SCOTTISH EXECUTIVE

Health Department
Directorate for Service Policy and Planning

28 July 2006

Dear Colleague

FORENSIC MENTAL HEALTH SERVICES

1. The Forensic Mental Health Managed Care Network (Forensic Network) was established in 2003 to advise on policy and service development in respect of forensic mental health services.

2. The Forensic Network has worked in a consultative way with clinicians, managers, service users and others to develop papers on a range of issues relevant to service delivery. The consultation papers and comments on the papers can all be viewed or downloaded from the web at www.forensicnetwork.scot.nhs.uk.

3. At the "Beyond Walls" conference on 4 October 2005, Dr Kevin Woods, Chief Executive NHS Scotland, announced that the Health Department would review the outcome of those consultations and identify the elements that would be published as national policy and guidance. This is summarised below.

Policy	Guidance
Secure Care Standards	Services for Women
Conflict Resolution	Services for Learning Disabilities
Liaison between NHS Boards and the Scottish Prison Service	Definitions of Levels of Security

Configuration of Forensic Mental Health Services

4. In addition work has been taken forward by the Forensic Network in conjunction with the Chairs of the Regional Planning Groups on the configuration of forensic mental health services. The agreed Scotland and regional analysis of inpatient beds is set out as Annex A to this HDL and the analysis should guide NHS Boards and Regional Planning Partnerships in the development of local services.

5. There are now clear expectations of the forensic service configuration that is required within Scotland to provide a full range of forensic inpatient services and the level at which those services should be commissioned. Those expectations are set out in the table below.

Addresses

For action
Chief Executive, NHS Boards
Chief Executive, The State Hospitals Board for Scotland
Medical Directors
Regional Planning Directors

For information
Chairs, NHS Boards
Chief Executives, NHS Local Authorities
Directors of Social Work/Chief Social Work Officers
Chief Executive, NHS National Services Scotland
Chief Executive, NHS Education for Scotland
Chief Executive, NHS Quality Improvement Scotland
Director, Mental Welfare Commission for Scotland
Chief Executive, Mental Health Tribunal for Scotland
Medical Director, Forensic Network
Royal College of Psychiatrists, Scottish Division
Royal College of Nursing, Scottish Division
British Psychological Society, Scottish Division
Scottish Social Services Council
Scottish Commission for the Regulation of Care
Chief Constables
Crown Office
Northern Ireland Office
Home Office
Scottish Partnership Forum
Appropriate voluntary organisations

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National	Regional	Local
High secure male mental disorder High secure male learning disability Medium secure female mental disorder Secure child and adolescent services	Medium secure male mental disorder Medium secure learning disability Low secure female mental disorder	Low secure male mental disorder* Low secure learning disability* Community services

*though in each case smaller boards may wish to commission services regionally or from other Boards

6. We recognise that even as the forensic estate develops and is better able to provide a range of regionally and locally based inpatient services there will still be patients whose needs can only be met through out of area placements.

National Overview of Patient Flow/Appeals against Excessive Security

7. The Minister has established, following consultation with NHS Chairs, a national overview group to monitor patient flow from the State Hospital to ensure that the system is functioning as it should and that patients are not held in conditions of higher security than is appropriate to the risk that they present. The group is chaired by Garry Coutts, the Chair of NHS Highland and reports to the Minister. The specific tasks of the group are to:

- track applications to and decisions made by the Mental Health Tribunal for Scotland
- monitor the progress of NHS Boards in acting on decisions of the Tribunal
- track the progress in resolving entrapped patient cases (this is the group of patients who we have decided do not need to be held at the State Hospital)
- work with and receive reports from the regional groups to ensure that provision was in place for patients should accommodation be required
- develop an assessment of the number of patients at the State Hospital who might make a successful application to the Tribunal
- consider national commissioning arrangements for places outside Scotland where accommodation is not likely to be available

8. In addition, the Minister has decided that forensic sub-groups should be established by each of the three Regional Planning Groups working under the framework established by NHS HDL (2004) 46. The role of these sub-groups will be to:

- continue to develop regional services for forensic patients
- monitor patient flow through the system to ensure capacity continues to become available for new cases as they arise
- have in place commissioning and purchasing arrangements for out of region placements
- take forward clinical governance to assess quality and performance issues across the region

POLICY

Care Standards

9. The care standards for medium secure forensic services are attached as Annex B. Health Board Clinical Governance Committees and the new forensic sub-groups of the Regional Planning Partnerships are responsible for monitoring implementation and compliance with the standards.

Resolving Clinical Conflicts

10. The clinical conflict resolution mechanism is attached as Annex C. The Forensic Network will provide secretariat services for the conflict resolution group, but the costs involved in the conflict resolution process will be borne by the responsible health board for each patient in question.

Security Liaison

11. The arrangements for liaison between the Scottish Prison Service and the NHS are attached as Annex D.

GUIDANCE

Definitions of Levels of Security

12. Security has always been a necessary part of psychiatric care and can be considered as having environmental, relational and procedural aspects. We adopt the following principle:

> *The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community*

13. The primary determinant of appropriate level of security is the best estimation of risk posed by an individual to themselves or others. When a patient is admitted to forensic mental health care historical risk information must be documented which would satisfy but not be limited to the information required for PCLR and HCR-20 thus allowing for a detailed formulation and characterisation of risk. That document should follow the patient through different settings and should be updated as new historical information comes to light rather than recreated. This historical risk document should document the necessary information which may then be scored for the purpose of risk assessment. Issues of patient mix, availability of appropriate therapeutic services, public safety and continuity of care may be important secondary considerations, but would not in isolation justify a level of security in excess of that estimated to satisfactorily safely contain the risk posed.

14. The matrix of security report (which is available on the Forensic Network website) contrasts procedural and physical aspects of security against what is currently available in Scotland in terms of high, medium and low secure care. It provides a useful guide to matching the appropriate level of security for a patient and the risk that patient poses. Relational security is also of key importance but should be of similar quality irrespective of the level of security and would include for example competent risk assessment and management.

Services for Women

15. The Forensic Network commissioned an expert group to consider the services required for women. The group concluded that there is no need to have beds at high security level for female patients and that community based specialist services be developed including a small bed base at the medium secure level. The needs assessment work by the Forensic Network backs up this conclusion with no female patients expected to require high secure care in the future.

17. There should be one national medium secure service for women and regional low secure units. Each regional service should develop multi-disciplinary teams; these teams should be overall responsible for services within the areas covered by each of the regional consortium. As well as providing direct care within secure units within the region, they should be involved in providing other inpatient care and community care either directly or in consultation with other local services to maintain "joined-up" services.

Services for Learning Disabilities

18. There is a continued need for high secure care at The State Hospital for this client group and regional medium secure and local low secure services need to be developed. Robust services should be weighted towards the community with the development of regional multi-agency risk management groups required in terms of developing the multi-agency risk governance to maintain "joined-up" services. Generic learning disability services will have a lead role in the provision of local care. The principle of co-locating medium secure learning disability services with either low secure learning disability services or medium secure mental illness services is endorsed.

Further Work

19. Further work is being taken forward by the Forensic Network and the Health Department in the following areas:

- the Forensic Network is supporting the Risk Management Authority in the work that it is taking forward on risk assessment and management of restricted patients;

- statutory guidance on how the Care Programme Approach should operate in respect of patients subject to the provisions of the Management of Offenders (Scotland) Act 2005 is being prepared and will be published later this year;

- standards are being developed for high and low secure services (which will be similar in range and scope to the standards for medium secure services);

- there will be a further consultation on the structure and nature of Forensic Community Mental Health Services;

- proposals for a Forensic School for Scotland are being developed;

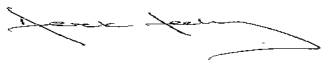
- updated guidance on Critical Incident Reviews is being prepared;

- work on the development of secure care forensic services is being taken forward by the Health Department in conjunction with colleagues from other Departments, the NHS, the Care Commission and others;

- the Health Department is considering the recommendations in the sub-group report on Personality Disorder in conjunction with colleagues elsewhere in the Executive.

Other information about the Forensic Network's work programme is available on the Network's website.

Yours sincerely



Derek Feeley
Director of Health Care Policy and Strategy

Annex A

CONFIGURATION OF FORENSIC MENTAL HEALTH SERVICES

Introduction

1. This paper offers guidance on the configuration of forensic mental health services in Scotland. It has been agreed with the Chairs of Regional Planning Groups.

2. The policy background is *Health, Social Work and related services for Mentally Disordered Offenders in Scotland* (NHS MEL (1999) 5, Scottish Office 1999). The policy statement examined the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work department, The State Hospital, other psychiatric services in hospital, and in the community. There were also proposals for the organisation and further development of these services throughout Scotland.

3. MEL (1999) 5 continues to be Scottish Executive policy. It explicitly adopted the principles set out in the Department of Health Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services (the Reed Report, 1994), that mentally disordered offenders should be cared for:

- with regard to quality of care and proper attention to the needs of individuals
- as far as possible in the community rather than institutional settings
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life
- as near as possible to their own homes or families if they have them.

4. In 2004 an expert working group commissioned by the Network produced the report 'Definition of security levels in psychiatric inpatient facilities in Scotland'. The report was subject to consultation resulting in wide support and was endorsed by the Forensic Network Board. A Matrix of Security was developed which contrasts eleven aspects of physical and procedural security against high, medium, low locked and low open inpatient facilities. (The full report and Matrix of Security can be viewed on the Forensic Network website). Although service planning was the primary reason for this group new mental health legislation has given it added importance.

Assumptions

5. In this paper the following assumptions are made:

- No further legislative changes
- No changes in Scotland to the practice of not admitting mentally disordered offenders with a primary personality disorder diagnosis
- No substantial change to either the rate of serious crime or the rate of serious mental illness/learning disability
- That following new mental health legislation, making all remand patients restricted, the continued practice of admitting remand patients to low open general adult psychiatry wards will become unsatisfactory
- That the mixing of forensic patients and an IPCU population is unsatisfactory except in urgent acute circumstances and then only for a short period
- That the conclusions of the Network reports which have been subject to consultation and endorsement by the forensic board should be influential
- That mixed adult accommodation is not acceptable
- For victim issues some patients will require to be rehabilitated and resettled in areas outwith their home Health Board.

Experience of Secure Services 1999-2005

6. From the Reed report (DoH 1994) estimates were made of the necessary size of the medium secure estate in England. These figures can be extrapolated to 200 beds in Scotland. However such estimates do not take into account differences between England and Scotland (for example the number of patients with a primary personality disorder being much higher in England) nor was there a definition of medium security.

7. The Orchard Clinic was opened in 2001 with a bed capacity of 50. During the last three years to March of this year average bed occupancy ranged between 38 and 40. This includes patients who only would require low locked security, e.g. pre-discharge or certain remands. Patients are not admitted unless there is a diagnosis of mental disorder (excluding a primary diagnosis of personality disorder) and, all can be reasonably expected to move on.

8. The population of medium secure patients from Lothian over the last three years up until March 2005 has varied by 13.5%. This includes all the remand population in Lothian. Extrapolating the results from a survey conducted by the Forensic Network in summer 2005 and subsequent consultation, RMOs at the Orchard Clinic indicated that between 25% and 45% of the Lothian population of the Orchard Clinic might be managed at a lower level of security.

9. The need for medium secure beds is highlighted in the forthcoming appeals against excessive security, but the same legislation also requires justification for the use of medium security in a way never envisaged by Reed or planners in England. Based on experience over the past three years it would be reasonable to conclude that there is the need for development of high quality low locked forensic inpatient facilities to complement a more modest medium secure estate than that planned across Scotland.

10. The State Hospital has undertaken security needs assessments in 2003 and 2005. The results are consistent with The State Hospital survey (Thomson *et al* 1997) and indicate that a third of the population at the State Hospital do not require high secure care.

11. A comprehensive medium and low secure estate will reduce the population of the State Hospital both by moving on the patient population who do not require to be there but also by increasing throughput through shorter lengths of stay. From benchmarking exercises with England it is possible to assume that the average length of stay will reduce from 6.5 to 2-3 years. It is also reasonable to assume that there will continue to be approximately 60 admissions per year but the overall population will fall to 140. An essential part of national planning remains the re-provisioning of the State Hospital, benchmarked to the English special hospitals for high secure care. The development of the whole spectrum of forensic services will be challenging in financial and workforce capacity.

12. Where low locked security has been developed in forensic services, patients who are destined to be followed up by specialist forensic community teams are usually discharged straight from such an environment. In many areas in England there has been no development in low locked security and discharges to the community from medium secure care is common (see Levels of Security report for a literature review on this topic). There will always be a certain number of patients who will progress from forensic to generic services, but for those patients who will remain within forensic care there requires to be seamless continuity of care within the same service.

13. With a greater number of tiered security levels within a service there is a greater risk of bed redundancy. For the purpose of this exercise the estimated numbers of low locked beds could be further divided if required. As suggested elsewhere, for example, for low secure female mental illness, the use of flexible living accommodation should reduce the risk of bed redundancy. Mechanisms continue to need development for the allocation of patients who cannot be rehabilitated and resettled in their home Health Board area because of victim issues.

Male Mental Disorder

14. Male mental disorder represents 80-85% of the mentally disordered population. The bulk of provision will be for this category of patient and greatest confidence can be placed on the estimates of number of beds required.

15. It is now possible to propose the likely requirement for male mental disorder medium and low security by region. Appendix I shows the current provision of services, current plans and proposed adjustments given the Orchard Clinic statistics and Network reports. This results in an overall shift in balance in the estate with a reduction of the medium secure planned estate and an increase in low locked secure provision.

South East Region

16. It is clear that 50 medium secure beds is an overprovision (10 beds were always estimated to be for out of area referrals rather than for SE Scotland). It is recommended that there is some reduction in South East Region reducing the male mental illness medium secure function for the region to between 30 and 40 beds and creating locked low security for Lothian and Borders once the medium secure estate is in place (2007 – 2009).

17. A further 20 low secure are estimated to be required for the rest of the region (Fife and Forth Valley). This includes provision for remands which currently go to IPCUs. There is already some low secure provision in the wider region but the facilities are not completely forensic and include some long term patients who might be moved on to community services.

West Region

18. The number of medium and low secure beds suggested for the West are higher by population than elsewhere. This reflects the differences in demographics and relatively higher population of mentally disordered offenders. Although medium security can be centralised, low security might be split between a small number of Health Board sites developing existing resources. A role for low secure beds would include the remand patient population which currently within the region utilises a number of IPCU and general adult beds.

North Region

19. Configuration for the North would support one medium secure unit co-located with a low secure unit. Given geographical and population considerations one further low secure unit is required. Exceptional considerations in remote areas might apply to the use of an IPCU for acute admission before transferring to a medium or low secure forensic unit.

Female Mental Disorder

20. The Forensic Network commissioned an expert group to consider the services required for women. It should be noted that the group did not discriminate between low and medium secure services. The group provided a report that made several recommendations, including:

- Dedicated multidisciplinary teams should be established across Scotland
- The core patient group should be adult women with complex mental health needs and should not exclude women with personality disorders
- Provision should be made within Learning Disability services for the small number of learning disabled women who have forensic needs
- Secure beds should be provided in small, self contained units of no more than ten beds
- Living accommodation for women should be separate from that for any male patients
- High secure provision should rarely be required and the service at the state Hospital should close with the use of high secure services in England in exceptional cases.

21. Having completed the needs assessment at The State Hospital and in view of the experience at The Orchard Clinic, most of the female mentally disordered population require low locked security. Also, the much smaller numbers given the low base rate for offending in mentally disordered women there is greater fluctuations in patient population. The requirement therefore is to develop female regional low secure services in combination with the male services. Flexible accommodation in male and female living spaces would minimise bed redundancy.

22. Given the recommendations for male mental disorder services, it is recommended that there should be one low locked provision in the East and in the North, with two in the West. Each should have a 4-6 bedded female low locked unit joined on to low locked male accommodation. These units should form the base for regional services as outlined in the Network report.

23. There will continue to be the need for medium secure female services but so low are the likely numbers only one national facility should be planned. This should be accommodated in one of the three medium secure units. Again there is the possibility of flexible accommodation within medium security.

24. There is not a requirement for high secure provision. Liaison with English services for exceptional referrals to high security needs to be completed along with agreement about the criteria for such referrals. Medium secure care must be able to contain a patient for the necessary period of time to allow for transfer arrangements. A patient can appeal against transfer to England, but it would be clinically undesirable to house a patient in a unit of one or two compared to a appropriately functioning high secure service, and that is unsustainable in Scotland.

25. The proposed services for women are outlined in Appendix II

Learning Disabilities (Male and Female)

26. The main emphasis in the Forensic Network's learning disability report is on the need to develop specialist community services. The bulk of forensic learning disability will be within generic learning disability services and there is a particular need for close engagement with such services.

27. Over half of The State Hospital's learning disability population have been assessed by the needs assessment not to require High security. At this point the planning assumption is for 12 beds at high security.

28. The learning disabilities report recommends two 8 bedded medium secure units. There are advantages to have such a unit in combination with a low secure learning disability units and this is what is proposed. An alternative is to co-locate with medium secure male mental disorder.

29. The existing number of placements for low secure learning disabilities appears satisfactory although not all of the buildings come up to the standard required. Also numbers in certain regions may reflect difficulties in the provision of specialist supervised community facilities.

30. An outline of the proposed service configuration is given in Appendix III

Child and Adolescent Services

31. The new Mental Health legislation regards children with mental disorder in a special way. It can no longer be acceptable to admit 16 or 17 year olds to The State Hospital or to the Orchard Clinic. Appendix IV shows the number of children admitted to adult facilities together with data from the MWC about the number of children detained under forensic mental health act sections. Waiting lists to English provisions can be lengthy.

32. The Network draft report on Child and Adolescent services recommended the provision of an 8 bedded low locked secure national facility. The Executive is currently taking forward work in respect of the provision of such a service in Scotland.

Community Services

33. In many areas there are developments of specialist Forensic Community Mental Health Teams (CMHTs). The Network draft report gives a model for how such services could be configured. Whereas not all areas will require to follow such a model, all areas must have adequate community provision for the needs of MDOs in the community.

34. It is hoped that there will not be the need for very long term low secure care and that in particular some learning disability models involving high supervision in a community facility might be used with the long term mentally ill population.

Benchmarking Exercise

35. Appendix V gives benchmarking data with beds per 100,000 population for the Scottish proposals with services in England. English Health Authorities have been selected because of their comparative population size, a variety of rural and urban and availability of reliable data. The following observations can be made:

- the variation in provision is of an order of magnitude in some cases and some variation is secondary to demographic factors (though research has shown the closest guide to the rate of violence for people with mental health problems is the base rate of violence for their locality. The rate of mentally disordered offenders in a population will reflect the rate of criminal activity in that population)

- variation will be due to some of the services being regional (in particular learning disability services are likely to be organised regionally)

- in the calculation of female services about half are in mixed accommodation and half in single sex settings. In the mixed facilities case the assumption is that 15% of patients are women

- many services will also have patients with primary personality disorder and some regions have designated personality disorder units (some 25% of the high secure population have a primary diagnosis of personality disorder).

- there is variation in the development of low secure forensic services (in some areas only medium secure within the forensic estate is available)

36. Overall although benchmarking to England is useful all the caveats above must be considered. If England was obliged to work within Scottish legislation it is likely that low secure would have to be developed. Significantly there is no agreed definition of medium or low secure in England so not all services described in a similar way are likely to be providing a service of equivalent security.

37. While the main mental illness that effect this cohort (schizophrenia and bi-polar disorder) tend to be fairly evenly distributed within the community, other contributing factors in relation to offending (substance abuse; lack of social support; homelessness) tend to be more concentrated in areas of social deprivation with the effect that there are greater pressure son services in such areas.

Risk Assessment

38. With tiered security levels and high variation in the specific populations there is inherent chance of bed redundancy. The risks of under provision and over provision are summarised in the table below. It will be for Regional Planning Partnerships and Boards to decide how to address these risks in developing the forensic estate.

Under-provision	**Over Provision**
• Immediately full, once commissioned • No flexibility • Higher security risks • Patients effectively 'stuck' in the wrong level of security • Increased appeals and subsequent fines for NHS Boards • Increased use of private sector and increased costs • State Hospital unable to ensure predicted turn-over • Reputational risk • Increased pressure on low secure • Failure to properly take account of potential work-load from prisons • Patients remain in prison, who require healthcare	• Under-utilised estate • Financial risk to organisation • Patients inappropriately detained • Unable to commission because staffing requirements too high • Increased length of stay • Lowered throughput • Resource for developing the next level or community services

Appendix I – Male Mental Disorder

Region	Population		High Secure Beds			Medium Secure Beds			Low Secure Beds**		
			Current	Planned	Proposed	Current	Planned	Proposed	Current	Planned	Proposed
NATIONAL			**193**	**128**	**128**						
South East	**1.5m**										
Lothian	750,000					50	50	30 – 40	0	0	20 - 30
Fife	350,000										
Forth Valley	290,000								24	24	0
Borders	100,000										
West	**2.3m**					0	64	60-70			
Glasgow	870,000								33	22	0
Lanarkshire	500,000								15	11	15
Dumfries & Galloway	150,000										
Argyle & Clyde	420,000								0	0	50
Ayrshire & Arran	370,000								16	16	15
North	**1.2m**										
Tayside	400,000					0	40	30	27	35	30
Grampian	500,000								24	24	20
Highland	210,000										
Islands	100,000										
		TOTAL	**193**	**128**	**128**	**50**	**154**	**120- 140**	**139**	**132**	**160 -170**

**all current services include women

Appendix II – Female Mental Disorder

Region	Population		High Secure Beds			Medium Secure Beds			Low Secure Beds		
			Current	Planned	Proposed	Current	Planned	Proposed	Current	Planned	Proposed
NATIONAL			21	0	0						
Supra regional						0	0	8*			
South East	**1.5m**					Variable					4-6
Lothian	750,000										
Fife	350,000										
Forth Valley	290,000										
Borders	100,000										
West	**2.3m**										8-12
Glasgow	870,000						8				
Lanarkshire	500,000										
Dumfries & Galloway	150,000										
Argyle & Clyde	420,000										
Ayrshire & Arran	370,000										
North	**1.2m**										4-6
Tayside	400,000										
Grampian	500,000										
Highland	210,000										
Islands	100,000										
		TOTAL	**21**	**0**	**0**	**0**	**8**	**8**	**0**	**0**	**16-24**

*Supra-regional unit, could be either in East or West
#Two separate 4 – 6 bedded units in the west

Appendix III – Learning Disabilities (Male and Female)

Region	Population		High Secure Beds			Medium Secure Beds			Low Secure Beds		
			Current	Planned	Proposed	Current	Planned	Proposed	Current	Planned	Proposed
NATIONAL			26	12	12						
South East	**1.5m**										
Lothian	750,000								13	12	12
Fife	350,000					0	0	8	12	12	10
Forth Valley	290,000										
Borders	100,000										
West	**2.3m**										
Glasgow	870,000								8	8	8
Lanarkshire	500,000										
Dumfries & Galloway	150,000										
Argyle & Clyde	420,000					0	0	8	8	8	8
Ayrshire & Arran	370,000										
North	**1.2m**										
Tayside	400,000								8	8	8
Grampian	500,000								12	12	12
Highland	210,000										
Islands	100,000										
		TOTAL	**26**	**12**	**12**	**0**	**0**	**16**	**61**	**60**	**58**

* includes 1 female patient
**to be reviewed

Appendix IV – Under 18s admissions

Under 18s Admissions

The State Hospital	Since 1995	9 admissions (6 male, 3 female)
The Orchard Clinic	Since 2001	4 admissions
Blair Unit	Since 1995	4 admissions (3 female, 1 male)

Detentions under CPSA under 18
(from MWC)

2004-5	5 males
2003-4	2 males 5 females
2002-3	7 males
2001-2	2 males
2000-1	3 males 1 female
1999-2000	7 males 1 female
1998-9	10 males 3 females

Appendix V – Benchmarking with England

Male Mental Disorder

England			
English SHA	**Population**	**MMD beds per 100,000**	
		Low	Med
Trent	2.7 m	5.37	5.18
Cheshire & Mersey	2.7m	0.63	1.26
Cumbria & Lancashire	2.4m	2.63	0.67
Greater Manchester	2.7	0	5.6
Northumberland, Tyne & Wear	1.7 m	0.35	1.35
South Yorkshire	1.5 m	0	3.8
North & East Yorkshire	1.6 m	0	7.38
Co Durham & Tees Valley	1.1 m	0	4.9

Scotland			
Region	**Population**	**MMD beds per 100,000**	
		Low	Med
West	2.3m	3.48	2.6
South East	1.5	2.6	2.0
North	1.2 m	3.34	2.5

Female Mental Disorder

England			
English SHA	**Population**	**FMD beds per 100,000**	
		Low	Med
Trent	2.7 m	1.81	1.93
Cheshire & Mersey	2.7m	0.12	0.56
Cumbria & Lancashire	2.4m	0.46	0
Greater Manchester	2.7	0	0.44
Northumberland, Tyne & Wear	1.7 m	0	0.12
South Yorkshire	1.5 m	0	0.87
North & East Yorkshire	1.6 m	0	1.44
Co Durham & Tees Valley	1.1 m	0	0.82

Scotland			
Region	**Population**	**FMD beds per 100,000**	
		Low	Med
West	2.3m	0.35 – 0.52	0.16
South East	1.5	0.27 – 0.4	
North	1.2 m	0.34 – 0.5	

Learning Disabilities

England						
English SHA	**Pop**	**LD beds per 100,000**				
		Male Low	Male Med	Female Low	Female Med	Total
Trent	2.7 m	0.34	6.3	0	0.26	6.9
Cheshire & Mersey	2.7m	0	0	0	0	0
Cumbria & Lancashire	2.4m	0	0.42	0	0.21	0.36
Greater Manchester	2.7	0	0	0	0	0
Northumberland, Tyne & Wear	1.7 m	0	0	0	0	0
South Yorkshire	1.5 m	0	0.67	0	0	0.67
North & East Yorkshire	1.6 m	2.81	2.94	0.13	1.06	6.94
Co Durham & Tees Valley	1.1 m	0	0	0	0	0

Scotland			
Region	**Population**	**LD beds per 100,000**	
		Low	Med
West	2.3m	0.35	0.70
South East	1.5	1.47	Linked with North
North	1.2 m	2.67	0.30

Annex B

MEDIUM SECURE CARE STANDARDS

Introduction

1. These standards have been written for forensic mental health organisations providing care and treatment in conditions of medium and security (as defined in the Forensic Network report – *Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland*). Work is underway to prepare standards for high and low security (which will be similar in range and scope to these standards).

2. In developing these standards we have accepted the environmental, procedural and relational model of security within mental health services adopted by Kennedy (2002) and reiterated by the Forensic Network Levels of Security group.

- Environmental or physical security includes items such as perimeter fence, building security, observation systems and alarm systems. It is the provision, maintenance and correct use of appropriate buildings and equipment by properly trained staff.

- Procedural security includes all patient related policies and practices which control, for example, access, communications, personal finances and possessions. It also includes policies and practices in relation to quality and governance.

3. Kennedy comments that relational security is nearer to quality of care and is closely linked to resources and recurring costs. It would include staffing, staff to patient ratios but also the provision of appropriate multi-disciplinary teams with the right range of skills and the availability of the right range of therapeutic activities. It relates to the formation of the therapeutic alliance between staff and patients based on a detailed knowledge of the patient. It is closely linked to risk assessment and risk management.

4. Standards 1-3 deal with relational security. The Levels of Security report excluded relational security from definitions. Relational security does not provide clear delineation between levels of security. The infrastructure required to provide assessment and treatment in low security is not significantly different from that required in high security, although staff numbers may vary. In essence, the report states that relational security, such as patient assessments, treatment planning, delivery of services and availability of staff, should be similar irrespective of the level of secure environment. However, in developing standards for forensic services, it is essential that relational security is included, albeit those standards may not differ significantly throughout the levels of security.

5. Standards 4-11 deal with the elements of physical and procedural security which were identified within the Forensic Network Levels of Security group to be delineating factors between different levels of security and therefore there are versions of these standards for each of the three levels of inpatient secure care services (high, medium and low)

Overarching Principles

6. Although standards are a useful tool when used within a range of complementary techniques, they cannot usefully exist or be used in isolation. Standards should be used within continuous quality improvement. The range of tools and techniques for quality improvement include activities such as clinical audit, integrated care pathways, outcome measures, key performance indicators and service user consultations, all of which can be used in conjunction with standards, defining the questions to be asked, measurement that can be made and evidencing progress and improvement.

7. When using these standards the following overarching principles should be applied.

Governance & Risk Management

8. For each standard area, the organisation should be able to demonstrate clarity around governance arrangements and the effectiveness of reporting arrangements to the Board or other governing body.

9. Risk reporting arrangements should exist that supply regular reports to the organisations governance body. The organisation should have active and dynamic risk registers which document the consideration of risks around each of the standard topics. The associated risk management action plans should demonstrate a planned approach to minimising risk. In addition, risk assessments for individual patients or units should demonstrate considered approaches to minimising risk.

Quality Improvement

10. The organisation should be able to demonstrate systems that exist to ensure practice is monitored and measured, benchmarked against existing best practice and that practice development arrangements exist to conduct and disseminate and adopt the evidence base. As mentioned previously, there are a range of tools and techniques used within quality improvement which should be used by organisations.

11. There is also evidence of internal audit of security arrangements performed at all levels.

12. The organisation is able to demonstrate evidence of external audit of physical and procedural security arrangements. This should be performed by an appropriate body providing a similar or higher level of security, or providing expertise in a specialist area, e.g. technical expertise.

13. For each standard the following evidence is suggested:

Standards, Governance & Audit	
• Audit reports • Action plans • Reports to Governance body	• Minutes of Governance Body • Organisational chart including governance • Job descriptions
Risk Management	
• Risk Register & reviews • Minutes of Risk meetings • Reports to governance body	• Risk assessments • Action plans with review dates & targets • Evidence of action plan being implemented, disseminated

Policies and Procedures

14. Throughout the standards, specific policies and procedures are recommended to support achievement of the standards in practice. Policies and procedures must have a supporting system of development, review and implementation around them to ensure that they are reflecting, shaping and driving practice. Each policy, procedure or protocol should have an implementation date & a review date. Each should have evidence of consultation, communication and dissemination amongst staff, patients and visitors with notices to staff,

patients and visitors when appropriate. In addition, properly resourced training and education plans should exist that ensure effective implementation.

15. For each standard the following evidence is suggested:

Policies & Procedures	
Each standard has a list of specific Policies and Procedures including implementation and review dates.	
• Minutes of meetings to consult, communicate & disseminate policies • Policy framework documents	• Policies & Procedures folders in workplaces • Relevant communication to users and carers (e.g. notices in reception, patient areas etc)

Links, Liaison and Joint Working

16. For each standard area the organisation should be able to demonstrate that it is regularly liaising with relevant external organisations for the purposes of ensuring effective joint working with local partner organisations, or for examining others and own practice to benchmark and improve quality.

17. For each standard the following evidence is suggested:

Links, Liaison & Benchmarking	
• Minutes and action plans from regular meetings with Local emergency services • Interagency procedures, protocols, responses • Minutes / action plans from other liaison	• Results of benchmarking exercises • Action plans (including those signed off by governance body) • Reports to governance body • Minutes of governance body meetings

Standard 1 Assessment and care planning

Standard 1.1 Statement:

Organisations will have in place systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform the treatment plan and enhanced Care Programme Approach.

Standard 1.2 Rationale:

The aim of forensic mental health services is to deliver the right care, at the right time, to the right patient. These aims should be delivered through a system of:

- needs assessment;
- risk assessment;
- risk management; and
- treatment planning and delivery.

Each of these processes are conducted as part of a structure or system in order to realise a number of benefits including:

- All of the multi disciplinary team caring for the patient, the patient themselves and their carers should be able to share information regarding the identified needs, risks, objectives, interventions and treatments.
- Each should understand decisions that are being made and have reasonable expectations of what should be delivered and when.
- The multidisciplinary team should be able to use the assessment and planning structure to avoid duplication in their work, identify any gaps and to prioritise the interventions, treatment and support they provide.

The Schizophrenia standards (CSBS 2001) and the best practice statement on admission to adult mental health (QIS 2004) both have important guidance on assessment and care planning which is relevant to secure care settings.

The Risk Management Authority (RMA) has recently been set up by the Scottish Executive (January 2005) to address these issues for Scotland. Organisations should be aware of the RMA guidance and standards as they become available.

The key objectives of the RMA are given as being:

To become a national centre of excellence in the field of risk assessment and risk management by examining what is effective in risk assessment and risk management in a Scottish context based upon research with the UK and the rest of the world.

To promulgate best practice guidance, set standards for risk assessment and risk management of high risk offenders, assess and accredit the assessors, the risk assessment techniques and risk management plans of the relevant agencies to ensure that the risk management of high risk serious violent and sex offenders is based up on the set standards.

To advise Scottish Ministers on issues of national policy and developments in the field of risk assessment and risk management.

Standard 1.3 Criteria

The organisation is able to demonstrate evidence of audit of multi disciplinary assessment of need and risk, coupled with evidence of risk and care management and planning

Risk assessment and management should include use of appropriate risk assessment tools combined with full discussion of all risk factors within the multidisciplinary team.

Both local & organisational risk registers include a consideration of failure to assess, plan or deliver care or treatment

There are corporate risk management action plans that demonstrate a planned approach to minimising risk and regular reports to Governance body

Policies and procedures describe the systems in place to assess risk and need, then plan to meet those risks and needs.

Multidisciplinary working (as in the Care Programme Approach) is central to the assessment and care planning processes.

Standard 1.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Standards, Governance & Audit	
• Risk assessment tools	• Treatment plan templates
Policies & Procedures	
• Referrals and admissions policy • Clinical risk assessment policy and procedure • Treatment planning procedure • Care Programme Approach policy • Needs assessment framework	

Standard 2 Delivery of generic and specialist treatments, interventions and support for recovery

Standard 2.1 Statement:

Organisations will have in place an infrastructure that delivers a range of generic and specialist treatments, interventions, and support for recovery, appropriate to the health and social care needs of patients and fulfilling the multidisciplinary treatment plan.

Standard 2.2 Rationale:

Patients in forensic services are more likely to have complex needs, including resistant psychotic illness, disadvantaged socioeconomic background and comorbid substance abuse problems, compared with the patient population of general adult mental health services. They are also more likely to be living with the consequences of previous institutional care.

Therefore, organisations must be able to provide an holistic range of interventions, treatments and support for recovery through in-house provision, externally sourced services and community access when appropriate. The provision of interventions, treatment and support should be needs led and available throughout the levels of security in forensic mental health inpatient (and community) services to ensure continuity of care.

Specialist treatments for specific offending behaviours are required to reduce the risk posed by patients to themselves and others.

Any organisation that detains people has a responsibility for the quality of patients lives.

It is not appropriate for a patient to be held at a higher level of security because the treatment is only available there.

It is also inappropriate to delay treatment, intervention or support solely because it is unavailable in the current service.

Standard 2.3 Criteria

The organisation is able to demonstrate evidence of audit of delivery of planned interventions, treatments and support.

Treatments, interventions and support for recovery should be delivered according to best practice and the current evidence base. There should be regular audit of effectiveness of treatments and interventions.

Policies and procedures describe the systems in place to source and deliver treatments, interventions and support for recovery.

The organisation is able to demonstrate that it is regularly liaising with external organisations for the purposes of ensuring effective joint working including joint delivery of treatment and intervention programmes. They should also foster links with external organisations to benchmark and improve quality.

The organisation is able to demonstrate that they are monitoring unmet need within the patient population they serve and have put in place measures to address those needs.

Standard 2.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Standards, Governance & Audit	
• Treatment and Intervention protocols	
Risk Management	
• Risk Register & reviews • Minutes of Risk meetings • Reports to governance body	• Corporate Risk assessments • Action plans with review dates & targets • Evidence of action plan being implemented, disseminated
Policies & Procedures	
Clinical Effectiveness Strategy including implementation and review dates	
Links, Liaison & Benchmarking	
• Joint treatment protocols • Service level agreements and contracts	

Standard 3 Teams, Skills, Staffing

Standard 3.1 Statement:

Organisations will have sufficient staff numbers and skills available to deliver effective treatment and maintain a safe environment.

Standard 3.2 Rationale:

The wide ranging variety of needs within a forensic mental health patient population mean that in order to assess, plan and deliver care, treatment, intervention and support for recovery, the teams which care for them have to be truly multidisciplinary. Organisations should therefore have in place mechanisms to assess the need of the populations they serve and to ensure availability, numbers and skills of staff required to meet those needs.

Standard 3.3 Criteria

Strategies should exist on three levels:

Long term

Should be centred on the clinical strategy of the organisation, the range and level of services they aim to provide. Aids to long term planning will include existing work on demographic information (Butler) guidance on staffing in forensic mental health services (Kennedy) and large scale needs assessment (Thompson)

Medium Term

To ensure the availability of skills and resources that may require to be developed, redeployed or sourced externally. Aids to medium term planning will include monitoring reports to governance bodies detailing trends in patient population and needs.

Short Term

To provide a response to immediate care issues and ensure the safety and security of the environment. Dynamic risk assessments should be in place, which drive immediate responses to changes in need. Aids to short term planning will include local management reports and responsive arrangements to identify activity and needs on a daily or even more frequent basis.

Organisations should also plan and deliver support and development opportunities to their staff. As well as contributing to medium and long term manpower strategies it is also important to ensure that there is adequate support for staff working in a potentially stressful and challenging area

The organisation is able to demonstrate capture and use of appropriate key performance data on assessment of need and delivery of treatments/ interventions (e.g. waiting times). They should also be able to show that this data is used in the formulation of their medium and long term workforce plans.

The organisation is able to demonstrate that it is regularly liaising with external organisations for the purposes of ensuring effective joint working with local partner organisations, or for examining others and own practice to benchmark and improve quality

Standard 3.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Standards, Governance & Audit	
• Audit reports • Workforce plans • Reports to Governance body • Staffing establishment data	• Key performance indicators • Organisational chart including governance • Service development proposals • Job descriptions
Risk Management	
• Risk Register & reviews	• Corporate Risk assessments
Policies & Procedures	
• Recruitment and selection policy (professional registration) • Observation policy (day to day staffing)	
Links, Liaison & Benchmarking	
• Secondments (both out of and into the organisation)	

Standard 4 Maintenance of Detention

Standard 4.1 Statement:

Medium Security Forensic inpatient services will have in place a range of appropriate physical and procedural security measures to manage the risk of escape and subsequent adverse consequences. These should be proportionate to the level of risk posed by the patient population and take account of the impact these measures have on the rights of patients, visitors & staff, and on patients' quality of life.

Standard 4.2 Rationale:

Medium security forensic inpatient units must maintain the detention of their patients as part of their duty of care to the patient, staff members and the public in general, including carers, previous and potential victims.

Patients in the forensic mental health system are at risk of non-compliance with aspects of their care and treatment. If a patient escapes from an inpatient facility, they no longer have the support of the environment, staff and medication and could suffer rapid deterioration, with potential for an increased danger to themselves and the public.

Physical and procedural security measures support staff members in maintaining the detention of forensic mental health patients. This should reduce the risk of violence to staff in enforcing detention or in returning patients who have escaped.

The public has to expect that patients who have been placed under orders of detention in secure environments will be detained. Carers are entitled o expect that patients will be detained for the appropriate time to enable treatment and ensure that the patients' return to the community will be safe for all concerned, including that patient. Victims and potential victims also have the right to expect to be protected from the offending behaviours that forensic patients could display if they are in the community prematurely.

Detention is conducted in the context of the legal framework of the Mental Health (Scotland) Act, Criminal Procedure (Scotland) Act and the Human Rights Act. Therefore, the measures in place to maintain detention and prevent escape should be proportionate to the risks posed by the patient population.

Patients assessed as requiring a medium security environment:

- may pose a high risk of opportunistic attempts, but are less likely to combine all of the elements of planned escape; and
- will not be a serious and immediate danger to the public; and
- a sophisticated and assisted escape attempt is unlikely.

Standard 4.3 Criteria

In addition to the over arching principles the following criteria exist in this standard.

- There are named individuals with specific security responsibilities & specialist knowledge is available.

- It is part of the risk assessment and management of the patients to consider the likelihood of escape attempts. Specialist advice is sought.

- The secure perimeter may be formed by the outside wall of a building or courtyard but is of sufficient build quality to withstand a concerted effort to escape.

- The windows and doors of any facility where the perimeter is formed by a building housing patients is of an appropriate standard to prevent smuggling items to facilitate escape (see control of items)

- The secure perimeter and linked procedures detect and delay any escape attempt for a period that allows the effective deployment of sufficient resources to manage the incident.

- A combination of the following factors is in place to ensure escape risk is minimised:

    - Barriers, e.g. secure perimeter fence / wall
    - Locked / secure doors and windows
    - High / robust build quality
    - Perimeter detection systems
    - PA Alarm system
    - Radio network
    - Handheld metal detectors

- Each technical system or item of equipment is supported by a Maintenance contract with associated maintenance records showing testing and calibration. Procedures exist for operation of each system or item of equipment under all conditions as detailed above.

- Training is given for full use of all systems and equipment, this being regularly updated and competence re-assessed.

Standard 4.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Policies & Procedures	
• escape & attempted escape • use of all equipment to prevent escape • monitoring equipment performance • monitoring patients in grounds • maintaining up to date patient descriptions & photographs • accounting for all patients	
Equipment:	
• Observation • Procedures for use, activation, calibration / testing	• Records of use, activation, calibration / testing • Maintenance contract & records • Training records

Standard 5 Suspension of Detention (previously Leave of Absence)

Standard 5.1 Statement:

Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk of absconding and subsequent adverse consequences proportionate to the level of risk and effect of the measures on the rights of patients, visitors and staff, and on patients' quality of life.

Standard 5.2 Rationale:

Suspension of detention is a term used to describe any movement by a patient outside the hospital providing detention.

In common with the rationale for maintenance of detention, forensic inpatient services have a duty of care to the patient, staff and the public in general. Suspension of detention is a necessary function of forensic inpatient services in order to facilitate aspects of patient treatment and rehabilitation, in medium secure care most patients will be preparing for safe transfer to conditions of lesser security and eventual care in the community.

This requires graduated testing out with carefully graduated increases in freedoms. In such circumstances patients wouldn't be given suspension of detention until it was assessed that the risk they pose to others should they abscond, is low.

In addition, an exceptional suspension of detention may be arranged by a service on compassionate grounds, to provide acute care services, or to progress legal processes. These exceptional suspensions of detention may be arranged prior to a low assessed risk and therefore additional controls in the form of procedural safeguards are required.

The arrangements necessary to facilitate a suspension of detention are in place in order to prevent the patient absconding from the service and to ensure that the suspension of detention is successful in its aims: that the patient's treatment is progressed; the acute care is provided; the court appearance is made and that public protection is maintained. In medium security these measures may, in rare circumstances, include police liaison and a high number of nursing staff; Most suspension of detention will involve a low staffing level or unescorted suspension of detention in the local area, as clinical risk assessments will suggest that, although absconding is a possibility, any risk to the public is low.

As a patient moves from a higher level of security it is likely that they will be involved in much more suspension of detention, as being unable to access the community would be disproportionate, and as the clinical team use a community environment to facilitate more rehabilitation and risk assessment. This increases the chance of absconding, but only with patients judged to pose a lower level of danger to the public and themselves.

Standard 5.3 Criteria

In addition to the over arching principles the following criteria exist in this standard.

Units providing low or medium security that also have very low levels of absconding should examine their practice to ensure they are not being disproportionately restrictive.

In each case, a full multidisciplinary risk assessment should take place within the context of a suspension of detention policy and procedure. The management plan that arises from the risk assessment should ensure that measures taken to prevent absconding are proportionate to the level of risk.

There are named individuals with specific security responsibilities & specialist knowledge is available.

Equipment that may be necessary for Suspension of detention may include:

- Vehicle
- Mobile Phones
- Radios

All equipment is, when necessary, supported by a Maintenance contract with associated maintenance records showing testing and calibration. Procedures exist for operation of all equipment under all conditions as detailed above. Training is given for full use of all equipment, this being regularly updated and competence re-assessed.

Standard 5.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Standards, Governance & Audit
• Suspension of detention Key Performance Indicators
Risk Management
• Risk assessments of suspension of detention & individuals
Policies & Procedures
• Suspension of detention policy including individual risk assessment by clinical teams • Suspension of detention policy includes arrangements for Schedule 1 & Sex offenders • Suspension of detention policy includes assessment of suitability of location • Procedure for absconding or attempt including notification to police • Exceptional suspension of detention policy

Standard 6 Management of Violence

Standard 6.1 Statement:

Medium security forensic inpatient services will have in place appropriate physical and procedural measures to manage the risk of harm to persons through aggression or violence.

Standard 6.2 Rationale:

Patients in forensic settings may have a previous history of violence, and may have been admitted to forensic services because of violence or aggression. Patients in forensic settings may also have an increased incidence of mental illness combined with substance abuse, thus increasing the risk of violence. Offending behaviours & previous histories may include serious & sustained violence and use of weapons.

The therapeutic aim of inpatient forensic services is to address violent, aggressive & offending behaviour; in addition, organisations have a duty of care to ensure all reasonable efforts are made to reduce the risk to patients, staff, visitors & the public from violence & aggression.

Approaches to minimising violence and aggression must reflect most recent guidelines & research on the management of violence. Although forensic settings may differ in the potential severity and frequency of aggression and violence, and the measures taken may also differ, (for instance the quality and response to alarm systems) the domains in these guidelines are valid.

Standard 6.3 Criteria

Approaches to minimising violence and aggression must recognise the wide range of causative factors and minimisation techniques.

The organisation has taken account of guidance including, but not limited to:

- Royal College of Psychiatrists (RCPsych) *Management of Imminent Violence guidelines;* and
- NHS in England and Wales National Institute for Clinical Excellence Guidelines (NICE) on "*the short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments*".

RCPsych emphasise:

- ***Ward design & organisation***
    - Calming features & ensuring a secure environment
    - Activities
    - Day accommodation
    - Protocols for effective care environments
    - Policies for effective care environments
- ***Anticipating & preventing Violence***
    - Responsibilities of staff and management
    - Risk assessment and action to anticipate and de-escalate violence
    - Reasons for using restraint
    - Training for restraint

- Protocol for seclusion (as the last resort)
- Policy issues relating to restraint and seclusion

- ***Use of medication***

  - Rapid tranquilisation & protocols for use
  - Avoiding high doses & polypharmacy
  - Auditing emergencies

NICE emphasise:

- Environment, organisation and alarm systems
- Prediction (antecedents, warning signs and risk assessment)
- Training
- Service user perspectives, including those relating to ethnicity, gender and other special concerns
- Searching
- De-escalation techniques
- Observation
- Physical intervention
- Seclusion
- Rapid tranquillisation
- Post-incident reviews
- Emergency departments

The "Zero tolerance" campaign is endorsed by the organisation and publicised, including notices to patients and visitors

The organisation has in place a range of equipment to minimise the risk from violence and to provide support to staff, patients and visitors. These may include:

- CCTV
- Handheld Metal detectors
- PA Alarms

Procedures exist for operation of all equipment, which is, when necessary, supported by a Maintenance contract. Training is given for full use of all equipment, this being regularly updated and competence re-assessed

Standard 6.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17.

Risk Management	
• Risk assessments of individuals and general risk of violence	
Policies & Procedures	
• Risk assessment • Observation • Medication & emergency tranquilisation • Seclusion • Searching • "Zero Tolerance"	
• Evidence of "Zero tolerance" including Notices in reception, patient areas etc	•
Equipment:	
• Observation • Procedures for use, activation, calibration / testing	• Records of use, activation, calibration / testing • Maintenance contract & records • Training records

Standard 7 Excluded Items

Standard 7.1 Statement:

Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk associated with the introduction of potentially harmful items or substances proportionate to the level of risk & the effect of the measures on patients, visitors & staff rights, and the effect on patients quality of life

Standard 7.2 Rationale:

Excluded items are excluded because their makeup or properties are hazardous. This may be because:

- they could be used to harm others;
- could be used in attempts to escape;
- because of their harmful properties (such as drugs or alcohol);or
- their intrinsic illegality such as child pornography or drugs.

As a number of patients within medium security units may have histories that include offending or exploitative behaviours, exclusions may include items used to trade & encourage criminality such as pornography. The potential for patients or carers to be coerced into bringing excluded items in, may also exist and should be addressed.

Standard 7.3 Criteria

- Efforts to ensure excluded items are not present should include ensuring patients and visitors are aware of the exclusions, and of the efforts that may be made to enforce the exclusions.

- Efforts may include handheld metal detectors, drug detection equipment & searches of patients and areas; each of these needing to be considered and proportionate measures taken.

- The organisation has reception arrangements that include Lockers / secure storage for visitors & staff

- At local level, staff have Hand held metal detectors available. CCTV covers reception.

- Procedures exist for operation of all equipment, which is, when necessary, supported by a Maintenance contract. Training is given for full use of all equipment, this being regularly updated and competence re-assessed

Standard 7.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17.

Risk Management	
• Risk assessments for excluded items	
Policies & Procedures	
• Policies and procedures for searching patients and areas • Policies for detection measures to detect drugs / weapons • Policies to assess danger of items, maintain "excluded items" list, search areas and individuals • Substance abuse policies that address prevention and detection	
Equipment:	
• Observation • Procedures for use, activation, calibration / testing	• Maintenance contract & records • Training records • Records of use, activation, calibration / testing

Standard 8 Control of Restricted Items

Standard 8.1 Statement:

Medium security forensic inpatient services will have in place appropriate procedures to manage the range of items and substances that require controls on their availability, use and storage in order to manage the risks they may present. These measures will be proportionate to the level of risk presented and the effect they have on the patients, visitors and staff rights, and patient quality of life.

Standard 8.2 Rationale:

Similar to excluded items, restricted items are those that are restricted because their makeup or properties are hazardous. This may be because they could be used to harm others, or be used in attempts to escape. As a number of patients within forensic units may have histories that include offending or exploitative behaviours, restrictions may include items used to trade & encourage criminality such as pornography. The potential for patients or carers to be coerced into bringing restricted items in may also exist and need to be addressed.

Items may be restricted but not excluded because they can be valuable tools in encouraging normalisation and resisting institutionalisation, providing diversionary, recreational, educational, social and rehabilitative value.

Access to some restricted items is a necessary function of forensic inpatient services in order to facilitate aspects of patient treatment and rehabilitation

In medium secure care most patients will be preparing for safe transfer to conditions of lesser security and eventual care in the community. This requires controlled exposure to restricted items that may be freely available in the destination setting, with carefully graduated increases in freedoms. This must be in the context of risk assessment of the individual patient and the restricted item to be considered.

Standard 8.3 Criteria

Forensic services must have measures in place to assess the risk from items both generally in relation to the item, and specifically in relation to individual patients. Measures taken and policies & procedures must demonstrate proportionality, balancing realistic assessments of risk with the therapeutic benefits of the item.

Efforts to ensure restricted items are not present should include ensuring patients and visitors are aware of the restrictions, and of the efforts that may be made to enforce the restrictions.

Efforts may include handheld metal detectors; and searches of patients and areas, each of these needing to be considered and proportionate measures taken.

At local level, staff have hand held metal detectors available.

Procedures exist for operation of all equipment, which is, when necessary, supported by a maintenance contract. Training is given for full use of all equipment, this being regularly updated and competence re-assessed

Standard 8.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17.

<table>
<tr><td colspan="2">Risk Management</td></tr>
<tr><td colspan="2">• Risk assessments of restricted items and individuals</td></tr>
<tr><td colspan="2">Policies & Procedures</td></tr>
<tr><td>• Use of tools
• Cameras
• Recording equipment</td><td>• Cutlery
• Sewing equipment
• Sharps</td></tr>
</table>

Standard 9 Communication and Technology

Standard 9.1 Statement:

Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk of criminality or harm to persons through communication media (physical, electronic, verbal communication) proportionate to the level of risk and the effect of the measures on the rights of patients, visitors and staff, and the patient's quality of life.

Standard 9.2 Rationale:

Communication media is a rapidly expanding field, with technological advances creating more ways of communicating and more complex communication devices. Items & technologies considered include, but are not limited to,

- Mail
- Telephones (land lines and mobiles)
- Computers (desktop, laptop, palmtop & PDAs)
- Mini hard drive or electronic memory devices (Digital cameras & MP3 players)
- Video & DVD players and recorders
- Electronic games
- 2-way radios
- Email
- The internet

These items & technologies can be valuable tools in ensuring contact with family friends and the wider community, encourage normalisation and resist institutionalisation, provide diversionary, recreational, educational, social and rehabilitative value. Conversely, they could be used singly or in combination, to:

- arrange or introduce risk situations or items that threaten victims, witnesses & others;
- arrange drugs, weapons etc;
- arrange escape;
- arrange criminal activity;
- store & transfer data including pornography;
- transfer items through mail;
- coordinate activity within unit;
- access pornography; and
- access information on the creation of weapons / terrorism / other threats.

Standard 9.3 Criteria

Forensic services must have measures in place to assess the risk from items and technologies, both generally in relation to the subject, and specifically in relation to individual patients. Measures taken and policies & procedures must demonstrate proportionality, balancing realistic assessments of risk with the therapeutic benefits of these technologies & items.

Procedures exist for operation of all equipment, which is, when necessary, supported by a Maintenance contract. Training is given for full use of all equipment, this being regularly updated and competence re-assessed

Standard 9.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Risk Management
Risk assessments of communication media & technology
Policies & Procedures
• Telephone policy • IT policy • Video game policy • New technology policy

Standard 10 Movement of Personnel

Standard 10.1 Statement:

Medium security forensic inpatient services will have in place appropriate procedures to manage the risks created by the movement of patients, visitors and staff proportionate to the level of risk posed, and the effect of those measures on the rights of patients, staff and visitors, and the patients quality of life.

Particular care will be taken regarding child visitors the welfare of the child must be paramount in any decisions about child visits. Particular care must be taken in any child visiting policy to include close liaison between mental health services and social work, and to fulfil all statutory requirements with regard to child protection.

Standard 10.2 Rationale:

Medium security services will exercise a level of control to ensure that risk is minimised when individuals move around the unit. This may be associated with risk of self-harm, escape, movement of items, hostage taking, concerted activity, criminality or violence.

Locations of individuals within the unit will be known at all times, though patients will access grounds or community unsupervised, with general limits on their location.

Standard 10.3 Criteria

The organisation has in place the necessary equipment and systems to minimise risks associated with movement of personnel. These may include:

- Manned reception with controlled entry
- Barriers
- CCTV
- PAAs
- Electronic locking
- Locked doors

Procedures exist for operation of all equipment, which is, when necessary, supported by a maintenance contract. Training is given for full use of all equipment, this being regularly updated and competence re-assessed

Standard 10.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraphs 6 to 17 above.

Policies & Procedures	
• Suspension of detention • Escorted Patient movement • Unescorted patient movement • Staff movement • Patient Visitor movement • Other visitors movement • Child visiting policy	
Equipment:	
• Observation • Procedures for use, activation, calibration / testing	• Records of use, activation, calibration / testing • Maintenance contract & records • Training records

Standard 11 Contingencies

Standard 11.1 Statement:

Forensic inpatient services will have in place appropriate contingency plans to manage the impact of a range of events, which although low likelihood, can be expected to occur at some time in the life of the service. Many of these plans will be drawn up in collaboration with other agencies (e.g. fire service, police)

Standard 11.2 Rationale:

All services are vulnerable to incidents that may interrupt normal business; Forensic services are vulnerable to some types of incident that would be unlikely in services that do not combine detention with other objectives.

When incidents occur, organisations must have in place systems and processes to manage incidents, if not properly managed, they may result in loss of public confidence in the organisation, loss of assets and unnecessary proliferation of loss.

Standard 11.3 Criteria

Organisations should plan and prepare an organised response to all major incidents and emergency situations that affect the provision of normal services. The organisation should have emergency planning arrangements which are in compliance with NHS guidance (*NHSiS manual of guidance responding to emergencies*) and which have been devised in liaison with key stakeholders.

Medium Security forensic inpatient services must also consider responses to escape attempts and absconding.

The organisation has a range of Contingency plans for a range of events including:

- Escape
- Absconding
- Fire
- Major service / utility disruption
- Equipment failure

Standard 11.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at paragraph 6 to 17 above.

Standards, Governance & Audit	
Contingency plans for: • Escape • Absconding	• Fire • Rooftop protests • Major service / utility disruption
Risk Management	
• Risk Register & reviews assessing events and associated risks	Risk assessments for individual events
Policies & Procedures	
• Policy for review of contingencies • Related to individual contingencies	

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 patients 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)

Constitution:

Meet quarterly, but in close contact between meetings – identify executive officers that meet more regularly and managed operationally by Clinical Lead and Project Manager. The group should decide its own ways of working at its first meeting.

Role in Conflict Resolution Process:

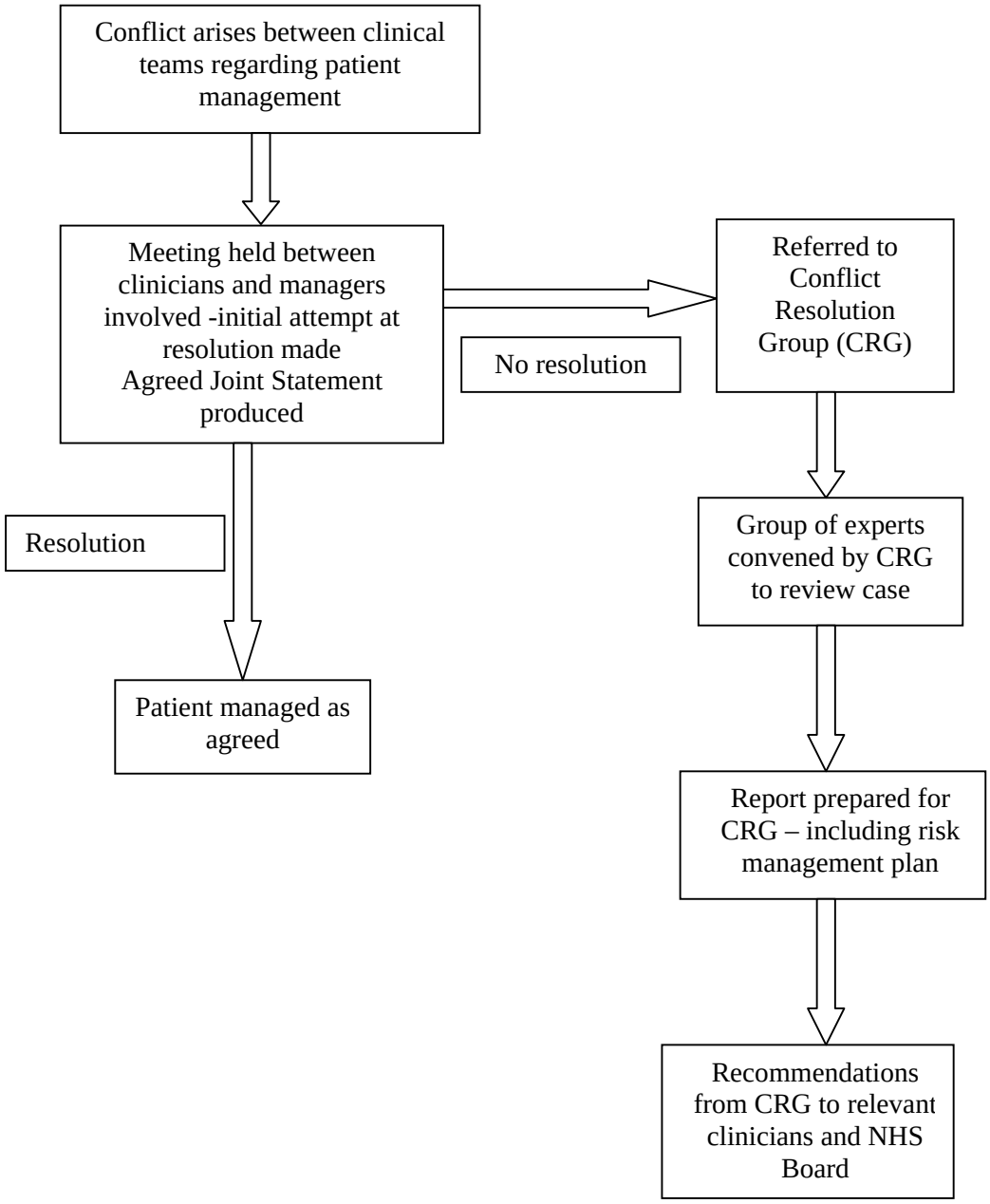
Allocate Experts to cases
Instruct experts
Decide who convenes experts
Receive report from experts
Question experts or agree report

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.



Annex D

FORENSIC MENTAL HEALTH SERVICES AND SCOTTISH PRISON SERVICE SECURITY LIAISON

Introduction

1. One important source of admission to forensic services is from the Scottish Prison Service, and closer liaison and awareness in both services of each others security assessments is desirable. In addition, security intelligence should be available to admitting clinical teams so that a safe level of security can be identified.

2. The Scottish Prison Service exists for a very different purpose to Forensic Mental Health Services, however sometimes they can look and sound the same, using similar terminology to mean different things.

3. The key aims of the SPS are

- To keep in custody those committed by the courts;
- To maintain good order in each prison;
- To care for prisoners with humanity;
- to provide prisoners with a range of opportunities to exercise personal responsibility and to prepare for release; and
- To play a full role in the integration of offender management services

4. Forensic Mental Health Services will reflect the principles and values in "Health, Social Work and related services for Mentally Disordered Offenders in Scotland"(NHS MEL (1999) 5) which adopted the "Reed" Principles that mentally disordered offenders should be cared for:

- with regard to quality of care and proper attention to the needs of individuals;
- as far as possible in the community rather than institutional settings;
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life; and
- as near as possible to their own homes or families if they have them.

5. These two sets of aims clearly demonstrate the different approaches. Both organisations have similar aims in terms of care and security, but have traditionally placed perhaps different emphasis on particular elements. The most commonly used terminology to discuss differing security approaches to individuals are high, medium and low. These again have differing meanings to the two organisations. In health, high, medium and low refer to levels of risk and of security provided by units, with the underpinning assumption that as a patient is assessed as moving from high to low risk, they should move from a high security unit to a low security unit.

6. The Scottish Prison Service (SPS) estate is not divided into high, medium and low levels of security; those establishments providing higher levels of security may also have prisoners there because of the length of their sentence rather than assessed risk. High, medium and low are applied as supervision levels to an individual prisoner within the establishment.

7. The SPS supervision levels, the Levels of Security matrix and the work of Kennedy (Kennedy H.G. (2002) Therapeutic uses of security: mapping forensic mental health services

by stratifying risk**.** *Advances in Psychiatric Treatment*, **8**, 433-443) can be mapped across as at Appendix III. This is potentially useful for services to compare approaches and also to highlight areas of difference when using apparently common language.

Way Forward

Protocol for referral and transfer from SPS to Forensic Mental Health Services.

8. A protocol has been developed under which the SPS visiting psychiatrist, SPS intelligence staff and Health Centre staff should discuss and agree the referral route and relevant intelligence information to be shared as part of the referral. It is attached as Appendix I.

Protocol for return to SPS from Forensic Mental Health Services.

9. Returns to the SPS should take place under Care Programme Approach (CPA) arrangements. This second this protocol provides reminders about key areas of information of use to the SPS. The diversity of CPA policies across different parts of the Forensic Mental Health system means a detailed protocol is impractical. Any reception to an SPS establishment is assessed under the prisoner supervision system and allocated a supervision level within 48 hours of reception. This decision will be informed by the CPA meeting and relevant intelligence. This protocol is attached as Appendix II.

Further Work

10. Further work in developing liaison arrangements between the SPS and NHS has been identified as follows:

- Preparation of a document mapping SPS and Forensic Mental Health Services organisations and key individuals with contact details

- Agreement of arrangements for sharing intelligence about individuals or organisations out with referral and transfer.

- Creation of a Forensic Mental Health Services Security Operations group to link with the SPS Operations Managers Group.

- Preparation of a basic information booklet dealing with the interface between the SPS and the NHS including the protocols and the products of the work programme above

- Creation of a regular Information Sharing Group to combine Forensic Mental Health Services and SPS Network Board representatives and operational staff from both organisations (to consider changes of model of risk or security; significant service developments; critical incidents and reviews; quality of Information; relevant or appropriate research and audit; delays, misunderstandings and problems; key Personnel changes).

11. This work will be taken forward by the Forensic Network in conjunction with the SPS.

Appendix I

PROTOCOL – PRISONER BEING REFERRED FROM SPS TO FORENSIC MENTAL HEALTH SERVICES UNDER THE TERMS OF THE MENTAL HEALTH ACT

1. If a prisoner is identified as likely to require transfer under the Mental Health Act, the SPS Healthcare Manager will arrange for the visiting consultant psychiatrist to see the prisoner and convene a case conference for the same day/session, giving 3 working days notice if possible.

2. The following will be involved and will arrive prepared with relevant information

- Visiting Consultant Psychiatrist
- Healthcare Manager – prisoners medical history
- Residential Unit Manager – prisoners sentence management details
- Intelligence Analyst/Security Manager – prisoners security and intelligence records

3. The case conference will consider all necessary aspects of the prisoners/patients situation including known security concerns. The Intelligence Analyst will pass on all relevant information (or the gist of such information, if the detail is prejudicial to third parties or security). The visiting consultant psychiatrist will decide on the most appropriate referral, based on the feedback received from case conference members.

4. A record of the case conference, including risks (prepared in a manner that can be fully disclosed to the prisoner/patient) will be prepared by the Healthcare Manager and will form part of the referral, and ultimately, documentation accompanying the prisoner/patient.

Appendix II

PROTOCOL – PERSON BEING REFERRED FROM FORENSIC MENTAL HEALTH SERVICES BACK INTO SPS CUSTODY

1. The decision that a patient is deemed suitable for transfer will be supported and informed by multi-professional assessment by the Forensic Mental Health Service. Ideally, this assessment should include the ongoing involvement of SPS healthcare services. When a patient is identified as likely to transfer to prison, the Forensic Mental Health Service will convene a case conference giving 3 working days notice if possible.

2. The following will be involved and will arrive prepared with relevant information.

- Responsible Medical Officer
- Forensic Mental Health key worker, case manager or CPA coordinator
- SPS Residential Unit Manager
- SPS Healthcare Manager, Clinical Manager or Mental Health Nurse

3. The case conference will consider all necessary aspects of the patient's situation including known security concerns. The RMO will pass on risk assessment, risk management, treatment and care plans and other information (or the gist of such information, if the detail is prejudicial to security or third parties). This will be supported and informed by the Forensic Mental Health key worker, case manager or CPA coordinator.

4. The SPS Residential Unit Manager will, based on feedback received from case conference members, decide on the most appropriate location and care regime for the patient and discuss a suitable transfer date. This decision will be supported and informed by the Healthcare Manager, Clinical Manager or Mental Health Nurse.

5. A record of the case conference, including risks (prepared in a manner which can be fully disclosed to the patient) will be prepared by the Forensic Mental Health key worker, case manager or CPA coordinator and will form part of the documentation accompanying the patient.

Appendix One

General Descriptor	SPS Supervision Definitions		SPS Supervision Flowchart		Kennedy – Table 1 & 3	Kennedy – Table 2	Security Matrix – Forensic Network	
							Physical	Procedural
High	All Activities and movements require to be authorised, supervised and monitored by prison staff	All have implications for sentence planning: appropriate establishment, location within establishment, planning of offending behaviour programmes, work placements, timescale of transfer to open conditions and security measures if out with establishment	Any of 1 – 4 + "yes" requires HIGH supervision. Any of 5 – 10 + "yes" requires MEDIUM supervision. None of 1 – 10 = "Yes" requires LOW supervision	1. Within 12/12 of sentence of 4 years or over for a serious assault (Placement in long term prison)	Homicide, stabbing penetrates body cavity, Fracture Skull, strangulation, serial assaults	Immediacy – unpredictable=, inaccessible to staff	Range of physical factors including differences in construction of perimeter, type of access control, guild standard, alarm, detection and observation systems and other technology and equipment	Range of procedural factors including differences in Pt access to communications, degrees of restriction or prohibition of items, control of patients visitors and movement, degree of access to community facilities and likely incidents and contingencies
				2. Previous history of serious violent offending within past 3 years	↓	Specialist Forensic Need – sadistic paraphilias associated with violence		
				3. Means and willingness to escape, now or a history of behaviour in last 2 years	Move from HIGH to MEDIUM Security: Stability – 2 years, possibility of abrupt relapse Insight – accepts legal obligation to take prescribed medicine Rapport – Tolerates daily intuitions and constriction Leave - none	Absconding – can co-ordinate outside help, prev h/o absconding from M or H security		
				4. Means and willingness to organises serious indiscipline eg drug dealing		Public Confidence Issues – national notoriety		
					↓			
Medium	Activities and movement are subject to locally specified limited supervision and restrictions			5. Previous involvement in violence or fear including behaviours in last year (in prison)	Use of weapons to injure, arson, concussion or long bone fracture, sexual assault, stalking with threats to kill	Immediacy – relapses abrupt and unpredictable		
				6. Current substance abuse	↓	Specialist Forensic Need – arson, jealousy, resentful stalking		
				7. Significant psychological/ psychiatric history in last year	Move from MEDIUM to LOW Security Stability – 1 yr, possibility of abrupt relapse Insight – accepts legal obligation to take prescribed medication, is supported by friends and family. Rapport – openness and trust with MDT, limited exploration of current mental state Leave – Regular escorted in grounds, occasional escorted community	Absconding – pre-sentence serious change other obvious motive		
				8. Serious outstanding charge		Public confidence issues – predictable, potential victims, local notoriety		
				9. Impulsive behaviour in past year				
				10. Likelihood of vulnerability in present location				
Low	Activities and movements specified locally are subject to minimum supervision and restrictions.*				↓	Immediacy – Acute illness or crisis liable to resolve in 3 – 12 months Specialist Forensic Need – Current mental state associated with violence, recall of prev H or M pt Absconding – impulsive absconding Public confidence – short term family issues		
					Repetitive assaults causing bruisising, self harm or attempts suicide that cannot be managed in open conditions			

*(and could include license conditions and unsupervised activities in the community).