The Journal of Forensic Psychiatry & Psychology

ISSN: 1478-9949 (Print) 1478-9957 (Online) Journal homepage: www.tandfonline.com/journals/rjfp20

Introducing a MAPPA Level 1 referral procedure for patients detained under hospital orders: reflections on the implications for risk management

Alison Commissiong, Helen Codd, Emily Turley, Christine Crossman, Claire Hopkins & Rabia Zeb

To cite this article: Alison Commissiong, Helen Codd, Emily Turley, Christine Crossman, Claire Hopkins & Rabia Zeb (04 Apr 2026): Introducing a MAPPA Level 1 referral procedure for patients detained under hospital orders: reflections on the implications for risk management, The Journal of Forensic Psychiatry & Psychology, DOI: 10.1080/14789949.2026.2647909

To link to this article: https://doi.org/10.1080/14789949.2026.2647909

Published online: 04 Apr 2026.

THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY
https://doi.org/10.1080/14789949.2026.2647909

Routledge
Taylor & Francis Group

Introducing a MAPPA Level 1 referral procedure for patients detained under hospital orders: reflections on the implications for risk management

Alison Commissiong[a], Helen Codd[b], Emily Turley[a], Christine Crossman[d], Claire Hopkins[d] and Rabia Zeb[a]

[a]Lancashire and South Cumbria NHS Foundation Trust, Preston, UK; [b]Emerita of Law & Social Justice,University of Lancashire, Preston, UK & Seahorse Criminal Justice, Preston, UK; [d]Lancashire and South Cumbria Foundation Trust, Preston, UK

ABSTRACT

This article describes how one community healthcare trust in England introduced a referral procedure to support risk management for patients detained under Mental Health Act Hospital Orders, with and without restriction, who had been assessed as requiring management under MAPPA Level 1. In the Trust, it was routine for MAPPA referrals to be made for individuals who were assessed as falling under Level 2 or Level 3, but not Level 1, there being no requirement to do so. This article sets out the background to, and justifications for, the introduction of the process and gives information about the number of referrals and patient characteristics since the procedure was introduced in 2021. The referral process is illustrated with two case studies. The article includes reflections on the information gathered and makes recommendations for future research including the need for an empirical assessment of the impact, if any, of the process on offending and re-offending. It makes recommendations for future policy, practice, and research so as to support detained patients at Level 1 and enhance victim safety planning and public protection.

ARTICLE HISTORY Received 16 June 2025; Accepted 13 March 2026

KEYWORDS MAPPA; risk assessment; risk management; victims; public safety; discharge planning

Introduction

Multi-Agency Public Protection Arrangements (MAPPA) were introduced in England and Wales by the Criminal Justice and Court Services Act 2000, reinforced by the (Criminal Justice Act, 2003) and the Sexual Offences Act 2003. These arrangements were created to manage the risks to the public posed by violent and sexual offenders (Nash &

CONTACT Helen Codd hlcodd1@uclan.ac.uk

Williams, 2024) and require collaboration between the police, probation, and prison services (the 'Responsible Authorities') with a statutory duty for other agencies to cooperate, including mental health services (HM Prison and Probation Service [HMPPS], 2021).

Under the MAPPA framework, each agency is responsible for identifying, risk assessing, and managing MAPPA Level 1 cases when they have 'lead agency' responsibility. Thus, the responsibility for MAPPA-eligible mental health patients, both as inpatients and in the community, lies with the relevant individual NHS trust or independent mental health provider (HMPPS, 2021).

A number of well-publicised incidents since the early 1990s have highlighted serious injuries and deaths caused by people with a history of mental health needs and indicators of potential serious risk of harm. These cases span the time period before and after the introduction of MAPPA and have raised questions about whether there have been multiple care failings (Cooling, 2002; Nash & Williams, 2024; Prins, 1994; Theemis Consulting, 2025). In two of the most well-known such incidents, one in 1992 before MAPPA and one more recently in 2023, both individuals were high-functioning before experiencing declining mental health. Their families raised concerns and both underwent multiple brief hospitalisations, including detentions under the Mental Health Act 1983 (MHA). Both failed to comply with treatment and were subsequently discharged from services. Both then committed homicides involving strangers and were sentenced subsequently to hospital orders with restrictions and detained in high security settings. The key issue is that people with severe mental illnesses have committed serious violent offences after being discharged without any MAPPA involvement because of the focus on their history as a mental health service user rather than as an offender.

The MAPPA framework

There are four categories of MAPPA registration, the category to which individuals are allocated being determined primarily by offence type:

(1) **Category 1**: Registered sexual offenders.
(2) **Category 2**: Violent offenders sentenced to 12 months or more, including those under hospital or detention orders.
(3) **Category 3**: Other dangerous individuals assessed as posing a serious risk of harm.
(4) **Category 4**: Terrorist or Terrorism-Risk Offenders (TTROs), including those subject to investigation or prevention measures.

Mental health professionals are most likely to work with individuals in Categories 1, 2 and 3, though there is increasing engagement with Category 4 cases (Ministry of Justice, 2024).

There are three levels of MAPPA management to differentiate the extent and scope of resources required to manage individual risk. Level 1 involves supervision primarily by a lead agency with input from other agencies. Level 2 provides a formal co-ordinated multi-agency meeting structure and active risk management, and Level 3 provides senior multi-agency involvement to commit required resources to manage high-risk offenders, including Critical Public Protection Cases (CPPC) (Ministry of Justice, 2020). Individuals may move between these levels depending upon changes in dynamic risk factors and further offending. 98% are managed at MAPPA Level 1, led by a single agency with access to shared information, communication, and support (Ministry of Justice, 2024). Some MAPPA arrangements have been updated since their inception, as a consequence, for example, of Maguire et al. (2001) noting insufficient prison service involvement in release planning and Kemshall's 'Four Pillars of Risk Management' approach which was developed for MAPPA in 2012–2014.

The number of people managed under MAPPA has increased substantially over the last decade, driven mainly by increased prosecutions for sexual offences and domestic abuse, and continues to rise (Ministry of Justice, 2024). Updated guidance (HM Prison and Probation Service [HMPPS], 2024) for probation practitioners highlights the need for a more systematic and comprehensive review of MAPPA Level 1 cases but does not include people in mental health settings, this omission, arguably, reinforcing the need for health service providers to adopt similar procedures independently.

MAPPA and mental health services

The NHS long term plan and Forensic Mental Health pathways endorse proactive risk management and collaborative care planning, particularly for mentally disordered offenders whose risks relate to violent, sexual, or terrorism-related behaviours. However, the literature on MAPPA in mental health settings is limited, with no specific monitoring nor guidance from professional bodies or regulators. The Royal College of Psychiatry's guidance (Taylor & Yakeley, 2013) has not been updated since 2013 and psychiatrists are advised to follow local policy. Due to lack of NHS guidance and resources, levels of participation and collaboration with public protection arrangements vary. Referrals are prompted by rising levels of violence in mental health units (Gerdtz et al., 2020; van Leeuwen & Harte, 2017) alongside index offence considerations. Bed pressures often lead to discharge after stabilisation rather than full recovery, supporting the need for MAPPA in complex, high-risk cases post-discharge when risks are known to increase (Tyler et al., 2019). Data from 13 healthcare trusts that provide mental health services, obtained by the team by means of Freedom of Information requests, demonstrated that there is no consistent model for MAPPA arrangements.[1]

MAPPA Level 1 meetings enable multi-agency information sharing, clarification of the index offence, and risk analysis so as to formulate management plans for leave and discharge. While MAPPA Level 1 cases in probation indicate lower risk (Taylor & Yakeley, 2013), index offence patterns differ in mental health settings. Where mental health services have the lead role in care and risk management, the MAPPA level may not be determined primarily by index offence, Level 1 suitability often being influenced by positive engagement and response to treatment. Consultant guidance issued in 2013 stated that for such cases, 'information-sharing to MAPPA will consist of basic leave and discharge details only, management will be solely by mental health services, and there will be MAPPA notifications only, but no referral, multi-agency discussion, or management plan' (Taylor & Yakeley, 2013). This guidance has not been updated nor amended by the Royal College of Psychiatry, but advises that consultants should follow national and local MAPPA policy arrangements. This is potentially confusing for practitioners and does not support effective risk management nor victim safety planning, in contrast to people leaving prison under strict licence conditions who are deemed suitable to be managed under Level 1. It could be argued, especially in the context of heightened media and public concern, that most detained patients should be presumed to fall within the scope of MAPPA, particularly those detained in secure settings or with offending histories. However, the existing schedule for MAPPA Level 2 does not have the capacity to incorporate all health cases nor would it be appropriate for routine referral as treatment and risk assessments are managed primarily by clinical teams, with the necessary expertise. Therefore, it is imperative that mental health services, supported by other relevant partnership organisations, establish procedures to manage MAPPA-eligible patients for whom mental health services are the lead agency.

Introducing the risk management referral procedure

This article describes how one healthcare trust in the North West of England[2] established an innovative and experimental MAPPA Level 1 structure in April 2021 to improve the risk assessment and management of MAPPA-eligible patients at critical points within their care pathway, aiming to enhance victim safety planning, public protection, and effective community leave and discharge arrangements. This included patients detained under court-directed Hospital Orders under s.37 and s.37/41 of the Mental Health Act 1983 and also patients who were 'notional s.37' patients (Sarkar, 2010). In this Trust, it was routine for MAPPA referrals to be made for individuals who were assessed as falling under Level 2 or Level 3, but not Level 1. A designated team manages the process with no additional resources or funding.

This paper sets out the background and justifications for the introduction of this procedure, outlines the information gathered about the referrals made, and identifies directions for future research. Two brief case studies are introduced to illustrate the use of this referral procedure in relation to individual patients. This article reflects on the process and the information gathered and provides the foundation for a potentially larger-scale, longer-term, funded empirical study. Such a study would require additional designated resources and research staff and would evaluate this referral procedure, including any impacts on risk management and post-discharge reoffending.

The structure was introduced in response to inconsistent risk assessments. Data were gathered on referrals including demographics, offence types, and mental health diagnoses and were reviewed in the context of a thematic analysis of the relevant research literature including the policy background.

The structure created aligns with national policy that recommends a designated MAPPA lead/team; local MAPPA guidance integrated into care planning and risk policies, along with defined roles for clinicians and managers. Referrals are made by clinical staff and must be signed/approved by the consultant or team manager: without this, a referral is not accepted. The designated team discusses referrals every week and sends written feedback accepting or declining the referral and requesting any further information, such as medication details. Once approved, a MAPPA Level 1 professionals' meeting is arranged, which follows a set Chair's format and minutes template to ensure consistent record-keeping and governance. Referrals are subject to audit, and more recently, referrer satisfaction questionnaires have been introduced, alongside training feedback.

The procedure has several key aims, aspirations, and principles:

Mental health professionals must be able to identify MAPPA-eligible individuals promptly upon admission or referral

This requires completion of MAPPA I notification forms for eligible cases on admission or acceptance by teams and close liaison with probation and police to access MAPPA information/databases including ViSOR (Violent and Sex Offenders Register) for cases of concern. MAPPA status is incorporated into initial and situational risk assessments, care plans, and electronic patient records, and there must be close work between all multi-disciplinary team members to confirm eligibility, risk-related behaviours, legal restrictions, and victim concerns.

MAPPA must be embedded into clinical risk management

MAPPA should not be regarded as a separate or purely forensic process, but as an integral component of clinical risk management.

Information gained from risk tools should be interpreted alongside clinical judgement and in discussion with relevant partner agencies to determine if risk is manageable under MAPPA Level 1 or requires escalation to Level 2. Mental health teams should integrate this approach into regular MDT reviews, ward rounds, leave, and discharge planning.

Communication and information sharing is key

Effective MAPPA Level 1 processes require appropriate recording and communication platforms, combined with effective, timely, and proportionate information sharing, compliant with data protection and GDPR regulations, via named points of contact in each agency and endorsed through MAPPA Senior Management Boards.

Discharge and community transition planning is a critical area for MAPPA level 1 management

Discharge, and the transition from in-patient to community settings, requires a pre-discharge MAPPA screening form (MAPPA Q) to be completed. Relevant community services (e.g. Community Mental Health Teams, housing, social care) must be involved or informed. Community forensic teams often maintain MAPPA Level 1 management post-discharge, with monitoring embedded into routine care and risk reviews. A 'Trigger Plan' containing contingency, relapse prevention, and risk indicators should be created, incorporating victim(s) and public protection. This plan should include consideration of whether the case requires escalation to MAPPA Level 2 or 3 — e.g. if there are victim concerns, housing risk, or if greater multi-agency coordination is needed.

Staff need appropriate training and competence

To identify eligible patients, all clinical staff, particularly those in secure, acute, and community settings, should undertake training that includes understanding MAPPA categories and levels and the responsibilities of clinicians; awareness of the need to balance therapeutic care with victim safety planning and public protection; and knowledge of approved record-keeping and information sharing protocols. Training should be mandatory with two formats i.e. a basic awareness package for administrative staff and practitioner-focused training for clinical staff. This should be included in induction for new starters, particularly those working in forensic, PICU, and acute services.

Balancing care and control

While MAPPA is a risk management framework, mental health professionals must also ensure care remains person-centred, trauma-informed, and compliant with relevant legislation. Patients should be informed of their MAPPA status (where appropriate); complete offending behaviour, and victim empathy-based interventions and understand how it affects their care planning and discharge. Where possible, patients should be involved in risk management planning and supported in building appropriate protective factors, such as social connection, housing stability, and therapeutic engagement.

Integration of audit, quality assurance, and reflective practice

Once a MAPPA Level 1 process is established, cases should be audited regularly to ensure consistency and compliance, including audits of MAPPA I forms. Supervision and reflective practice are necessary to support staff in managing ethical tensions. There should be liaisons with local MAPPA coordinators to review compliance with 'duty to cooperate' standards.

Findings from initial exploratory data collection

As explained above, this paper discusses the potential benefits and challenges of introducing a MAPPA Level 1 referral system, in the context of our preliminary introduction of such a system within one trust in the North West of England. During this process, we collected data from two areas within the trust. Annual data on the number of referrals were collected along with information about index offences, mental health diagnoses, and demographic characteristics and were combined and analysed for all referrals during the relevant time period.

Numbers of referrals

Within these two areas of the trust, referrals have been at a steady rate, increasing in 2024, attributable potentially to a modest increase in staffing and the provision of training in secure, acute and community Trust sites (Figure 1). There were 348 referrals in total, 90% from Area 1 which is a large area with a diverse population, a mix of urban and rural settings and communities of substantial deprivation, and 10% from Area 2 which is predominantly rural. Referrals have been largely male, reflecting the higher number of male acute/secure beds, male involvement in criminal justice, and greater recognition of high-risk behaviours in males.

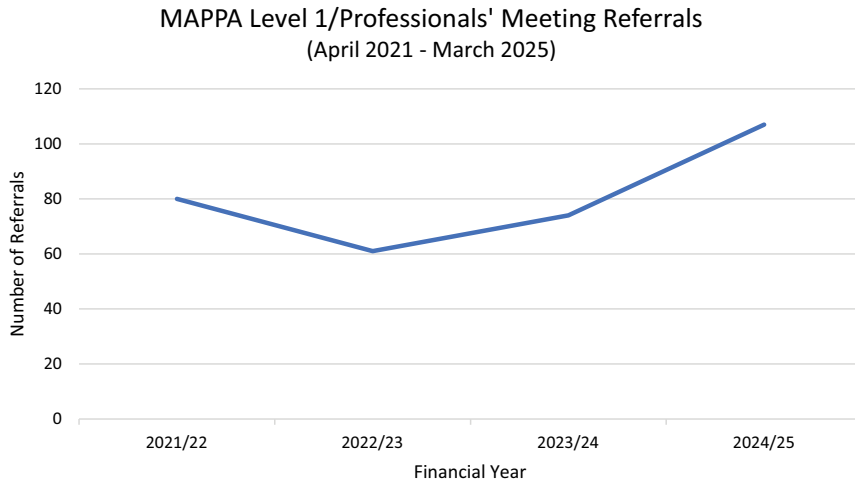

Figure 1. Referrals April 2021-March 2025.

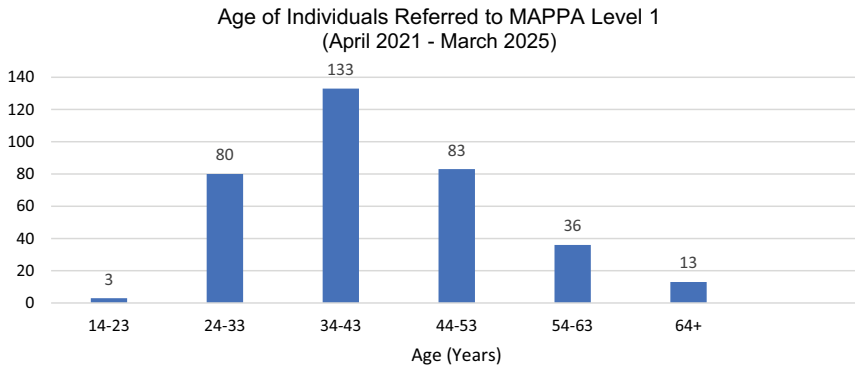

Figure 2. Age of individuals referred to MAPPA 1 April 2021-March 2025.

Ethnicity

77% of the patients referred have been 'white', 11% Black, Asian, mixed ethnic heritage, or other ethnic group, and 8% British (not specified), applying the NHS ethnicity definitions, although ethnicity has not been recorded for all the individuals referred. For MAPPA Level 2 and 3 cases across England and Wales, 7% are Asian, 9% Black, 6% mixed heritage, 72% white, and 6% unknown/other ethnicity (Ministry of Justice, 2023). Members of minority ethnic groups are over-represented throughout the CJS and are five times more likely to be detained under the Mental Health Act 1983 than white people (Davies, 2022; NHSE, 2024; Race Equality Foundation, 2019). One national study (HMPPS, 2021) found that 16% of restricted hospital order

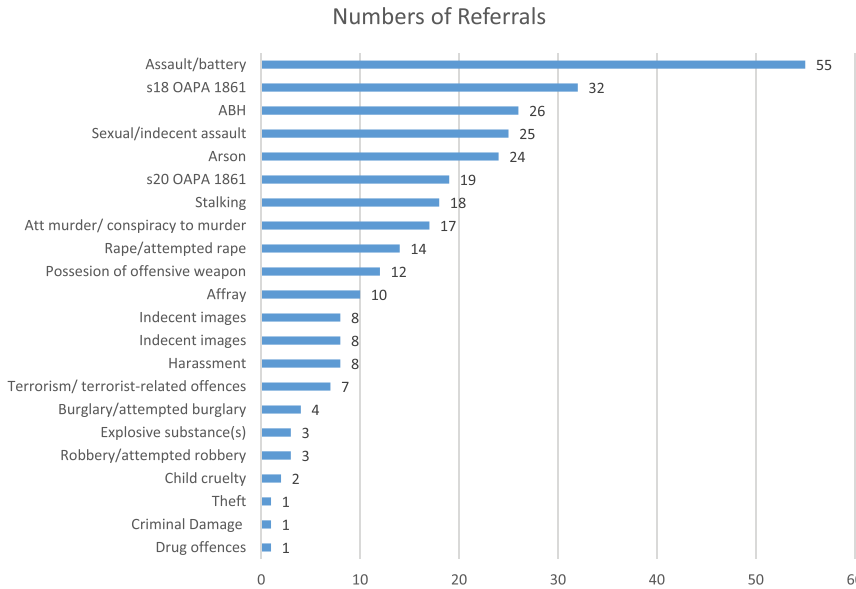

Figure 3. Index offences April 2021-March 2025.

Schizophrenia	42
Personality Disorder	12
Autism Spectrum Condition	7
Schizoaffective Disorder	6
ADHD	5
Acquired Brain Injury	4
Psychosis/Drug-Induced Psychosis	4
Depressive Disorder	3
Substance Related Disorder	3
Learning Disability	3
Delusional Disorder	3
Bipolar Disorder	2
Post-Traumatic Stress Disorder	1
Other	5

Figure 4. Diagnoses of those referred to MAPPA Level 1 April 2021-March 2025(%).

patients were Black or Black British, despite making up 3% of the general population. While no acknowledged over-representation exists within MAPPA for members of minority ethnic groups, this is possible given higher imprisonment and Mental Health Act detention rates. Unconscious bias may

affect risk determination, particularly in relation to terrorism, where the patient's race, ethnicity, and cultural background can influence forensic decision-making (Buongiorno et al., 2025; Day et al., 2022; Dean & Lloyd, 2022; Hall, 2020; Liell et al., 2022; Meyer & Valença, 2021; Neal et al., 2018).

For the Level 1 referrals, ethnicity data have not been recorded in all cases, leading to gaps, and some individuals had multiple referrals. The majority of patients referred in each MAPPA category were White British. In Category 1, there were 27 referrals, comprised of 21 White British men, 1 Black British Caribbean man, 5 Black men, 1 Asian man, and 2 not recorded. Across all categories, only a small minority had repeated meetings. The largest number of men referred was in Category 2, where there were 176 referrals in total for 156 individuals. Again, as in Category 1, the majority were White British (123). There were 5 referrals of Black men, 5 for Asian men, 2 for Syrian men, and 6 Polish men. 11 men did not have their ethnicity recorded. In CAT 3, 4 were White British, 1 was Black, and 5 had ethnicity not recorded. There was only one person referred under CAT 4. The patient was white British and had 7 referrals for meetings with NSD/CT police. The patient's diagnosis was of autism and learning difficulties. For the women referred, there were two Eastern European women (Polish) and the rest were White British.

Age

Most patients referred have been aged between 25 and 54 years, although there are small numbers of referrals across the lifespan, which is similar to national figures (Ministry of Justice, 2024) (Figure 2).

Index offences

The index offences within the cohort have been primarily for significant violence (including murder, manslaughter, and section 18 or 20 of the Offences Against the Person Act 1861), which represents 78% of the total. 14% have convictions for sexual offences including rape of adults/children and internet-based offending. Further serious offending includes stalking, harassment, and possession of offensive weapons. A tiny minority has index offences of terrorist-related behaviours. Further examination of the index offence data highlights 10 referrals for convictions of arson, which occurred primarily in community settings including shared residential properties/ 'houses of multiple occupancy' (HMOs) (Figure 3).

As well as the index offences shown above, the data include a large group of unconvicted patients who are recorded as demonstrating 'risk behaviours'. This represents referrals for individuals on bail/remanded in custody and those presenting with significant risks without being charged or convicted. Examples include self-reporting thoughts of harming others and possession

of an offensive weapon (threats to slit throat/carrying a knife due to paranoid thoughts); stalking and harassment (on bail); possession/internet searches for child abuse imagery/grooming (bail); rape of a child under 13 (remand); and risk of physical and sexual assault to staff members/underage girls/children/general public (not convicted or charged).

There were differences in index offence for men and women. No women had index offences within Cat.1 (sexual offences). Two had index offences relating to offensive weapons/affray/assault. Two had index offences of s.18 OAPA 1861 and two for s.20 OAPA 1861 (i.e. grievous bodily harm) and six for, s.47 OAPA 1861 (relating to actual bodily harm). There were two women whose index offence was attempted murder. There were two whose index offence was making explosives but the nature, date, and details of the offence meant these were not defined as Cat. 4 (terrorist) offences. Significantly, three had index offences of child cruelty, which was not an index offence for any of the men.

For the men, Cat.2 violent offences were the index offence for 176 men (50% of the total). 27 men had referrals for Cat.1 (sexual) offences. 10 men were referred under Cat. 3. There were 7 referrals under Cat.4 but these all related to one person. Nearly a third of the men were referred for professional meetings.

The data highlight the significant index offences for this group, which are similar to those of the prison population who are recognised as MAPPA eligible/MAPPA level 1 until 6–12 months prior to release when prison probation practitioners may consider referral to Level 2 or 3. The most significant finding drawn from this offence information is the predominance of offences involving interpersonal physical violence for all individuals and sexual violence being an index offence for men and not for women. This information has clear implications for risk assessment.

Mental health diagnoses

It is striking that patients with schizophrenia make up the largest group across all categories for both men and women. Treatment-resistant schizophrenia is characterised by impaired insight and persistent symptoms despite treatment adherence. Patients may not cooperate with treatment, disengage, and have relationship issues, often compounded by trauma histories. Relapses occur rapidly, often requiring depot injections or clozapine. This population experiences ongoing symptoms, with some using substances. Social networks are unstable and often diminish with prolonged mental health service involvement or incarceration (Pearsall, 2016). Risks can escalate quickly during relapse, requiring a rapid response. Discharge requires caution and awareness of indications of relapse, which needs immediate intervention. A multidisciplinary team approach through MAPPA is beneficial, without

which the patient's relapse may lead into reoffending and escalating risks to self, victims, and the general public. Schizophrenia with substance misuse was also prevalent. The most noticeable exception is the one individual in Category 4 referred 7 times, who had diagnoses of autism and learning difficulties (Figure 4).

Two thirds of the women were living in the community following discharge at the time of their referral. For the other women, who were in hospital, schizophrenia or schizo-affective disorder were the most common diagnoses, also including Personality Disorder(s) and substance misuse. The most common diagnoses for the women living in the community were schizophrenia, delusional disorder, EUPD, bi-polar disorder, autism, and substance misuse.

In contrast, the majority of men for all four categories were in hospital. For Cat.1, 22 were in hospital, including 19 in secure care and 3 in acute or PICU settings. In Cat 2, only 7 were in the community, with 131 in secure care and 9 in acute or PICU. For Cat 3. and 4, there was one person for each in the hospital. For those referred to professionals' meetings 66 were in the community; 3 were in custody preparing for release and 21 were in secure care, and 2 were in an independent hospital which had been requested by the CMHT in preparation for discharge.

Referrals for murder/manslaughter

Acknowledging public and media concerns about homicides linked to severe mental illness, an analysis was conducted of the data relating to a distinct sub-group of 8 patients, all men, whose index offence was murder or manslaughter (Figure 5). 5 were convicted of murder, and all 5 had schizophrenia and substance misuse recorded. Of those, 3 killed family members/s such as a spouse, child, or parent. For the 3 convicted of manslaughter, the most common diagnosis was schizophrenia along with substance misuse. One patient had killed a family member, one a neighbour, and one a stranger. All were White British.

Case studies

The long-term impact is yet to be assessed. However, two anonymised case studies illustrate how the MAPPA Level 1 referral process has operated and highlights potential relevance to future risk management.

Case study 1 – Mr A

Mr A had been detained on an unrestricted hospital order in a private secure hospital for 10 years for sexual offences. Although his mental state had

	DIAGNOSIS	MHA Section	Offence
1	Paranoid Schizophrenia/ABI	s.37/s.41	Manslaughter
2	Paranoid Schizophrenia (Also diagnosed with organic PD).	S.47/s.49.	Murder
3	Paranoid Schizophrenia	s.42	Murder
4	Paranoid Schizophrenia/substance use	s.37/s.41	Murder
	Paranoid Schizophrenia	s.37s./41	Manslaughter
6	Paranoid Schizophrenia	s.37/s.41	Murder
7	Paranoid Schizophrenia	s.47/s.49 (IPP)	Murder
8	Paranoid Schizophrenia	s.47/49 (IPP)	Manslaughter

Figure 5. Details of patients referred for murder/manslaughter.

remained stable, the clinical team did not progress discharge due to ongoing concerns about the risk of further offending. By 2023, he was compliant with antipsychotic and antilibidinal medication, and the team considered him suitable for discharge, determining that any future offending would fall within the remit of the criminal justice system.

He was subsequently referred to, and accepted by, the Community Mental Health Team (CMHT). No MAPPA referral had been made at any point during his inpatient admission, despite his access to the local community without an agreed multiagency risk management plan. The CMHT completed a MAPPA Level 1 referral, and the ensuing meeting identified that Mr A continued to experience sexual attraction to children despite antilibidinal treatment, indicating that his risk of harm could increase following discharge.

The MAPPA Level 1 meeting resulted in a coordinated multiagency risk management plan. Actions included further offence-related work with a focus on victim impact, identification of a supervised community placement experienced in managing individuals with sexual offending histories, prioritised assessment of sexualised risk in the community, and active involvement from MOSOVO.[3] The information shared across agencies led to a decision to escalate the case to MAPPA Level 2 to ensure enhanced monitoring during his transition to community living. At the time of writing, Mr A remained under MAPPA Level 2 management.

Case study 2 – Mr B

Mr B was detained in a secure hospital on Section 37/41 with an index offence of Section 20 wounding. He responded well to treatment and progressed

through the hospital pathway without a MAPPA referral. Upon transfer to stepdown provision, a change in clinical team identified concerns about underlying aggression and bullying towards other patients, consistent with behaviours linked to the index offence. As a result, a MAPPA Level 1 referral was submitted.

During the MAPPA meeting, previously undisclosed information emerged, including a conviction for stalking and a lifelong restraining order. The clinical team were unaware of this conviction, its context, or the associated victim details, including the current location of the victim's home address. No PNC check had been undertaken on admission, and existing risk assessments focused solely on the current index offence. Police reported incidents of racially abusive behaviour, which had not been reflected in clinical risk assessments but carried implications for patient and staff safety.

Following the meeting, further assessment of Mr B's psychological treatment needs was undertaken, which highlighted the need for further psychological treatment, effectively halting any further progression towards leave or discharge planning. Had a MAPPA referral been made earlier, the patient's pathway disruption could have been avoided, and relevant risk information incorporated into treatment planning prior to transfer to the stepdown setting. Despite the late referral, the MAPPA Level 1 process prevented discharge without appropriate assessment, intervention, and risk management that if not addressed could have posed a risk of serious harm to the victim and, potentially, the wider public.

Discussion

This research is original in that it examines the initial data emerging from the implementation of a health-led MAPPA Level 1 framework in one trust in North West of England. It renders visible the significant potential for risks to others and how current risk assessments in mental health services may fall short in understanding patients' risk profiles effectively.

The review of current policy and practice identified limitations faced by clinical teams in accessing information. When patients are admitted from courts or transferred from prisons, they often arrive with limited information, and while psychiatric referrals or sentencing reports may be available, key documents often remain inaccessible. Although police disclosure requests are possible, they are time-consuming and outcomes may be incomplete. The MAPPA Level 1 framework in question facilitates multi-agency information sharing, including details of offences, convictions, victim perspectives, and risk. This, in turn, can support individuals' inpatient and community treatment, victim safety planning, and public protection arrangements and also minimise potential litigation against healthcare trusts if former patients go on to cause harm.

Key practical lessons have emerged from the process. Establishing a MAPPA Level 1 framework requires an effective single point of contact, referral forms, structured meetings, formal minutes, actions, and timescales. Information, practitioner guidance, and a comprehensive training programme are required for staff working in inpatient and community settings including acute, PICU, and secure care.

Limitations and implications for future research

The team acknowledge that gathering data over time, so as to allow trends to be identified, would be a valuable element of any planned, longer-term evaluation going forward. Being able to point out the 'direction of travel' in terms of index offences, diagnoses and demographic shifts (if any) would assist in planning future provision, resourcing, and training.

This exercise has found gaps in patient referral information recording practices, especially around ethnicity. Age information has also not been easily accessible as ages have to be calculated from the date of birth. For ease of analysis in the future, if a larger-scale and more in-depth evaluation is conducted, each referral could include a basic questionnaire including demographic information, index offence, diagnoses, and mental health history. The MAPPA focus on an 'index offence' may obscure background information that would be relevant to risk management, as is illustrated by murder convictions that have a sexual element, but the potential sexual offence charges may have been subsumed into the broader and more serious offence category of murder or manslaughter, leading to the sexual offence element being overlooked in risk planning.

This exploratory research analysed index offences within the broad MAPPA categories. It would be useful for risk management purposes to undertake a deeper dive into the precise and specific offences committed, their circumstances, and dynamics, either for all patients or, if resources are limited, a chosen sample. For example, there is a distinction in risk management between non-contact (usually internet-based) sexual offending and contact offending and the likelihood of someone with a history of non-contact offending committing contact-based offences. Similarly, the categories of violent offences include offences of domestic abuse, including a diverse range of victims, settings, and methods. This broad-brush categorisation follows MAPPA classifications, but detailed qualitative analysis of case files, combined with criminal and mental health history, could provide more in-depth information which could inform risk management.

Focusing on a person's main diagnosis may render invisible other, less dominant, mental health issues. For example, someone with schizophrenia may also be living with anxiety, depression, and the effects of trauma including PTSD/CPTSD. This possibility of multiple diagnoses being recorded may

be of specific relevance to autistic people and people diagnosed with ADHD, or both, alongside other conditions. There has been an expansion in ASD/ADHD diagnoses over the last ten years, including diagnoses of older people, and thus, it could appear surprising that this does not seem to be reflected in the diagnosis figures collected, especially in the light of research on the prevalence of ASD/ADHD in forensic mental health settings (Chester et al., 2025). Penological research shows that a high proportion of people involved with the criminal justice system, including those in prison, are neurodivergent (Blackmore et al., 2022; Collins et al., 2023; Slavny-Cross et al., 2022) (Byrnes & Idrizi, 2025). Research has also explored the impacts of 'missed diagnoses', especially of women. The situation is complex because research shows a high level of prevalence of neurodivergence within highly secure hospitals (Walker et al., 2025) It could be the case that the judiciary is more likely to recognise a diagnosis of schizophrenia as being appropriate for a hospital order than ASD or ADHD, and this may also relate to the criminal law's definitions of culpability, such as in relation to diminished responsibility. Put simply, although the number of people being diagnosed is increasing, courts may impose hospital orders if they are living with schizophrenia and not if they are living with autism/ADHD as their primary diagnosis. Awareness of neurodivergence needs to inform future research because of the backdrop of rising numbers of diagnoses and what we already know about prevalence within criminal justice and mental health settings.

At this stage, it is not possible to draw any firm conclusions as to the impacts of the MAPPA Level 1 referral process on risk management, public safety, and offending behaviour. To do this requires longitudinal tracking of patients referred, including after discharge from custody, over a substantial time period. The time period would need to extend over several years after discharge at least, as some patients continue to engage with services, including taking their medication, in the initial period of release, but then relapse after being stepped down from the initial level of professional mental health team oversight. Others may cope well with discharge initially but then, for a range of possible reasons, re-engage with substance abuse, cease to engage with mental health professionals, or stop taking medication. This article is a snapshot of a patient group and to assess the impact of this referral process requires longer-term and ongoing empirical research. Such research would be ground-breaking and of potential significance in relation to policy and practice for forensic mental health patients in the UK and beyond if the referral process and subsequent support and monitoring interventions inherent in MAPPA lead to decreased risk of reoffending for this patient group. After all, MAPPA Level 1 monitors the majority of MAPPA nominals, and, at present, patients under s.37/s.41 (and 'notional s.37 patients) are not monitored nor supported in the way they would be if they had not been given a hospital order. Forensic patients with severe mental illnesses, and often

histories of substance abuse, are a highly vulnerable population, and it is anomalous that they are not managed in the same way as people who have committed similar offences, with similar risk profiles. This lack of monitoring can mean that indicators of increased risk of reoffending, such as resumption of substance use or association with known offenders, are not picked up at any early stage, and instead, the person does not come to the notice of the police or other agencies until they have committed another, potentially serious, offence.

Conclusions

Early identification of MAPPA-eligible cases is crucial, as failing to consider MAPPA referrals could hinder effective risk management and increase risks to staff, teams, victims, and organisations. With this in mind, the MAPPA Level 1 framework can be linked to a 7-stage patient pathway, each stage prompting MAPPA considerations by clinical teams and services. This framework provides clarity about what is relevant for clinical teams at each stage (Figure 6).

There is a gap regarding victim perspectives in safety planning within mental health services even though victim safety is one of the 'four pillars of risk management' underpinning MAPPA decision-making and developed by Professor Hazel Kemshall (HM Prison and Probation Service, 2022). The Level 1 referral process included questions about victims' relationship to perpetrators, residence, and restrictions and the VLO was invited to meetings for insight into the victim's perspectives. However, more victim input is needed, especially before key decisions including leave and discharge planning, and in developing victim-informed training.

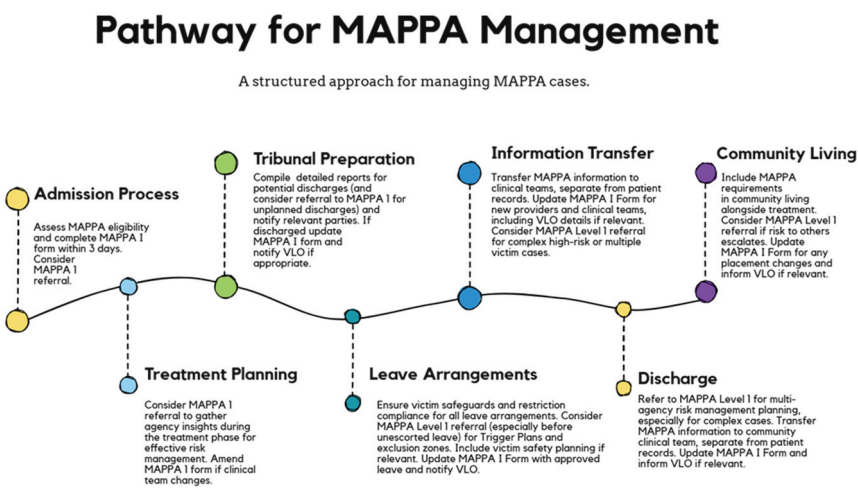

Figure 6. MAPPA 1 patient pathway.

Expertise from clinicians is essential in shaping this victim involvement because the clinician's focus is on the mental health of the patient. This is a source of potential tension because, from a purely clinical perspective, the experiences and needs of victims may not be relevant to the mental well-being of the patient. However, risk management of forensic patients is a holistic and dynamic exercise which involves patients, clinicians, criminal justice professionals, and victims working together towards public protection. There could, for example, be situations in which direct contact between a patient and their victim could be beneficial to both, as seen in victim-offender programs operating in community justice and prison settings (Dalhuisen et al., 2024; van Denderen & van der Wolf, 2023). Although it is outside the scope of forensic mental health practice, victim involvement may lead to improved outcomes for both patients and for victims themselves.

Service user perspectives, feedback, and narratives are lacking although service users can be supported to contribute to risk reduction through dialogue and strength-based approaches, including clinically justified positive risk-taking, especially after engagement with offending behaviour and victim empathy work. Patient narratives can inform training, policy development, and service evaluation.

Henson and Riordan (2012) explored professionals' views on MAPPA and identified that revising the National MAPPA Guidance to address specific issues for offender-patients would be beneficial for staff managing them. The absence of national policy, standards, and resources leads to disparate practices that can obstruct patient pathways, risk management, and public protection. Additionally, providing further training to these staff members could also be advantageous. Over a decade later, this remains an ongoing concern. There is a need for a nation-wide survey of current processes, making use of Freedom of Information requests if necessary, so as to provide a clear picture of the current situation, combined with research into how these current approaches operate, whether national guidance is necessary or appropriate, and, if so, what form it should take.

Implementing a MAPPA Level 1 framework within mental health services requires staff training, commitment to the process, and support from clinicians. Further research is needed to track the impacts on risk and safety in the short, medium, and longer term. Mental health teams stand to benefit significantly from MAPPA engagement through enhanced risk assessments, gaining a broader understanding of offending behaviours, such as predatory patterns, victim selection, instrumental violence, insight, and victim empathy. This enhanced awareness of risk can contribute to a safer working environment for staff who, without the information gained from MAPPA, may not possess sufficient specific knowledge of the patient's offending behaviour and related risk.

The current policy landscape promotes the need to improve risk assessment, yet gaps in practice, such as in mental health, persist. Strengthening governance, embedding victim safety planning, and increased focus on 'risk to others' are key areas for robust victim and public protection in the future.

Notes

1. Freedom of Information requests were sent to 57 community and mental health trusts across England and Wales in January 2024. Twenty-three organisations responsible for the provision of inpatient and/or community mental health services responded, of which 13 provided information about MAPPA arrangements.
2. The identity of the trust and the case studies included have been anonymised, with any identifying details removed.
3. MOSOVO stands for the Management of Sexual or Violent Offenders and is a specialised and police-led approach to manage risks, monitor offenders in the community and protect the public by preventing further offences (McManus & Halford, 2023).

Acknowledgements

The authors wish to acknowledge the support of Brad Simms, for which they are very grateful.

They would also like to thank the Editor and the anonymous reviewers for their thoughtful, detailed, constructive, and supportive comments.

Disclosure statement

No potential conflict of interest was reported by the author(s).

References

Blackmore, C. E., Woodhouse, E. L., Gillan, N., Wilson, E., Ashwood, K. L., Stoencheva, V., Nolan, A., McAlonan, G. M., Robertson, D. M., Whitwell, S., Deeley, Q., Craig, M. C., Zinkstok, J., Wichers, R., Spain, D., Roberts, G., Murphy, D. G., Murphy, C. M., & Daly, E. (2022). Adults with autism spectrum disorder and the criminal justice system: An investigation of prevalence of contact with the criminal justice system, risk factors and sex differences in a specialist assessment service. *Autism*, *26*(8), 2098–2107. https://doi.org/10.1177/13623613221081343

Buongiorno, L., Mele, F., Petroni, G., Margari, A., Carabellese, F., Catanesi, R., & Mandarelli, G. (2025). Cognitive biases in forensic psychiatry: A scoping review. *International Journal of Law and Psychiatry*, *101*, 102083. https://doi.org/10.1016/j.ijlp.2025.102083

Byrnes, K., & Idrizi, K. (2025). Justice for all? The overrepresentation of those with autism spectrum disorder in the criminal justice system. In Neophytos L., Papaneophytou, & Undurti N. Das (Eds.), *Understanding autism* (pp. 335–352). Elsevier.

Chester, V., Melvin, C., Bunning, K., Alexander, R., & Langdon, P. E. (2025). Autistic people within forensic psychiatric services and the criminal justice system: A systematic review. *Journal of Forensic Psychiatry & Psychology*, *36*(5), 711–773. https://doi.org/10.1080/14789949.2025.2558833

Collins, J., Horton, K., Gale-St. Ives, E., Murphy, G., & Barnoux, M. (2023). A systematic review of autistic people and the criminal justice system: An update of King and Murphy (2014). *Journal of Autism & Developmental Disorders*, *53*(8), 3151–3179. https://doi.org/10.1007/s10803-022-05590-3

Cooling, N. J. (2002). Lessons to be learnt from the Christopher Clunis story: A mental health perspective. *Clinical Risk*, *8*(2), 52–55. https://doi.org/10.1258/1356262021928869

Criminal Justice Act. (2003). (325–327. https://www.legislation.gov.uk/ukpga/2003/44/contents

Dalhuisen, L., Knoppers, M., Rijnhout, R., & Meynen, G. (2024). Victim involvement in forensic psychiatric treatment: Opportunities and challenges from a restorative justice perspective. *International Review of Psychiatry*, *36*(7), 676–684. https://doi.org/10.1080/09540261.2024.2303056

Davies, M. (2022). Chart of the week: The over-representation of black people as restricted patients in secure hospitals, Nuffield Trust.

Day, A., Woldgabreal, Y., & Butcher, L. (2022). Cultural bias in forensic assessment: Considerations and suggestions.In G. C. Liell, M. J. Fisher and L. F. Jones (Eds.), *Challenging bias in forensic psychological assessment and testing* (pp. 245–258). Routledge.

Dean, C., & Lloyd, M. (2022). Challenging bias in the assessment of extremist offending. In Liell, G.C., Fisher, M.J., & Jones, L.F (Eds.), *Challenging bias in forensic psychological assessment and testing* (pp. 423–438). Routledge.

Gerdtz, M., Daniel, C., Jarden, R., & Kapp, S. (2020). Use of the Safewards model in healthcare services: A mixed-method scoping review protocol. *British Medical Journal Open*, *10*(12), e039109. https://doi.org/10.1136/bmjopen-2020-039109

Hall, J. (2020). Terrorist risk offenders: Independent review of statutory multi-agency public protection arrangements, Ministry of Justice.

Henson, T., & Riordan, S. A. (2012). MAPPA and detained patients: Views from professionals about referral. *Journal of Forensic Psychiatry & Psychology*, *23*(4), 421–434.

HM Prison and Probation Service. (2021). Mental health casework section. Guidance: Multi-agency public protection arrangements (MAPPA) and the restricted patient system, Home Office.

HM Prison and Probation Service. (2022). Risk of serious harm guidance 2020. Updated 2023. V.2. Public Protection Group.

HM Prison and Probation Service. (2024). Probation service management of MAPPA level 1 cases policy framework, Ministry of Justice.

Liell, G., Fisher, M., & Jones, L. (2022). *Challenging bias in forensic psychological assessment and testing*. Routledge.

Maguire, M., Kemshall, H., Noaks, L., Wincup, E., & Sharpe, K. (2001). Risk management of sexual and violent offenders: The work of public protection panels. Police research series paper. Home Office 139.

McManus, M., & Halford, E. (2023). Policing serious, violent and sexual offending. In *Forensic Psychology, Crime and Policing* (pp. 241–250). Policy Press.

Meyer, L. F., & Valença, A. M. (2021). Factors related to bias in forensic psychiatric assessments in criminal matters: A systematic review. *International Journal of Law and Psychiatry*, *75*, 101681. https://doi.org/10.1016/j.ijlp.2021.101681

Ministry of Justice. (2020). *Oj ethnicity and the criminal justice system, 2020. Published 2 December 2021 ethnicity and the criminal justice system, 2020 - Gov.uk*. www.Gov.uk .
Ministry of Justice. (2023). *Multi-agency public protection arrangements (MAPPA) annual report 2023.4*.
Ministry of Justice. (2024). *Multi-agency public protection arrangements (MAPPA) annual report 2023.4*.
Nash, M., & Williams, A. (2024). *Politics and public protection*. Emerald Publishing Limited.
Neal, T. M. S., Hight, M., Howatt, B. C., & Hamza, C. (2018). The cognitive and social psychological bases of bias in forensic mental health judgments. In M. K. Miller & B. H. Bornstein (Eds.), *Advances in psychology and law* (Vol. 3 , pp. 151–175). Cham, Springer. https://doi.org/10.1007/978-3-319-75859-6_5
NHSE. (2024). *Mental Health Act statistics annual figures 2023-4*. NHS England.
Pearsall, A. (2016). *Enhancing the transitional care experiences of arrestees and remand prisoners with mental illness through intensive case management* [Unpublished Ph.D. thesis]. University of Manchester.
Prins, H. (1994). All tragedy is the failure of communication'(John Wilson)-the sad saga of Christopher Clunis. *Medicine, Science, and the Law*, *34*(4), 277–278. https://doi.org/10.1177/002580249403400401
Race Equality Foundation. (2019). *Racial disparities in mental health*.
Sarkar, S. (2010). Mental health law and the mentally disordered offender. In A. Bartlett & G. McGauley, *Forensic Mental Health: Concepts, Systems and Practice* (pp. 259–273). Oxford: Oxford University Press.
Slavny-Cross, R., Allison, C., Griffiths, S., & Baron-Cohen, S. (2022). Autism and the criminal justice system: An analysis of 93 cases. *Autism Research*, *15*(5), 904–914. https://doi.org/10.1002/aur.2690
Taylor, R., & Yakeley, J. (2013). Working with MAPPA: Guidance for psychiatrists in England and Wales. *Royal College of Psychiatrists' Faculty of Forensic Psychiatry: Faculty report FR/FP/01*. Royal College of Psychiatrists.
Theemis Consulting. (2025). *An independent investigation into the care and treatment provided to VC*. NHS England.
Tyler, N., Wright, N., & Waring, J. (2019). Interventions to improve discharge from acute adult mental health inpatient care to the community: Systematic review and narrative synthesis. *BMC Health Services Research*, *19*(1), 883. https://doi.org/10.1186/s12913-019-4658-0
van Denderen, M., & van der Wolf, M. (2023). Meetings between victims and mentally disordered offenders in forensic mental health facilities: A qualitative exploration of subjective experiences. *The International Journal of Restorative Justice*, *6*(1), 13–44. https://doi.org/10.5553/TIJRJ.000120
van Leeuwen, M. E., & Harte, J. M. (2017). Violence against mental health care professionals: Prevalence, nature and consequences. *Journal of Forensic Psychiatry & Psychology*, *28*(5), 581–598. https://doi.org/10.1080/14789949.2015.1012533
Walker, F., Murphy, D., Gröger, L., & Moore, E. (2025). Prevalence of neurodiversity in a UK high secure psychiatric hospital cohort: A records study. *Criminal Behaviour & Mental Health*, *35*(3), 170–178. https://doi.org/10.1002/cbm.2363