

MAPPA and mental health – 10 years of controversy

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Summary Multiagency public protection arrangements (MAPPAs) were established in England and Wales 10 years ago to oversee statutory arrangements for public protection by the identification, assessment and management of high-risk offenders. This article reviews MAPPAs' relationship with mental health services over the past decade. Despite areas of progress in the management of mentally ill offenders, inconsistent practice persists regarding issues of confidentiality and information-sharing between agencies, which calls for clearer and more consistent guidance from the Royal College of Psychiatrists, the Ministry of Justice and the Department of Health.

Declaration of interest All the authors have some involvement in MAPPA policy.

It seems timely to appraise the impact on psychiatric practice of multiagency public protection arrangements (MAPPAs) in the management of offenders over a decade after they came into force in 2001. Since their introduction, MAPPAs' relationship with mental health services has been characterised by controversy, raising questions as to whether their public protection function is appropriate or compatible with that of a medical or mental health service 'duty of care'. Despite such concerns, there is evidence that progress has been made in the multiagency management of high-risk violent and sexual offenders in the community since MAPPAs were introduced, particularly improvements in the consistency of their implementation throughout the country. However, significant difficulties remain, most notably a lack of clarity regarding issues of confidentiality and information-sharing between agencies, and variations in practice between different mental health services. Coincidentally, confidentiality and the management of sex offenders are again topical issues in the public domain following the closure of the tabloid newspaper *News of the World* in the aftermath of the phone hacking scandal. It is perhaps ironic that public support for the newspaper's strategy of nullifying the privacy and confidentiality of known sex offenders in their 'Sarah's law' campaign may have declined recently following the revelations that its journalists violated Sarah Payne's family's own privacy by hacking into their mobile telephone messages.¹

Background and developments

Multiagency public protection arrangements were introduced in England and Wales with the aim of minimising the risk of sexual and violent offences to the general public posed by identified high-risk individuals living in the community. Increasing social and political concern about violent and sexual offenders in the 1990s fostered closer working relationships between the police,

probation and prison services, which were incorporated into legislation in the Criminal Justice and Court Services Act 2000. This legislation introduced MAPPA in each of the 42 criminal justice areas in England and Wales. The police, probation and prison services were established as the 'responsible authority' to oversee statutory arrangements for public protection by the identification of high-risk offenders, the assessment and management of their risk, and the sharing of relevant information among the agencies involved.

The Criminal Justice Act 2003 further strengthened these arrangements by imposing on health and social service agencies a 'duty to cooperate' with MAPPA. The purpose of this clause was intended to enhance multiagency work by the coordination of different agencies in assessing and managing risk, and to 'enable every agency, which has a legitimate interest, to contribute as fully as its existing statutory role and functions require in a way that complements the work of other agencies' (p.196).² In practice, cooperating agencies, which include the National Health Service (NHS) and primary care trusts, youth offending teams, local housing authorities, local education authorities and Jobcentres Plus, are expected to attend case conferences, share information about offenders and provide advice regarding management.

Mapping MAPPAs

There are three tiers (levels) to the MAPPA management system at which risk is assessed and managed. Level 1 (ordinary risk management) is for offenders whose risk is classified as low or medium and who can be managed by one lead agency, such as the police, probation or mental health. Level 2 (local interagency risk management) is for offenders whose management requires the active involvement of more than one agency. Here the work is coordinated at monthly multiagency meetings where there is permanent representation of the core agencies of the police, probation

and prison services, supplemented by representatives of other involved agencies where needed. Level 3 (multi-agency public protection panels) is reserved for the minority of offenders who are considered as posing the most serious risk and/or requiring complex risk management. These cases will be discussed at the regular monthly level 2 meetings, but also on an individual basis at emergency level 3 meetings. Overall, MAPPA are meant to provide a strategic framework to manage high-risk offenders, enabling a focus on the small group of offenders responsible for a high proportion of crime.³

In our work with MAPPA over the past 10 years, we have observed several positive developments. These include a shift towards adopting more stringent criteria for referral to MAPPA, enabling a more selective focus on a smaller group of high-risk cases; a more consistent and coordinated approach in MAPPA implementation and practice in different areas throughout England and Wales, with greater routine involvement of mental health services; the introduction of key performance indicators; and the inclusion of lay members on the regional MAPPA strategic management boards to provide an independent perspective. In our opinion, lay members have added a useful 'common sense' element to strategic discussions and have not, to our knowledge, been involved in breaches of confidentiality as some had predicted. It is important to note that lay members do not sit on level 2 MAPPA meetings at an operational level, although they may observe them as part of the monitoring function of strategic management boards.

Challenges

Measuring the effectiveness of such interagency collaboration, however, has proved more problematic. Despite anecdotal reports that serious further offence rates are lowered in offenders covered by the MAPPA process, hard evidence is lacking. A comprehensive review of the evidence on interagency collaborations in offender health and social care, including MAPPA, introduced by successive Labour administrations since 1997, revealed that although this subject area is awash with literature in the form of government policy, opinion and national evaluations, there is little independent research and systematic review.⁴ The current evidence available confirms the presence of continued structural, procedural and cultural barriers that impede effective partnership working in interagency collaborations aimed at crime reduction. Key difficulties include conflicting targets imposed by individual agencies, and divergent ethical and professional values of the different agencies involved across the care control divide.

One of the few published audits of a forensic mental health team's involvement with MAPPA 7 years ago highlighted the problems they encountered.⁵ This included confusion regarding the role and contribution of mental health teams; additional burden on clinical teams with no increased financial resources; lack of protocols and guidelines; ambiguity about the meaning of 'duty to cooperate'; poor integration of criminal justice system members' views about risk with a forensic mental health perspective; and lack of cooperation of non-patient offenders with mental health teams. Despite the publication of clearer guidance on

MAPPA by the National Offender Management Service,² many of these difficulties persist today, particularly tensions around information-sharing with health and social care agencies. Reluctance to pass on information regarding patients to MAPPA may arise for a range of reasons such as a lack of awareness of the appropriate guidance, concern about the potential for criticism by professional bodies such as the General Medical Council (GMC), and concern that disclosure could have adverse consequences for therapeutic trust and engagement. It can be argued that a breach of therapeutic trust could paradoxically increase risk by interfering with treatment that has the potential to reduce risk (e.g. a disclosure arising from an out-patient sex offenders group that results in a group member dropping out of treatment). Information-sharing may also lead to faulty risk assessment due to the sheer volume of information which may swamp MAPPA and prevent systematic analysis and informative and holistic risk assessment of the individual offender.⁶

In our opinion, there is a risk of 'promiscuous' information-sharing due to the lack of clarity and discrepancies in the guidance available for psychiatrists regarding communication and disclosure of information about patients with the MAPPA process. There are implicit discrepancies between documents from the Royal College of Psychiatrists⁷ and the Ministry of Justice,⁸ and lack of sufficient detail that calls for urgent clarification as argued by Buchanan & Grounds.⁹ The report on confidentiality and information-sharing published by the Royal College of Psychiatrists contains a short section on MAPPA (pp.33–34).⁷ This clarifies that the duty placed on health services to cooperate with MAPPA does not extend to any statutory duty to disclose information to other agencies involved in these multiagency arrangements. It also states that the same medical duty of confidentiality applies as in normal clinical practice, so that considerations about disclosure should be on a public interest basis. It states that requests for information from outside agencies, including the police, should be treated as all other requests, by informing the patient and seeking consent for disclosure, unless there are overriding considerations which may include statutory obligations, and that all employing organisations should have a policy governing their relationship with MAPPA. Most importantly, the report clarifies that although psychiatrists have a duty to cooperate with MAPPA, this does not mean an obligation to disclose. The duty to cooperate is not imposed on individual clinicians but is imposed on the mental health trust (as an agency bound by a duty to cooperate). It has been argued that in a mental health trust the information in clinical records is the property of the trust and therefore a chief executive of a trust has the discretion but not a duty to disclose. In practice, medical staff are often relied on to make decisions about records and disclosure.

However, the brief section on MAPPA within the overall Royal College of Psychiatrists guidance document on confidentiality is vague and potentially at odds with current MAPPA guidance produced by the National Offender Management Service Public Protection Unit in 2009 (which is in the process of revision and due to be re-issued later this year),² and MAPPA guidance from the

Ministry of Justice released in 2010.⁸ This last document advocates the routine disclosure of information on 'MAPPA-eligible' mentally disordered offenders at designated points in their care pathway. For detained patients on restricted hospital orders it is recommended that MAPPA is notified about any detained patient who is a MAPPA-eligible offender when there is any planned move of the patient outside the secure perimeter, such as leave or transfer to another hospital, and also at their first care programme approach (CPA) meeting where a discharge is considered. The Ministry of Justice 'strongly recommends' that 'the [MAPPA] Co-ordinator should be informed by the care team of any occasion when the patient will be unsupervised in the community' (p. 3).⁸ Given that a patient detained under a restriction order has, at the point of sentence, been deemed by a criminal court to pose a risk of 'serious harm' to the public, then from a responsible authority's point of view routine notification is arguably justified as the criterion of 'serious harm' risk has been met. The expectation is that most mental health cases in MAPPA will be managed at level 1 and only referred to MAPPA when the CPA process is not adequate to manage risk or there is a need for multiagency management.

Confusion arises in several areas when dealing with graduated leave and discharge from long-stay forensic mental health units. Current MAPPA guidance recommends that notification should be used at the point of first (usually unescorted) leave so that the MAPPA in the discharge locality area will be informed and can plan as necessary. As forensic patients may be in regional units away from their home area, initial leave may be in a different MAPPA locality from final discharge area, thus two MAPPA panels may be involved. In addition, although the Mental Health Casework Section of the Ministry of Justice makes leave decisions for restricted cases, it delegates MAPPA notification to the discretion of the mental health team, which becomes the conduit for information between two criminal justice agencies (MAPPA and the Ministry of Justice). Furthermore, notification does not necessarily request or require MAPPA to take any action, which may allow a MAPPA level 2 panel to have information about a patient but do nothing to manage or reduce their risk. The situation may be even more confusing for non-restricted patients where the criterion of 'serious harm' has not been established by a court and where the Ministry of Justice may no longer be involved, even though some unrestricted cases in forensic units may be former sentenced prisoners (Mental Health Act Section 47/49 transfers whose sentences have expired) with substantial risk histories.

From a mental health perspective, our experience is that routine notifications may force the clinician into an unhelpful and counterproductive monitoring role, which may increase, rather than decrease, the patient's risk to self and others by interfering with a critical therapeutic alliance. For example, patients on planned escorted home leave may receive unexpected visits by the police, which may be experienced by the patient as intrusive and may disrupt the treatment process. Further risks in the blurring of professional boundaries may occur at MAPPA meetings where less experienced health representatives may be unprepared for the, often subtle, pressures placed on them

to disclose information on patients known to them, without having the opportunity to consider the requests in detail and discuss with the mental health team.¹⁰

Psychiatrists are also bound by other codes of practice regarding confidentiality, notably guidelines produced by the GMC¹¹ and the *NHS Code of Practice on Confidentiality*¹² produced by the Department of Health, which are guidelines for all NHS staff. *Supplementary Guidance on Public Interest Disclosures*¹³ was added to the *NHS Code of Practice* in 2010. In addition to health-specific guidance, any decision by a public authority must also be compliant with the Article 8 'right to privacy' of the Human Rights Act 1998. Although MAPPA is not explicitly mentioned in the *NHS Code of Practice* or the *Supplementary Guidance*, these documents make additional important points regarding confidentiality and disclosure that are potentially at odds with the MAPPA guidance. The *NHS Code of Practice* highlights the centrality of seeking patient consent for the disclosure of confidential information, whereas in the MAPPA guidelines, although it is stated that 'It is preferable that the offender is aware that disclosure is taking place and, on occasion, they may make the disclosure themselves' (p. 70),² the specific issue of consent is not mentioned. Furthermore, the *NHS Code of Practice* stresses the importance of balancing the need for disclosure against not only the duty of confidentiality towards individual patients, but also against the interest of public confidence in the NHS as a confidential service. In this respect, the disclosure of confidential information for one patient could indirectly damage the treatment of other patients whose confidence in the service may be undermined. Finally, psychiatrists should remember that although legislation may create a 'statutory gateway' to allow information disclosure, this generally 'stops short of creating a requirement to disclose, therefore the common law obligations of confidentiality must still be satisfied' (p. 38).¹² This means that it is still the clinical decision of the doctor to judge, on a case-by-case basis, whether disclosure is necessary to prevent serious harm or abuse.

Recommendations

We fully support the College guidance that all health organisations should:

- (a) have policies that cover the role of psychiatrists and other members of the multidisciplinary team in the MAPPA process;
- (b) have representation at MAPPA meetings;
- (c) withhold and disclose information in accordance with good practice guidelines;
- (d) conduct assessments at the request of a MAPPA meeting; and
- (e) be represented on a MAPPA strategic management board.⁷

However, given the ambiguities in the current available guidance documents, particularly regarding the frequency and circumstances of disclosure for detained MAPPA-eligible patients, we are also recommending the publication of more explicit and detailed national guidance for psychiatrists on their involvement in the MAPPA process. Whether we like it or not, MAPPA is here to stay, and it is

important that we, as mental health professionals, remain thoughtfully involved in protecting the interests of our patients, while being mindful of public protection.

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