Conflict Resolution Process

The Forensic Network developed a process for resolving clinical conflicts between forensic mental health services in 2005. This became Scottish Government Policy in HDL (2006) 48, Annex C. The process aims to assist services in Scotland to find a suitable resolution within a reasonable timeframe.

The process is managed by the Conflict Resolution Group which is chaired by the Lead Clinician of the Forensic Network and involves three stages:

1. Initial Resolution;
2. Referral to Conflict Resolution Group and;
3. Judgement.

This document contains an overview of the Conflict Resolution process as initially developed – **HDL (2006) 48, Annex C (pg. 2)**. It also contains an **Addendum to Annex C (pg. 6)** which outlines adaptations made to the process through learning from cases over the last 15 years.

An expedited conflict resolution model has also been developed of which an overview is contained in the Addendum to Annex C **(pg. 8)**

For further information or advice on use of the Conflict Resolution Process, please contact the Forensic Network office at tsh.forensicnetwork@nhs.scot or on 01555 842 018.

HDL (2006) 48, Annex C

RESOLVING CLINICAL CONFLICTS BETWEEN FORENSIC MENTAL HEALTH SERVICES IN SCOTLAND

Introduction

1. This Annex sets out the arrangements for resolving clinical conflicts.

Caveats

2. This conflict resolution model takes into account that Responsible Medical Officers (RMO) cannot be obliged to accept a patient whom, in their professional judgement:

- does not meet the criteria for compulsory detention under current mental health legislation; or
- would be inappropriately managed at their level of security – either that the level of security is excessive for the risks posed or insufficient to ensure safe care and treatment; or
- would be inappropriate in terms of the treatment available in their facility.

In the case of an upheld tribunal as a result of the Mental Health (Care and Treatment) (Scotland) Act 2003 the responsibility to find a suitable location for a patient's treatment lies with the Health Board and not any particular RMO.

Conflict Resolution Group

3. A new Conflict Resolution Group will be established to manage the process. The group will be chaired by the Lead Clinician of the Forensic Network and will consist of experts such as Consultant Forensic Psychiatrist and other appropriate independent multi-disciplinary practitioners. The membership of the Group is set out at Appendix I.

Stage One – Initial Resolution

4. Where there is a dispute about the placement of a patient there should be first attempted an initial resolution which would involve a meeting between the two areas (referring Board and receiving Board); the referring Board should initiate the meeting. The meeting should involve the clinicians concerned and relevant managers. The meeting will either result in an agreement as to the appropriate clinical course of action (in which case there is no need for Conflict Resolution Group involvement) or an Agreed Joint Statement (AJS) of points of agreement and disagreement about the particular case.

Stage Two – Referral to Conflict Resolution Group

5. In the event of a failed initial resolution the case should be referred to the Conflict Resolution Group via the Forensic Network Lead Clinician. If there is a conflict of interest involving the Lead Clinician and any workings of the Group another member will take his/her role. Any member of the Group with a conflict of interest will not participate in any decisions relating to such a case.

6. The review of the case will be carried out by two or three experts, commissioned by the Conflict Resolution Group, independent to the case at hand. This expert group will carry out their review as they see fit and produce a report to be considered by the Conflict Resolution Group. It would be expected that the experts preparing the report would review case records, examine the patient and discuss clinical issues with relevant staff. At least one of those experts will be a Consultant Forensic Psychiatrist. The other one or two experts preparing a report on the case will be appropriate independent multi-disciplinary practitioners.

7. Within the experts' report there should be included a risk management plan.

8. It is expected that, except in exceptional circumstances, experts will provide a joint report. Commissioners of the report should set out timescales at the time and will pay particular regard to Mental Health Tribunal timescales. Commissioners of the report should also consider geographical practicality when selecting experts as well as ensuring there is no conflict of interests. The timescale should not be inhibitive to the patient's care. Given the range of expertise now available in Scotland the use of experts from England or elsewhere would be exceptional and only in the circumstance of no available Scottish expert.

9. The experts will provide an independent report to the Conflict Resolution Group via the Forensic Network Lead Clinician.

10. It must be agreed prior to referral to the Conflict Resolution Group who will pay for reports and consideration should be given to the costs involved for multi-disciplinary practitioners as well as consultant psychiatrists.

Stage Three – Judgement

11. The Conflict Resolution Group will consider the independent report. In most cases this could be done without the need for a meeting. The group will then make recommendations to the clinicians and Health Boards involved.

12. This conflict resolution model is illustrated in a flow diagram at Appendix II.

APPENDIX I

Conflict Resolution Group

Membership:

- Network Lead Clinician (Chair)
- Regional Clinical Leads
- Senior Social Worker
- Psychologist
- Nurse
- Occupational Therapist
- First Minister's Psychiatric Advisor (In attendance)
- Chair of Forensic Executive Group (In attendance)
- Forensic Network Project Manager (Secretariat)

Role in Conflict Resolution Process:

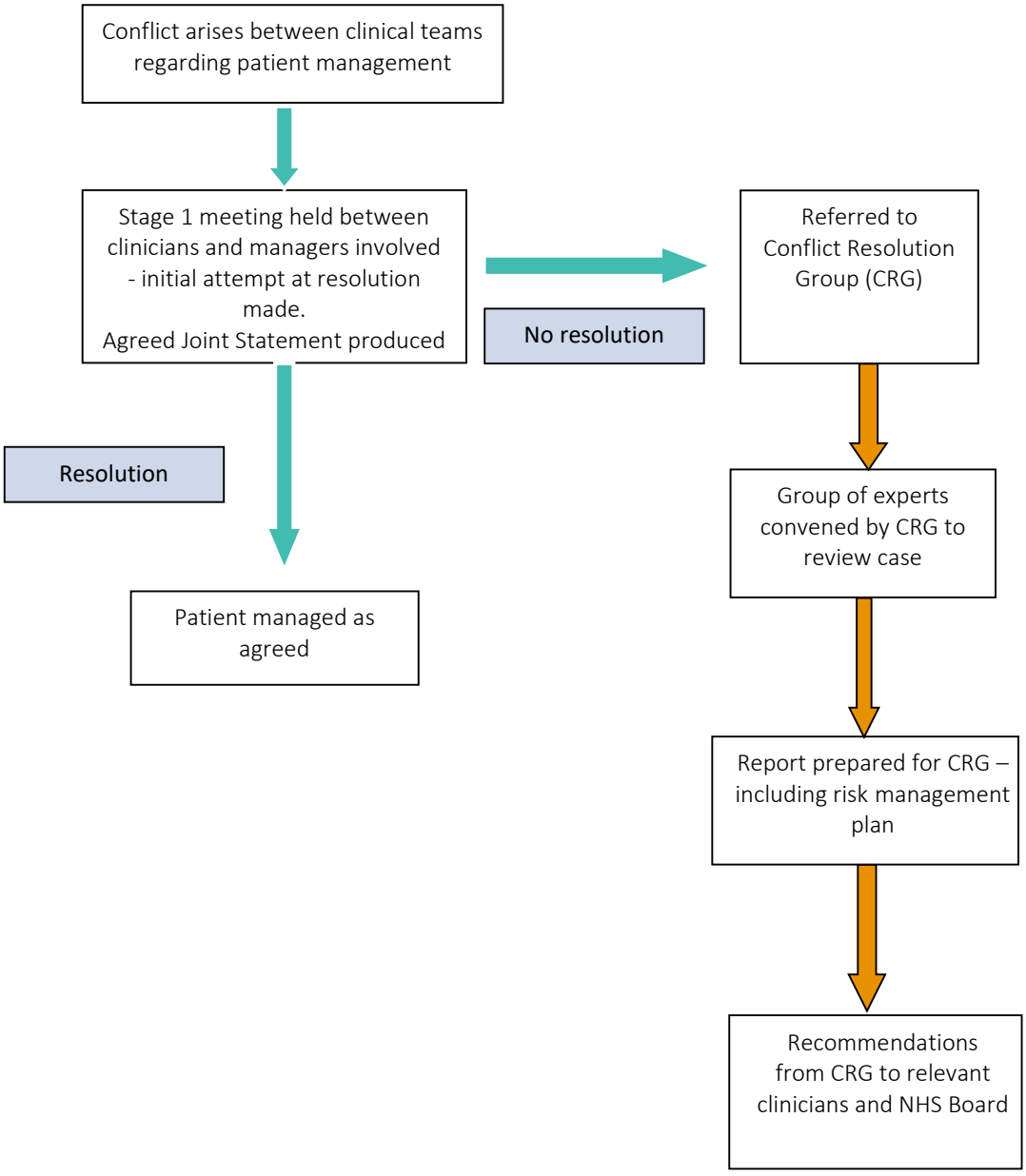
- Allocate Experts to cases
- Instruct experts
- Decide who convenes experts
- Receive report from experts
- Question experts or agree report

APPENDIX II

CONFLICT RESOLUTION MODEL

This conflict resolution model takes into account that Responsible Medical Officers (RMO) cannot be obliged to accept a patient whom, in their professional judgement:

- does not meet the criteria for compulsory detention under current mental health legislation; or
- would be inappropriately managed at their level of security - either that the level of security is excessive for the risks posed or insufficient to ensure safe care and treatment; or
- would be inappropriate in terms of the treatment available in their facility.



Addendum to Annex C

Introduction

This addendum collates the learning from previous addendums (August 2008 and January 2009) with learning from recent conflict resolution cases to provide one Supplement to Annex C of HDL (2006) 48 – Resolving Clinical Conflicts between Forensic Mental Health Services. This document should be read in conjunction with the arrangements outlined in Annex C. The numbering matches the numbering of Annex C for ease of reference.

Information on the Expedited Conflict Resolution process can be found within this document.

Addendum Information

Introduction

1. The arrangements relate to all clinical conflicts between forensic mental health services in Scotland and not only those involving differences of opinion with regard to levels of security.

Caveats

2. Conflict Resolution Group (CRG) Recommendations will also be sent to Mental Welfare Commission. This should not include the Expert Report in its entirety.

Stage 1 – Initial Resolution

4. Services are not required to inform the Forensic Network of cases at Stage One Initial Resolution. However, to date some services have done so and this has been helpful.

The Forensic Network Office will provide guidance on what should be included in the agreed joint statement. This should include points of agreement and disagreement on the case in general, and should also include any points of agreement and disagreement against the admission criteria.

Stage 2 – Referral to Conflict Resolution Group

5. Conflict of Interest is defined by the group as "*when a member of the group has a direct clinical involvement in a case or has had in the past in a way that is directly relevant to the current area of conflict. Working within a specific NHS Board area involved within the conflict resolution process is not in itself a conflict of interest. Any member of the CRG that meets this criterion will not participate in any decision relating to the case*." This model is similar to the one used by Mental Health Tribunal Scotland

Instructions to the review panel of experts must be clear on commission and should include use of the referral criteria.

6. The two or three experts appointed to each case should be from different clinical teams.

In each case, the clinicians involved in the conflict will be asked to confirm that proposed experts are acceptable to them on the grounds that they are appropriately independent.

A minimum dataset to be reviewed by the expert panel will be developed and outlined in the instructions when commissioning the report.

7. Each case is likely to require a different level of Risk Management Plan, therefore instructions to the experts who will review the case will not be too prescriptive, allowing the experts to determine the appropriate level of plan required.

8. Location of experts will be taken into consideration when appointing experts secondary to availability.

9. Clinicians involved in the case will be given the opportunity to check the Expert Report for agreement of facts before it is presented to the CRG. Experts should give the Clinicians involved ten days to review the facts outlined in the report, this should be co-ordinated through the Network Office. Commissioners of the report will clearly outline these instructions to the experts.

10. The fees and payment arrangements for producing expert reports will be based on the model utilised by the Mental Health Tribunal.

Stage 3 – Judgement

11. The CRG will use the Agreed Joint Statement and Expert Report only to reach a judgement, therefore avoiding reaching a conclusion based on previous or outside knowledge of the case.

The Experts, or a representative from the expert review panel, will be invited to attend the CRG to present their conclusions.

Members will be asked to vote in the first instance and then justify their answer as to not influence others.

The report should be added to the patient's notes unless there are concerns around third party information. The expert panel should be asked about any concerns with this. If there are difficulties including the full report in the patient's notes the recommendations from the CRG should be included.

It was recommended that the process should state that any decision for the patient involved should be to either stay in their current unit or move to the unit with whom there was the dispute, rather than being moved to an alternative service. Without this there could be a bias in the process which could result in a service engaging in conflict resolution to avoid any further involvement in a case.

Appendix 1 – Membership

- Membership will be explicitly outlined, including the inclusion of the three Regional Leads and State Hospital Lead representation. Professional Group representatives (Senior Social Work, Psychologist, Nurse, Occupational Therapist) will be sought from the Chairs of the Forensic Network Professional Groups. The First Minister Psychiatric advisor will be the Principle Medical Officer at Scottish Government and the Chair of the Forensic Executive Group is the Royal College of Psychiatry in Scotland Chair.

Overview of the Expedited Conflict Resolution Process

The conflict resolution model takes into account that Responsible Medical Officers (RMO) cannot be obliged to accept a patient whom, in their professional judgement:

- does not meet the criteria for compulsory detention under current mental health legislation; or
- would be inappropriately managed at their level of security – either that the level of security is excessive for the risks posed or insufficient to ensure safe care and treatment; or
- would be inappropriate in terms of the treatment available in their facility.

In the case of an upheld tribunal as a result of the Mental Health (Care and Treatment) (Scotland) Act 2003 the responsibility to find a suitable location for a patient's treatment lies with the Health Board and not any particular RMO.

Stage One – Initial Resolution

Where there is a dispute about the placement of a patient there should be first attempted an initial resolution which would involve a meeting between the two areas (referring Board and receiving Board); the referring Board should initiate the meeting. The meeting should involve the clinicians concerned and relevant managers. The meeting will either result in an agreement as to the appropriate clinical course of action (in which case there is no need for Conflict Resolution Group involvement) or an Agreed Joint Statement (AJS) of points of agreement and disagreement about the particular case.

Stage Two – Referral to Conflict Resolution Group

In the event of a failed initial resolution the case should be referred to the Conflict Resolution Group via the Forensic Network Lead Clinician.

At the point of referral, referring clinicians may request to use the **expedited** process in cases where an urgent decision requires to be made. The expedited process differs from the full process in the following ways:

- The review of the case will be carried out by only one clinician, a Consultant Forensic Psychiatrist, independent to the case at hand.
- The appointed clinician will prepare a report outlining their findings and recommendations which will be provided to the Forensic Network Lead Clinician.

All parties involved are required to indicate their agreement for the expedited process to be used at the point of referral.

Regardless of the process used, it is expected that in the course of reviewing the case, the Consultant Forensic Psychiatrist would review records, examine the patient and discuss clinical issues with relevant staff. It must be agreed prior to referral who will pay for the preparation of reports.

The expedited process is typically less time-consuming than the full process given the involvement of only one clinician. This may be of particular benefit when an urgent decision requires to be made regarding patient care. However, the expedited process may not be suitable for particularly complex cases.

Stage Three – Judgement

Under the expedited process, the recommendations made within the report to clinicians and Health Boards involved will be accepted as the outcome of the case.

An overview of recommendations and a full copy of the report will be shared with the Health Boards involved at the earliest opportunity to allow decisions to be made regarding patient care.