mentalwelfare
commission for scotland

Too close to see

Full report of our investigation into deficiencies in the care and treatment of Mr F

Section 1

Background to the investigation

1.1 Introduction

1.1.1 The Mental Welfare Commission has a duty under section 11 of the Mental Health (Care & Treatment) (Scotland) Act 2003 to investigate the case of any person subject to ill-treatment, neglect or some other deficiency in care and treatment.

1.1.2 The Commission became aware of Mr F's case on 7th June 2007. Mr F had been admitted to an Intensive Psychiatric Care Unit (IPCU) following an incident which resulted in the death of his father. The Police wanted to remain within the IPCU to 'guard' Mr F and the supervising Consultant Psychiatrist contacted us for advice about the implications of this for Mr F's rights, care and treatment. Having looked into the circumstance of the case and following a request from the Minister for Public Health, the Commission decided to formally investigate the case. Whilst enquiry was made into Mr F's entire life history, the focus of the investigation was the period 2005 until the present day.

1.2 Investigation Team

Ms Linda Graham

H.M. Commissioner, Mental Welfare Commission

Chair of the investigation

Mr Douglas Seath

Nursing Officer, Mental Welfare Commission

Ms Julie Paterson

Social Work Officer, Mental Welfare Commission

Dr Elizabeth Calder

Medical Officer, Mental Welfare Commission

The investigation was assisted by Mr Mark Manders, Casework Manager, Mental Welfare Commission

1.3 Method of undertaking the investigation

1.3.1 The investigation began with a detailed examination of Mr F's medical, nursing and social work records. We reviewed records pertaining to Mr F held by voluntary organisations and housing services. We also reviewed GP records pertaining to Mr F's father as his presentation and behaviour formed an important part of a complex situation.

1.3.2 The investigation team then interviewed those people it considered could contribute important information. This included meeting with Mr F and also his mother and siblings. These two meetings were deliberately conducted out-with the formal interview process given the unique circumstance of the case but were minuted and given the same importance as the other interviews. In total, nineteen individuals were interviewed. A comprehensive listing of people who gave evidence is provided at the end of this report. Interviews took place within the geographical area where the case was located. We made a written record of each interview and sent it to the person concerned for correction with regard to factual accuracy.

1.3.3 For reasons out-with the control of the investigation team, it was not possible to interview two key people involved in the care and treatment of Mr F and we were therefore reliant on their written notes and, with one individual, the supplementary evidence of their direct line manager and supervisor. Where this has left any unanswered questions, this is clearly stated in the text. One of these individuals was a social worker involved with Mr F in the past and the other the community mental health nurse that was involved with Mr F in the period immediately prior to and during the incident.

1.3.4 It was made clear to all those interviewed that we would publish the report of the investigation.

1.4 Acknowledgement

The investigation team received a high degree of co-operation from HB A with regard to the practicalities of the investigation and are grateful for this.

Section 2

Statement of Fact

2.1 Mr F was born in 1968. He grew up with his parents and two sisters in a small Scottish town. He progressed through school with no problems and left at fifteen years of age with no qualifications. Mr F's early family life was adversely affected by his father's behaviour. He was recognised as a very difficult man who was dependent on alcohol by the time Mr F started school. He also had poor physical health from an early age. Mr F describes his father as having been a "cruel man" who was verbally abusive and physically violent towards him. The family was regularly left struggling without enough money because of his father's alcohol use. One of Mr F's siblings left the family home at nine years of age because of the nature of the environment.

2.2 In his adult life Mr F disclosed that he had been a victim of childhood sexual abuse by multiple perpetrators over a period of ten years. This started when he was seven years of age and continued until after he had left school. One of the main perpetrators was a "lodger" that Mr F senior moved into the house.

2.3 There were no statutory agencies involved with the F family during Mr F's childhood.

2.4 In his teenage years, Mr F worked as an apprentice baker, casual labourer and machine operator. However, he too developed a serious alcohol problem which then interfered with his ability to work. Mr F had his first contact with mental health services in Health Board A (HB A) in 1990. At this time he gave a six month history of chest pains, panic attacks, increased irritability and explosive outbursts where he would throw objects around the house. He also physically assaulted his fiancée. He was drinking heavily at this time and was given an initial diagnosis of panic disorder and personality disorder. Mr F was discharged from the service when he failed to attend for follow-up appointments. His GP re-referred him in 1992 with anxiety problems. He was still drinking heavily and when assessed this was seen as the main problem. Mr F's difficulties were not viewed as meeting formal diagnostic criteria for any other disorder and he was discharged without follow-up.

2.5 Mr F moved to a different part of Scotland with his fiancée between 1992 and 1996. They had two sons during this period. Mr F had regular contact with mental health services in Health Board B (HB B) having been diagnosed by them as having schizophrenia. He was treated with anti-psychotic medication. As the case notes from this Health Board area were not scrutinised, it is not clear on what exact grounds this diagnosis was made. Unfortunately, Mr F's relationship failed because of his alcohol use and other problems and he moved back to his home area in 1996. He moved in with his parents, this situation being further complicated by the fact that Mr F Senior had sustained a partial spinal cord injury in March 1996 after falling from a stool; this resulting in him requiring a wheelchair.

2.6 Although it is recognised that Mr F attempted to keep contact with his sons after moving, his relationship with his ex-partner was more difficult and she eventually obtained an interdict against him. This followed an incident where Mr F appeared at her home with an acquaintance and, having forced the door open, assaulted her and her new partner. He also threatened to set the house on fire and stab the new partner. Mr F was convicted of this offence and given a large fine. By this juncture, he had previous convictions only for Breach of the Peace and Road Traffic Offences.

2.7 Mr F was assessed by a Consultant Psychiatrist (Dr A) from General Adult Psychiatry services in mid-December 1996 and referred for Community Mental Health Team (CMHT) involvement. However, he was admitted to Hospital A shortly thereafter for a period of one week before leaving against medical advice. During this time he sought help from the local social work department (SWD A) with regard to payment of his court fine and because he was homeless. The Housing Department received a Homeless Person application at this time. Mr F was re-admitted to hospital only three days later and remained there for three weeks over the festive period. Notes detail that he was experiencing thoughts of self-harm and violence and had beliefs that he was in danger from other people. It is also noted that Mr F did not want his father to visit. Mr F Senior was abusive to staff when informed of this fact and Mr F seemed relieved that someone else had witnessed how his father could be. The discharge letter from this time details Mr F as having a "mixed anxiety depressive state with obsessional symptoms" set in the context of alcohol misuse. It explicitly states that no true psychotic symptoms had been seen and that, as Mr F tended to abuse prescription medication, the prescribing of benzodiazepines should be avoided. He was referred to the CMHT again but defaulted from the appointment given and discharged.

2.8 An assessment of Mr F's housing application in January 1997 judged him to be "intentionally homeless" although this was not upheld on appeal. Whilst living in Bed and Breakfast accommodation, Mr F was referred to the local Day Hospital. He was noted to be aggressive and verbally hostile but also low in mood. At this stage, Mr F was on two different anti-psychotic medications without a clear rationale evident for this from case-notes.

2.9 Mr F was referred to the Home Detox Team (HDT) in February 1997. SWD A closed Mr F's case around this time stating that there was "no apparent need for further social work involvement". Mr F was still in B&B accommodation at this time and returning to live with his father was ruled out given the "stormy relationship" between the two. Dr A also made a referral to Clinical Psychology asking for help with poor coping skills and an inability to manage stress. The diagnosis is again listed as long-standing personality difficulties with anxiety and obsessional symptoms. The lack of efficacy of anti-psychotic medications is noted with this being in contrast to his treatment in HB B where an antipsychotic depot was viewed as helpful (Dr A having knowledge of his treatment there).

2.10 Mr F failed to attend an appointment with the HDT and was discharged.

2.11 Mr F was given notice to quit his temporary hostel accommodation by the housing department. He was ruled intentionally homeless. Mr F sought advice from SWD A who directed him to deal with the housing department directly and thereafter SWD A closed the case.

2.12 Mr F appears to have experienced particular problems arising from childhood sexual abuse at this time. There was an emergency hospital admission and he was voicing that there were four people he had to deal with in order to protect other children from harm. A month later in April 1997, Mr F was admitted to Hospital B for planned detoxification. He had self-harmed a number of times. The detoxification was successfully implemented and follow-up was arranged with the HDT and from Consultant Psychiatrist, Dr B, from the Dual Diagnosis Team (DDT).

2.13 Mr F approached SWD A a few days later, his room at the homeless accommodation having been burgled. He had been refused a crisis loan. SWD A advised him to attend the crisis loan office again to ask for a review of that decision. Mr F was noted to be "able and articulate" and the case closed again.

2.14 Unfortunately, Mr F was drinking heavily again by the end of the month and was admitted briefly to Hospital B having superficially cut his wrists. He was discharged because he took benzodiazepine medication that had not been prescribed whilst on the ward. In July 1997, Mr F admitted that he had started carrying a knife feeling that people were out to get him and that he would "get them before they get me." The response to this was for Community Mental Health Nurse A (CMHN A) to deliver anxiety management and look at ways of dealing with anger more appropriately. CMHN A wrote to the GP detailing this.

2.15 In August 1997, the HDT found that Mr F had begun drinking and described him as "self-medicating with alcohol as antipsychotic medication not working." In November 1997, due to Mr F's continued drinking he was discharged from CMHN A's caseload and it was agreed that Consultant Psychiatrist, Dr C, from the Addictions Team would provide follow-up. He arranged to review Mr F and persevered until he actually attended. Dr C viewed the paranoid ideas as non-delusional but stated that the anti-psychotic medication started by the GP should continue. This was increased shortly thereafter. It is of note that Mr F had made a formal complaint of childhood sexual abuse some time previously. The case came to Court in November 1997 but no convictions followed.

2.16 During early 1998, Mr F was again in touch with the Housing Department. He received some medical housing points but was then judged "not homeless" as he had been admitted to hospital. On discharge ten days later he was judged homeless and B&B accommodation found. This was withdrawn three days later when it was found that Mr F had not resided there. The hospital admission to a general adult ward at Hospital A under the care of Consultant D, noted "no evidence of mental

illness" with Mr F having been detoxified. There is no documented evidence which suggests liaison with any of the previously involved Consultants.

2.17 It appears that Mr F was living between his parents and girlfriend's residences at this time.

2.18 Mr F was made subject to a Probation Order of eighteen months duration in April 1998 having been convicted of Breach of the Peace. Criminal Justice Social Work (CJSW) closed the case before the period of Probation was over but no explanation for this was given. CJSW records from this time had been destroyed by the time this investigation began.

2.19 Mr F failed to attend for follow-up appointments with Dr C in December 1997 and February 1998. Re-referral was made in October 1998 and an appointment offered five weeks later. In the interim, Mr F was assessed at A&E complaining that people were trying to interfere with his brain and that his mother was trying to sedate him. He was admitted to Hospital A under the care of Consultant Psychiatrist, Dr E and Mr F remained in hospital for two weeks. Dr E detailed that the presentation appeared to have changed quite considerably and believed Mr F to be acutely psychotic with a "complex paranoid system involving a conspiracy by his girlfriend and father to have him killed." He was eventually detained under mental health legislation with the assessing Mental Health Officer believing that he lacked insight and did not wish to be kept in hospital. On discharge from hospital, Mr F was referred to the DDT and follow-up arranged with Dr A and CMHN A. Mr F was prescribed oral anti-psychotic medication.

2.20 In December 1998, Mr F Senior contacted services stating that his son was non-compliant with oral medication and suggesting that he would be better placed on depot medication, having done well on this when living in HB B and being at risk of over-dosing on tablets if available.

2.21 After a short admission in January 1999 Mr F was commenced on depot medication. Mr F himself was expressing the belief that many of his problems would be solved if he could secure independent housing. He was followed up by CMHN A of the DDT. She assessed Mr F as "clearly becoming unwell again" despite the depot and detailed "auditory hallucinations, ideas of reference and feelings of paranoia, expression that he had thoughts of murdering someone mainly his father." An informal hospital admission was arranged and Mr F's depot increased. Non-compliance with anti-depressant medication is noted.

2.22 Mr F had a period of consistent contact with the DDT at this time. They noted that whilst he was still drinking every day, the amount consumed appeared to increase on those days when he was staying with his father. No mention is made of his father's own alcohol problem and whether this is related. Mr F was viewed as having schizophrenia but with risk issues and prognosis more linked to continued

alcohol misuse. By September 1999 there was a consensus that Mr F was benefitting from depot medication.

2.23 In November 1999, Mr F Senior contacted the SWD and asked for an assessment of needs for his son; particularly with relation to housing issues. This was passed to the Community Care Senior Social Worker. Mr F Senior telephoned again in January 2000 to challenge the apparent inaction and the case was allocated to a student Social Worker. It is worth noting that Mr F Senior was in intermittent contact with the HDT for his own alcohol addiction during this time and was found to be loud and derogatory towards staff.

2.24 Whilst Mr F appears to have been living with his girlfriend for much of the year 2000, he moved back in with his father in October. The CMHN involved at this time noted a fear that the father may be a negative influence on Mr F's alcohol use and behaviour. In January 2001 medical assessment detailed Mr F suffering "bad thoughts" of stabbing his father but that these were recognised as abnormal and that he was managing them by avoiding his father as much as was possible. In-patient notes of the multi-disciplinary team meeting of 5th February 2001 detail that Mr F was openly discussing his thoughts of harming his father and that it was his father's voice telling him to do so. He was taking a knife out and stabbing the kitchen worktop at times when this happened. The outcome of the meeting was a reduction in his anti-psychotic medication.

2.25 In March 2001, Mr F still did not have a tenancy and was asked to widen the area where he was willing to live in order to increase the chance of something suitable becoming available. This information was logged by the Community Care Social Work (CCSW) team and closed the same day. The next contact with this team was in October 2001 when Mr F's mother telephoned to express concern about his mental health and the fact that he was threatening to kill his father. Mr F was contacted at this time and asked whether he wished social work involvement. Mr F said yes. The case was allocated to SW 1 in late November 2001 after Mr F's mother reported that his two children had stayed with him over the weekend and thought this may be a permanent arrangement. Social Work notes record "Mr F ... (has) a history of non-compliance with social services at an area team level." This judgement does not seem to reflect the previous facts.

2.26 Mr F presented at the Housing Department eight days later with his two children and lodged a homeless application. Temporary accommodation was arranged but this was not utilised. Housing notes state that the CCSW team had been telephoned and that they intended to initiate the Care Programme Approach. There is no evidence that this ever occurred.

2.27 On 5th December 2001 there was a Child and Family meeting. It was noted that Mr F's ex-partner no longer felt able to care for the children. SW 1 stated at this meeting that "Mr F's psychiatric condition was under control and that this should not

present a danger to the children." There is no evidence that SW 1 had consulted with health service staff before reaching this conclusion or that any attempt at risk assessment and management had taken place. The outcome of the meeting was that the children should continue to live with their father with the situation monitored by SW 1.

2.28 Over 2002 Mr F was finally allocated a house but was reluctant to move in. Attempts were made to make the house 'lived-in' such that Mr F could then apply to the Housing Department for a transfer of tenancy. Mr F rejected suggestions that he be provided with extra support stating that he preferred help only from his mother and girlfriend. Mr F spent his community care grant monies intended to furnish his house on alcohol and never actually took up the tenancy. His mental state appears to have been quite good but he continued to drink alcohol and have poor compliance with oral medication. His care continued to be given by the DDT with a hospital admission in April/May overseen by Dr A. A change in medication to clozapine or an atypical anti-psychotic depot was considered but neither was initiated.

2.29 In August 2003 SW 3 conducted a Community Care Review for Mr F Senior. Care Support Workers were attending the house twice each day to help Mr F Senior with personal care. It is notable that SW 3 was fully aware of risk issues arising from Mr F Senior's behaviour with workers initially attending in pairs because of this. SW 3 found the family supportive of Mr F Senior and described that they were able to modify their behaviour when this was asked of them. Mr F Senior was reluctant to pay for his care, however, and this was eventually stopped leaving Mr F and his mother to provide what was needed. In addition to his alcohol and physical health problems, Mr F Senior took an overdose of paracetamol in this month.

2.30 In October 2003 Mr F was admitted to Hospital A for assessment of his mental state following a violent incident involving his father whilst under the influence of alcohol. It was recognised that Mr F was disinhibited when under the influence of alcohol. He was discharged after only one day and his nursing input was changed to CMHN B from the DDT. This worker also discovered Mr F to be describing thoughts of an aggressive nature and, although believing Mr F capable of distracting himself from them, asked for Dr B to review the situation. Dr B reviewed Mr F two months later when prompted to do so. Dr B has told us that he is often not advised of his patients' discharge from hospital and this, coupled with his large caseload, may have meant that until reminded he had forgotten to send MR F an appointment. Dr B made no reference to the thoughts in his subsequent communication.

2.31 Another hospital admission was required in April 2004. Mr F's parents had expressed concern about his mental health following a number of family stressors. Mr F talked freely to nursing staff about ongoing thoughts of harming his father and about non-compliance with oral medication. In July 2004 during an in-patient admission a member of nursing staff documented that Mr F was reporting "previous bad thoughts where he thought he had murdered his girlfriend with a pair of scissors

and his father with rose pruners. Reports he still experienced thoughts of harming his father i.e. standing in the kitchen whilst his father watches TV and looks at the knife block." The summer and autumn months saw a very similar pattern of events and Mr F Senior was referred to mental health services for his own problems. He was assessed by the CMHT but referred on for counselling. There was no information in the notes to suggest that the appropriateness of this referral had been discussed with the counselling service and he failed to engage in due course. Further, neither services dealing with Mr F or his father initiated a carers' needs assessment. It is worth remembering that Mr F's sons, now aged 14 and 13 years, were intermittently living in this situation. The care team have stated that although the children's visits were often at short notice, they were aware that they were present in the house. Contact with social work was "tailed off" in early 2003 and eventually closed again in 2004.

2.32 By February 2005, Mr F had developed physical problems because of his alcohol use. He continued to misuse alcohol and his mental state appeared to be worsening. He is said to have developed "agoraphobic type" symptoms and was hardly leaving the house. A full, hospital based, review of his medication ended after two weeks when Mr F left against medical advice. On discharge, the care was handed back to Dr B and the DDT but mention is made of Dr A trying to keep contact also. Around this time, another of the men said to have sexually abused Mr F pled guilty and was remanded to custody.

2.33 CMHN B asked Dr B to review Mr F and this took place in May. Dr B's letter states that "I find myself becoming extremely concerned about him" and mentions that he may need to utilise the mental health act. However, there was no immediate action following on from this. Mr F described using alcohol as an anaesthetic against the thoughts in his head and his mother reported that the alcohol was making him more aggressive and difficult to manage at home. Mr F was drinking up to two bottles of vodka each day.

2.34 Dr B appears to have reviewed Mr F more regularly over the next few months but the next hospital admission in October 2005 was again unplanned. The picture remained the same. In December 2005, an Occupational Therapist became involved (OT 1) with a view to dealing with "anxiety issues." Specifically, it appears that she intended to implement a graded desensitization programme for Mr F's reluctance to leave the house. This proved difficult because Mr F did not engage. There are no direct entries by OT1 in the DDT record but specific written comment is made by CMHN B that Mr F was receiving "input from my colleague (OT1) to assist with his anxiety issues and work towards a desensitisation programme in regards to his agoraphobic type symptoms." At the same time, CMHN B had begun a training course in "psychosocial interventions" (PSI). This required CMHN B to combine new academic learning with an actual clinical case. He considered that Mr F may have benefitted from what he was learning and therefore chose Mr F. Over the next nine months Mr F received joint support from CMHN B and CMHB C who ultimately took

over the lead role in August 2006. CMHN C administered Mr F's depot medication and attended to general care issues whilst CMHN B implemented the PSI. CMHN B has stated that the PSI was to help Mr F over-come "concrete thinking" by assisting him to generate alternative thinking about a number of issues including his core beliefs, automatic cognitions and his father's behaviour. CMHN B expressed the view that Mr F's lack of confidence and motivation may not purely be arising from his schizophrenic illness but rather reflect problems with negative beliefs about himself and others. He specifically hoped that as Mr F's confidence improved this would lead to the development of "confrontational skills". This work was supervised by a Clinical Psychologist who had no direct links with the DDT and who had no direct contact with Mr F. It is unclear why two different psychological approaches were implemented at the same time.

2.35 Dr B was fully aware of the work of CMHN B. At interview he told us he was not aware of the work of OT1 but case-notes suggest that he was informed by letter that this had been initiated. Dr A expressed the view that Mr F's case was of a complexity that meant that only a very skilled worker should have been undertaking psychological intervention and highlighted that whilst the ward that Mr F was normally admitted to had a clinical psychologist working there at one point in time, the multi-disciplinary team went long periods of time without this resource.

2.36 Mr F was admitted to Hospital A for a period of five weeks in January/February 2006 after having been assessed at A&E. He was successfully abstinent from alcohol at this time. It is documented, by the SHO, that Mr F was experiencing command hallucinations to harm his father, seeing images of his father on television even when it was switched off and experiencing voices telling him that his father was a beast and a paedophile. The PSI work continued. Mr F was now on an atypical depot injection, oral anti-psychotic and anti-depressant medication.

2.37 Over April and May 2006, two issues are of note. Firstly, that Mr F began to consume large amounts of caffeine. Secondly, he reported that he intended to begin carrying a weapon again to protect himself from strangers. The records of CMHN B and CMHN C detail that he was advised against this and what the consequences might be. Dr B expressed the view that "until such times when we can remedy Mr F's living situation (with ample support) everything is going to continue to be responsive to high levels of expressed emotion that he is currently experiencing." Mr F was due to get married and this appeared to be adding to his stress levels.

2.38 Mr F's family began to express the view that his mental state was deteriorating in the days before his depot medication was due to be administered. He was also more aggressive at these times and expressing increased thoughts about harming himself. They also reported that he was not using the oral anti-psychotics available to him because of side-effects. This included sexual dysfunction which, in the context of his recent marriage, was a particular concern to

him. When reviewed by Dr B it was noted that Mr F's "delusions are more intense and fixed than ever."

2.39 An Emergency Detention was used on 15th June 2006 because of acute suicidal ideation but Mr F was also psychotic. The voice of an angel was telling him to kill his father or take an overdose and Mr F appeared distressed by this experience. During the admission, Mr F overdosed and self-harmed. He also assaulted another patient specifically as a result of misidentifying people, another symptom of psychosis.

2.40 On 16th June 2006, a referral was made to SWD A. This was allocated on 26 June 2006 with a target completion date for the Single Shared Assessment (SSA) of 27th July 2006. Unfortunately the allocated social worker (SW2) then went off sick for a period of six months. Mr F received no contact from SWD A during this time. The various workers from HB A made no formal approach to SWD A to highlight the inadequacy of this and, instead, simply checked frequently whether SW 2 was due to return. SW2 returned in January 2007 and the case was re-activated.

2.41 Mr F's marriage was short-lived and he was again living with his father by autumn 2006. He had a hospital admission between June and August and was described as being "very unwell and very paranoid." It was evident that Mr F was self-harming regularly. On discharge, Mr F was still being followed up by the DDT and was being seen regularly by CMHN C. CMHN C was quite concerned about Mr F whose thoughts about harming his father and himself continued. However, he had also developed beliefs that his medication contained poison. His oral medications were being held and administered by his family. Mr F started to misuse alcohol again and there was question whether he was developing a Wernicke's Encephalopathy, a common consequence of long-standing alcohol misuse.

2.42 In early November 2006, CMHN C completed a standard SSA requesting six hours of support from an established agency (SA 1). SA 1 had been given a specific remit to work alongside the DDT with finance coming through "Supporting People" monies. Supporting People monies can only be utilised to provide certain types of support and, indeed, are ordinarily only used to support people already within their own tenancies. Special permission was sought to accept Mr F's referral given his position of living with his father.

2.43 When CMHN C completed the SSA document, in response to the "Person Centred and Environmental Risk" form the section "history of aggressive or violent behaviour" the response given was "no history of violent or aggressive behaviour; no known risks associated with client's home; no known vulnerabilities." It thus indicated that there were no risks associated with visiting the house (recall that Mr F Senior had a history of being abusive to health service staff and was required to move GP practices several times over the years because of his behaviour). The

application stated that Mr F "plans to obtain own tenancy once mental health is stable."

2.44 Support Agency Worker 1 (SAW1) and CMHN C visited Mr F together on 14th November 2006. It was agreed that the areas of support to be offered were socialisation, independent living skills and emotional support. The latter is described as being "one to one counselling with mental health issues." Mr F was admitted to Hospital A the next day, however, following an incident where he self-harmed by cutting his arms and attempting to stab himself in the kidney. Worryingly, his sons were again staying with him at this time and the stabbing incident happened in the presence of his now sixteen year old son (they shared a bed due to lack of space in the house) who was extremely distressed by the incident. The assessing doctor stated that there was a need to "reconsider risk assessment in light of this behaviour." During the admission, Mr F punched another patient in the face fracturing his nose but he was not considered to be a risk and the other patient was simply moved to another ward.

2.45 On 27th November 2006, CMHN C initiated the process to secure an independent tenancy and detailed that intensive community support would be required to deal with this. SAW1 continued to have contact with Mr F during his hospital admission in order to establish a therapeutic relationship. On discharge, the hours of support being given were increased from six to nine and SAW3 added to the care team to help deliver these. SAW1 left a message for SW2 in January 2007 requesting that she visit Mr F to discuss housing issues and also prompted Dr B that Mr F was awaiting an out-patient appointment. A further call was made to SW2 eleven days later as no arrangements to visit had been made and she then visited Mr F on 25th January 2007. Mr F confirmed that he wanted his own house with two bedrooms given that he had unlimited access to his sons. Local authority housing and housing associations began to be considered. Mr F's CMHN changed again.

2.46 SA 1 records over late January and early February indicate that Mr F was hard to engage and was non-compliant with his medication which he was thought to be storing up. Whilst the main purpose of contact was to encourage Mr F to socialise and undertake practical tasks, he refused to participate in this and, instead, was talking at great length to support workers about his thought processes and the sexual abuse he suffered. This was discussed by the workers within SA 1 and the content of the interactions viewed, by them, as being out-with their expertise. This information was communicated to CMHN D.

2.47 Dr B saw Mr F in the out-patient clinic on 16th February 2007 after his parents reported that he was increasingly paranoid and hallucinated. He was also aggressive towards his mother which was very unusual. Whilst it was stated that admission was "indicated," this was not pursued because of Mr F's apparent fear and dislike of hospitals. It was negotiated that Mr F would be given diazepam if he

agreed to increase his oral anti-psychotic medication. Mr F's risk assessment plan was due to be updated by 8th January 2007 but this did not occur.

2.48 A review meeting involving SW 2, CMHN D, SAW1 and SAW2 and Mr F took place on 1st March 2007. This review was set-up and chaired by SA 1. No concerns were noted and Mr F was encouraged to use his support time "more proactively." However, it is clear that Mr F was refusing to leave the house with support agency workers, that the home environment limited the type of rehabilitation work that could be undertaken and the proactive involvement of Mr F's mother in housework and shopping often meant that there was little to do. Instead, Mr F was spending periods of two or three hours talking to workers about his mental health and previous history of sexual abuse. Workers were aware that they did not have the expertise to deal with these issues and therefore adopted a listening stance without giving back any advice or direction. Mr F Senior would frequently try to intrude on the support time to talk about his own difficulties and, on occasion, discussed personal matters that made the attending worker uncomfortable.

2.49 SW 2 completed the SSA documentation on 6th March 2007. This stated that whilst abstinent from alcohol, Mr F was now drinking 40 cans of cola each day. It stated that he heard voices, believed people to be tampering with his food, is fearful of Irish people and is so afraid at night he is urinating in a bucket in his bedroom. Yet, the question "Are there any concerns to public safety/harm to others?" is answered "no" and the question "has a carer assessment been offered?" is marked "not applicable."

2.50 SW 2 assisted Mr F to complete housing application forms and submitted a supporting letter. However, this did not indicate any degree of urgency or risk and simply stated that "living with his father can be stressful at times." The Housing Department record activated at this time conveys a degree of surprise that no specific medical form was submitted with the application (which may have resulted in higher priority being given).

2.51 Mr F was admitted to Hospital C (the local general hospital) overnight on 25th March 2007 following an overdose but left soon thereafter. When SAW 1 visited on 27th March 2007, Mr F was expressing fears about dying or being murdered for having contact with SAW 1. He expressed the belief that SAW 1 was conspiring with his father to harm him and that CMHN D was not administering the correct medication. M F was described as making "menacing looks." Contact was made with CMNH D to report this and SAW 1 advised to make no further visits until the situation could be assessed. There is no evidence that CMHN D made contact with Mr F at this point and simply visited for her next scheduled appointment.

2.52 On 1st April 2007, Mr F was seen by a junior doctor and CMHN D jointly at the out-patient clinic in Hospital A. His mother reported that his mental health appeared to deteriorate in the second week following his depot being administer (this being

given every fourteen days) and that he had not taken any oral medication for three days. Mr F was avoiding taking his oral medication because he believed his father was coming into his room at night and needed to remain alert to manage this. Mr F was still abstinent from alcohol at this point and seemed particularly aggrieved that he had discovered his father walking when he had led everyone to believe that he was wheelchair bound. The interview, which took place with the parents present, deteriorated and Mr F Senior was noted to be shouting at his son. The outcome of the meeting was for CMHN D to monitor the situation. There was no evidence of medication changes being made given Mr F's mother's report. Similarly, the assessment did not trigger an attempt to link with the SWD to investigate whether the housing situation was nearing resolution.

2.53 Dr B assessed Mr F on 16th April and, in light of apparent over-sedation, reduced the prescribed dose of oral anti-psychotic and anxiolytic medication.

2.54 On 17th April 2007, Mr F was brought to Hospital A by his parents. He was assessed by a junior doctor who effectively found an identical picture to his colleague of 1st April. Mr F believed that his father had been rummaging through his possessions. His mother directly asked whether the frequency of his depot medication could be increased. The doctor noted that he was "struck by high level of expressed emotion" from Mr F Senior to his son. Hospital admission was considered indicated but Mr F did not want this and, as assessed not detainable under the Mental Health Act, he was allowed home with review from CMHN D the next day. The DDT had access to both junior doctor assessments but appear to have minimised the significance of them believing that they had a fuller appreciation of the case.

2.55 Mr F was resisting SA 1 being involved at this time although they did appear to be keeping telephone contact in the hope that this position would change. Mr F's mother contacted SW 2 on 30th April 2007 to report that Mr F Senior had thrown her and Mr F out of his house the previous day and had been showing a high level of aggression for the last two weeks. She also communicated that Mr F's reluctance to accept support from SA 1 was based on delusional beliefs. It was noted in the records that Mr F had "points" with two different housing authorities but that this placed him 369th on the waiting list. This led, in due course, to a request to widen the area in which he was willing to live and to SW 2 checking on the progress of applications with other housing associations.

2.56 Review by Dr B on 14th May 2007 noted the continuing conflict within the family home and the only change initiated was a further cut in benzodiazepines. The GP made contact a week later to confirm what Mr F is supposed to be prescribed in total as this had become quite unclear to him and the dispensing pharmacist.

2.57 SW 2 visited Mr F on 23rd May 2007 and found him to be "quite well at present." A telephone call was made the next day to CMHN D to pass on information about the housing position. Interestingly, Mr F Senior had contact with the Out of Hours service on 24th May for his own physical health and their records state that he is "very abusive and could be violent ... advised home visit within one hour with Police Escort."

2.58 On 5th June 2007, SA 1 sent Mr F a letter suggesting that they meet the next week to discuss resuming involvement. This was copied to CMHN D. At interview, SAW 2 told us that the plan was for SAW1 and SAW2 to visit Mr F together with CMHN D before support was commenced. She also stated that she expected a risk assessment to have been carried out by CMHN D prior to services being reinstated. CMHN D was not available for the investigation team to interview and we therefore do not know what was planned. What is clear, is that the notes do not contain a new risk assessment at that juncture despite the reasons for withdrawal of support in the first instance.

2.59 On the night of 6/7th June 2007, the Police received a telephone call from Mr F Senior claiming his son had assaulted him. Shortly thereafter, Mr F telephoned his mother asking her to come to the house. He stated that he had called an ambulance as his father was bleeding but was unable to say what had taken place. When help arrived, both Mr F and his father had stab wounds. Mr F Senior subsequently died as a result of his injuries.

2.60 The only available account of the incident comes from Mr F himself and it should be noted that this account has changed somewhat over time. It is believed that Mr F's stab wounds were self-inflicted and Mr F Senior's stab wounds were inflicted by his son. Mr F's medication at the time of the incident comprised risperidone in the form of Risperdal Consta 50mg fortnightly; quetiapine 100mg in the morning and 200mg at night; chlordiazapoxide 20mg twice daily, lofepramine 140mg at night; diazepam 5mg as required; and then thiamine, vitamin B strong and omeprazole.

2.61 After receiving medical attention, Mr F was conveyed to Hospital A under a Short Term Detention Order. He was placed in the IPCU and assessed the next day by a Consultant Forensic Psychiatrist from the State Hospital. Mr F was admitted to the State Hospital shortly thereafter and, in due course, having been found to be insane at the time of the offence, was made subject to a Compulsion Order with a concurrent Restriction Order. Mr F remains in the State Hospital at the time of this investigation.

2.62 Mr F had last been seen face-to-face by the DDT on 25th May 2007 when his depot medication was administered as planned. He was scheduled to be seen again by CMHN D to administer his depot medication on 8th June 2007.

2.63 On 19th September 2007, HB A convened a Critical Incident Review (CIR). This was chaired by a Forensic CMHN (FCMHN 1) who had no involvement in the case and was attended by SAW 1, SAW2, CMNH D and her Team Leader (CMHN E), OT1, the GP, SW 2, Dr B and a Patient Services Manager (PSM 1). FCMHN 1 had never chaired a CIR before and had no training in how to conduct these. There were no policy or guidance documents made available to the FCMHN 1 to assist this process. He had, however, participated in a previous CIR and the process was therefore structured around what he had experienced himself. The convened group were informed that no discussion could take place with regard to the incident itself. Dr A, who had regular involvement with Mr F when he was an in-patient was not invited to the review and the reasons for this are not clear. At interview, FCMNH1 told us that he had received only three days notice of our intention to interview him and wished to caution that the information he could accurately recall may be limited as a result.

2.64 Within the CIR Mr F was described as having "no major forensic history" with mention made only of "motor offences in his young adult life ... and Breach of the Peace at his father's home ... there are unconfirmed reports of an assault on his father." This appears to represent a significant under-reporting of violent incidents.

2.65 The discussion at the CIR indicated that "everyone was of the opinion that there were no signs that Mr F's behaviour was any different from usual and there was no information from any source that he may become involved in a violent act ... Whilst there were tensions in the house Mr F chose to stay as he felt supported by his mother and various services."

2.66 The CIR report stated that the group considered that better services for people who have been sexually abused and a general increased availability of support worker time may be useful service improvements. The conclusions of the CIR were:

- It should be noted that the MDT appeared to have done everything possible to the highest of standard and their approach to the care of Mr F (written as per the actual document)
- The MDT communicated effectively with each other
- It is felt that no more could have/should have been done to alter the outcome.

2.67 It is notable that there was information discussed at the CIR which SA 1 had never heard before. This was especially with regard to risk issues. SAW 2 therefore requested that their organisation look independently at the case. A number of

changes were made within the organisation as a whole as a result of this, especially with regard to risk information.

2.68 When interviewed, Dr B stated that he was surprised that the CIR process was not more exacting and described the CIR process and outcomes as “a little too self-congratulatory.” The attendees from SA 1 were unclear as to the purpose of the CIR given that what had gone wrong was not to be discussed and SW 2 stated that as she had never attended a CIR before, she did not know whether the process had covered all the relevant areas.

2.69 HB A made a decision in February 2008 to “re-open the Critical Incident Review” following Mr F’s mother talking to the media. A Consultant level medical manager (Dr G) therefore looked into matters further. He primarily wished to satisfy himself that correct procedure had been followed and that the outcome of the CIR had been valid. Dr G considered it important that Mr F’s mother was offered a meeting and asked the Forensic CMHN to make contact. She did not respond to a letter to get in touch and this was therefore not pursued. Mr F’s mother reported never having received this letter but it is available within the case record. Dr G had FCMHN interview CMHN B and CMHN D individually and fully review the case-notes and electronic patient record. He then reviewed this information.

2.70 The outcome of the supplementary CIR was that “there are no additional specific recommendations to make.”

Section 3

Analysis of key problem areas

3.0 In reviewing all the information about Mr F's care and treatment, we identified five key areas to address. These were:

- Treatment of Illness
- Impact of the Home Situation
- Risk Assessment
- Social Work/Social Care Action
- Critical Incident Review

3.1 Treatment of Illness

3.1.1 Mr F had brief contact with Mental Health Services in HB A between1990 and 1992. He was in receipt of care and treatment from HB B during the period 1992 to late 1996.

3.1.2 From December 1996 up until the time of the incident, Mr F was in almost continuous contact with Mental Health Services in HB A. There was one short period in May 1998 when he defaulted from contact and was discharged but he was re-referred in October 1998 and remained in contact with services thereafter; albeit with sometimes erratic compliance with particular components of his care and treatment. This good level of engagement is worthy of note.

3.1.3 Mr F was what is described as "a Dual Diagnosis patient". This means that he was recognised as having a complex presentation, involving both a psychotic illness and substance misuse. In Mr F's case, he had paranoid schizophrenia and alcohol dependence but occasionally also misused prescription drugs and, latterly, caffeine. Dual Diagnosis patients are recognised as some of the hardest patients to engage and therefore often have erratic contact with services or experience exclusion from services.

"the importance of organising care in order to support and encourage a good therapeutic relationship is at times as important as the specific treatments offered." (NICE Guideline)

3.1.4 Mr F was initially treated by the generic CMHT but referred to the Dual Diagnosis Team (DDT) in 1998. Thereafter he received treatment primarily under the care of the same Consultant, Dr B, and from the same small team of DDT community mental health nurses. Mr F had appointments with Dr B and his various CMHNs regularly. These were supplemented by additional appointments if requested. Requests from Mr F or from his family for early review, were generally addressed to the CMHN, who would involve Dr B if this seemed necessary.

3.1.5 Mr F's GPs confirmed the evidence in the case-notes, that there was generally a prompt response by the DDT to any concerns raised.

3.1.6 The DDT does not have dedicated in-patient beds available to patients experiencing a high level of disturbance. When requiring admission to hospital, DDT patients are admitted to 'general adult psychiatry' wards and the Consultant care temporarily switches to the general adult psychiatry Consultant who runs the ward. The majority of Mr F's numerous hospital admissions were into the same ward and under the care of the same in-patient Consultant, Dr A.

3.1.7 It was clearly evident to the investigation team from an early stage that this was not a case in which there had been a failure to provide any care and treatment. Mr F had not experienced the reluctance of services to take responsibility for the provision of consistent care and treatment that so many people who attract a Dual Diagnosis experience. All professionals involved in Mr F's care appeared to have a high level of commitment and to have maintained a consistently high level of contact.

"Continuity of care from professionals capable of communicating warmth, concern and empathy is important and frequent changes of key personnel threaten to undermine this process. " (NICE Guideline)

The care Mr F received from his GPs, and the CMHNs and Consultants involved in his care afforded him this type of support.

Our comments and conclusions about the treatment of his illness fall under the following headings:

a) Diagnostic Formulation

b) Pharmacological Interventions

c) Psychological Interventions

d) Use of Hospital-based (In-patient) Care

a) Diagnostic Formulation

3.1.8 It is clear from the record that although there was some initial diagnostic uncertainty – in his early contacts within HB A, Mr F attracted diagnoses of drug induced psychosis and possible personality disorder – by 1999 there was a consensus that Mr F had a paranoid schizophrenic illness, in addition to his established alcohol dependence. This was certainly the view of both Dr A and Dr B (and their respective Teams) who viewed Mr F as requiring treatment with antipsychotic medication alongside any intervention that might be in place for his addiction or other issues. Case-notes and information gained at interview, however, point to there being a different emphasis on these two components of care and

treatment and that the differing ‘ethos’ and ‘philosophy’ of the two teams led to some discontinuity in treatment decisions. In addictions work, the focus is on respecting choice and always seeking engagement, because the addiction problem is in part a lifestyle choice, and can only be addressed by services with the consent and cooperation of the individual. In General Adult Psychiatry, the situation is more complex in respect of consent, autonomy and the right of the individual to receive adequate treatment, even if he/she is not capable of seeking or consenting to it. Clinicians will often, therefore, have more need to consider appropriate treatments whether or not the patient would choose these for himself.

3.1.9 For patients with a Dual Diagnosis, there has to be a meeting of these models and formulations.

3.1.10 This confusion is perhaps most evident in the interpretations made about the signs and symptoms that Mr F described and exhibited. Paranoid ideas about people intending to do him harm, fear of people and of being in public places and thoughts and urges about harming his father were clearly attributed by Dr A to Mr F’s paranoid psychosis; Dr B and the DDT conceptualised these as manifestations of an independent and separate primary anxiety state or panic disorder.

Mr F described chronic delusions of reference, particularly about the television which he believed broadcast programmes about, or featuring, himself and people known to him. He also believed he could influence the broadcast, and described hearing or seeing his father on the programme. At times he also described passivity experiences, believing for example that his arms were under the control of a force other than his own. The notes make it clear that over a considerable period , these fixed delusions were of sufficient intensity as to make him avoid the television. There are also detailed notes from a hospital admission in June 2006 which document Mr F misidentifying people around him. This delusional misidentification subsequently led to him assaulting a fellow patient by punching him in the face. Whilst both services seem to have recognised these as psychotic, varying degrees of significance were attached to them.

Finally, the CMHNs in the DDT appear to have wrongly conceptualised Mr F’s expressed views that he wished to harm his father as “thoughts” rather than properly ascribing them as delusions and command hallucinations. Although Dr B did to some extent, this does not appear to have been explicitly shared with or discussed within the wider DDT.

3.1.11 At interview Dr A said: “I think they were mainly psychotic in nature and certainly the times that I saw him where he expressed hostility towards his father they were a part of the psychotic process.” Dr B on the other hand said: “they were seen as being a direct response to his father’s continual criticism of him. I don’t think there was ever any serious thought that they would translate into any action, certainly not at that stage.”

3.1.12 Dr A and Dr B told us that there was no point at which they considered Mr F to be "well" in respect of his psychosis. He was described as always having residual symptoms. However, they differed quite considerably in their view of whether the intensity of psychotic symptoms varied according to the level of alcohol misuse. In the view of Dr B, Mr F's psychosis was dependent on the extent of his drinking, and was poorly influenced by antipsychotic medication. Dr B also believed that when abstinent from alcohol Mr F was much less distressed by his psychotic symptoms. This led to him being disinclined to make any changes to Mr F's antipsychotic medication even though he expressed the view that Mr F had a "treatment resistant" psychosis.

3.1.13 Dr A on the other hand was strongly of the view that Mr F had a primary schizophrenic illness, which was adversely affected by his alcohol problem, but which was a separate entity. Dr A did not describe psychotic relapses, or chronic residual psychotic symptoms as being directly determined by his alcohol problem. He would not have categorised Mr F as having a treatment resistant psychosis (he did not consider that adequate trials of different antipsychotics had been made to justify this). It is evident that when Mr F was in the ward under Dr A's care, it was his clinical opinion that a change of antipsychotic should be considered, or attempted. This included a view that a trial of Clozapine should take place. Dr A was clear that Mr F continued to experience residual psychotic symptoms in the ward environment even when the more acute psychotic symptoms had receded.

3.1.14 We are of the view that Dr A's more assertive approach to the psychosis aspect of Mr F's care would have represented the best care and treatment. However, Dr A stated that he was "wary" of making changes to Mr F's medication because he considered Dr B more "attuned" to the overall situation. As such, he preferred to "suggest" treatments which may or may not then be implemented. This was acknowledged by Dr A and Dr B as the major, problematic aspect of lack of continuity of Consultant care between community and in-patient care. In the absence of this direct continuity, there was also never a *formal* meeting involving the two different Teams which may have allowed the emergence of this view as the 'unified' clinical opinion. At no time did either component of the service actively engage with the other to try and reach an agreed treatment strategy. It is likely that this situation was not helped by the fact that the majority of hospital admissions were not planned or initiated by the DDT.

3.1.15 All professionals involved in Mr F's care acknowledged the severity of his addiction to alcohol and the impact of alcohol abuse on Mr F's physical health and capacity to care for himself. Dr B told us that the primary goal of Mr F's treatment at times was "keeping him alive." Keeping him engaged with services was paramount because that was the only way they could influence change and ensure his health was properly looked after. It must be noted that within this picture of severe and chronic alcohol dependence the DDT did successfully assist Mr F in achieving long periods of abstinence. That this happened in the face of all the other stressors

highlighted in this report is testimony to their, and Mr F's own, sustained efforts. We acknowledge the success of this work.

3.1.16 A related issue, however, is the question of when a patient with difficulties like those of Mr F should be discharged from the DDT and their care and treatment provided from a 'standard' CMHT. It is unusual for someone to remain under the continuous care of a DDT for as long as did Mr F. These are generally small, specialised teams with limited resources and often with more limited access to wider parts of mental health services. The pros and cons of specialist teams are not the subject of debate here but there is a clear need for agreed protocols to govern the transfer in and out of specialist teams. When interviewing people we were told, instead, that referral between the services is largely dependent on the quality of relationship between Consultant colleagues.

3.1.17 There is evidence that there were times when, because of successful treatment of his alcohol problem by the DDT, Mr F's predominant problem was his psychotic illness. Despite this, there was no point at which he was referred back to the CMHT. In this case, it seems that Mr F remained with DDT at least in part because he had a high degree of attachment to the staff there, which was reciprocated.

b) Pharmacological Treatments

3.1.18 As detailed above, Dr B took overall lead in treatment decisions. Dr B himself is clear that this was the case. His treatment strategy, driven by the primary goal of keeping Mr F alive, was to keep him engaged with services. Dr B considered that Mr F's alcohol abuse was the main determinant of his psychosis, which he felt was largely unresponsive to antipsychotic treatments. He was therefore disinclined to make radical changes to Mr F's treatment. He adopted a stance of "negotiation" in changing Mr F's medication when he requested it and also in agreeing to prescribe certain medications if Mr F remained abstinent of alcohol.

"The process of engaging successfully with individuals with schizophrenia may at times require considerable persistence and flexibility from professionals. Establishment of trust is crucial and reliability and constancy on the part of professionals is an important component of this" (NICE Guideline)

3.1.19 Mr F was treated initially with a typical depot anti-psychotic medication. He was treated by injection because it was recognised at an early stage that Mr F was liable to be erratic in taking oral medication. When oral medication was prescribed in addition to this depot, his compliance was indeed poor. There are frequent references by staff and family and acknowledged by Mr F himself that at times he failed to take his medication at all, whilst at other times he took more than prescribed. Sometimes he intentionally hoarded tablets to take an overdose.

3.1.20 At times Mr F was also prescribed anti-depressant medication.

3.1.21 In early 2006 Mr F's typical depot anti-psychotic was changed to an atypical depot anti-psychotic medication. This was a reasonable strategy in keeping with the existing evidence base. Mr F was not getting complete symptom control from the original medication and there is evidence that in alcohol dependent co-morbidity, atypical anti-psychotics produce better outcomes in relation to both psychosis and alcohol abuse, than do typical anti-psychotics (Wobrock & Soyka, 2008).

3.1.22 Mr F's family, both at the time and subsequent to the incident, expressed the view that Mr F's depot was "wearing off" in the two or three days prior to it being due again. This pattern was an acknowledged problem with typical depots and would often lead to the dosage of medication being increased or the frequency with which it was given being increased. However, in the atypical depot that Mr F was prescribed, the action of the medication is such that it works over a roughly six week cycle and therefore does not wear off in the same way.

3.1.23 In addition to this depot, and despite the problems with oral medication outlined above, Mr F was also prescribed an oral anti-psychotic. The rationale for this is not explicitly outlined in the case-notes and at interview neither Dr A nor Dr B could recall the reason for this. The NICE Guidelines acknowledge that this may be necessary but advise that there is a review of "*clinical indications, frequency of administration, therapeutic benefits and side effects each week or as appropriate"* and that the general 'rule of thumb' should be *"Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication)".* They also advise that care should be taken to ensure that if the various medications in combination reach 'high dose' levels, this is appropriately monitored.

3.1.24 Prescribing guidelines are clear about the benefits and risks of combined anti-psychotics. It is not our intention to comment specifically on the exact medication choices made for Mr F. However, it appeared to us that there was little evidence of any MDT evaluation of treatment effectiveness and treatment options, which should have been the basis upon which any decision to use more than one anti-psychotic was determined. We also question the wisdom of using oral medication for psychotic symptoms that persisted despite the depot medication with someone known to have such erratic compliance with tablets.

3.1.25 The phrase 'treatment-resistant' is commonly used to describe people with schizophrenia whose illness has not responded adequately to treatment. The essence of treatment resistance in schizophrenia is the presence of poor psychosocial and community functioning, which persists despite trials of medication that have been adequate in terms of dose, duration and adherence. (NICE Guideline). The good practice recommendation for interventions for people with

schizophrenia who have an inadequate or no response to pharmacological or psychological treatment states clinicians should:

• review the diagnosis

• establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration

• review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families

• consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness. (NICE Guideline)

In everyday practice, schizophrenia would only be seen as treatment resistant when there had been adequate trials of one typical anti-psychotic and two atypical antipsychotic medications and there was a degree of confidence that the patient had been compliant with these.

3.1.26 The issues with Mr F would therefore seem to be whether he was adequately medicated in terms of his psychosis, whether Consultant B was rigorous enough in his review of anti-psychotic prescribing and whether enough consideration was given to whether Mr F met criteria for treatment-resistant psychosis.

3.1.27 We acknowledge that Mr F's family were involved in efforts to supervise his oral medication, recognising the importance of Mr F taking what had been prescribed for him. The clinical team were aware of this but we were given conflicting accounts from Dr A and Dr B and from CMHN B and CMHN C about which parent took this role. It seemed to us that there had been only very superficial discussion with his carers about this key issue and this view was confirmed by Mr F's mother. An associated issue is that, at times, Mr F was refusing to take his oral medication specifically because he believed it to have been tampered with (usually he believed this to have been by his father). The only specific measure we could identify which was taken to address compliance issues was the introduction of 'blister packs.' Blister packs contain all the oral medication an individual needs to take, set out for the different days of the week and the different times of the day that the medication needs to be taken. We believe there was an over-confidence in this measure in achieving good compliance with oral medication and an inappropriate involvement of Mr F Senior in holding medication given the relationship between father and son and Mr F's delusional beliefs about his father. Together, we consider that this may have resulted in a systematic under-treatment of Mr F's psychosis.

3.1.28 Throughout much of this time Mr F was prescribed both regular and "as required" benzodiazepines - mainly chlordiazepoxide and diazepam. He was

prescribed these on both an out-patient and in-patient basis, when admitted for detoxification from alcohol and when admitted with psychotic relapse. Again, we could find no evidence of systematic review of this prescribing. The use of benzodiazepines in the short term to cover withdrawal symptoms during detoxification is common, and within prescribing guidelines. Dr B told us that he sometimes prescribed benzodiazepines over a longer timescale because his clinical experience persuaded him that this had been of benefit in enabling some individuals to reduce their level of alcohol misuse. In the case of Mr F he told us that this "harm reduction" rationale explained the prescribing of regular benzodiazepines.

3.1.29 We noted that there was explicit reference in the records to the prescribing of diazepam on an "as required" basis in addition to this for relief from distress caused by psychotic symptoms. In Feb 2007, Mr F was presented for hospital admission by his parents acutely paranoid, experiencing hallucinations and behaving aggressively towards his mother. Dr B did not want to admit Mr F to hospital as he considered this to make him more distrustful and, instead, negotiated with Mr F that he would be prescribed diazepam if he would increase his oral anti-psychotic medication. Dr A told us that it was his understanding that chlordiazepoxide or another benzodiazepine was prescribed to Mr F in relation to alcohol withdrawal and that it was on this basis that he continued to prescribe these to Mr F when he was an inpatient. He was clear that he would not have seen a role for benzodiazepines in relation to management of his psychotic symptoms.

3.1.30 These uses of benzodiazepines fall out-with prescribing guidelines, and out-with licensed indications for the drugs concerned. There are certainly circumstances in which treatment can be quite properly given out-with these guidelines, but good practice requires adequate clinical discussion, exploring of alternatives, and efforts to utilise the evidence base. Currently, there are emerging views about the role of benzodiazepines as an adjunct treatment to allow dose reduction of anti-psychotic medication, particularly to reduce side-effects. This converse approach is an individual approach and one which we consider would have been more properly managed within a full review of treatment and with specialist pharmacy input. There are additional "consent to treatment" issues when prescribing off-licence. We can find no evidence that these issues were addressed with Mr F

c) Psychological Treatments

3.1.31 The NICE Guidleines state that people with schizophrenia should: " receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment."

3.1.32 No full psychological assessment was ever sought for Mr F. There was no dedicated psychological input to the DDT and various professionals interviewed told us that there was great difficulty in accessing clinical psychology for individuals with

severe mental illness. We were told that long waiting times put people off making referrals and that, in the case of the in-patient unit, staff changes would result in long periods where no cover was available. When this input was available it was described in very positive terms.

3.1.33 Mr F did receive psychological treatments. CMHN B embarked on PSI interventions when undergoing training in this area with this work supervised by a clinical psychologist ordinarily working in general adult psychiatry. The clinical psychologist had no direct knowledge of Mr F. Dr B was fully aware of and approving of this work being undertaken. When undertaking this work with CMHN B, Mr F was assigned additional CMHN support in order that the psychological approach could be delivered separately from the other nursing functions. This indicates that the DDT planned the process of implementing PSIs well.

3.1.34 OT 1 who was linked but not an integral part of the DDT also initiated a psychological approach at roughly the same time. OT 1 was involved with a view to taking on "desensitisation" work on "anxiety issues"; specifically a graded exposure programme to address Mr F's reluctance to leave the house. Dr B did not ask for this treatment to be initiated. At interview he told us that he did not know about the treatment but clinical records indicate that he received copies of letters sent from OT1 to Mr F's GP outlining what she was doing. This work ended because Mr F attended appointments erratically.

3.1.35 Both of these pieces of work were largely predicated upon a model of understanding Mr F's difficulties which was not psychosis based. Mr F's "agoraphobic" symptoms were seen as being an anxiety disorder in their own right rather than being an emotional consequence of psychotic beliefs and the directing of PSI towards his "concrete thinking" around his father appears based upon the view that Mr F had angry *thoughts* and intent towards his father because of resentment about his father's past and current abuse and criticism. In line with this, the treatment plan included teaching Mr F "confrontational skills" that he could use when his father was being difficult. Implicit in all of this was a view that Mr F could assert conscious control over his thoughts and the way he behaved in response to these thoughts. This is not a view that we share.

3.1.36 Dr A told us that he had known that Mr F was being offered PSI but mistakenly thought this related specifically to work with Mr F's family, aimed at reducing the counter-therapeutic dynamics within his family and living environment . When made aware of the exact work being undertaken he offered the opinion that Mr F's case was of a complexity that meant that only a very skilled worker should be undertaking psychological intervention stating "you certainly wouldn't want it to be anyone's first case." Dr B acknowledged at interview that it became clear to him that the PSI was not helping.

3.1.37 Additionally CMHN B and CMHN D, SW2 and SAW 1 and SAW 2 were involved, to varying extents, in “emotional support” work around Mr F’s experience of childhood sexual abuse. It was reported to us that much of this work was a response to Mr F seeking out opportunities to talk about the abuse suffered as opposed to a planned intervention. We found no evidence that Mr F had been offered appropriate psychological assessment and treatment with respect to this issue. We also found a lack of awareness that ‘allowing’ Mr F to spend considerable periods of time talking about these experiences may have had a detrimental effect on his mental state.

3.1.38 Having reviewed Mr F’s care and treatment, we have a number of concerns about the psychological treatments delivered. The primary issue appears to be the lack of a comprehensive *psychological* assessment and formulation which would then guide the interventions required. This would also have established the complexity of the case and determined which aspects of psychological treatment could be delivered by staff with basic psychological skills, which by staff with some training and experience in specific psychological therapies and which required intervention by a clinical psychologist.

3.1.39 We consider there to have been inadequate recognition of the evidence that Mr F was experiencing psychotically-driven , fixed delusional beliefs about his father and command hallucinations to harm his father. It is likely that it was this psychotic process which then resulted in an array of distressing emotional states, avoidance behaviour and more obviously risky behaviour such as carrying a knife. It may well have been the case that in addition to this process, Mr F had unresolved resentment towards his father with regard to the verbal and physical abuse experienced in childhood and his father’s role in introducing a man into the family home who sexually abused Mr F.

3.1.40 We consider that the psychological assessment and treatment planning that took place did not pay adequate attention to the family dynamics or establish whether family intervention may have been useful. Fuller comment is given to this issue later in this report.

3.1.41 Finally, it is our view that there was inadequate communication across all parties involved in Mr F’s care of what these treatments were about and who was responsible for them. This was especially evident with regard to issues related to childhood sexual abuse. It is not clear that there was proper evaluation of the effectiveness of treatment or monitoring for any unintended or adverse effects. We note that the work of CMHN B was supervised by a clinical psychologist but are concerned that the lack of direct knowledge of the case and lack of direct relationship with either the DDT or the ward to which Mr F was frequently admitted effectively rendered the supervision meaningless.

d) Use of Hospital (in-patient) Based Care

3.1.42 Mr F had a large number of admissions to hospital in HB A. In the earlier years, admissions had a planned element to them in that they were goal-oriented for detoxification from alcohol. These were sometimes problematic because Mr F changed his mind. Latterly, however, most of Mr Fs admissions were in response to crises in his home or social circumstances. At these times there was clear evidence of distress in relation to psychotic symptoms with his family reporting worrying psychotic symptoms (including fixed paranoid delusions, and hallucinations and specific and longstanding paranoid ideas about his father). His family reported that Mr F would sometimes be aggressive, which, as all parties reported, was out of his character when he was well. As a result, Mr F's admissions were not subject to joint planning and although they were sometimes mediated by staff from the DDT, there is no evidence from the records, or from our interviews, that there was consultation or agreement between the DDT and GAP inpatient team about the goal of admission.

3.1.43 Admissions meant that Mr F was entirely under the care of the GAP team. We accept, despite there being little paper-evidence, that there were telephone discussions at times between the Consultants, (Dr A and Dr B in most instances but with other in-patient Consultants sometimes involved) and sometimes between the ward nurses and the current CMHN. If this had not happened then one would expect to see periods where Mr F went without services and this never occurred. During the time he was involved with Mr F's care, CMHN B did visit the ward and attended some ward reviews. We acknowledge this good practice on his part.

3.1.44 The above indicates, however, that care planning was largely informal. The same was true of discharge planning where we found no attempts to formally incorporate all involved parties in the process. Formal discharge planning was often made difficult because Mr F sought early discharge or was discharged while on pass from the ward if things were going well. Whilst common practice will often see people spending periods of transition between the ward and home (referred to as "passes home") this was difficult to implement with Mr F as he would often return to the ward intoxicated. The lack of formal admission goals and discharge planning appears to have resulted in a failure to form a shared view on the diagnostic formulation, an agreed prescribing strategy, the usefulness of hospital as a treatment strategy and a shared view of what was causing or contributing to relapse. It also led to a lack of clarity about who was responsible for updating assessments of the home situation, of carer's needs and risk assessments (these three issues being discussed further later in this document). We believe the DDT would have benefited from hearing about Mr F's mental state in a situation where he was away from his family and was free from substances.

3.1.45 It was clear to the investigation team from records and from interviewing Dr A and Dr B, that they held very different views with respect to how useful hospital admissions were for Mr F. Dr B held the view that being in hospital made Mr F worse, that he became more paranoid and fearful and should thus be used as a last resort. Mr F did not like being in hospital and, as his primary aim was to keep Mr F

engaged in treatment, Dr B tried to avoid admission or keep admissions as brief as possible. Dr A, on the other hand, was clear in his view that hospital admission benefitted Mr F greatly and, indeed, that admission was the mainstay of his treatment when he was acutely unwell. He offered the opinion that " Mr F was not someone you would have been happy to manage outside hospital acutely psychotic" and records show that there were occasions when Dr A "would have liked to have kept him in longer , (in order) to get a clearer view of what is really happening with him".

3.1.46 We consider that the over-arching view of hospital admission by the DDT may have resulted in under-use of hospital based treatment. Given all that was known about Mr F's erratic compliance with medication, as well as the confounding potential of his living circumstances and his abuse of substances, it is our view that a proactive use of a longer spell of in-patient care may have allowed a more adequate assessment of his mental state and could have informed a proper review of the efficacy and appropriateness of his anti-psychotic treatment.

3.1.47 At points in 2005, it is clear that Dr A was concerned about adequacy of control of psychosis, and was considering a change of antipsychotic medication. In the event, Mr F's depot was changed from a typical to an atypical in early 2006. Changes in dosage were made by Dr B at various points while Mr F was attending him as an outpatient but no further changes in the type of anti-psychotic agent were made.

3.1.48 Dr A told us that he is unhappy about the discontinuity of care for patients under the care of specialist services such as DDT or Forensic teams, when they require admission to hospital and come under the temporary care of a general adult psychiatrist. Although he said that he would hope that the situation would not prevent him from taking a clinical decision which was clearly necessary, he did acknowledge that there may be a degree of inhibition of usual practice, and a reluctance to "interfere" with another consultant's treatment, particularly when he might not be in a position to take ongoing responsibility for assessing the outcome of any change, once the patient was discharged. We share this view and see discontinuity of consultant care between in-patients and community services as potentially problematic for just this reason. Where it has to occur there is even more need for formal arrangements to govern liaison between the involved teams.

3.1.49 We formed similar views with regard to the use of Mental Health legislation. From examination of the records, and, especially records of in-patient episodes in 2006 and 2007, it appears clear that incidents of self-harm , including several overdoses using prescribed medication, and repeated, albeit minor, lacerations to his forearms, were increasing, in frequency and severity. In one incident in November 2006, Mr F cut his arms and attempted to stab himself in the kidneys while in bed with his teenage son. During the same time-frame, he was involved in incidents with other patients, including one incident when he punched another patient in the face.

All of this was happening in the context of Mr F describing command hallucinations to harm his father, describing seeing his father on television, and hearing voices telling him that his father was a paedophile. He also reported that he intended to begin carrying a weapon as he believed people were out to harm him.

3.1.50 At home, by early 2007, SAW 1 and 2 reported that Mr F was staying awake at night to watch out for his father who he believed was going through his belongings at night. Mr F was urinating in a bucket because he was afraid to leave his room at night to use the bathroom.

3.1.51 Taken together, the case-notes set out a clear picture of escalating acts of aggression, directed at both himself and others, during 2006 and into 2007. Mr F was abstinent from alcohol for a substantial part of this time. There is considerable evidence, in our view, to indicate that these behaviours were largely driven by psychosis. We therefore believe that there was clearly emerging evidence during 2006 and early 2007, that Mr F's psychotic illness was inadequately controlled, and that he was showing an increasing propensity to act upon his psychotic experiences and thoughts.

3.1.52 It must also be noted that many, but not all, of Mr F's admissions ended prematurely. This is evident throughout the period of contact with services in HB A. Examples include Mr F being "discharged on request a.m.a (against medical advice)", "did not return from pass, discharged in absence", "discharged on request from pass" and "self-discharge on pass with no medical review." Much of this appeared to be a result from Mr F's belief that being in hospital made his paranoia worse and that he was 'better off' at home. This was a view that was shared by Dr B and the DDT but not by Dr A.

3.1.53 Given this picture of worsening psychosis and an unwillingness to remain in hospital for a period long-enough for a meaningful review of treatment to take place, we question whether adequate consideration was given to the use of compulsory measures to allow this. We believe that the over-riding attitude that Mr F did not like hospital and the DDT's primary goal of keeping Mr F engaged resulted in a situation where the use of Compulsory measures as being of benefit to Mr F in the medium to longer-term was not sufficiently considered.

3.1.54 Having reviewed the evidence relating to all aspects of Treatment of Illness we find:

a) There was a failure by the DDT to properly recognise the extent of Mr F's psychotic illness and the degree to which this was independent of his addictions. There was no established rationale for the pharmacological management of Mr F's psychotic illness, inadequate reference to appropriate prescribing guidelines, lack of systematic review of treatment effectiveness and lack of consideration of alternative prescribing strategies for an illness which may have been classed as "treatment resistant"

b) There was an over-reliance on oral medication in a poorly compliant individual which contributed to under-treatment of his psychotic illness.

c) There were insufficient efforts made to address compliance issues with oral medication. Mr F's carers were both under-used in assisting with this (his mother was present daily with a willingness to become involved but was never properly engaged by the clinical team in this task) and used inappropriately (the clinical team being aware that Mr F's father may be administering his medication in the context of conflict and specific beliefs that his father was trying to poison him).

d) The DDT formed a view that hospital admission was detrimental for Mr F. This view was not shared by the in-patient team who viewed admission as both necessary and desirable at those times when Mr F's psychosis was acute. We believe that this led to a situation where the DDT failed to properly consider the role that planned, goal orientated hospital admission may have achieved. We further believe that the DDT philosophy of negotiation and keeping the patient engaged may have created a situation where compulsory treatment under mental health legislation may have been of benefit but was not fully considered.

e) Mr F was not afforded a comprehensive assessment of his psychological needs. This led to a situation where those psychological interventions which may have been of greatest use (for example, family therapy, guidance for the clinical team on how to manage the history of childhood sexual abuse or detailed risk assessment) were not offered. We consider that those treatments that were offered contained fundamental formulation errors which were not picked up in the process of clinical supervision. This included a failure to accurately separate out thought processes from psychotic experiences which, in due course, contributed to a systematic under-estimation of risk. Indeed, the treatment approaches planned (for example, using confrontational skills) may actually have increased the risk of an adverse event occurring between father and son

3.1.55 Recommendations with regard to Treatment of Illness

i) HB A must critically review their model of care for people with Dual Diagnosis. This must include explicit consideration of whether a model of providing shared care between addiction services and general adult services would offer more safeguards than a stand-alone DDT. Also, HB A must critically examine whether the risks associated with patients receiving in-patient care and out-patient care from different Consultant Psychiatrists is too great for the practice to continue. The risks inherent in a service where there is discontinuity in Consultant responsibility between inpatient and outpatient care for an individual are clear and amply illustrated by the case of Mr F.

ii) Whilst, and if, HB A continue with a model where different Consultants are involved in delivering in-patient and out-patient care, there must be a documented discussion on admission (and where possible prior to admission) and again at discharge to determine the purpose of admission, develop an agreed treatment plan and proactively plan aftercare. Use of the Care Programme Approach (CPA) for all patients falling into this category may prove a useful framework. In this case, the use of CPA would also have better allowed Mr F's family to contribute information on his mental state and presentation.

iii) Whilst, and if, HB A continue with a separate DDT service, HB A must define the criteria/point at which patients are moved on from the DDT to general adult services and ensure that patients are subject to regular, formal case-review which includes general adult psychiatry services in order that transition can be considered and planned for.

iv) HB A should review the care and treatment needs of patients currently receiving treatment from the DDT to ensure that their mental illness needs are being adequately treated.

v) HB must examine the availability of clinical pharmacy support to all mental health teams (in-patient and out-patient) and this should include reference to current good practice guidance on the use of licensed medicines for unlicenced applications (Royal College of Psychiatrists CR142).

vi) HB A must address the clinical psychology provision to in-patient services and to small specialist teams such as the DDT. This provision should be of a level which allows the assessment and treatment of the most complex cases and the supervision of other staff conducting psychological interventions. With regard to the supervision component, care must be taken to ensure that the supervising clinician is close enough to the work of the team to be familiar with the cases being discussed

3.2 Impact of the Home Situation

a) family functioning

3.2.1 There are over five decades of research describing the impact of psychosis on family life and functioning. Care giving has a clear and measurable impact on family members (Kuipers, 1993) who experience high levels of worry, reduced social networks and a range of emotional problems. In 1985 Leff & Vaughn were instrumental in defining the construct "expressed emotion" (EE) as a way of understanding family attitudes and behaviour. The presence of high EE is a robust predictor of outcome in schizophrenia with individuals living in high EE situations

much more likely to experience a relapse of their condition than those living in low EE situations (see for example, Kavangh 1992 & Butzlaff & Hooley 1998). Importantly, the more time spent immersed in a high EE environment, the more likely relapse is, whereas high contact with a low EE relative (more than 35 hours per week) provides a significant degree of protection (Bebbington & Kuipers 1994).

3.2.2 The presence of EE is formally established using the Camberwell Family Interview. This measures the relative presence or absence of Critical Comments (CC), Hostility (H), Emotional Over-Involvement (EOI), Warmth (W) and Positive Remarks (PR). CCs are described as expressions of dissatisfaction of the person said with a critical tone of voice and H as expressions of rejection of the person. The element of EOI can be over-looked but is equally important. It is characterised by over-protective, devoted behaviour where the care-givers own needs are put aside in order to meet those of the person being looked after.

3.2.3 The term EE is now more often described simply as the "emotional environment" of the family in question and family intervention is not seen as being uniquely required only by families exhibiting high EE.

3.2.4 Family Interventions are largely based on behavioural, cognitive and systemic ideas, adapted to the particular effects of psychosis. They are designed to help families cope with their relative's problems more effectively, provide support and education for the family, decrease levels of distress and improve the ways in which the family communicates and problem solves. Randomised controlled trials involving nearly 2500 participants provide robust and consistent evidence that family interventions are efficacious and achieve reduced rates of relapse, a reduction in time spent in hospital during the treatment period and a reduction in the severity of symptoms experienced by the service user during, and for at least 24 months after completion of, treatment. Mueser & Glynn (1999) have concluded that "family treatment is the most widely studied and empirically validated psychological treatment for schizophrenia."

3.2.5 The importance of all of these issues are embodied in current NICE Guidelines. These recommend that:

- Families and carers should be provided with written and verbal information on schizophrenia and its management, including how they can help through all phases of treatment
- Carers should be offered a carers assessment
- Families and carers should be provided with information about local support groups and voluntary organisations and offered help to access these
- The needs of any children in the family must be assessed
- All families should be offered "Family Intervention"

b) Risk Within the Family

3.2.6 Issues relating to risk assessment and management are thoroughly examined in the next section of this report. However, specific issues are relevant here. The MacArthur Foundation's Community Violence Risk Study found that whilst people with a major mental disorder diagnosis are no more likely than the general population to engage in community based violence (indeed, those with a major mental illness who have never received hospital treatment have a lower rate that the general population), those individuals who have a major mental disorder diagnosis and misuse substances, commit more acts of violence than the general population. This risk of violence increases further in this group for those people who have received hospital based treatment.

3.2.7 Studies have also shown that the prevalence of violence in people who meet criteria for alcoholism is twelve times higher than that of the general population.

3.2.8 Perhaps more importantly, the National Confidential Inquiry into Homicide and Suicide by People with Mental Illness have highlighted that 68% of victims of homicide by people with mental health problems are family members or partners. This compares with 37% of victims of homicide by people who do not have mental health problems.

3.2.9 Family dynamics and risk issues within families need to be considered *together* when formulating which intervention a family requires. This will never be a straightforward issue and any intervention would need to be reviewed and evaluated on a regular basis to ensure that it was not making matters worse rather than better.

3.2.10 We consider, given the presence of high EE and command hallucinations specifically towards his father, that active steps should have been taken to secure separate accommodation for Mr F and his father. It should have been recognised that this needed to happen with a degree of urgency, driven by relative risk, and those risk issues should have been explained to Mr F and his family in order that an *informed* choice could be made.

3.2.11 Mr F spent most of his adult life living with his father. The family history was complex. Important factors include Mr F senior's alcohol misuse, his difficult behaviour and violence towards Mr F during childhood and his role in introducing a lodger into the family home who went on to sexually abuse Mr F. The family described him as a "strong" character whom they loved but who had a "nasty side" to him, especially when under the influence of alcohol. This picture was clear to health and social services involved with Mr F senior in his own right, with him having been asked to move GP practices on a number of occasions, workers attending the house in pairs and out-of-hours services asking for police escort when visiting. Mr F

was listed as one of his father's carers and, as such, even leaving Mr F's psychosis aside, the family environment was likely very difficult.

3.2.12 Mr F's care team also recognised the problems associated with his home life. Workers took active steps to avoid or minimise their own contact with Mr F senior and there was a universally shared view that the relationship between father and son was harmful. Workers saw Mr F in his bedroom to try and prevent his father interrupting sessions but even these measures would sometimes not work. This led to a view that Mr F would be better off living in his own accommodation and Dr A and Dr B and a number of junior doctors clearly described the existence of "high expressed emotion." However, it was viewed that Mr F was *choosing* to remain in that family situation, his having returned to the family home on a number of previous occasions being used as evidence that that was where he wanted to be.

3.2.13 Having reviewed the evidence relating to all aspects of the family situation, we find:

a) There was a failure to consistently recognise the extent and significance of a problematic history between father and son. Mr F was subject to emotional and physical abuse at the hands of his father throughout childhood and his father, albeit unwittingly, introduced a man into the family home who sexually abused Mr F and another family member. These abusive dynamics continued into adulthood and were witnessed by various members of the care team who described experiencing acute discomfort at these times. However, this does not appear to have generalised into an appreciation as to what it must have been like for Mr F to be subject to these interactions with no means of escape

b) Mr F senior was dealt with as someone to be avoided. There is no doubt that he was a difficult individual who presented challenges to those around him. However, this appears to have led to a 'hands-off' approach with the entire family. We found no evidence of pro-active attempts to engage the wider family. Mr F's mother delivered care daily yet was never involved in care planning or reviews. It appears that the care team may have viewed her as enmeshed and over-involved and, as such, obstructive of attempts to improve Mr F's level of skills and independence. No consideration appears to have been given to the possibility that her contact offered 'protection' against the more problematic dynamics between father and son. Further, at no point in a period spanning more than ten years, was Mr F's mother offered a carer's assessment. Nor indeed was Mr F senior. It is perhaps worth noting that Mr F senior's social worker, albeit involved for a short period of time, did successfully conduct care planning and review meetings with the family. At interview he told us that the family were able to change their behaviour when

asked. The use of the Care Programme Approach may have provided a way of better engaging with the family

c) Dr A, Dr B and at least two junior doctors raised the issue of "high expressed emotion." However, the involved nursing and social work staff seemed completely unaware of this concept. Importantly, no-one appeared to conceptualise Mr F's reluctance to leave the family home within the framework of emotional over-involvement. At no point was an attempt made to measure the presence/absence of EE. Those staff who did 'recognise' it as a possibility, took it as evidence that Mr F needed to leave the family home. However, despite the likely role of the family environment in the frequent crises and relapses experienced by Mr F, there was a lack of action to address this. At no point was family work considered – either in its own right as a treatment approach or as a way of helping the family as a whole move towards Mr F living independently. Further, there was a complete lack of urgency in the attempts to secure housing. This is seen on numerous occasions over the years but most latterly where the DDT were not assertive enough in their dealing with social work colleagues when SW2 went off sick and, indeed, on the part of SW2 herself when Mr F was placed 369th on a waiting list following an under-reporting of the need and urgency for re-housing to the special needs housing committee

d) As part of the above thinking, it appears that when psychological approaches were considered for the family, these were targeted towards Mr F himself. Whilst we fully endorse the use of psychological interventions in psychosis where appropriate and would not disagree with all aspects of the individual formulation detailed by CMNH B, we consider there to be short-comings in the approach adopted. Mr F was rightly identified as an individual who had developed negative beliefs about himself, other people and the world in general resultant from his childhood experiences. However, proper cognisance was not paid to the fact that the formation of most of these beliefs was heavily influenced by Mr F senior's behaviour towards his son and family. Instead, there was a narrow focus on the sexual abuse that Mr F suffered at the hands of people out-with the family. Mr F's day-to-day existence with his father is likely to have served to reinforce and validate his negative beliefs. All members of the care team witnessed how critical and "nasty" Mr F senior could be towards his son. We therefore consider it, at best, naive to have initiated individual psychological intervention with Mr F. We noted that an explicit goal of this therapy was to have Mr F practice "confrontational skills." We saw and heard no evidence that the appropriateness of this had been considered in the context of risk. Indeed, CMHN B described Mr F as having "thoughts" of doing harm towards his father whilst the involved psychiatrists were quite clear that Mr F was experiencing command hallucinations to harm his father. Risk deliberations would be quite different in each of these

circumstances. Finally, engagement in psychological therapy tends to generate an implicit expectation of change; as it was unlikely that Mr F could achieve meaningful change whilst daily life continued to be negative and critical, it would be possible that this lack of change would be experienced as failure on the part of Mr F

e) Throughout the various lengthy periods that Mr F was living with his father, he was seen to be there through choice; both on the part of Mr F and his family. We question whether this was an informed choice. We saw no evidence that the risks associated with the living situation were discussed with Mr F and his family. Indeed, it may be that the clinical team systematically underestimated the risk of violence within the family because Mr F had been experiencing urges and impulses to harm his father for a considerable number of years and had not acted on these and this was the implicit message that the family absorbed. However, given the history between Mr F and his father, the presence of alcohol misuse, the presence of high EE, the presence of poorly controlled psychosis and the presence of command hallucinations, we consider that the existence of an increased *potential* for violence should have been discussed with Mr F and his family in order to better ensure that the choices made about living circumstances were *informed* ones.

f) Mr F had two sons who lived with him at various points in time. The care team appeared to have an awareness that the children were sometimes present in the house but were unclear as to the formality of this arrangement. Indeed, Dr A (who had contact with Mr F only when he was in hospital) had no awareness that Mr F had custody of his children for prolonged periods and was clear in his assertions that had he been aware of this, he would have acted upon it, doubting Mr F's practical ability to parent and the appropriateness of the household. Latterly, Mr F's oldest son was present during a significant act of self-harm and although this was highlighted as a risk issue that needed to be re-visited by the DDT, no action appears to have been taken. We consider that an assessment of need should have taken place with regard to Mr F's children. Further, there should have been regular assessment of risk with regard to the childrens' wellbeing and Child Protection Procedures should have been initiated (or not) on the basis of those considerations.

3.2.14 <u>Recommendations with Regard to the Home Situation</u>

i) HB A must ensure that all staff are aware of the relationship between family environments and relapse in psychosis. This is equally relevant for those SWD 1 staff working with adults with psychosis

ii) HB A must ensure that all teams dealing with people with severe and enduring mental health problems have access to evidenced-based family interventions. Where teams are viewed as too small in their own right to support a worker trained in a structured family intervention, there must be clear arrangements as to how this can be accessed from elsewhere

iii) HB A must ensure that all teams have access to expertise in psychological assessment – including risk assessment – in order to maximise the likelihood of the correct intervention being implemented. Many psychological interventions, including structured family interventions, can be implemented by staff from varying disciplines and do not require a Clinical Psychologist to conduct these. However, most teams will have cases of a complexity that do require this higher level of skill either to decide upon the appropriateness of a particular intervention and/or to implement this. HB A must therefore examine the availability of Clinical Psychology to the DDT and other teams delivering care to people with severe and enduring mental health problems

iv) HB A must put procedure in place that ensure that staff properly re-examine the home environment at key points in the care process. This must include documented consultation with carers and other people living in that environment

v) HB A and SWD1 must ensure that where teams do not have integrated social work provisions there is clear guidance as to why, how and when services can be accessed

vi) HB A and SWD1 must ensure that all workers involved in the Mr F case receive refresher training in child protection issues. Further, examination should be made of whether this is equally applicable to the rest of the workforce

vii) HB A and SWD1 must ensure that the Care Programme Approach (CPA) is being used in accordance with its own current guidelines

3.3 Risk Assessment

3.3.1 The National Confidential Inquiry Into Suicide and Homicide by People With Mental Illness (2008) rightly details that the potential for mental health services to prevent homicide is a sensitive subject. Prevention is seen as difficult and prediction – identifying the highest risk patient from the many who present some degree of risk – unreliable. However, it is also explicitly states that "the management of risk can always be improved." This is a view that we share.

3.3.2 Scotland has around 100 homicides each year. Approximately 12% of these are carried out by individuals who are, or have recently been, receiving care and treatment from mental health services. However, when one looks specifically at people with a diagnosis of schizophrenia, there are, on average, 3 homicides per year in Scotland perpetrated by people with schizophrenia, of whom only one will be a current or recent patient. The National Confidential Inquiry, in a 5 year period, found 15 people convicted of homicide with a confirmed diagnosis of schizophrenia. 10 of out the 15 had a history or alcohol or drug misuse and 10 had previous conviction for violence. There is a higher than average "use of a sharp instrument" as the method of homicide in people with schizophrenia and in people with alcohol dependence. Unlike suicide, there is no peak for homicide in the three months post-discharge from hospital and clinically and behaviourally, those patients who commit homicide have characteristics similar to those who do not; except that they are likely to have had multiple admissions to hospital and experience a premature discharge from hospital either by initiating this for themselves or being discharged because of breaching hospital rules.

3.3.3 There is significant literature outlining those factors which increase the risk of violence. The Department of Health Document "Best Practice in Managing Risk" (2007) details a good summary of these. In Scotland, the Sainsbury Centre for Mental Health's "A Clinical Tool & Practitioner Manual" by Morgan (2000) forms the basis for many of the risk assessment processes used within mental health services. This is the case for HB A which has in place a formal risk assessment document. Morgan identifies fourteen factors in the Aggression/Violence Indicator :

- Previous incidents of violence
- Previous use of a weapon
- Misuse of drugs/alcohol
- Male gender, less than 35 years of age
- Known personal trigger factors
- Expressing intent to harm others (the presence of thoughts alone increasing the risk, with this increased further by the presence of intent)
- Previous dangerous impulsive acts
- Violent command hallucinations

- Signs of anger and frustration
- Sexually inappropriate behaviour
- Preoccupation with violent fantasy
- Admission to secure settings
- Denial of previous dangerous acts

3.3.4 The process of risk assessment & management has been identified as having a number of difficulties. When all diagnoses are taken into account, of those patients in contact with mental health services within 12 months of the offence (58 people in total), 18% had been seen within 7 days of committing homicide. Assessment at the final contact revealed abnormalities of mental state in 57% of cases but staff judgement of risk was “low” or “absent” in 74% even though there had been a previous conviction for violence in 58% of cases. Judgement of this risk is more likely to be made as “moderate” or “high” in these circumstances when a Consultant grade doctor is involved.

3.3.5 Pott (1995) identified thirteen factors which health professionals do not take into account sufficiently in practice, thus weakening the risk assessment process. These include minimisation of historical events, over-reliance on recent progress, infrequent or discontinuity of assessment and non-verification of statements by patient and/or others. The idea of “underestimation” of risk is further expanded within the National Confidential Inquiry which raises the idea that clinicians may be likely to get drawn into the “here and now” factors at the expense of historical factors such as previous violence or substance misuse which suggest substantial risk even when mental state appears normal. It is also raised that managing patients with complex, multiple risk factors, may result in clinicians becoming desensitised to the risk of a single individual; these issues therefore needing to be at the heart of risk management procedures and training.

3.3.6 In 1998 Reith highlighted that the accuracy of predicting risk depends upon relevant training, experience, acuity, possession of related date and a global assessment involving a large degree of personal judgement. With a wide variation in training, experience and access to information, a systematic and co-ordinated approach is essential in multi-agency working.

3.3.7 The above issues are embraced in the Mental Health Reference Group (MHRG) document entitled “Risk Management,” a guidance document for those working in mental health services. The Group recognised that in working with people with mental health problems, it is necessary to be aware of and manage risk continuously. Good communication, record keeping and sharing of information are seen as key elements in this risk management process. The Care Programme Approach (CPA) is cited by the MHRG as one formal mechanism through which this can be best achieved.

3.3.8 Mr F presented with a number of risk factors. Most significantly, he had a previous history of violence. Not all members of the clinical team were aware of this. Whilst he had never used a weapon as part of an actual assault, there were occasions when Mr F had armed himself with a knife. These events are documented but there is no good description of the exact ideas motivating this behaviour, his intent (self-defence or pro-active attack), his appreciation of the illegality of the behaviour or likely consequences of the behaviour. Mr F also had a history of alcohol misuse. The significance of the history of alcohol misuse appears to have become lost in favour of current abstinence. Mr F is male and still of relatively young age. He consistently expressed thoughts to harm others (primarily his father) and these ideas were expressed in the context of both paranoid delusions about others and violent command hallucinations. There is not enough detail in the case-notes to determine whether some of Mr F's behaviour could be classified as "previous dangerous impulsive acts" although the nature of some of his later acts of self-harm would seem to fit into this category. The clinical team were clear that, at times, Mr F was consuming large amounts of alcohol as a way of coping with life with his father and his illness. It may be the case that signs of anger and frustration were therefore masked. Regardless of these latter two points we consider that Mr F's risk of harm to others should have been consistently recognised as high.

3.3.9 Instead, the clinical team viewed Mr F as a "gentle giant." The significance of historical risk factors, voiced ideas and psychotic beliefs about harming his father were eclipsed by an over-confidence that since he had experienced thoughts about his father for many years and had not acted upon them, then he was therefore unlikely to do so. The DDT, who had excellent relationships with Mr F, appear to have lapsed into a view of Mr F as someone not 'capable' of killing another person and therefore wrongly minimised the significance of new events when they occurred.

3.3.10 In the two years leading up to Mr F killing his father, there were four formal risk assessments completed. CMHN B completed three of these in an eight month period from August 2005 to March 2006. CMHN C completed one further assessment in October 2006. These assessments respectively documented "thoughts of harm towards father", "ideas of harming father," "thought of self harm/harm towards father" and "thoughts of harm towards father." The actions to be taken as a result of these assessments include early review by medical staff, consideration of hospital admission, discussion of coping strategies and encouraging abstinence from alcohol. There is no evidence that the risks were discussed with the family or prompted a sense of urgency in Mr F needing to be permanently housed elsewhere. There is also no evidence that commissioning a more detailed, formal assessment of risk of violence was considered.

3.3.11 Between the formal risk assessment documents, there are a number of occasions where risk issues were highlighted by health professionals out-with the

DDT. Although this information was available to the DDT through the electronic record system, the occurrence of these events did not trigger a re-assessment of risk. Particularly important, in November 2006 Mr F was assessed at A&E following an episode where he had harmed himself in the presence of his son. The act appears to have been driven by delusional beliefs. In December 2006 whilst an in-patient, Mr F assaulted a fellow patient by punching him on the face. This act also appears to have been driven by delusional beliefs, in this case that Mr F felt at risk of being killed by others whom he believed (wrongly) thought he was a paedophile. In April 2007 during an urgent review by a junior doctor and CMHN D, Mr F was noted to be aggrieved about his father's behaviour and the interview was halted because Mr F was shouting at his son. Later that same month, an out-of-hours assessment indicated that Mr F believed his father to be rummaging through his possessions. Finally, it should be noted that SA 1 were *instructed* by CMHN D to withdraw from contact with Mr F when he was expressing delusional beliefs about one member of staff and one other experienced member of staff had felt threatened. There was no formal assessment of risk prior to SA 1 approaching Mr F to re-establish contact and no evidence that matters had changed in any way that would allow this to happen safely.

3.3.12 We believe these acts may have represented an escalation in the risk that Mr F was presenting but we found no evidence that they had been systematically considered by the DDT within the overall framework of risk management.

3.3.13 Mr F was scheduled to have his risk assessment "reviewed" on 8th January 2007. There is no evidence that this was carried out nor any reasons given as to why it was not completed. The system of risk management within the DDT prior to this indicates that this would have been the responsibility of CMHN D. As stated in the introduction to this document, CMHN D was not available for us to ask about this.

3.3.14 Of particular concern, is the formal communication of risk information to other involved agencies/practitioners. When CMNH C completed the standard SSA documentation requesting support hours from SA 1 in November 2006, in response to the question "Is there any history of aggressive or violent behaviour?," she responded that there wasn't. It also indicated that there were no risks associated with visiting the Mr F household. When SW 2 completed the comprehensive SSA documentation in March 2007, the question "Are there any concerns to public safety/harm to others?", this too was answered no. None of these answers reflects the true level of risk. Support agency staff, housing officers and GPs were thus wrongly informed as to the level of risk that Mr F presented.

3.3.15 When SW2 became involved in the case she did not complete any form of risk assessment. Nor did she formally ask for copies of risk assessment documents from the DDT. At interview, SW2 told us that had risk issues been apparent, she would have expected CMHN D to tell her about these and expressed the view that 'health' were much better at "these things" than social work. She stated that there had been

no formal social work risk assessment procedure in place at the time of Mr F being referred but that there was now (at point of interview in March 2009).

3.3.16 Having reviewed the evidence relating to all aspects of risk assessment, we find:

a) HB A had a formal process for risk assessment and management in place. However, in the case of Mr F, this process did not capture enough accurate detail of historical or occurring events to meaningfully inform the process.

b) There is no evidence that this formal process was undertaken after October 2006 with the review date in January 2007 missed completely. We consider that a number of important events should have triggered the completion of this process

c) The DDT became 'too close' to Mr F to keep the process of risk assessment and management distinct from influence of their good relationships with him. This led to a consistent under-estimation of the risk that Mr F presented, especially in relation to his father. When more distant health professionals assessed risk, they did so more accurately but this information was minimised by the DDT who considered their personal knowledge of Mr F to better place them to make such judgements

d) The DDT, in failing to accurately assess risk for themselves, also failed to pass risk information accurately to SA 1, SWD and GP colleagues

e) SW 2, rather than becoming actively involved in the risk assessment process and forming an independent opinion, simply relied on the risk assessment of others. This was a missed opportunity for someone less involved in the case to objectively reflect on the decisions being made

f) No single person involved in Mr F's care had an *accurate* picture of how often he cared for his two sons. Mr F's mother could easily have provided this information as she would often have to have one or both boys sleeping overnight with her because of lack of space, the degree of conflict between Mr F and his father or Mr F's poor mental state. At no point beyond the initial assessment and discharge by social work services in 2001/2002 was the welfare of these children formally considered. They were certainly never included in the risk assessment equation. Even when Mr F's oldest son was noted by A&E staff to be "extremely distressed" by the incident where Mr F attempted to cut out his kidney whilst in bed beside him, the need for Child Protection measures was not

considered nor any help offered

g) The DDT, given the level of risk present and the nature of this risk towards specific individuals, should have utilised the Care Programme Approach (CPA) with a specific goal of engaging Mr F's family in this process

3.3.15 Recommendations with regard to Risk Assessment

i) HB A and SWD1 should look to reviewing their agreed, shared risk assessment *process.* Whilst the documentation to assist this is clearly established, documentation alone does not ensure the accurate recording of information or help individual professionals or groupings of professionals to make the appropriate "assessment" or judgements about levels of risk. HB A and SWD1 must therefore:

- Audit the process of risk assessment and management to determine whether this is occurring at the specified intervals and that significant new risk-relevant events trigger a formal re-visiting of risk assessment and management
- Ensure that there is a regular cycle of training which clearly outlines contemporary knowledge and best practice with regard to risk to others and, importantly, covers the known problems and weaknesses that may creep into the process and lead to a systematic under-estimation of risk
- Put in place processes whereby risk assessment and management information is shared by all people/agencies involved in the care (including GPs)

ii) HB A and SWD1 must give serious consideration to extending or clarifying CPA criteria to ensure that this process is invoked for any individual experiencing persistent psychotic symptomatology or other factors which indicate elevated risk to others

iii) Where risk involves someone to whom the patient has access, there must be a detailed assessment of that risk. Where families form an integral part of a patient's life, the findings must be shared with the family in order that they can meaningfully assist in the risk management process and make fully informed choices about the type and frequency of contact to have with their family member

iv) Where the risk involves a family member to whom the patient has access, SWD 1 must ensure that a Carers Needs Assessment is undertaken and that this is properly considered as an integral part of the original care plan

3.4 Social Work/Social Care Action

a) The Right to an Assessment of Need

3.4.1 The Social Work (Scotland) Act 1968 places a duty on Local Authorities to assess needs and determine whether the needs of the person being assessed call for the provision of services. The Community Care and Health (Scotland) Act 2002 extended the range of duties placed on Local Authorities, the aim of which was to ensure faster and better assessments, more integrated professional working and better information sharing across boundaries. Good quality, fully informed assessments aim to maximise the strengths and abilities of the person and target appropriate services timeously. Effective assessment is an ongoing, dynamic process rather than a one-off event.

3.4.2 Mr F had contact with the Local Authority social work service (SWD 1) at various times from December 1996 until June 2007. Initial contacts related to practical issues and homelessness in particular; the outcome was brief social work intervention and signposting to other agencies. Mr F's parents contacted the social work service individually to request an assessment of need for their son and emphasised the fact that Mr F continuing to live with his father was detrimental to his mental health. The Local Authority housing department suggested that a more proactive approach should be taken to Mr F's housing situation and believed that agreement had been reached to arrange a Care Programme Approach (CPA) meeting accordingly in December 2001. The CPA meeting did not take place and a 'lost contact decision' was made by the housing department in January 2002.

3.4.3 Mr F was finally allocated a social worker in his own right in November 2001 following concerns about the fact that his children had been placed with him over the weekend at the house he shared with his father. It was thought that this was to be a permanent arrangement. At a Child and Family meeting two weeks later, the allocated social worker stated 'in her opinion Mr F's psychiatric condition was under control and that this should not present a danger to the children'. The outcome of the meeting was that the children were to continue to live with Mr F and his father and the situation was to be monitored by 'regular' visits by Mr F's social worker. Records evidenced no consultation with other professionals or relatives, no risk assessment and no needs assessment or support plan.

3.4.4 Although the social work allocation system recorded Mr F as having a social worker from November 2001 to October 2004, there is a two year period during this time where no actual social work contact is recorded. Social work involvement is characterised by ad hoc interventions. For example, when Mr F was allocated a tenancy he did not feel was right for him, social work advice to his mother was to "make the tenancy look lived in" so that a housing transfer could then be applied for. Notes record "he had been advised to contact sw if he wanted any assistance". The case was subsequently closed when the allocated social worker happened to bump

into Mr F and his mother at a hospital gala day. Closure of Mr F's case was discussed at this informal occasion and the social work record subsequently completed stated: "The case can now be closed as the family no longer have any expectation of sw input". There was no reference to the fact that Mr F's children were continuing to spend time at the house he shared with his father.

3.4.5 Mr F was detained according to an emergency detention certificate on 15th June 2006 and a referral was made to SWD 1 the next day. A social worker (SW2) was allocated on 29th June and the target date for completion of the single shared assessment (SSA) was 27th July 2006. The SSA process was introduced by the Scottish Executive to streamline systems, speed up the delivery of services and improve outcomes for individuals. Unfortunately the allocated social worker went on sick leave and did not return to work until January 2007. During this 7 month period, despite meeting the eligibility criteria for allocation of a social worker to assess his needs, Mr F received no assessment and no social work service. During this period no other professionals working with Mr F raised this unmet need with the managers of the social work service.

3.4.6 SW2 returned to work in January 2007 and immediately began to assist Mr F with the completion of housing application forms. A SSA was completed approximately six weeks later. SSA is an opportunity to consult all involved agencies to contribute to a person-centred holistic assessment. The social worker, however, primarily consulted with CMHN D who had also only recently become directly involved in Mr F's care. At interview, SW2 told us that "we were learning about Mr F between us, but we did communicate fairly frequently". No risk assessment was undertaken by the social work service and SW2 did not access the risk assessment/risk management plan completed by health colleagues. SW2 did not attend any review meetings with the DDT but stated she "would have been very surprised if there hadn't been systems in place to review Mr F's care".

3.4.7 SW2 confirmed that assistance was given in relation to completing housing application forms for Mr F but that at no stage had action been taken to make alternative housing a *priority*. SW2 explained that social work contact also extended to listening to Mr F talk about his family, his experience of abuse and his thoughts about the television and radio communicating with him directly.

b) Housing Related Support

3.4.8 'Supporting People' was introduced in 2003. It is a national policy initiative and funding framework for housing support services. Section 91 of the Housing (Scotland) Act 2001 defines housing support as practical assistance to support individuals to move into their own house and live independently or to continue to occupy their own home sustaining their capacity to do so. At the time of referral for

housing support, there were no proactive plans in place to secure alternative accommodation for Mr F.

3.4.9 Mr F was allocated 6 hours housing support per week in November 2006 following receipt of referral by CMHN C; the care provider was SA1. The agreed areas of support were recorded as socialisation (going out in the community), independent living skills (support to fulfil own tenancy) and emotional support (one to one counselling with mental health issues). The hours were subsequently increased to 9 hours per week in January 2007 to assist with the completion of application forms. As noted above SW2 became involved in Mr. F's care at the same time and was also assisting with the completion of application forms.

3.4.10 SA1 support staff had great difficulty encouraging Mr F to go out in the community and reported that Mr F left the house with workers on only approximately 4 occasions over a 7 month period. Whilst living in his father's house, Mr F met with SA1 support staff in his bedroom. His mother assisted with all daily living tasks and, as such, promoting Mr F's independent living skills proved impossible. The 9 hours of housing support offered per week therefore primarily took the form of "emotional support" where we were told that Mr F usually talked about music, religion, his experience of abuse and his odd thought processes about the radio and the television.

3.4.11 Having reviewed all the evidence relating to all aspects of social work/social care intervention, we find:

a) Mr F had contact with social work services over an 11 year period and there is no evidence to suggest that a full assessment of his needs, including housing needs, was ever undertaken. Throughout this period decisions regarding social work intervention appeared to take place in isolation and were characterised by a lack of partnership working and consultation with other agencies. This led to inaccurate information being recorded (for example the SSA noted no concerns in relation to public safety/harm to others and noted a carer's assessment in Mr. F's case was 'not applicable) and a complete lack of urgency in the attempts to secure alternative appropriate accommodation for Mr. F. Following completion of housing application forms in 2007 (with no medical form attached) Mr. F's needs were placed as 369th on the housing waiting list.

b) SWD 1 required all available relevant information to decide if there was genuine cause for concern in relation to Mr. F's two sons living at home with their father and grandfather. Effective practice was not evidenced in this case. As noted previously, SW1 formed a view that the children were not at risk although the basis of this view is not evidenced in records. Dr A advised that he had no awareness of the fact that Mr F had custody of his

children at times. SW2 was aware of this arrangement but unlike Dr A she stated her view that she had no concerns. She was, however, surprised to learn that Mr F's son was present when Mr F made a significant attempt to self-harm in November 2006. The basis of effective child protection is reliable communication at all levels together with ongoing review to identify any sources of potential harm to the children and to assess the degree of risk. The practice in the case of Mr F's children's did not meet this standard.

c) SA1, funded by supporting people monies, was the agency in most regular contact with Mr F from November 2006 despite the fact that the likelihood of Mr F securing his own tenancy in the near future was low. It was clear that SA1 had difficulty trying to provide support with practical issues at the outset. The main focus thus appeared to be "emotional support", rather worryingly recorded as "counselling in relation to mental health issues". Supporting people staff are not qualified to provide formal counselling and supporting people funding does not extend to specialist or formal counselling. Visits by SA1 staff and SW2 involved primarily listening to Mr F talking about a range of matters for which, at interview, they confirmed they had no expertise. Questions must therefore arise as to the therapeutic benefit of this to Mr F and, indeed, whether the constant revisiting of his abusive past may have contributed to his poor mental state.

d) The SSA process should identify a lead professional to co-ordinate assessment and care planning. The care team was not clear about whose role this was. Six hours of housing support was commissioned from SA1 by CMHN C in November 2006 and this was increased to nine hours in January 2007. SA1 organised the only *formal* multi-disciplinary review of Mr F's care in March 2007 and the hours remained the same. Questions arise regarding the responsibilities of the purchaser in this case particularly with regard to reviewing the SA1 service. It seemed that review of the housing support service lay with the service provider in Mr F's case. Moreover, in the absence of any care co-ordination, it would appear that SA1 support staff, funded and qualified to provide practical housing and preventative support were instead being used to boost support levels within an intensive care package to try to meet Mr F's very complex needs.

3.4.12 Recommendations with Regard to the Social Work/Social Care Action

i) SWD 1 must put in place a system where staff absence does not result in cases being left for prolonged periods without review or intervention.

ii) SWD 1 must ensure that an assessment of need is undertaken in line with the Social Work (Scotland) Act 1968 and Community Care and Health (Scotland) Act 2002 at the point of initial contact with the service.

iii) SWD 1 and HB A must ensure that all workers involved in the Mr F case receive refresher training in the systems and processes involved in the single shared assessment process and their role in it.

iv) SWD 1 and HB A must ensure that all workers involved in the Mr F case receive refresher training in child protection issues. Further examination should be made of whether this is equally applicable to the rest of the workforce (this recommendation has already been made in Section 3.2.14 but is repeated here because of it's importance).

v) HB A and SWD 1 must give serious consideration to the structures in place to support a co-ordinated approach to the delivery of a multi-disciplinary care package. The Care Programme Approach, for example, ensures active participation of all relevant parties, including carers, in the care planning and review process.

vi) HB A and SWD 1 must give serious consideration to the structures in place to support a co-ordinated approach to the delivery of a multi-disciplinary care package. The Care Programme Approach, for example, ensures active participation of all relevant parties, including carers, in the care planning and review process.

vii) SWD 1 and HB A must ensure that where services are secured for an individual, the service provided is scrutinised by the purchaser and reviewed regularly to ensure that the particular service remains appropriate to the assessed needs of the individual.

3.5 Critical Incident Review

3.5.1 In October 2000, the Mental Health Reference Group (MHRG) produced a report entitled "Risk Management", a guidance document for those working in mental health services. Appendix D of this report details Critical Incident Review (CIR) as "the best means by which an organisation can learn from failures of the system, identify deficiencies and introduce change."

3.5.2 Homicide allegedly committed by someone receiving out-patient treatment for mental health problems falls within one of four types of critical incident that should be

subject to a formal CIR. The purpose of that review is said to be "to establish matters of fact, not attribute blame or responsibility."

3.5.3 The guidance advocates that the review should be chaired by a senior member of staff from another part of the organisation. All information relating to the event as well as face to face contact with staff, workers from other agencies, individuals involved and relatives/carers will then be taken into account. The patient records from all disciplines are made available to the Chair of the review. When the review is complete, a copy of the report should be made available to all relevant staff, including General Practitioners, and it is recommended that a meeting is convened to discuss the content of the report and consider any implications arising from it. In particular, the guidance advocates that the review should determine whether any aspect of patient care contributed to the incident and whether any recommendation should be made with regard to current practice or policy. Where the incident involves suicide or sudden death, reference should be made to subsequent contact with the family and what support has been offered.

3.5.4 The timescales recommended in the guidance are that the CIR should be completed within four weeks and the meeting to discuss its findings within six weeks.

3.5.5 In the absence of any specific national guidance on critical incident reporting, Health Boards may independently develop their own policies and protocols for conducting reviews. In the case of HB A, there was no formal policy for CIR to refer to at the time of the incident.

3.5.6 The Chair of the review (FCMHN) was chosen by a Patient Services Manager on the basis of his experience as a senior nurse within forensic psychiatry. Whilst he had had no direct involvement with the patient, he managed the service to which Mr F was admitted immediately after committing the offence. This is not strictly in keeping with the MHRG recommendation that the Chair should be from another part of the organisation.

3.5.7 The Chair had previously participated in CIRs, but only as a contributing member of the group. Prior to this CIR, he had no experience of chairing a review, nor had he received any training in the role. His assumption was that people learned how to chair a review "on the job". Consequently, the format of the review mirrored those the chair had previously experienced as a group member. The approach taken, however, left some participants unclear as to the purpose and function of the review.

3.5.8 The purpose and scope of the review of September 2007, was to look at the care and treatment of Mr F in the few months leading up to the incident and determine whether there were any learning outcomes leading to recommendations for the organisation. Prior to the review, the Chair had access to the clinical records for Mr F in both written and electronic format.

3.5.9 The review itself examined the background history, care provision, roles of staff involved and risk assessments carried out. The Chair also viewed the CIR as having a supportive role, observing that, whilst people were being open and reflective in the discussion, they were clearly shocked and upset by the events. Many staff interviewed found the review to be particularly supportive towards participants. However, it was also perceived by some to lack critical analysis and to have a poor focus. With the emphasis placed on support to participants rather than the incident itself, it was felt particularly by SA 1 staff present that some issues which could have been discussed were missed.

3.5.10 At the time of the review, there had not yet been a court case regarding the homicide. Therefore, it was deemed inappropriate by the Chair of the review for them to assume the outcome of the court hearing or even to draw conclusions from the available evidence. This appeared to some to curtail the scope of the discussion further.

3.5.11 The relevant background information sought for the CIR involved family and forensic history. The family history was well documented in case files and made available to the review team. The information about forensic history available at the first CIR appears to have been incomplete and this may, therefore, represent a significant gap in the information available to staff who had been carrying out risk assessments. The only forensic history noted by the review related to road traffic offences in Mr F's early adult life. There was no mention of a conviction for assault, threatening with a knife and threats of fire-raising towards his ex wife and her new partner in 1996; additionally, no account was taken of an alleged assault on his father whilst under the influence of alcohol in 2003; an assault on another patient whilst in hospital in 2006; and another incident later that year when he tried to stab himself in the kidney area in the presence of his 16 year old son.

3.5.12 A further risk identified repeatedly throughout the case notes is variously described as command hallucinations experienced by Mr F urging him to harm or even to kill his father. These are expressly referred to in the formal risk assessments of February 2005 by CMHN B and in October 2006 by CMHN C but are also detailed in many psychiatric assessments from 2004 onwards. The risk is qualified on most occasions by stating that, although Mr F feared he might harm someone, he frequently stated that he had no intention of acting on these commands. There appears to be no further formal risk assessment, initially planned for January 2007, documented prior to the incident.

3.5.13 During the review, the aspect of the risk to others, is given less emphasis than risk of self harm presumably due to the fact that Mr F had rarely acted on these commands. The review did not question why it was only Mr F's father who tended to be the subject of these auditory hallucinations or whether living with his father may have been a contributory factor. Most of the comments on this subject at the review

refer to the absence of any perceived recent “violent thoughts” expressed by Mr F towards his father.

3.5.14 The communication between professional staff involved in the care of Mr F was generally carried out 1:1 either face to face, by telephone or in writing. Those engaged in his care tended to stay involved for lengthy periods of time and so they got to know Mr F and became very familiar with his thoughts and behaviour from the perspective of their own area of work. He had not been subject to the Care Programme Approach and there were no regular multi-disciplinary meetings comprising all those involved.

3.5.15 As a consequence of this, because of frequent attendance on an emergency basis at the GP practice or A&E when concerns arose, treatment could often be changed unilaterally without there being a general discussion and agreement with all parties. Emergency presentations were usually in the company of one or both parents. In this way, what evolved latterly tended towards a reactive rather than proactive approach to care and treatment. Emergency admission to hospital was typically followed by early discharge or discharge against medical advice.

3.5.16 The philosophy of the Dual Diagnosis Team appeared to support the view that, other than the occasions when detoxification was necessary, care at home was the preferred option. Mr F frequently stated his dislike of hospital in-patient care and any admissions, which may have been precipitated by a crisis at home, often appeared to give rise to an increase in delusional beliefs. The review did not consider whether a longer period of observation in a hospital setting may have provided an opportunity to have a more thorough review of the effectiveness of treatment options.

3.5.17 There was a general consensus from those involved that Mr F was receiving a significant package of care and support from a wide variety of services. However, it is not clear that this was co-ordinated and focussed in the best way. On no occasion did the care providers all meet to discuss care arrangements for Mr F, nor was there the opportunity to share information across health and social care face to face on a more formal basis. The use of CPA was not raised as an issue at the CIR.

3.5.18 Although a letter of invitation had been sent to the family of Mr F to contribute to the review, because no reply was received, it was assumed that the family did not wish to participate. Mr F’s mother could not remember ever having received the letter. Moreover, it appears that it had not been custom and practice for family members to be part of previous critical incident review meetings in HB A.

3.5.19 When there was no response to a subsequent letter of invitation to contribute at the time of the second CIR, this was similarly interpreted as a lack of willingness to engage. Although there were staff available who had formerly had a lengthy working relationship with Mr F’s mother, a personal approach to seek her views was

not pursued due to concerns about the amount of time that had elapsed since the incident.

3.5.20 The second CIR was instigated in June 2008, in response to a newspaper article in which Mr F's mother implied that there were aspects of his care and treatment which may have contributed to his state of mind at the time of the incident. In particular, Mr F's mother believed that the medication he was prescribed was not effective in controlling his symptoms and that he was constantly tormented by voices telling him to harm his father. Mr F's wife had also expressed this concern when she accompanied him to A&E in June 2006. Moreover, because of the difficulties he had in living with his father, his mother thought he should have been helped to find accommodation of his own.

3.5.21 This second review took on a different format and was more limited in its scope. A Medical Manager, Dr G, together with the Chair of the original CIR, reviewed the available information. In addition, they interviewed two of the CMHNs in most regular contact with Mr F.

3.5.22 The review concluded that Mr F was receiving appropriate prescriptions in view of his psychiatric symptoms, alcohol dependence and poor compliance issues. He received a fortnightly depot injection and oral anti psychotic medication for breakthrough symptoms. In addition, he received oral benzodiazepines to help him to remain abstinent during his periods of sobriety and when free from substance misuse.

3.5.23 It was further noted that, in spite of the command hallucinations telling him amongst other things to harm his father, and the high expressed emotion environment in which he lived, that Mr F chose to live with his father and he was perceived as gaining an element of support from this arrangement. The lack of available alternative accommodation was not seen as a contributory factor to the incident and, because Mr F had not acted on the commands in the past, the risk associated with these was assessed as low.

3.5.24 In reviewing the Critical Incident Review process, we find:

a) HB A had no written policy and procedure for conducting the Critical Incident Review process. This meant that there was no system in place for selecting an appropriately trained, skilled and experienced Chair to conduct the review. Although the Chair was viewed as independent, in that he managed a Forensic Service, he did actually manage the ward Mr F was referred to immediately following the incident and where he remained until being transferred to the State Hospital.

b) The format of the review was shaped by the experience gained by the Chair as a participant in previous reviews he had attended. This limited the

quality and consistency of the review process and the contribution participants were able to make. Participants described being unsure of the purpose and scope of the review, and viewed it as lacking a clear agenda, structure or focus. Recommended time scales were not adhered to. Not all participants interviewed received a copy of the review and there was no meeting convened to discuss the findings of the review. Some participants only saw the review document immediately prior to being interviewed by the Mental Welfare Commission for purposes of this investigation (around 18 months after the event).

c) The lack of input from family members to the CIR limited the balance of information available to the review participants and prohibited those providing the closest support to Mr F from contributing to the review process. Efforts could have been made to determine whether family members received notification of the plan to hold a review. Instead, it was assumed that the letter had been received and the lack of response indicated a lack of desire to participate. Additionally, no account was taken of the need for the family to have support around the time of the incident.

d) Participants appeared confused as to whether the purpose of the review was a form of debriefing, a support mechanism or a forum for full analysis of the facts. The Mental Health Reference Group guidance indicates that support to relatives and staff and a full debrief should come in the period soon after an incident. The role of the Critical Incident Review is to examine the facts from the written record and from those involved in providing care and treatment in order to establish whether there are any learning outcomes to inform future practice. In this case, the recommendations did not appear to be in keeping with the contributory factors, issues relevant to the assessed risks or matters raised by the participants at the review. Most participants expressed surprise when given a copy of the review to read that the main recommendation related to providing counselling for adult survivors of childhood sexual abuse.

e) Given the above, we consider the scope, conduct and reporting of the CIR to fall well short of the expected standard, especially given the serious nature of the index incident

3.5.26 Recommendations with regard to Critical Incident Review

i) NHS QIS should develop and oversee the implementation of standards for Critical Incident Reviews for use across all mental health services in Scotland

ii) In the period until NHS QIS guidance is available, HB A must, as a matter of urgency, develop and implement policy governing CIRs. This should include direction with regard to when CIRs are required; who should be involved; the expertise of the Chair; the scope and purpose of the CIR; and the need to involve families in the process at an appropriate juncture/level. The Chair of any CIR must be, and be seen to be, independent to the service, have appropriate training in conducting CIRs and have expert knowledge of the subject area being reviewed

iii) There must be clear splitting off of the function of staff support/debrief from an exacting examination of the facts. HB A should develop guidance to issue to staff involved in CIRs to ensure that they are fully aware of the process and what will be involved

A Special Note on The Care Programme Approach

3.6.1 All but one of the sections above highlighted aspects of this case that indicate a clear role for the use of CPA. If used, it may have allowed for better co-ordination of medical care and treatment, helped the DDT systematically review the approach being used, provided an opportunity for engaging the family, provide a check that risk assessment measures were completed and reviewed and formalised the links between health, social work and Support Agency 1 (SA1). The only process approximating this was the care review process initiated by SA1 and we acknowledge their good work in attempting to ensure all involved parties came together. However, this occurred late in the process and the functions served are different to those of CPA.

3.6.2 Members of the DDT informed us that CPA is being used with other service users and at a wider level with HB A. At interview, members of the DDT acknowledged that, with the benefit of hindsight, it may have proved useful.

3.6.3 CPA is not a new concept. It was introduced in 1992 and has the advantage of formal government policy backing (Scottish Office Circular SWG 16/96). It is about “identifying needs, assigning an individual or organisation to meet those needs in an agreed and co-ordinated way and regularly reviewing progress with the people who receive the service and with those who care for them” (MHRG, 2000).

3.6.4 Research by the Social Work Services Inspectorate and the Accounts Commission in 1998 identified significant variation across the regions Scotland in

CPA use. At that stage, however, the focus was on services having the actual process, with accompanying policy and procedure, in place. This reflected similar findings in England (Audit Commission, 1994) where subsequent research by the Commission for Health Improvement (2003) clearly identified that there were large numbers of people not being placed on CPA or allocated a care-co-ordinator who met criteria for the same.

3.6.5 Whilst it would now be expected that all regions of Scotland have CPA fully operationalised, there has been no national review of the process since 1998. This is in contrast with England and Wales where the Department of Health have reviewed and formally consulted on the CPA and have acknowledged that "audit and monitoring remain essential components of successful implementation of CPA. Organisations, locally and nationally, should be working to ensure that systems are in place to monitor the quality and implementation of the CPA with the main focus on achieving desirable outcomes for those who use services." Audit tools for service self-scrutiny are readily available.

3.6.6 At the present time, therefore, there is no way of knowing whether mental health services across Scotland are actually utilising CPA at an expected level or whether the quality of the process is such that it is achieving desirable outcomes for people with complex mental health problems.

3.6.7 Recommendations With Regard to CPA

i) The Scottish Government should commission a review of the current use of CPA in Scotland with a view to establishing patterns of use across different regions and the quality of the processes being used. Where problems are identified steps should be taken to rectify these. NHS QIS may have a key role in this

Section 4
Summary of Recommendations

4.1.1 The previous five areas of analysis have given rise to a total of twenty five recommendations. The majority of these are directed towards HB A. However, we consider that all services across Scotland should be cognisant of the findings and make changes to their own systems as necessary.

4.1.2 The recommendations are as follows.

4.1.3 Recommendations with regard to Treatment of Illness

- HB A must critically review their model of care for people with Dual Diagnosis. This must include explicit consideration of whether a model of providing

shared care between addiction services and general adult services would offer more safeguards than a stand-alone DDT. Also, HB A must critically examine whether the risks associated with patients receiving in-patient care and out-patient care from different Consultant Psychiatrists is too great for the practice to continue. The risks inherent in a service where there is discontinuity in Consultant responsibility between inpatient and outpatient care for an individual are clear and amply illustrated by the case of Mr F.

- Whilst, and if, HB A continue with a model where different Consultants are involved in delivering in-patient and out-patient care, there must be a documented discussion on admission (and where possible prior to admission) and again at discharge to determine the purpose of admission, develop an agreed treatment plan and proactively plan aftercare. Use of the Care Programme Approach (CPA) for all patients falling into this category may prove a useful framework. In this case, the use of CPA would also have better allowed Mr F's family to contribute information on his mental state and presentation.

- Whilst, and if, HB A continue with a separate DDT service, HB A must define the criteria/point at which patients are moved on from the DDT to general adult services and ensure that patients are subject to regular, formal case-review which includes general adult psychiatry services in order that transition can be considered and planned for.

- HB A should review the care and treatment needs of patients currently receiving treatment from the DDT to ensure that their mental illness needs are being adequately treated.

- HB must examine the availability of clinical pharmacy support to all mental health teams (in-patient and out-patient) and this should include reference to current good practice guidance on the use of licensed medicines for unlicenced applications (Royal College of Psychiatrists CR142).

- HB A must address the clinical psychology provision to in-patient services and to small specialist teams such as the DDT. This provision should be of a level which allows the assessment and treatment of the most complex cases and the supervision of other staff conducting psychological interventions. With regard to the supervision component, care must be taken to ensure that the supervising clinician is close enough to the work of the team to be familiar with the cases being discussed

4.1.4 Recommendations with regard to the Home Situation

- HB A must ensure that all staff are aware of the relationship between family environments and relapse in psychosis.

- HB A must ensure that all teams dealing with people with severe and enduring mental health problems have access to evidenced-based family interventions. Where teams are viewed as too small in their own right to support a worker trained in a structured family intervention, there must be clear arrangements as to how this can be accessed from elsewhere.

- HB A must ensure that all teams have access to expertise in psychological assessment – including risk assessment – in order to maximise the likelihood of the correct intervention being implemented. Many psychological interventions, including structured family interventions, can be implemented by staff from varying disciplines and do not require a Clinical Psychologist to conduct these. However, most teams will have cases of a complexity that do require this higher level of skill either to decide upon the appropriateness of a particular intervention and/or to implement this. HB A must therefore examine the availability of Clinical Psychology to the DDT and other teams delivering care to people with severe and enduring mental health problems.

- HB A must put procedures in place that ensure that staff properly re-examine the home environment at key points in the care process. This must include documented consultation with carers and other people living in that environment.

- HB A and SWD1 must ensure that where teams do not have integrated social work provisions there is clear guidance as to why, how and when services can be accessed

- HB A and SWD1 must ensure that all workers involved in the Mr F case receive refresher training in child protection issues. Further, examination should be made of whether this is equally applicable to the rest of the workforce.

- HB A and SWD1 must ensure that the Care Programme Approach (CPA) is being used in accordance with its own current guidelines

4.1.5 Recommendations with regard to Risk Assessment

- HB A and SWD1 should look to reviewing their agreed, shared risk assessment *process.* Whilst the documentation to assist this is clearly established, documentation alone does not ensure the accurate

recording of information or help individual professionals or groupings of professionals make the appropriate “assessment” or judgements about levels of risk. HB A and SWD1 must therefore:

- Audit the process of risk assessment and management to determine whether this is occurring at the specified intervals and that significant new risk-relevant events trigger a formal re-visiting of risk assessment and management.
- Ensure that there is a regular cycle of training which clearly outlines contemporary knowledge and best practice with regard to risk to others and, importantly, covers the known problems and weaknesses that may creep into the process and lead to a systematic under-estimation of risk
- Put in place processes whereby risk assessment and management information is shared by all people/agencies involved in the care (including GPs)

- HB A and SWD1 must give serious consideration to extending or clarifying CPA criteria to ensure that this process is invoked for any individual experiencing persistent psychotic symptomatology or other factors which indicate elevated risk to others.

- Where risk involves someone to whom the patient has access, there must be a detailed assessment of that risk. Where families form an integral part of a patient’s life, the findings must be shared with the family in order that they can meaningfully assist in the risk management process and make fully informed choices about the type and frequency of contact to have with their family member.

- Where the risk involves a family member to whom the patient has access, SWD 1 must ensure that a Carers Needs Assessment is undertaken and that this is properly considered as an integral part of the original care plan.

4.1.6 Recommendations with regard to Social Work/Social Care Action

- SWD 1 must put in place a system where staff absence does not result in cases being left for prolonged periods without review or intervention.

- SWD 1 must ensure that an assessment of need is undertaken in line with the Social Work (Scotland) Act 1968 and Community Care and Health (Scotland) Act 2002 at the point of initial contact with the service.

- SWD 1 and HB A must ensure that all workers involved in the Mr F case receive refresher training in the systems and processes involved in the single shared assessment process and their role in it.

- HB A and SWD 1 must give serious consideration to the structures in place to support a co-ordinated approach to the delivery of a multi-disciplinary care package. The Care Programme Approach, for example, ensures active participation of all relevant parties, including carers, in the care planning and review process.

- SWD 1 and HB A must ensure that where services are commissioned, the service provided is scrutinised by the commissioner and reviewed regularly to ensure that the particular service remains appropriate to the assessed needs of the individual.

4.1.7 Recommendations with regard to Critical Incident Reviews

- NHS QIS should develop and oversee the implementation of a standardised process for Critical Incident Reviews for use across all mental health services in NHS Scotland.

- In the period until NHS QIS guidance is available, HB A must, as a matter of urgency, develop and implement policy governing CIRs. This should include direction with regard to when CIRs are required; who should be involved; the expertise of the Chair; the scope and purpose of the CIR; and the need to involve families in the process at an appropriate juncture/level. The Chair of any CIR must be, and be seen to be, independent to the service, have appropriate training in conducting CIRs and have expert knowledge of the subject area being reviewed

- There must be clear splitting off of the function of staff support/debrief from an exacting examination of the facts. HB A should develop guidance to issue to staff involved in CIRs to ensure that they are fully aware of the process and what will be involved.

4.1.8 Recommendations With Regard to CPA

- The Scottish Government should commission a review of the current use of CPA in Scotland with a view to establishing patterns of use across different regions and the quality of the processes being used. Where problems are identified steps should be taken to rectify these.

4.1.9 **Section 5**
What happens now?

5.1 The findings of this investigation will be made known to all involved services, the Scottish Government and discussed with Mr F and his remaining family

5.2 An anonymised version of the investigation will be publicly available and other mental health and social work services will be made aware of its existence

5.3 The Commission will meet with all involved services to discuss the findings. We will require the involved services to prepare an action plan to address the issues raised and we will monitor the progress being made. We will report on this in publications like our Annual Report.

Section 6
References

Bebbington, P.E. & Kuipers, L. (1994) The Predictive Utility of Expressed Emotion in Schizophrenia : an Aggregate Analysis Psychological Medicine, 24, 707-718

Butzlaff, R.C. & Hooley, J.M. (1998) Expressed Emotion & Psychiatric Relapse : a meta-Analysis Archives Gen Psychiatry, 55, 547-552

Community Care and Health (Scotland) Act 2002

Core Interventions in the Treatment & Management of Schizophrenia in Primary and Secondary Care (2002 and update in 2009). NICE Guidance

Department of Health (2007) Best Practice in Managing Risk : Principles & Guidance for Best Practice in the Assessment & Management of Risk to Self & Others in Mental Health Services Department of Health, London

Housing (Scotland) Act 2001

Kavanagh, D.J. (1992) Recent Developments in Expressed Emotion and Schizophrenia British Journal of Psychiatry, 160, 601-620

Kuipers, L. (1993) Family Burden in Schizophrenia : Implications for Services Soc Psychiatry Psychiatr Epidemiol, 28, 207-210

Leff, J. & Vaughn, C. (1985) Expressed Emotion in Families Guilford, London

Mental Health (Care & Treatment) (Scotland) Act 2003

Meuser, K.T. & Glynn, S.M. (1999) Behavioral Family Therapy for Psychiatric Disorder Oakland, CA, New Harbringer

Morgan , S. (2000) Clinical Risk Management : A Clinical Tool & Practitioner Manual Sainsbury Centre for Mental Health, London

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2008) University of Manchester

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness – Lessons for Mental Healthcare in Scotland (2008) University of Manchester

Potts, J. (1995) Risk Assessment & Management : A Home Office Persepctive. In Psychiatric Patient Violence – Risk and Response (Ed J. Crichton), pp 35-42 London, Duckworth

Reith, M. (1998) Risk Assessment and Management: Lessons from mental health inquiry reports Medicine Science and the Law, 38, No 3. 221-226

Risk Management (2000). The Mental Health Reference Group. The Scottish Executive, Edinburgh

Royal College of Psychiatrists CR142 *REF*

Social Work (Scotland) Act 1968

Steadman, H.J., Mulvey, E.P., Monahan, J. et al (1998) MacArthur Foundation Community Violence Risk Study : Violence by People Discharged from Acute Psychiatric In-patient Facilities & By Others in the Same Neighbourhoods Archives of General Psychiatry, 55, 393-401

Worbrock, T. & Soyka, M. (2008) Pharmacotherapy of schizophrenia with co-morbid substance misuse – reviewing the evidence and clinical recommendations Prog Neuropharmacol Biol Psychiatry, 1:32(6), 1375-1385