restrictions on the Service User leaving their home (e.g. restrictors on doors/windows)?
- Is the person sectioned under the Mental Health Act?

- Does any other legislation, community order and/or bail conditions etc impose any lawful restrictions?

Article 8: The right to respect for private and family life, home and correspondence

- Is the person aware of the reasons for any restrictions?
- Does the restriction prevent the Service User from being able to have meaningful participation in the community? Is this proportionate?
- Is there a restriction on the ability for the Service User to develop personal and sexual relationships?

2-4) Sexual offending

Article 5: Right to liberty and security

- Are doors locked to prevent the Service User from going out and potentially sexually offending?
- Is the person sectioned under the Mental Health Act?
- Does any other legislation, community order and/or bail conditions etc impose lawful restrictions?

Article 8: Respect for family and private life, home and correspondence

- Is the Service User prevented from going to certain areas within the community?
- Is the Service User restricted from going to any place/area within the community because they would be at risk from others?
- Are any restrictions of the Service User's movements within the community part of a court judgement/ruling?
- Does any strategy mean that the Service User's choices about where they live have to be refused? Is this explained and understood by the Service User?
- Does the strategy restrict visits to or from family members and friends?
- Is information relating to sexual offences shared on a 'need to know' basis?

FREDA

If the Service User is suspected of/known to have committed a sexual offence, are they treated with dignity, fairness and respect? Do staff and services treat them equally?

2-5) Stealing

Article 3: Right to be free from torture or inhuman and degrading treatment

- Is the Service User ever searched if they are suspected of stealing? This would raise Article 8, but standard practice of always searching the person with no reasonable grounds could constitute degrading treatment.

Article 5: Right to liberty and security

- Are there any restrictions placed on the Service User leaving the property to prevent stealing?

Article 8: Right to respect for family and private life, home and correspondence

- Are there restrictions placed on accessing certain rooms within the Service User's home?
- Consider protecting the rights of the staff team/family/public (see risk guidance)
- Are the Service User's room or belongings ever searched if they are suspected of stealing?

FREDA

- Is the Service User treated with dignity and respect despite suspected or potential stealing behaviour?
- Does the Service User have the same freedom and equality as other Service Users who do not display this risk?

2- 6) Arson

Article 3: Right to be free from torture or inhuman and degrading treatment

- Is the Service User ever searched for fire-setting materials? If this is done on a daily basis e.g. when the Service User returns home after being in the community, this could constitute degrading treatment.

Article 8: Respect for private and family life, home and correspondence

- Is the Service User's access to the community restricted? (see relevant section)
- Are there restrictions on the Service User's finances? (see relevant section)

Safeguarding Children

Consult 'Keeping Me Safe and Well Screen' guidelines for the rights of children that the strategy must aim to protect.

2-10 Managing any risk posed to children

Article 5: Right to liberty and security

- If the strategy imposes a restriction on the Service User leaving their home at any time; it could interfere with their right to liberty and security.

Article 8: The right to respect for private and family life, home and correspondence

- Is the Service User restricted from visiting any place/areas within the community where they could pose a risk to children (e.g. parks, areas close to schools, swimming pools)?
- Is the Service User restricted from going to any place/area within the community because they would be *at risk* there?
- Are any restrictions of the Service User's movements within the community part of a court judgement?
- Does any strategy mean that the Service User's choices about where they live have to be refused? Is this explained and understood by the Service User?

2 – 11) Strategies to support Service Users with dependants

Article 8: The right to respect for private and family life, home and correspondence

- Are proactive strategies in place to support the Service User to develop parenting skills and to help them to have a safe and productive family life with their child?
- If the Service User does not live with the child:
 - Does the strategy restrict the Service User's access to their children?
 - Does the Service User have to be supervised when spending time with their children?
- **N.B. The child also has the right to have a meaningful relationship with their parent.**

FREDA

- Is the Service User treated fairly and equally when being supported to develop their family life?

3 – 3-4) Strategies to protect the Service User from physical, sexual, emotional and financial abuse by others

See the 'Keeping Me Safe and Well Screen' guidelines for the rights of the Service User that need to be protected. These areas are likely to be quite complex and will entail a thorough, balanced decision making process.

N.B. The strategy could severely restrict the rights of family members, carers and friends. However this restriction may be rights compliant if it has the genuine aim to protect the Service User from ongoing torture or degrading treatment (e.g. if they were a survivor of physical abuse).

Article 8: The right to respect for private and family life, home and correspondence

- Are any restrictions placed on contact with family members or friends?
- Is the Service User involved in the development of strategies to protect them from abuse?
- Does the Service User have access to psychological therapies and counselling?
- Are the reasons for any restrictions explained to the Service User?
- Does the Service User have capacity?
- Have you fulfilled your duty to protect the Service User from ongoing abuse?

Article 1 of Protocol: The right to peaceful enjoyment of possessions

- Are there management strategies surrounding the Service Users finances to protect them from abuse? (see below)

Managing a Service User's money

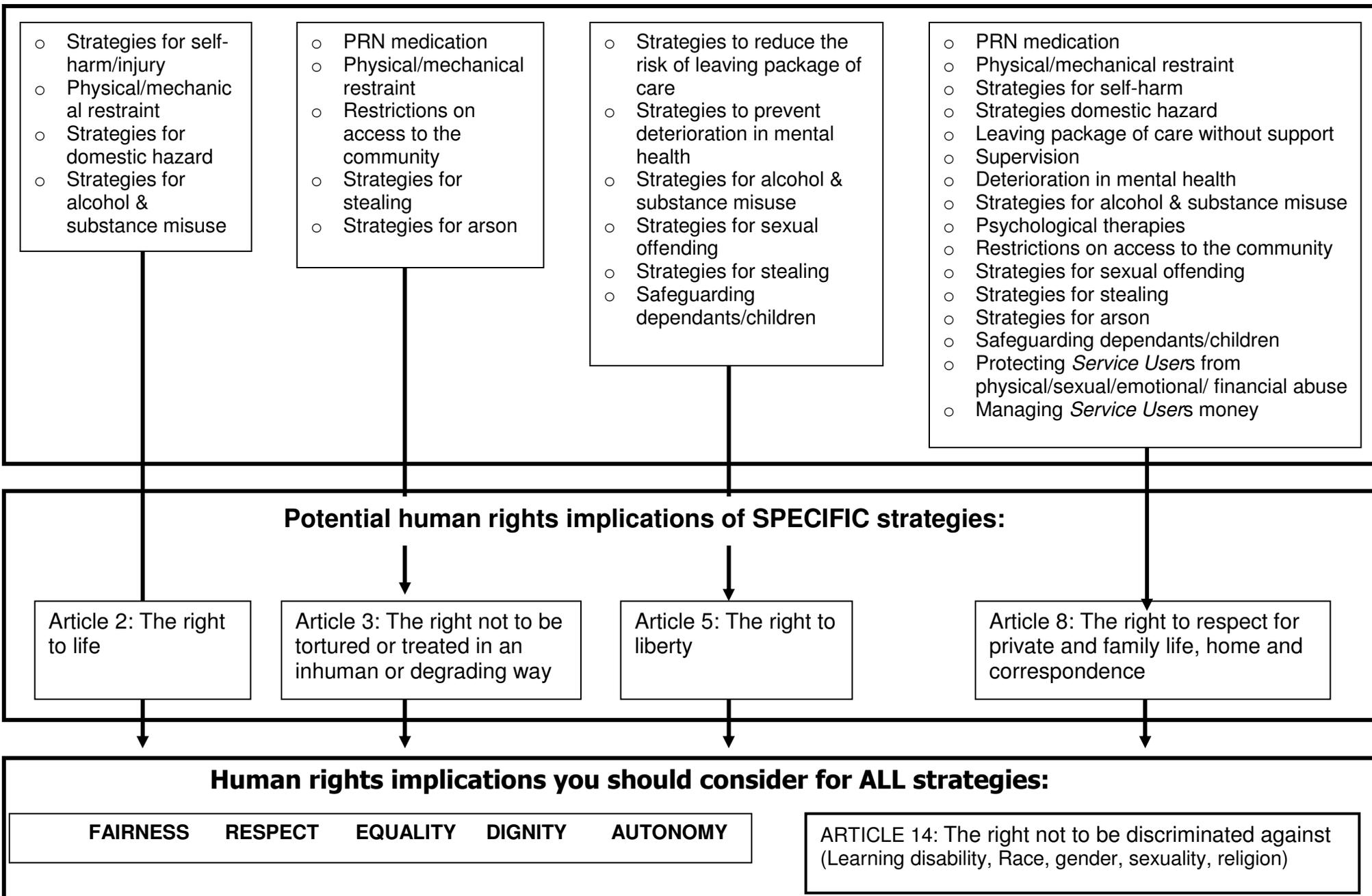
Article 1 of Protocol: The right to peaceful enjoyment of possessions

- If the Service User's money is managed, do they understand the reasons for this?
- Does the person have a say in how their money is managed?

Article 8: The right to respect for private and family life, home and correspondence

- Does the management of the Service User's money prevent access to activities that they would otherwise enjoy?
- Does the Service User have their own bank account even where they are assisted to manage their own money?
- Are restrictions on finances aimed to manage risks (e.g. alcohol/substance misuse)?

STRATEGY (there may be more than one right raised by an individual strategy)



Appendix 5

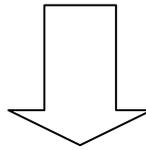
Human Rights Decision Making Form

This form is to assist your decision making process when developing risk management strategies. Any risk management decisions should be discussed within the MDT.

1. WHAT RIGHTS ARE INVOLVED IN THE RISK BEHAVIOUR?

(See 'Keeping Me Safe and Well' screen guidelines)

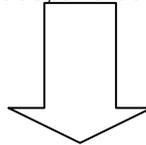
It will be useful to keep these in mind to make balanced decisions and when considering proportionality.



2. WHOSE RIGHTS ARE INVOLVED IN THE RISK?

(e.g. Service User, Staff, community, property)

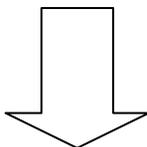
(In extreme cases, this could raise Article 3)



3. WHAT ARE YOUR STRATEGIES FOR RESPONDING TO THE RISK?

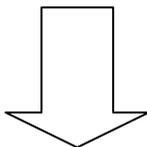
PROACTIVE

REACTIVE



4. WHO WILL BE AFFECTED BY YOUR STRATEGIES?

(E.g. Service User, Staff, community, property)



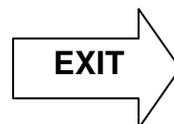
5. WILL THE STRATEGIES ENGAGE ANYONE'S RIGHTS?

(See human rights strategies guidance for suggestions)

IF NO: your strategies are likely to be human rights compliant and you do not need to continue with this flowchart.

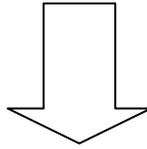
However:

- You should **reassess** the situation **regularly** - things may change!
- You should **consult the MDT** to reach this agreement
- You should ensure that you are still acting within the remit of the Mental Health Act/Mental Capacity Act/Deprivation Of Liberty safeguards



IF YES: Which rights does the strategy engage, and how?

Whose rights are they?



6. WILL THE STRATEGY RESTRICT ANYONE’S RIGHTS?

If no: your strategies are likely to be human rights compliant and you do not need to continue with this flowchart.



However:

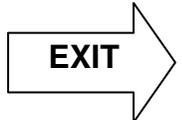
- Be aware that your strategy may affect whether particular groups or people can enjoy their rights.
- You should **reassess** the situation **regularly** - things may change!
- You should **consult the MDT** to reach this agreement

If yes:

a) Are any of the rights absolute?

If yes, then the strategy may not be human rights compliant. If you are concerned about this you should:

- Discuss your concerns with the MDT
- Change the strategy so that it does not restrict the right
- Consider seeking legal advice



b) Is Article 5: The right to liberty raised?

If yes, then the strategy may not be human rights compliant. There are specific circumstances in which Article 5 can be limited:

- Legal detention under the MHA (with regular reviews)
- Informal detention of Service Users who lack capacity to decide if they would like to be admitted to hospital
- Any restriction on Article 5 must be legal and proportionate



c) If the right is NOT absolute then . . .

i) Is the restriction of the right lawful? Do the MHA, MCA or DOL guidelines apply? Write down any relevant legislation.

ii) Do you have a legitimate aim that is in accordance with the Human Rights Act (e.g. the protection of other people)?

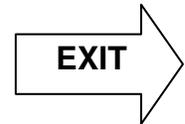
iii) Is the strategy necessary to achieve this aim?

iv) Is the strategy **proportionate**?

v) Are there any competing rights? Is your decision balanced?

If **yes** to **all** of these, the strategy is likely to be human rights compliant, however:

- You should **reassess** the situation **regularly** - things may change!
- You should **consult the MDT** to reach this agreement
- You may still need legal advice



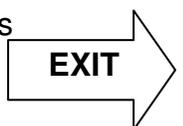
If **no** to (or you are unsure about any of these), then your strategy may not be human rights compliant. If a strategy is 'unsafe' there is potential for it to be an Article 3 (Freedom from torture or inhuman or degrading treatment) issue.

7. MINI CHECKLIST

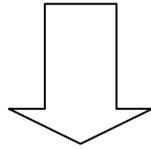
Some key considerations for all strategies include:

- Whose rights are they?
- How do I make sure I'm not breaching them?
- Is the strategy appropriate and not excessive to the risk posed?
- Is the interference with Service Users rights kept to a minimum?
- Is the least restrictive strategy being used?
- What will be left of the Service Users rights if you employ the strategy?
- Is there an alternative, less drastic strategy?
- Has the Service User or Service User consultant been involved in the development of the strategy?
- Has the MDT been involved in the decision making process?

If your answer is **yes** to all of these questions, your strategy is likely to be human rights compliant.



If your answer is **no** to any of the questions, then the strategy may not be human rights compliant. Consider all of the rights involved and aim to make a balanced decision.



8. WHAT NEXT?

If you are concerned that the strategy is not human rights compliant or with any of the decisions you have made, what action will you take? You could:

- Change the strategy so that it does not restrict the right
- Raise your concerns with the MDT
- Seek legal advice

