

Independent Review into the Delivery of Forensic Mental Health Services

What we think should happen

Final Report

February 2021

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Message from the Chair of the Review

In May 2019 the Minister for Mental Health, Clare Haughey asked me to chair a Review into the Delivery of Forensic Mental Health Services in Scotland. I was delighted to accept this invitation and began work on the Review in June 2019. I would like to thank the Minister for giving me the opportunity to lead this important piece of national work.



I could not have done this without the support of my employer Erskine (the veterans' charity). They allowed me to be seconded one day per week to undertake the Review. I want to thank them for this support and to colleagues in Erskine who also took on additional work to allow me the time I needed to focus on the Review.

As a new Chair, I felt it important to meet with Chairs from other reviews to gain their insights into the role I was about to undertake. I am therefore grateful to the Chairs who gave me their time and shared their expertise. A key piece of advice they gave me was about the importance of the secretariat in supporting reviews. Throughout the Review I have been extremely fortunate to be supported by a secretariat team who have been tenacious and hardworking. Their dedication has been invaluable.

I would also like to acknowledge two other groups who have generously and warmly shared their time and expertise with me.

First, I was fortunate to have made a series of visits to forensic mental health wards across Scotland before the coronavirus pandemic put a stop to such face to face engagement in March 2020. My requests to visit were universally welcomed and thoughtfully planned out to ensure I met with people from the widest range of services. I had the privilege of meeting with staff and the people receiving care and treatment on these wards, as well as the families of those in hospital and people in community settings. Other people took the time to submit their thoughts to me in writing or meet with me individually. To each person who gave of their own time to share their views and opinions, I'd like to say: 'Thank you for your input, thank you for sharing your experiences'.

Second, the work of the Review has been ceaselessly supported by people who volunteered their time and expertise to be in one of our three working groups. These 64 individuals, representing 49 different organisations, have been essential in helping me get to the heart of the issues. Group members were always available to provide further information, clarify facts and spread awareness of the work of the Review. I would like to acknowledge their contribution and say thank you to each member for sharing their wisdom and knowledge. They have been open, generous and rightly challenging with their expertise, opinions and suggestions throughout the work of the Review. However, the final recommendations in this report were not agreed with them and therefore their active participation in the work of the Review does not signify endorsement of the outcome.

I have also pulled on the expertise of other people to gain a deeper understanding of specific issues and happily accepted a number of invitations to participate in conferences and group meetings to discuss the work of the Review.

All of these people have helped shape this report. I'd like to say thank you to everyone who took the time to engage with this important piece of work.

The Review published its interim report in August 2020.¹ It brought together what people had told the Review were the key issues and challenges in forensic mental health services in Scotland. This final report focuses on my recommendations for tackling the issues highlighted. The interim report identified two over-arching themes characterising the forensic mental health services in Scotland: system-wide variation and severe challenges around capacity and the transitions of people through the forensic. The current landscape of services has developed organically over the years, responding to local pressures and demands. As such, whilst its day to day operation is characterised by a great deal of hard work and good will, it fails to deliver a consistent rehabilitation pathway for the people within its care.

¹ Independent Review into the Delivery of Forensic Mental Health Services (2020) *Interim Report: What People Told Us*. Available at: <https://www.gov.scot/publications/independent-forensic-mental-health-review-interim-report/>

Systemic variation poses a challenge to joined-up working which, together with pressures on capacity, lead to inefficiencies and inequalities that could surely be avoided. For instance, I was more than a little surprised to learn that NHS Scotland as a whole spends millions of pounds a year in cross-charges for accommodating people out of area, while at the same time fails to charge for people from North Ireland being treated at the State Hospital. This variation is compounded by incomplete data collection and monitoring across the system, which prevents the degree of co-ordination and planning that would be appropriate to this relatively small and highly specialist set of services. My take-away impression has been that forensic mental health services are sorely lacking a central co-ordination and management function and are in need of a governance structure that can provide both the proper oversight and authority to effectively deliver change.

These over-arching structural problems cannot be divorced from their impact on the lives of people within the system. Informed by the PANEL principles (a human rights based approach of Participation, Accountability, Non-discrimination, Equality, Empowerment and Legality), I have endeavoured to place the voices of people with lived experience at the centre of my thinking and actions in chairing this Review. I visited multiple inpatient settings to speak with people receiving care and treatment and the family members supporting them. I have therefore heard first-hand experiences of the detrimental impact that systemic variation and limited capacity have on people's lives. I was saddened and disappointed to witness people's frustration at having transitions delayed by reasons of procedural bureaucracy or unit capacity rather than being determined by their clinical need. Also to hear of the uncertainty created by different restrictions being applied in units at the same security level, and to see examples of vulnerable people being forced to share dormitories in the 21st Century, was especially troubling for me given the length of time people can spend in forensic mental health services. In light of the restrictions placed upon people within the forensic system, it is vital that all services prioritise person-centred practices underpinned by a commitment to upholding human rights.

For some groups of people, my concerns are particularly acute. This Review has confirmed existing fears that arrangements to provide high secure care for women outwith Scotland are not fit for purpose, neither procedurally nor from a human rights perspective. We must make urgent arrangements to offer high secure care for women within our own borders.

In many ways, I feel that this Review has been a timely one. I have been confronted by a system that appears to be nearing the edge of crisis. Despite the efforts of the hard-working and committed staff in the NHS and supporting organisations, it feels like only a matter of time before some parts of the system give way under the pressure or are subject to legal challenge. Nonetheless, I wish to conclude on a point of optimism. Many of the people I have spoken with, including staff, individuals and their families, have expressed hope that this Review could offer an opportunity for meaningful change. It is also my hope that the recommendations in this report can guide the establishment of a forensic system that works holistically, with co-ordinated services that offer a smooth and consistent rehabilitative pathway for all the individuals in its care.

A handwritten signature in black ink, appearing to read 'D. Barron', with a stylized flourish at the end.

Derek T Barron, RMN, MSc, FQNIS
Director of Care, Erskine
Chair of the Review

Acronyms and abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CFMHT	Community Forensic Mental Health Team
COPFS	Crown Office and Procurator Fiscal Service
CPA	Care Programme Approach
ECHR	European Convention on Human Rights
FASD	Foetal Alcohol Syndrome Disorder
FCAMHS	Forensic Child and Adolescent Mental Health Services
IPCU	Intensive Psychiatric Care Unit
ISD	Information and Statistics Division of NHS National Services Scotland
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team
MoP	Memorandum of Procedure on Restricted Patients
NSAIS	National Secure Adolescent Inpatient Service
NSD	National Services Division of NHS National Services Scotland
PANEL	A human rights based approach of Participation, Accountability, Non-discrimination, Equality, Empowerment and Legality
SOLS	NHS Lothian's Serious Offender Liaison Service
STAR	NHS Greater Glasgow & Clyde's Specialist Treatment Addressing Risk service
SUS	Suspension of Detention
The Tribunal	Mental Health Tribunal for Scotland

Introduction

Background to the Review

In March 2019, the Minister for Mental Health announced an Independent Review into the Delivery of Forensic Mental Health Services. Derek Barron, Director of Care at Erskine was announced as the Chair to the Review in May 2019 and began work at the end of June that year.

This Review was not being asked to investigate a specific negative event. Rather, it was set up in recognition that there had been significant changes in the way forensic mental health services were being delivered, over a number of years. Changes included a decline in the number of people detained in levels of high security at the State Hospital, the development of medium secure services, the introduction of appeals against conditions of excessive security and plans for a National Secure Adolescent Inpatient Service for Scotland.

The Review's remit and purpose as set down in its terms of reference was to review:

- Strategic direction, ongoing oversight and governance arrangements;
- Demand, capacity and availability across the forensic secure estate;
- High secure provision;
- Community forensic mental health services;
- Forensic mental health services and the justice system; and,
- Forensic mental health services for client groups with particular needs.

The 'client groups' were people with a learning disability or neurodevelopmental disorder; women; children and young people; and older adults. The Review's full terms of reference can be found at Annex A: Terms of Reference

The Review was supported by a secretariat team that started work in July 2019 and three working groups that were established over the summer of 2019. The work of the Review was suspended from 17 March 2020 until 20 July 2020 to allow the Chair and its working group members to focus their efforts on responding to the coronavirus pandemic.

As a result of its work, the Review was expected to make recommendations for change or improvements. It was also expected to identify any legislative issues or the need for any further reviews.

The Review's working groups

In June 2019, the Chair wrote to organisations representing people receiving, delivering and monitoring forensic mental health services. He asked them to nominate people who were interested in making a positive difference to these services. These people had to have the time and expertise to join working groups to support the Review's work. In July 2019, 53 people representing over 45 organisations met with the Chair to discuss the work of the Review. They were then asked to join, or nominate others, to join one of the Review's three working groups. There was a hospital working group, a community working group and a criminal justice working group.

The membership of these groups remained fairly constant throughout the work of the Review. Across the three working groups, there were 67 members representing 49 organisations. The full list of members and the groups they represented can be found at Annex B: Working group members.

The Review held three meetings with each group. These took place in person in October 2019 and online in August 2020 and October 2020. The first meeting focused on the pathways within and around forensic services and the areas of concern within them. It also agreed the evidence that the Review needed to gather and the ways in which the working group members could support that. Working group members representing people receiving these services and their family and friends met separately with the Review in September 2019 to discuss the specific ways in which the Review could ensure these groups were reached and their voices were heard. These working group members then not only facilitated access to group sessions with people for the Review, but organised their own events to collate views on the Review's behalf.

Meetings of the working groups originally arranged for March 2020 were postponed in response to the coronavirus pandemic. These meetings subsequently took place online in August 2020 where working group members provided their feedback on the Review's interim report.

The final meetings were held online in October 2020. Working group members were asked for their thoughts on priority areas for change and their ideas for the potential solutions. The Chair also asked the representative for the Scottish Human Rights Commission for an analysis of the issues raised in the interim report, from a human rights perspective. The Scottish Human Rights Commission published this report in January 2021.²

From August until the end of December 2020, and throughout the earlier work of the Review, members continued to be available to the Review team for additional evidence requests.

The Chair and secretariat of the Review are indebted to the support provided to them by the working group members.

Background to this report

This is the second and final report of the Review.

The Review gathered evidence during its 'listening phase' which ran between August 2019 and February 2020. The Review sought the views of people in two ways. There was a formal call for evidence that ran from 14 October 2019 until 31 January 2020. The Review received 103 responses from 56 organisations and 47 individuals. Alongside these written responses, the Chair went out and met people receiving and delivering forensic mental health services. He visited 10 secure hospital sites where he met with 88 people with lived experience, 16 family members and 118 staff. Advocacy workers supported and amplified the voices of people with lived experience at a number of these visits. He also met with people individually and spoke at a number of conferences.

An analysis of the evidence received by the Review was published in August 2020. This interim report, *What People Told Us*, provides an overview of the key issues and challenges in forensic mental health services in Scotland as they are experienced by the people receiving and delivering them.³ Between August and

² Scottish Human Rights Commission, *Forensic Mental Health Review: Human Rights Briefing*. Available at: <https://www.scottishhumanrights.com/media/2154/forensic-mental-health-review-hr-framework.pdf>

³ Independent Review into the Delivery of Forensic Mental Health Services (2020) *Interim Report: What People Told Us*. Available at: <https://www.gov.scot/publications/independent-forensic-mental-health-review-interim-report/>

October 2020, the Review invited feedback on the report. This allowed people another opportunity to bring any issues to the attention of the Review. A further 20 written responses were made during this period and the Chair arranged and accepted invitations to meet with interested groups and individuals. The Review team continued to proactively gather further information to address evidence gaps until December 2020.

The full list of engagement activities and organisations who responded to the Review's public calls for evidence are listed at Annex C: Responses to calls for evidence and Annex D: Engagement activities supporting the work of the Review. As well as the formal responses to the consultation exercises, the Review has received and considered over 300 other supplementary documents including reports, articles, guidelines and responses to specific requests for information.

This report is informed by the evidence of the interim report and the additional evidence the Review has gathered since its publication. It identifies the key issues that the Review considers need to be addressed to improve the delivery of forensic mental health services in Scotland. It also makes a number of specific recommendations as to how this should be done.

In this report the term 'forensic mental health services' includes forensic learning disability services.

1 Principles

Shared principles and aims can contribute to a cohesive culture within forensic mental health services that will support people to have a smooth journey through the system. Two frameworks that the Review feels are particularly important in the context of forensic mental health services are those of the European Convention of Human Rights, encoded in the Human Rights Act 1998, and the Millan principles underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003. These frameworks are relevant to the care and treatment of all people with a mental disorder, but are particularly important in the context of forensic mental health services because the people in their care are subject to significant restrictions. It is therefore integral that forensic mental health services are underpinned by principles that minimise unnecessary restrictions, reduce the adverse impact of the restrictions that are required and maximise people's opportunities to move on from these restrictive environments.

1.1 Detention and people's rights

People in forensic mental health services typically have a history of serious offending. This means that, in addition to meeting people's individual care and treatment needs, forensic mental health services must fulfil a public protection role by managing the risk of harm that they may pose to others. As such, forensic inpatient care involves a deprivation of liberty and detention in a highly regulated and restrictive environment. This means that people in forensic mental health services can experience significant reductions in their freedoms, autonomy and self-expression.

Adopting a human rights approach to the design and delivery of forensic mental health means establishing a standard of treatment that respects the dignity of all the people within the system. The Human Rights Act 1998 incorporates the internationally recognised standards from the European Convention on Human Rights (ECHR) into domestic law. Article 3 of the ECHR establishes a right to be free from torture or inhuman or degrading treatment or punishment. This means that if people are detained then they must be in conditions compatible with respect for human dignity. This includes receiving appropriate medical care and treatment if they have a mental disorder. Article 5 of the ECHR enshrines people's right to liberty

and security. This means that people cannot be detained without reason and that deprivations of liberty must not be arbitrary, disproportionate or unjustified. It is permissible to detain mentally disordered offenders for treatment within forensic mental health services. However, those services must guard against any infringements of people's liberty that are not a necessary part of their care, treatment and risk management. Article

Similarly, whilst the Mental Health (Care and Treatment) (Scotland) Act 2003 contains powers to place people under compulsory detention, it is also clear that such detention is only permissible if there is treatment available that might stop the person's condition getting worse or that might lessen their symptoms and help them to manage them better.

Decision-making about people detained in forensic mental health services should follow the least restrictive option. This is one of the Millan principles:

*Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.*⁴

The least restrictive option is especially important in forensic settings because of the length of time people can spend within these services. Following this principle when making decisions about people's care helps to minimise the impact of detention on their freedom, autonomy and self-expression.

1.2 Reciprocity, rehabilitation and recovery

Forensic mental health services must be underpinned by a principle of reciprocity.

Reciprocity is another of the Millan principles which states that:

*Where society imposes an obligation on an individual to comply with a programme of treatment of care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.*⁵

⁴ Millan report (2001) *New Directions: Report on the review of the Mental Health (Scotland) Act 1984*. Available at: https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

⁵ Millan report (2001) *New Directions: Report on the review of the Mental Health (Scotland) Act 1984*. Available at: https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

People within forensic mental health services are compelled to undergo treatment and subjected to substantial restrictions on their freedom. The principle of reciprocity means that forensic mental health services must maximise each person's opportunities to achieve and demonstrate recovery and rehabilitation in order that they may cease to be subject to compulsion and restrictions in the future. It also means that when people have these requirements imposed upon them, then services must ensure that they are not subject to unnecessary restrictions or unduly delayed from moving on to conditions of lesser security.

The related goals of rehabilitation and recovery are important cornerstones in delivering a service which has reciprocity at its core. Rehabilitative work can involve medication, therapy and training or skills development to help people to reduce the negative impact of their mental disorder. In addition to treating symptoms, it also means working with the individual to reduce the risk they pose to themselves and others. Successful rehabilitation should give people a sense of control over their life, hopes for the future and opportunities to build a 'life beyond illness'. As such, rehabilitation can help a person achieve 'recovery', where they can *'pursue their own, unique, life goals in the presence or absence of continuing symptoms'*.⁶

Definitions of rehabilitation and recovery will depend upon the individual. For some, it may mean treatment of symptoms and demonstration of reduced risk, thereby enabling social reintegration with fully independent living in the community. For others it may mean adopting strategies to prevent further offending and supported living that maximises independence and agency in the context of ongoing risk management.

1.3 Person-centred practices

People in forensic mental health services should be treated with dignity and respect. This means that they should be recognised as individuals and that the approach taken to their care, treatment and risk management should reflect a holistic multi-disciplinary assessment of their individual needs and risks. As such, forensic mental health services should refrain from taking a 'one size fits all' approach to people at

⁶ Drennan and Wooldridge. (2014) *Making Recovery a Reality in Forensic Settings. ImROC Briefing Paper 10*. Available at: <https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/making-recovery-reality-forensic-settings.pdf>

the same level of security, nor should they make decisions based on single elements of a person's case, such as their index offence, in isolation from other factors.

Person-centred practice is central to the delivery of the principles outlined above. For example, the least restrictive option for an individual will depend on their unique history of risks, progress in treatment, and presentation. Similarly, rehabilitation activities must reflect individual strengths and weaknesses: whilst one person may need to develop confidence in life skills such as shopping, another might require opportunities to pursue further education or gain employment. These practices need the support of a skilful and experienced workforce who are empowered to adopt a flexible and individualised approach in their work.

Ensuring that people have opportunities to participate in decision-making is a central element of person-centred practice. Wherever possible, individuals should be involved in all aspects of their care. They should be supported to participate in assessments and inform the development of their care plans, as well as being given choices about how they conduct their day-to-day life. People should also have opportunities to participate in decision-making at service and system levels, for instance through involvement in the development of policies or the design and delivery of interventions.

None of these principles are new. Together with the frameworks we have drawn from, they will be familiar to all professionals working in forensic mental health services. They are highlighted here to underline the prominence they should have in the design and delivery of forensic mental health services and to offer readers insight into the thinking that underpinned the Review's recommendations.

RECOMMENDATIONS

2 Strategic governance and oversight

Governance is the way in which services are structured, sustained and regulated. It is about the strategic oversight, direction and co-ordination of those responsible for leading service provision. Accountability is a key component of governance. It is the subsequent process of holding service managers to account for their actions, decisions, policies and service administration.

The current configuration of NHS Scotland's forensic mental health services for inpatients developed from principles set down by the then Scottish Executive to NHS Chief Executives in 2006.⁷ It also reflects the three different levels of secure hospital provision described by the Forensic Network in its Security Matrix.⁸ As such, in general:

- High secure services are provided at a national level;
- Medium secure services are provided at a regional level; and,
- Low secure and community services are provided at a local level.

The different national, regional and local commissioning levels set down for the different services creates a varied governance landscape across forensic mental health services in Scotland.

There is a unique level of transparency, oversight and accountability around the operation of the national high secure service. This service is located at the State Hospital and is governed by its own Special NHS Board - the State Hospitals Board for Scotland.

There are three medium secure units providing regional services. These are: Rowanbank Clinic at Stobhill Hospital in Glasgow; the Orchard Clinic at the Royal

⁷ The Scottish Executive (2006) *Forensic mental health services* (NHS HDL(2006)48). Online: Scottish Government. Available at: https://www.sehd.scot.nhs.uk/mels/HDL2006_48.pdf

⁸ The Matrix of Security can be found at Appendix 3 of the Forensic Network's *Guidance on Patient Referral to or within Scottish High and Medium Secure Services*. It recognises that that low secure services need not always be provided in wards that meet the standards for low secure forensic locked wards, but can also be provided in intensive psychiatric care units (IPCUs) and locked rehabilitation and open wards. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Guidance-on-Patient-Referral-to-High-Medium-Security-FINAL.pdf>

Edinburgh Hospital in Edinburgh; and, Rohallion Clinic at the Murray Royal Hospital in Perth. NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside, respectively, provide these services as part of the overall health provision for which they are accountable.

The development and oversight of low secure and community services is then the responsibility of local territorial Health Boards and/or Health and Social Care Partnerships. The provision of these services in each area varies as it has developed in response to local need over time, with some areas providing no specific forensic mental health services. More detailed information about the available provision at each security level across Scotland is provided at Annex E: Forensic mental health inpatient provision.

Each governing body has different priorities, resources and population needs. This has led to a disparity of forensic mental health provision as they have each made resource allocation decisions that best meet their own circumstances. This is understandable but when looked at from a national perspective can present as an inequality of access to services depending on where a person lives. It also means that the forensic mental health services in Scotland are a collection of distinct services rather than one integrated system where a system wide view of services, standards and resourcing can be achieved.

The Forensic Network was created as the mechanism to support strategic oversight of these services in 2003. It aims to:

- bring a pan-Scotland approach to the strategic planning of forensic mental health services;
- address fragmentation and inconsistency across the estate;
- streamline patient pathways throughout the estate; and,
- determine the most effective care for mentally disordered offenders.

The ability of the Forensic Network to do this work is made difficult in two ways. First, it lacks operational authority, particularly with regard to strategic decision-making and management. As such, it does not have the power to require services to follow its guidelines or implement its recommendations for change. It also has to rely on voluntarily engagement with its data collection exercises. Second, it is located in the State Hospital. This is a clear source of tension and disengagement for people

working in other levels of security. People suggested that it tended to come up with 'grand plans' that would only ever work in the State Hospital. They felt that for it to be seen as independently supporting all parts of the forensic system, it needed to be separated out from the State Hospital both in governance terms and physically.

The Review's interim report presents strong views about the wide variation and gaps in existing governance, oversight, responsibility, protocols, practice and provision across the forensic mental health services. Even in areas where guidance was described as 'ample', inconsistencies in practice were still felt to prevail. People highlighted marked differences in service provision, ethos and experiences of care, as well as a lack of clear pathways for people to access the services they needed. Staff spoke about services at the same security level having different requirements for admitting people into their care. Variation was found not only in forensic inpatient and community services but in the degree to which the expertise of forensic mental health professionals was available to the criminal justice sector. The issue was summed up by one clinician who described the system as missing a 'central brain'.

People recognised that flexibility to respond to local need was necessary to deliver person-centred care. However, the differences in services highlighted to the Review were experienced more as inconsistencies, inequalities and frustrations by the people for whom these services were provided and the staff delivering them. Such differences mean that people's experiences and outcomes are affected by factors that are not related to their care needs or risk management requirements. There were calls for a more integrated approach to service development and resourcing rather than what was described as a 'postcode lottery' affecting care and treatment.

There are also concerns that forensic mental health services are not allocated the resources they need for service delivery and improvement. Staff raised concerns that a lack of understanding of the complexity and level of risk associated with these services at Board or Health and Social Care Partnership level can mean that they are deprioritised due to financial considerations rather than need. People also questioned the current distribution of resources across different parts of the forensic system. In particular, people expressed frustration about a lack of resources in low secure services and in the community. This was often linked to the idea that the State Hospital receives a disproportionate amount of funding. People felt that resource allocation across the services had not been changed to reflect that the

number of people in high security has reduced since the introduction of appeals against excessive security in 2006.

2.1 Creating a single system

The Review found general consensus that there is a need for greater strategic oversight and accountability across forensic inpatient and community services as a whole. The lack of oversight is one reason that led to this Review being necessary and it is important that this is not perpetuated in years to come. There was not, however, consensus on how this would best be achieved. Suggestions made to the Review included:

- greater use of service level agreements;
- Scottish Government guidance or bolstering the powers of the Forensic Network;
- further regional development of services;
- a national approach to minimum standards or service specifications; and,
- the replacement of the State Hospitals Board with a national body with a wider remit across forensic mental health services.

The Review recommends that a new NHS Board is created for both forensic inpatient and community mental health services. This will provide oversight of the whole forensic system. It will have the operational authority to commission and manage services. It will also provide the high level of transparency and accountability that is appropriate to mental health services involved in restricting people's liberty.

The Review is conscious that a national body is not universally supported. There are concerns that the complexity of the current system rules this out as an option or, at the very least, would present long-term challenges in implementation. There are fears that creating a national body could negatively impact on the flexible and creative ways of working required to meet the needs of people in care at regional and local levels. Further centralisation of the system was also seen as risking a 'drain-away' of regional talent or expertise from other parts of the system already struggling to attract staff.

The Review appreciates these concerns. Steps will need to be taken to mitigate against these potential risks. However, the Review is strongly of the view that the

creation of a single national Board presents the opportunity to bring together all the existing forensic mental health services into a new, integrated and co-ordinated forensic mental health system. This new Forensic Board will then be able to meaningfully address many of the issues identified in the interim report which the development of standards alone could not. These include:

- the allocation of resources;
- the management of capacity and transitions across the system;
- information sharing internally and with partner organisations;
- the development of a specialist workforce;
- the identification of strategic priorities; and crucially,
- the establishment of clear pathways into, out of and through the forensic mental health system for the people in its care.

As a former Integrated Joint Board Lead Nurse, and advocate of integration, the Chair is acutely aware that the recommendation to include community forensic mental health services within the new Forensic Board may not seem aligned to the current Scottish Government policy on health and social care integration. However, the forensic population is both small and highly complex, carrying a high degree of risk. These services are not best supported by non-specialist management. As such, the Review believes that integration would be best achieved through the creation of a single national forensic mental health system.

Recommendation

Recommendation 1: It is recommended that a new NHS Board should be created for forensic mental health services in Scotland.

- All forensic mental health services, including both inpatient and community services, should be brought under the management of this new Forensic Board.
- Forensic learning disability services at high and medium security should also be brought under the management of this new Forensic Board. The Review considers, however, that forensic learning disability services at low security and in the community should remain under the management of, or transition to management by, generic learning disability services (see Section 7.1).
- The new Forensic Board should not be based in the State Hospital. To do so would be to further alienate and disenfranchise clinicians and managers across the country who already perceive there is significant power, resources and focus sitting inappropriately at the high secure level. The new Forensic Board must demonstrate practical engagement with all of its new service areas. Serious consideration should be given to basing the Board outwith the central belt, or as a minimum not within Edinburgh or Glasgow.
- The new Forensic Board will supersede the role of the Forensic Network in providing strategic oversight of the forensic system. However, care should be taken to ensure that the Forensic Network's valuable role in advancing governance and professional networks within the forensic system is not lost during this transition, and is incorporated into the governance framework of the new Forensic Board where appropriate. The School of Forensic Mental Health should also be retained: its role is discussed further under Section 8.3 of this report.

3 Defining forensic mental health services

To establish a new NHS Board with responsibility for forensic mental health services, it will be important to establish the boundaries between what is and what is not forensic mental health care. This will need to be supported by clear pathways into and out of forensic mental health services, for example by indicating when people move between forensic mental health services and general mental health services or criminal justice services, and how they would do so. The interim report explained that people had varying views on who should or should not be on forensic wards. Some felt that due to budget constraints the bar for accessing forensic mental health services had been raised, meaning some people who require specialist forensic mental health care and treatment are not getting it. Others felt that the bar had been lowered. They felt that forensic mental health services were now expected to accept people with non-forensic challenging behaviour and less serious offending as there was no other service available.

Forensic mental health services are set up to provide care and treatment to ‘mentally disordered offenders and others requiring similar services’.⁹ Many clinicians who spoke to the Review felt any attempt to restrict definitions of ‘forensic’ to those who had been detained under a criminal section of the mental health legislation would not be fully representative of the work they do or that they should be doing. Some people wanted to move towards a more needs-based approach, with fewer rules about who could be managed in forensic mental health services, and to move away from the focus on diagnosis and offending history. There were also calls for placing more focus on early intervention and prevention. However, people acknowledged that any extension to the remit of forensic mental health services should be accompanied by increased resourcing. Without additional resource, services would become stretched, risking the quality of provision for the existing forensic population.

⁹ The Scottish Office described it as such in its policy framework for health, social work and related services for mentally disordered offenders in its NHS Management Executive Letter in January 1999 (MEL(1999)5). Available at: http://www.show.scot.nhs.uk/sehd/mels/1999_5.doc
This was in keeping with definition in an earlier Review of such services in England by Professor Reed in 1992 and aligns with the current definition of forensic psychiatry used by the Royal College of Psychiatrists. Available at: <https://www.rcpsych.ac.uk/members/your-faculties/forensic-psychiatry>

Forensic mental health services in some areas have already extended their remit to fill gaps and address the needs of populations where the skills of their specialist clinicians add a great deal of value. Examples include provision of consultation and advice to generic health colleagues and partner agencies (discussed in Section 8), and inclusion of people with a primary diagnosis of personality disorder under some community forensic mental health services.

The position of people with personality disorder illustrates many of the tensions involved in defining a forensic population. As outlined in the interim report, the Forensic Network's guidance on referral criteria for admission to high and medium secure services recommends that people with a primary diagnosis of personality disorders are not admitted. As such people with a primary diagnosis of personality disorder are generally only admitted to forensic inpatient care on a short-term acute basis or to establish a diagnosis. If a person with personality disorder commits an offence then they are typically routed through the criminal justice system and may go to prison. There is widespread concern that this arrangement leaves a large population of people with personality disorder in prison with unmet needs. Forensic psychologists have indicated they have an appropriate skillset to lead on care and treatment for this group. This raises questions about whether people with personality disorder should be reconsidered as part of the forensic population, or whether a solution lies in a particular role for the new Forensic Board to provide in-reach support to professionals working with this population.

The establishment of the new Forensic Board provides an opportunity to reimagine how forensic mental health services will be delivered in Scotland. As such, consideration of its remit and purpose should not be undertaken in a reductive way. Equally, it will neither be possible nor appropriate for it to be 'all things to all people'. A clear remit is necessary to establish the boundaries between forensic and general mental health services, and forensic mental health services and criminal justice services. This will bring greater transparency to gaps in provision that are not being met by either forensic mental health, general mental health or criminal justice services. These gaps must then be met.

Recommendation

Recommendation 2: The definition and purpose of 'forensic mental health services' should be reviewed by the Scottish Government at a multi-disciplinary, multi-agency level to help inform the establishment of the new Forensic Board.

4 Women's pathways

The interim report noted widespread agreement that current arrangements for women's forensic care in Scotland are inadequate. People spoke of a lack of 'joined-up thinking' and co-ordination at both national and local levels. The absence of agreed pathways and services for women creates difficulties accessing appropriate services at medium and low security. It can delay women's rehabilitation and progress into the community. It also makes it more likely that they will have to move away from their home Health Board to access appropriate care and treatment. In particular, the lack of high secure provision for women within Scotland was universally seen as unacceptable. The existing arrangements to access the high secure provision available in England were also described as very challenging.

After the publication of the interim report, the Review heard from clinical teams and relatives of women who had spent years being moved from service to service to try to access the care and treatment they needed. This included experiences of high and medium secure care in England. They expressed frustration, despair and anger at the 'lamentable lack of facilities for women'. They described how the distance of these placements from home disrupts relationships with family and friends. This has an adverse impact on the women's mental health. However, it also affects the wellbeing of their families, particularly if they have children.

In recognition of these issues, NHS Board Chief Executives commissioned the Forensic Network to complete a review of the Women's Service and Pathways across the Forensic Mental Health Estate in January 2018. The results of its options appraisals and recommendations for development for all three security levels were published in March 2019.¹⁰ A Short-Life Working Group was set up to take forward its recommendations, but the Chair of that group agreed to postpone its work until the outcome of this Review was known.

Forensic mental health services need to develop clear pathways for women from high secure through to community services. This must include agreed pathways in and out of secure care, including transfers from prison. Parity of provision with men

¹⁰ Forensic Network (2019) *Women's Service and Pathways across the Forensic Mental Health Estate*. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Womens-Report-Public.pdf>

must be developed for women throughout the forensic system. Such provision should respond to any differences in needs between men and women whilst ensuring consistency in relational, physical and procedural security between services. In particular, there is an urgent need to make high secure provision available to women within Scotland.

4.1 High security provision

There is no high secure facility for women in Scotland. The State Hospital had previously provided this but closed the service in 2007/8. It was closed on the grounds that there was little or no demand for high secure services for women in Scotland. There had also been public criticism of the significant costs of the service per person. Women requiring high secure care therefore are referred to Rampton Hospital in Nottinghamshire, England. The National Services Division of NHS Services Scotland (NSD) supports this pathway through a national risk share scheme that provides funding for cross-border forensic mental health care and treatment.

The number of women transferred to Rampton confirms that there is demand, but it remains small. Since 2011, NSD has paid £4.5 million to Rampton for the high secure care and treatment of four women from Scotland. In each year, Scotland has been using either one or two beds.

The Review heard evidence that the Rampton high secure pathway is not fit for purpose. One issue is that the cross border nature of the pathway does not allow for the transfer of women who are on remand or have outstanding charges. Any woman in this position, who is in need of high secure care and treatment, has to be cared for within the medium secure female estate in Scotland until decisions on their legal issues are reached. Another issue is that the referral process is not quick and does not always result in Rampton agreeing to accept the person. This can leave teams in medium secure units in Scotland continuing to look after women they consider require high secure care and treatment for long periods of time. These gaps means that women with high secure needs can be detained in seclusion in medium secure units and it is not possible for them to engage with other people in those circumstances. The Review is also concerned about difficulties repatriating women back to Scotland because everyone who has progressed from Rampton has done so by transferring to medium secure facilities in England.

The lack of high secure care for women in Scotland raises human rights concerns on the grounds of gender discrimination. Requiring women to transfer to England for high secure care when men receive it in Scotland creates inequalities in respect of the right to a private and family life as well as access to the appropriate level of care and treatment. Additionally, women receiving high or medium secure care in England have no right to appeal against their detention in conditions of excessive security in the way that they would have in Scotland.

There is agreement there should be high secure services for women located in Scotland. There is disagreement however as to how that should be done. The Forensic Network Women's Services and Pathways options appraisal narrowly recommended a national high secure service for women be developed through co-location of high secure within one of the existing medium secure units. The second-placed option was to develop a women's service within the State Hospital. The report noted a significant divergence of views between which of these was the best option. The evidence received by the Review confirmed this significant difference of opinion remains.

The proposed co-location solution is seen to offer smoother transitions for women as well as a more flexible use of resources in response to the potentially fluctuating demand. However, as the Forensic Network's report highlights, the timescales of delivering the proposed co-location solution could be significant. NHS Lothian agreed to consider this proposal further, looking at how this could be realised within the Orchard Clinic, its medium secure unit. This consideration raised concerns about its feasibility and emphasised that progression on these developments should not be rushed.

The proposal to develop a women's service within the State Hospital was considered a better alternative by most people who spoke to the Review. They acknowledged that detention at the State Hospital could be extremely isolating for women due to the very low numbers requiring high secure care at any one time. However, many clinicians and managers pointed to the existing spare capacity and the relative speed with which this could be achieved set against the time and cost associated with any new build. They felt women would gain greater access to family and social support, years earlier, if this model was adopted.

The severity of the concerns about high secure provision for women are such that the Review considers arrangements need to be made urgently to provide high secure care for women within Scotland. It recommends that the high secure service is provided within the State Hospital in the immediate future.

Recommendation

Recommendation 3: A high secure service for women should be opened in the State Hospital within nine months of the publication of this Review.

- The design and staffing model for this unit must be able to appropriately flex to meet the care and treatment needs of both women with mental illness and women with a learning disability.
- It will be for the new Forensic Board to review and determine appropriate arrangements for high secure provision for women in the longer term.

4.2 Women's pathways in forensic mental health services

There is a lack of co-ordinated forensic mental health pathways for women. The original configuration for forensic mental health services outlined by the Scottish Executive in 2006 suggested that the needs of women with mental illness could be addressed by one national medium secure unit, regional low secure units and community based specialist services. This is not the configuration that developed. The Orchard Clinic in NHS Lothian and Rowanbank Clinic in NHS Greater Glasgow have medium secure beds for women but they are not nationally funded. This means beds can be purchased by other areas but only on a 'spot purchase' basis when capacity allows. There was no regional co-ordination in the development of low secure provision. As the interim report said, many NHS Boards rely on independent or out of area provision if they require low secure provision for a woman. Or, they place women in services which do not best meet their needs or aid their recovery, like intensive psychiatric care units (IPCUs). This lack of a clear pathway to access and progress through forensic mental health services for women needs to be addressed. Given the relatively small numbers of women involved, the

Review found a general consensus that there needs to be a national or regional solution.

The Forensic Network's Inpatient Census reported 65 women receiving forensic mental health services in November 2018. This number reduced to 37 in November 2019, 10 of whom were in medium secure. The overall reduction is primarily the result of the Ayr Clinic, one of the independent providers of low secure care, recording 30 fewer women in its return than the previous year. This was because they realised that these women did not meet the definition of 'forensic' set out by the Forensic Network for its census. The variation in these figures suggests that women may be disproportionately affected by existing ambiguities around the remit of forensic mental health services (discussed in Section 3). The Forensic Network's definition of 'forensic' for its census focuses on people who are detained and treated under a criminal section of our mental health legislation or who have previously been detained in high or medium secure services. It is recognised that this does not capture a group of people who are nonetheless cared for in low secure services. These people do not have offending histories but have been transferred into these secure settings because their behaviour has not been able to be safely managed by generic services.¹¹

The Review met a number of women in this category during its visits to low secure services. Many of them had a primary diagnosis of personality disorder. Their care and treatment was supervised by forensic clinicians in the Ayr Clinic and in NHS Forth Valley. Neither service considered these women to be 'forensic'. They need the skills of forensic specialists however to help them manage the risk of harm to themselves (as opposed to risk of harm to others).

4.2.1 Transferring women from prison to hospital

People raised concerns about prison transfers for women. The lack of forensic beds for women was felt to contribute to difficulties in transferring women from prison when they need secure hospital treatment. These concerns align with the findings from the European Committee for the Prevention of Inhuman or Degrading Treatment report on Scottish prisons in 2019. Their report found that while transfers

¹¹ See Section 5.5. 'Definition of "Forensic" Patients' Forensic Network (2019) *Women's Service Pathways across the Forensic Mental Health Estate*. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Womens-Report-Public.pdf>

for men were possible, the situation for women was entirely different. It suggested that the lack of high secure facilities appeared to play a key role in decisions to keep women in need of psychiatric hospital care in prison.¹²

Following the interim report, the review sought additional evidence from clinicians involved in the transfer of women from prison to forensic inpatient services. They argued that provision of high secure services for women would not, in itself, address the issues they face. This is because women's level of offending more often meets the criteria for low or medium secure care. As such, it is the provision in these settings alongside a lack of IPCU provision in the women's local area that creates many of the difficulties and delays they experience when trying to agree transfers. Another reason is that even when beds are available, community admissions will be prioritised over prison referrals as they need to be brought to a place of safety. There are concerns that this lack of access to beds for women in lower conditions of security may be creating a higher threshold for referring women out of prison than men, resulting in them potentially carrying a higher degree of psychiatric morbidity.

An additional limitation in the options for women in prison is that they can often present with complex trauma or behaviours that represent more of a risk of harm to themselves than others. If there is no diagnosed mental illness hospitals will be reluctant to admit, leaving nowhere for these women to be transferred to.

The Forensic Network established a system for monitoring transfers from prison to forensic mental health services in 2018. It reports five transfers from HMP Cornton Vale between February 2018 and May 2020. The Review considers it likely that this under-represents female transfers. NHS Forth Valley clinicians told the Review that there had been at least another four transfers by May 2020, and 11 altogether in the first 10 months of 2020. They also provided the length of time for referral for five transfers. The average length of time between referral and transfer was 43.2 days. A recommendation relating to data collection on prison transfers is made in Section 5.5.2.

¹² European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2020) *Report on the United Kingdom focusing on Scottish prisons*. Available at: <https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-report-on-the-united-kingdom-focusing-on-scottish-prisons>

The Forensic Network's Women's Service and Pathways report makes recommendations regarding the future of medium secure and low secure provision for women. The Review recommends that the Short Life Working Group set up in response to the Forensic Network report is reformed to consider how the issues around women's pathways should be addressed.

Recommendation

Recommendation 4: The Short Life Working Group set up in response to the Forensic Network's report on the Women's Service and Pathways should reform to complete its work related to women's pathways across in medium secure, low secure and community forensic settings.

- The Short Life Working Group should initially report to the NHS Chief Executives' Group pending the formation of the new Forensic Board.
- Its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required.
- It should also consider the care needs of the group of women who may not meet the definition of 'forensic', but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services. While it is important not to draw these women inappropriately into forensic mental health services, there needs to be clear pathways around their longer term care and treatment. As such, representatives from the independent sector must be invited onto the Group.

5 Capacity and transitions

Forensic mental health services should be underpinned by an ethos of rehabilitation, recovery-focus and reciprocity. As such, people need to be able to move, or 'progress', from higher levels of security through lower levels of security and back into their communities in a timely way. Currently, however there are waiting lists for services at low and medium security. This means that people's transitions between secure service and discharges to the community are being delayed. As they wait, they are not being held in the least restrictive conditions necessary to manage their risk. This risks breaching their human rights. There is an appeal process for people who think they are being held in conditions of excessive security at high and medium security levels but not at low.

Delays in transfers and discharges risks people becoming de-motivated and more vulnerable to further mental health setbacks and greater institutionalisation. Occupational therapists working in one low secure setting described how they found themselves having to develop new interventions to address issues for people that would not have occurred if a person had been discharged when they were first deemed ready. This situation is clearly counter-productive and conflicts with the principles of a recovery-oriented service and reciprocity. Keeping people unnecessarily in conditions of higher security also constitutes over-treatment and so represents low value health care.

The evidence in the interim report was clear that there was an issue with timely transitions through and out of forensic inpatient services. The Review met people waiting for accommodation to be identified to support discharge. Many people also spoke about the delays they experienced in transferring to conditions of lower security as they had to wait for beds to become available. One person in a low secure ward explained that there is 'always a waiting list for moving'. However, lack of capacity in the system also impacts on the ability of services to respond to emergency referrals from courts, prisons, the community and general adult services.

Clinicians spoke of finding it difficult to get a bed in either medium or low secure when they needed it. They explained that, ideally, forensic services should operate at around 80% capacity. This would allow the system to manage emergency admissions and transfers, as well as support the needs of people already in wards

more therapeutically. They spoke however of the current system operating at 100% and people being placed on the basis of who it might be least disruptive to move or where there was a bed rather than on clinical need. The requirement for clinical teams to constantly reprioritise and move people in response to new admission requests was witnessed by the Review team on more than one of its visits.

There are other indications that the system as a whole is under pressure. Data from the Mental Health Tribunal for Scotland (the Tribunal) confirms that people in both high and medium security continue to make applications about being detained in conditions of excessive security. People in high security have been able to make applications against their detention in conditions of excessive security since 2006. This right was extended to those detained in Scotland's medium secure units in 2015. Applications require to be supported by a report from an approved medical practitioner and nearly all of them are granted. However, a high number of cases return automatically to the Tribunal as the person has not been transferred to the conditions of appropriate security within the time period determined by the Tribunal (which cannot be more than three months).

In 2019, there were 14 applications from people being held in high security, only one of which was refused. The Tribunal held second hearings for eight cases where the person had not yet been transferred. That same year, there were 13 applications from people in medium secure units. Ten of these were granted (three people were transferred prior to the hearing). The Tribunal held second hearings for 12 cases they had previously granted, only one of which was refused. This supports the evidence in the interim report that these applications are driven by a lack of beds at the right security level, rather than disagreements over the appropriate level of security itself. This creates pressure to hold Tribunals that would not be necessary if beds were available. It also points to a system unable to effectively manage capacity in a person-centred, therapeutic manner and services that are often required to engage in brinkmanship when it comes to these appeals. The number of applications made to the Tribunal is also likely to under-represent the number of people who are being held in conditions of excessive security over this time. This is because, as the interim report detailed, not everyone who is entitled to appeal chooses to do so. One person, for example, explained to the Review that they had decided not to appeal, because even if they won, it was 'not as if a bed is magically going to appear'.

Another indicator of capacity issues is that people continue to be admitted to the State Hospital under the Exceptional Circumstances Clause. This process allows for a person, even though they do not require high secure care and treatment, to be cared for at the State Hospital for short periods of time when there is no bed available elsewhere. Data from the State Hospital shows that people can be waiting in excess of 6 months under these circumstances before a space becomes available in the appropriate level of security.

The State Hospital started charging other Boards for these beds in April 2019. Costs charged in this first year were £1.1 million, split between seven Boards. Between 2015 and 2018, there was an average of three exceptional circumstance admissions each year. In 2019, this increased to seven. In 2020, the State Hospital capped the number of exceptional circumstance admissions to eight. This was initially as a result of arrangements put in place in response to the coronavirus pandemic, and then as their own patient numbers increased. As such, the Forensic Network reported in August 2020 that this 'compensatory mechanism for medium secure overflow is close to being exhausted at present'.

The Review also met, and was told about, people who were receiving their care and treatment outwith their local or regional services due to lack of provision or available beds in their own area. These out of area placements place people further away from their support networks. They were reported to be more common for women and people with learning disabilities. The data the Review received from services about their out of area placements was incomplete. It did however show that the vast majority of NHS Boards have at least one person receiving forensic care and treatment out of area. Eleven Boards provided the Review with information on how much they had spent on out of area forensic care in 2019-2020. This totalled over £13 million. While this includes costs for independent care and provision in England, a considerable proportion of this is cross-charging between different NHS Boards within Scotland.

If actions are not taken to address the issues of capacity and the impact it is having on people moving through the system, the system is in danger of grinding to a halt. People must have access to the care and treatment they need in the correct level of security. There are two areas that require immediate attention: the pressure on medium secure beds and delays in the discharge process that are creating a

bottleneck of people waiting to leave low secure service. Until the latter is better understood, monitored and addressed, the full extent of the capacity issues across the system as a whole will remain unclear. To allow for more effective monitoring and management of capacity and transition issues longer term, a robust data management and monitoring system that covers forensic mental health provision across all levels of security and community provision must be developed.

5.1 Data collection and reporting

There are key gaps in the data collected and reported on around forensic mental health services. This makes it hard to assess how the system as a whole is performing. In particular, data needs to be collected to allow monitoring of community forensic provision, waiting times for transfer between services (including transfers from prisons) and delayed discharges. The Review was also surprised that no one is monitoring how long it takes for a person to complete their rehabilitation journey from initial admission into forensic mental health services until their discharge. Data is only reported on how long people spend at each level of security.

The Scottish Government and the Forensic Network collect annual data on the number of forensic inpatients in Scotland. They use different definitions to identify the forensic inpatient population and are snapshots of different moments in time but both indicate that the forensic inpatient population in Scotland sits at around 500 people.

Table 1 Total number of forensic inpatients in Scotland*

	2013	2014	2015	2016	2017	2018	2019
Forensic Network Census	522	502	526	456	503	510	478
Scottish Government Census	-	507	-	496	522	516	525
<i>(within NHS Scotland)</i>	-	507	-	458	484	475	488
<i>(placement outwith Scotland)</i>	-	-	-	38	38	41	37

* The Forensic Network's Inpatient Census provides an overall total that includes people in independent provision within Scotland. The Scottish Government Census reports numbers for people receiving their treatment from NHS Scotland separately from those who receive treatment out with NHS Scotland. Available at: <https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/>

There is no equivalent national data collection that captures the number of people receiving community forensic mental health services. Scottish Ministers monitor the number of people who are subject to a compulsion order and restriction order, who have been conditionally discharged into the community. As of December 2020, there were 63 people, but this is only one very specific group of people receiving forensic mental health services in the community. The Review asked the services in each NHS Board how many people were being looked after by community forensic mental health services across Scotland. Not all services provided this information, leaving the Review unable to shed any further light on this neglected but integral part of the system.

The Review repeatedly met, and was told about, people waiting to transfer to conditions of lower security people or waiting on community provision to support their discharge. However, there is no central collection or reporting on where people are waiting, or for how long. The Forensic Network collates weekly bed position figures for the high and medium secure units. This includes the number of people waiting to enter and leave these services but not the length of time people are waiting. No bed position figures are collected for provision at low security. Responses to the Review from services across NHS Boards indicated there is no consistent approach to monitoring and reporting on delayed discharges from forensic inpatient services.

Both the Scottish Government and Forensic Network annual surveys collect the average length of time people spend in their current hospital setting. In 2019, the Scottish Government reported the average time since admission for a forensic patient was two years and five months. It reported 48% of people had been admitted to their current unit between one and five years ago. 28% had been in the same place for over five years. The Forensic Network's annual census reported an average overall mean admission length of 1618 days (4.4 years). It also provided a breakdown of this by security level.

Table 2 Mean length of admission by security level

Security level	Mean length of admission
High Secure	2195 (6.01 years)
Medium Secure	998 (2.73 years)
Low Secure ¹³	1586 (4.34 years)

Source: Forensic Network Inpatient Census (2019).

Table 2 shows that people spend a number of years in each security level. While there are people who will spend significantly less time in forensic inpatient services, many require to progress through more than one level of security as part of their rehabilitation journey and so will be with the services for significantly more time. If a person currently in low secure services had spent the average length of time progressing through each security level as outlined in Table 2, they would have been in forensic inpatient services for over 13 years. However, no one is monitoring or reporting on the actual total length of time it takes for a person to complete their rehabilitation journey through these services. The Forensic Network advised that it is developing an Inpatient Database that will allow data from the entirety of a person's admission into forensic inpatient services to be examined.

It was people receiving the services who spoke to the Review in terms of the entirety of their time in forensic mental health services. One person in a low secure ward spoke of their 'slow and steady' progression from high secure. Overall, it had taken them 12 years and they reflected that they felt that for them, that timing 'was about right'. Another felt that there were predetermined times to get through different parts of the system. They suggested it takes between 10 to 20 years to progress from high secure to discharge.

¹³ This is the number of people recorded by the Network as being in a low level of security. It does not include people in locked LD, IPCU, open wards or assessment and treatment wards which the Network reports on separately.

Recommendation

Recommendation 5: The Scottish Government should commission the Information and Statistics Division (ISD) of NHS National Services Scotland to develop a data management system to accurately collect, monitor and report on performance across forensic mental health services, including on service capacity and the timeliness of people's transitions.

- This report identifies a number of further recommendations for specific data that should be collected, monitored and reported on within this system (see recommendations 7, 8, 20).

5.2 Pressures on medium secure services

As mentioned above, the Forensic Network collates the weekly bed positions for high and medium secure units. In August 2020, it completed a longitudinal analysis of this data from July 2018 to July 2020. Over 2019 and 2020, there was an average of 23 people waiting to transfer from high security to medium security each week. It does not collate the length of time people are waiting. The Review requested additional data from the State Hospital. This showed that in November 2020 there were 13 people waiting to transfer from high security. They had been waiting between 7 – 22 months.

The Forensic Network's analysis concluded that the medium secure services for people with mental illness remain 'under significant pressures'. It also suggested that medium secure services have been running at or close to capacity since 2016. It calculated that if all of the people waiting to transfer from medium security to low security could do so, there would be some capacity across the medium secure estate in Scotland as a whole, but that Rowanbank would still have a waiting list.

During the Review's visits to the medium secure units in autumn 2019, Rowanbank reported there were 20 people waiting for admission (including people currently in medium secure provision out of area) and 10 people waiting to move on. The Orchard Clinic had only started to have a waiting list for its service over that last year. It had seven people waiting to access its service and seven people waiting to transfer out. Rohallion reported that it typically had at least one bed available. The

Review followed this up with each of the units in October 2020. At that time, Rowanbank had 18 people waiting for admission (including those in medium secure provision out of area) and 11 waiting to transfer to conditions of lower security. The Orchard Clinic had seven people on their waiting list and 10 people who were identified for discharge, including to conditions of lower security, or whose discharge was delayed due to lack of accommodation in the community. Rohallion had no one on their waiting list but had five people waiting to transfer to low security.¹⁴ These numbers illustrate how the lack of beds available in low security is impacting on the ability of medium secure units to progress people through their service in a timely way. Only Rowanbank would continue to have a waiting list for admissions if all the people waiting to transfer out could do so.

NHS Greater Glasgow and Clyde is alert to these issues. They have been considering expansion plans for Rowanbank since 2013. A full business case for an additional 18 beds was completed in 2018. Progress on this had been postponed pending the outcome of this Review. Delays in progressing this are a source of frustration for staff there. In the meantime, the majority of applications against detention in conditions of excessive security continue to be brought against NHS Greater Glasgow and Clyde.

The medium secure estate is under pressure. On a national level, if movement of people to low secure were to improve, figures suggest that medium secure services could operate within its current capacity. However, this would still be at a relatively high bed occupancy rate. This would limit its ability to respond to emergency admissions from prisons, courts or general adult services. It would also not prevent continued waiting lists for Rowanbank. The Review therefore supports the proposal to extend Rowanbank. This should reduce the number of cases of people being held in conditions of excessive circumstances or under exceptional circumstances in high secure. It would also provide the opportunity for people currently placed out of area across the medium secure estate to be returned their home Health Board's regional unit, with the resultant benefits for the person, their family and their wider support network as well as the service itself.

¹⁴ The Forensic Network longitudinal analysis indicated that Rohallion typically reported waiting lists of zero or one throughout 2018 and 2019. In 2020, up to July, the list had risen to a constant two or three.

It will be for the new Forensic Board to review the extent to which this increased capacity in the West impacts on the capacity across the system in the longer term.

Recommendations

Recommendation 6: NHS Greater Glasgow and Clyde plans to extend medium secure provision at Rowanbank Clinic should be progressed.

Recommendation 7: The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland should collect, monitor and report delays incurred by people assessed as ready to transfer to a different level of security. Any delay of four months or over must be reported to the Scottish Government.

5.3 Delays affecting discharges into the community

As the previous section outlined, medium secure services are being negatively impacted by the lack of capacity in lower secure settings. People spoke of a 'bottleneck' in the system at low secure caused by delays in people being discharged from these services. The issue most often cited for these delays, and the consequent lack of available beds, was difficulties identifying appropriate accommodation and support packages in the community. These issues were said to particularly affect people with more complex needs, including co-morbidity or learning disabilities. Section 7.1 considers people with a learning disability in more detail.

5.3.1 Community accommodation and support packages

The successful rehabilitation of people through forensic inpatient services relies ultimately on there being places and support available for them to return to in the community. People told the review however that a lack of suitable accommodation and support packages with appropriately trained staff is leading to some discharges being excessively delayed sometimes for years. One Community Forensic Mental Health Team member suggested, 'it is not health that is holding up the process, it is accommodation'.

Family members felt like no one was taking responsibility for making the necessary arrangements in the community. One said that 'social work blame the NHS and vice versa'. Section 25 of the Mental Health (Care and Treatment) (Scotland) Act 2003 specifies that local authorities 'shall' provide the necessary care and support services (including residential accommodation) for people with a mental illness who are not in hospital. However, requirements for people in hospital are less stringent; local authorities 'may' provide such services. It seems that people at the point of starting the discharge planning process on the forensic pathway can be left in a netherworld between 'in hospital' and 'not in hospital' where no one is fully accountable for ensuring that the necessary arrangements are made.

As the interim report set out, people in hospital under a compulsion order with a restriction order (sometimes referred to as a CORO), a hospital direction or a transfer for treatment direction are subject to special restrictions. These 'restricted patients' need to have particular stages of their progression agreed by Scottish Ministers. Their Responsible Medical Officer or Mental Health Officer must inform the Restricted Patients Team in the Scottish Government of any undue delay in identifying accommodation. An official will then write to the relevant Director of Social Work. One team spoke positively about being able to take course of action which had helped accommodation to be identified.

The principle of reciprocity very much extends to a person ultimately being able to access the accommodation and support identified as necessary for them to be discharged. Financial restraints preventing or delaying the necessary support being put in place are indefensible from a human rights perspective.

A person in forensic mental health services can spend several years having their liberty restricted. This naturally leads to them losing any tenancy they previously had. On completion of sufficient progress with the treatment that society has deemed that they need to comply with, they should then have sufficient priority placed on their housing needs, by the local authority, to enable them to resume their life in the community. Sufficient priority makes no difference, however, if appropriate accommodation or support is simply not available.

Clinicians are concerned about the lack of variety of provision in the community to meet the many models of care required for people leaving forensic mental health services. They stressed the need for more creative or responsive housing models

rather than reducing choices, as some areas have, to either single occupancy tenancies or supported accommodation as these cannot meet the needs or wants of everyone.

These issues also exist within the wider context of the recruitment and retention issues facing social care providers. Successful support packages rely on there being people appropriately trained, supported and remunerated to staff them. Staff spoke of having been placed in the difficult position of having to consider inferior support packages that did not meet all of the requirements they had identified for a person's discharge, knowing that to do so would be effectively setting the person up to fail.

Providers of support packages in the community are commissioned by bodies such as Health and Social Care Partnerships, local authorities and the Scottish Government. Commissioners should ensure the remuneration structure for support workers working with people leaving forensic mental health services, is such that skilled, knowledgeable workers are retained in these specialist services.

Data is not collected on the number of people in low secure settings who are waiting on accommodation or a support package to support their discharge. The length of time that they have been waiting is also not collected. As explained earlier in this report, the Forensic Network collates weekly bed positions for the high and medium secure units which include the numbers of people waiting to access and transfer out of these services, but do not currently collect the same information for low secure settings. When the Mental Welfare Commission visited low secure wards in 2017, it identified 61 people who were waiting to move on to either a rehabilitation setting or the community. In autumn 2020, the Review asked low secure services for similar information. The information that was received indicated that 52 people were waiting for accommodation. The time they had been waiting ranged from three days to 5.5 years. Three services reported no delays.

The Review also asked how each service reported these delays. Most did record delays but the methods varied. People suggested that the current methods used underestimate the number of people affected. They also highlighted a lack of parity between how these delays were reported and monitored in acute (physical health) services. An additional issue is that the time at which a discharge becomes delayed can be harder to pinpoint for restricted patients. This is because they require to go

through a pre-discharge process which relies on accommodation being identified. They then need to have a series of overnight stays in this accommodation before their Responsible Medical Officer is able to apply for conditional discharge. As such, for them, it is any delay in progress towards conditional discharge as the result of waiting for accommodation or support packages that need to be captured, monitored and reported.

People should not be waiting excessive lengths of time for accommodation or support packages to support their discharge. They should certainly not be waiting years as the Review heard some people have been. Most of these people have been progressing through the forensic system for a number of years by the time they reach this point in the rehabilitation journey. Their arrival at this point should be a surprise to no one.

Recommendations

Recommendation 8: The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland must record delayed discharges in a way that is as transparent as data collected in the acute (physical health) sector.

- This should include delayed discharges and delays in progress towards conditional discharge as a result of waiting for accommodation or support packages. The 'clock' should start when the clinical team and the person agree that clinically they are ready to move to the next stage of their rehabilitation journey.

Recommendation 9: The management bodies of all forensic mental health services must identify anyone waiting for accommodation or support packages in the community to the extent that their discharge from these services - or their eligibility to start the process towards conditional discharge - has been delayed for six months or more.

- Management bodies here refers to the relevant Health Board, Health and Social Care Partnership or independent provider providing care and treatment for the person.
- Within six months of this Review being published, these bodies must submit plans to the Scottish Government to address the outstanding needs of anyone it has identified as being delayed in this way.
- These bodies must continue to record, monitor and report on these delays on an ongoing basis until this responsibility is assumed by the new Forensic Board.

Recommendation 10: The new Forensic Board must work with social work teams and local authority housing departments to ensure that the commissioning process in each area provides appropriate support services and accommodation options for people with the need and risk profiles typical of individuals within the forensic mental health system.

Recommendation 11: The new Forensic Board must work with social work teams and local authority housing departments to develop an accommodation strategy that ensures individuals have access to community accommodation so that they can begin the discharge process in a timely manner when clinically appropriate.

Recommendation 12: Commissioners of community support and accommodation services should ensure that remuneration for people working in these services reflects the complexity of the forensic cohort and the need to retain skilled staff.

5.3.2 Appeals against conditions of excessive security in low secure settings

There is general consensus that the difficulties exiting low secure services are made worse because there is insufficient legal redress for people who remain in low secure settings for reasons other than clinical need. As explained earlier in this report

people in medium and high security can make an application to the Mental Health Tribunal for Scotland (the Tribunal) if they feel they are being detained in conditions of excessive security. People in low secure services cannot. There was widespread agreement that an equivalent right is needed for people in low secure services.

People in low secure services should have the same rights as people elsewhere in the system in respect of challenging the conditions in which they are detained.

There also needs to be a legal mechanism to address the issue of people's discharge being delayed because of a lack of community resources. This mechanism needs to extend beyond people solely in low secure services as people can be discharged into the community from other levels of security.

Recommendations

Recommendation 13: We recommend that people in low secure units should be given the right to make an application to the Tribunal where they are being detained in conditions of excessive security. This right should be equivalent to the one which people in high and medium secure units have under the Mental Health (Care and Treatment) (Scotland) Act 2003. It should apply to anyone in low secure services, allowing them to be moved into conditions of lesser security, including into the community. People in secure units whose plans for discharge into the community are being delayed as a result of the non-provision of the necessary facilities for a phased move to the community should also be given a right to make an application to the Tribunal for an order that a relevant authority make the necessary provision.

- Where a Tribunal is satisfied that a person in low secure is being detained in conditions of excessive security, then it should make an order for the discharge process to begin. Where the person is to be discharged to the community, an order must also be placed on a relevant authority to provide the appropriate accommodation and support.
- An order from the Tribunal that a person in low secure is being detained in conditions of excessive security should provide for the same time frames as the equivalent orders at high or medium secure. This would mean the relevant authority is to make the necessary provision for the person to begin the discharge process within three months of the order being made.

Recommendation 14: A legal duty must be put on a relevant authority to provide appropriate accommodation, services and support for people who are due to be discharged from a secure hospital into the community. The Review considers the relevant authority should be the local authority.

5.3.3 Discharge planning processes for restricted patients

Restricted patients need to have particular stages of their progression agreed by Scottish Ministers. This includes transfers between hospitals or authorising any leave from hospital. The steps required to get these agreements are set out in the Scottish Government's Memorandum of Procedure on Restricted Patients (MoP). Clinical teams reported using similar procedures for non-restricted patients (minus the need to seek Ministerial approval).

The identification of accommodation is a key part of the pre-discharge process for restricted patients, alongside its approval by Multi-Agency Public Protection Arrangements (MAPPA) and a carefully thought out plan of Suspension of Detention (SUS). This plan is expected to include a series of overnight stays in that accommodation. The MoP expects that a person subject to a compulsion order and restriction order will complete at least four months of overnight stays prior to conditional discharge. It also expects the person to build up from one night per week to a maximum of four nights per week in monthly increments.

Clinical staff and people with lived experience felt that this pre-discharge process could be streamlined. The Review was told it was 'clunky', not responsive to individual need and left beds empty on wards for significant periods of time. The Review feels that some of these concerns may be based on either a lack of understanding of the degree of the existing flexibility available within the MoP or the frequency with which Responsible Medical Officers choose to make use of the flexibility. The MoP is a long and complex document which may add to confusion around what it does and does not say. The Scottish Government is in the process of updating it. This provides an opportunity to review any administrative aspects of the discharge process that could be streamlined, while continuing to appropriately support people's successful discharge and protect the public. It is also the time to

provide it in an accessible format to allow for greater transparency and understanding.

The staged progression of overnight stays to accommodation set down in the MoP has implications for a person's finances. Social security benefits to assist with housing costs are not available until the person is spending over 50% of their time in the accommodation. That would not be until the four-night stage. This means that for people who are eligible and reliant on these benefits, there is a period of time during which they require to go into debt to pay for their accommodation for the earlier testing stages in their accommodation. This adds an additional risk factor into what is already one of the highest risk transition points in a person's rehabilitation.

Recommendations

Recommendation 15: The Scottish Government should review with clinicians in both inpatient and community teams, as well as MAPPA and police representatives, the current discharge planning process for restricted patients to identify any aspects that can be streamlined while continuing to protect the public and supporting the best chance of a successful and sustainable discharge for people.

Recommendation 16: The update of the Scottish Government's Memorandum of Procedure on Restricted Patients should be available in an accessible format to increase transparency around the processes and the flexibility within it, and the role of Scottish Ministers more generally. This work should be prioritised.

Recommendation 17: The Scottish Government and the new Forensic Board need to identify funding to ensure that no one leaving forensic inpatient services has to go into debt for housing costs to complete overnight stays to accommodation as part of their required pre-discharge plan.

5.4 Community forensic mental health teams

Community forensic mental health teams (CFMHTs) play an important role in helping people to safely discharge from inpatient services and remain well in the community. They also support people through acute periods of mental ill health, helping them to avoid unnecessary returns to forensic inpatient services. However, as the interim report highlighted, people in these teams described themselves as the 'poor relations' in terms of resources and service development within the forensic mental health system.

Community services have been developed at a local level. There is no standard service specification for CFMHTs. It is unsurprising then that the Review found that the remit, referral criteria and staff composition for these teams vary. They are also not available in all parts of the country. This creates inequity in service provision depending on where a person lives.

There are variations in CFMHTs' referral criteria. Some services accepted referrals predominately or solely from forensic inpatient services. Others accept a broader population, taking referrals from GPs, social workers and prisons. These variations mean that people leaving prison or people who have a personality disorder diagnosis may be accepted by some CFMHTs and excluded by others. Some staff felt the remit of community forensic mental health services needed to be reviewed and discussed, particularly the extent to which they should be supporting people who are not subject to restriction orders or do not have a history of compulsory detention.

There is little guidance about the professional composition of CFMHTs or appropriate staffing ratios. These aspects of the teams therefore also vary between areas. There was however consensus about the importance of multi-disciplinary working at a community level. CFMHTs require fully multi-disciplinary staff teams in order to manage the diverse needs of those on their caseloads. Social workers have an especially important role here, for example, supporting the development of accommodation options and support package arrangements. There is also a requirement to liaise with MAPPA about people on restriction orders and many people managed by CFMHTs receive support packages from community third sector providers. Where CFMHTs' remits include managing people who have previously been detained in prison, they need staff members able to work more closely with the criminal justice system.

Community service resource and development should be given its due place in whole service planning. There has been a disparity in attention and provision for these services compared with medium and high security. Some CFMHTs reported not being able to meet the demand for their services. Others had experienced staff not being replaced when they left. If progress is made in addressing the bottleneck of people waiting to be discharged from low secure services, a growing number of people will require management under CFMHTs in the coming years. They must be appropriately resourced to meet this demand. Estimates of demand should consider that, at present, people on the pathway from low secure units to a CFMHT are not typically expected to be managed by generic mental health services for many years. Some may never move on to generic services. If CFMHTs are to operate with a broader remit than referrals from forensic inpatient services, this will also require additional resource.

Recommendations

Recommendation 18: The new Forensic Board should define the service remit of Community Forensic Mental Health Teams (CFMHTs).

- This service remit should specify the population that CFMHTs may work with. The new Forensic Board may consider that CFMHTs should have a broader remit than forensic inpatient services but this must be clearly defined in order to support consistency of provision across the country.
- The service remit should also specify the expectations for its multi-disciplinary team (MDT) composition, including a requirement for social work representation, and appropriate staffing ratios for CFMHTs.

Recommendation 19: CFMHTs should be appropriately resourced based on future projected demand as bottlenecks in low and medium secure services are eased.

- Using available figures together with any improvements in data from increased monitoring activity, the new Forensic Board should project the demand for CFMHTs over the coming years. This should inform what additional resources may be required by CFMHTs to meet future demand and be factored into its planning.

5.5 Prison issues

5.5.1 Mental health services in prisons

The Review was asked to consider the delivery of forensic mental health services in prisons. As set down in the interim report, in seeking to look at the specifically 'forensic' mental health services in prisons, the Review concluded that the current provision of 'forensic' services is limited, in the main, to visiting forensic psychiatrists who are primarily doing a general adult psychiatrist primary care role e.g. treating depression, anxiety and stress disorders. There is little work that is actually forensic in nature. Mental health nursing input does not come from a forensic specialism but rather from a community mental health nurse perspective, with a focus around primary care nursing, both physical and mental health, with little or no learning disability nursing input.

A distinction was therefore drawn by the Review between the specialist forensic mental health in-reach services to prison and the provision of general mental health care in prisons. The Chair felt strongly that the latter sat outwith the remit of the Review. If it were to be included, he felt it had the potential to dwarf issues specific to forensic mental health provision. Prior to the publication of the interim report, he wrote to the Minister of Mental Health on this basis.

The Chair confirmed to the Minister that the review would not be looking at prison healthcare in the general sense but would continue to look at the referral process from prison into the forensic system. The Minister accepted this. The Chair noted that prison healthcare was an important and complex area of healthcare that should be subject to its own review, and which may more usefully consider the provision of both physical and mental health care in prisons together. Working group members also felt it was worthy of a separate review and generally acknowledged the pragmatism of this approach. The Review wants to equally acknowledge here, however, that some members felt, and continued to consider any mental health care provided in a prison is forensic and so part of forensic mental health services.

5.5.2 Transfers between prisons and secure hospitals

People in prison can be transferred for forensic mental health treatment in hospital. Evidence provided for the interim report suggested these transfers for men take place relatively quickly, with positive comparisons made to the time taken elsewhere

in the UK. Section 4.2.1 has more detail about transfers for women. The Forensic Network started monitoring transfers from prison to forensic mental health services in February 2018. By May 2020, it had recorded 70 referrals. The average length of time for transfer following an urgent referral was 11.4 days. The average length of time for non-urgent referrals was 27.4 days. The time taken for transfer is calculated from 'referral' but it is not clear which part in the transfer process this refers to. The Forensic Network suggests it is typically the date on which the referring psychiatrist approaches a hospital service to request a further assessment and potential transfer, but recognises that there remains ambiguity about this.

The Review was told by staff about the multiple referrals, assessment and delays that can occur throughout the process. For example:

- it can take time to obtain the necessary detail about the person's full offending history, which is required to assess the appropriate level of security required;
- an initial referral for a high secure bed may be turned down which then requires a subsequent referral to be made to a medium secure service; and,
- a person requiring medium secure care will be assessed by their regional unit, but they may have no available bed and so a subsequent referral and assessment needs to be done by a medium secure unit that does.

The prompt transfer of people in prison requiring care and treatment in hospital is critical. However, in a system where waiting lists are operating at medium and low secure services, prison transfers can impact on the progression of people already within the hospital system. This is because the transfer of acutely unwell prisoners is likely to be prioritised over someone waiting to transfer from a higher level of security where they are known to be stable and well in a clinical environment.

The Review considers that the data collected by the Forensic Network on transfers from prison to forensic mental health services may be underestimating the time the process takes from start to end. It is not clear that the 'date of referral' from which the length of time is calculated at present is consistently interpreted or captures all the steps that have to take place prior to any formal referral being made.

Furthermore, given the voluntary basis on which the Forensic Network receives any data, the Review is concerned that it is not receiving the full information on the number of these transfers. As noted in Section 4.2.1, this is a particular concern in relation to women.

The Review was also concerned by the repeat assessments for referrals to medium secure units. This is linked to the current lack of capacity when a bed may not be immediately available in the person's regional medium secure unit. A person is initially assessed by their regional medium secure unit. If they are assessed as suitable for admission but there is no bed, they are then referred to a medium secure unit where there is a bed. This unit then carries out their own assessment. This repeat assessment process is not in the interests of the person in prison requiring forensic mental health hospital treatment. It seems to add additional delays into the process to reassure the professionals within it. The Review heard evidence that at least one person inflicted further self-harm upon themselves in prison in the time taken between two such medium secure assessments being done. It was suggested to the Review that there should be a single point of referral for access to medium secure services.

Recommendations

Recommendation 20: The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland must be able to collect, monitor and report on transfers and delays to transfers into forensic services from prisons.

Recommendation 21: The system of multiple assessments to facilitate transfers from prison should be reviewed with the aim of streamlining the process to the benefit of the person in need of forensic inpatient services. At the latest this should be reviewed by the new Forensic Board, however the Review considers

6 Person-centred practices

6.1 Care and treatment

6.1.1 Multi-disciplinary working practices

Multi-disciplinary team (MDT) working is the bedrock of high quality forensic mental health services. It refers to the collaboration between staff from different clinical professional backgrounds, including social work, to manage the care of people with complex health and risk management needs. It underpins holistic care and treatment, helping to ensure that people receive appropriate and timely interventions. Each member of the MDT brings a different perspective, a different skillset and a different way of working with people. It is this collective approach that adds value to a person's treatment and it is important each area of expertise is afforded appropriate respect and influence in decision-making.

Staff reported that good multi-disciplinary and multi-agency working is associated with better outcomes and reduces distress for people receiving care and treatment. However, when this fails was associated with negative outcomes such as people not receiving the services they require.

Terminology and language can be an insight into how a person or system functions. The interim report recorded concerns about the ongoing dominance of a 'medical model' in forensic mental health services. Overall, this Review has not seen evidence that forensic medical professionals are failing to adopt a 'whole person' or 'biopsychosocial' approach to care and treatment. However, the Review team did find that the phrase 'medical model' was used to raise concerns about medical dominance within MDTs. Partly this dominance occurs because of responsibilities and accountabilities set down in legislation. Whilst acknowledging this, the Review considers the over reliance on one discipline for decision making to be unhelpful and detrimental to whole system care, wrapped around the need of individuals.

Equally, the Review team was disappointed to witness failures to treat multi-disciplinary professionals with parity of esteem. For example, the Review Team heard the term 'my nurses' used more than once, by other professionals, in discussions. Nursing is a profession in its own right, and its practitioners carry their own professional accountability and autonomy of practice. Neither nurses nor other professional groups 'belong' to other professionals.

Many people highlighted examples of integrated and collaborative MDT working well at a local level. They indicated that good MDT working is supported by clear guidance about different professions or agencies' roles and responsibilities and strong information sharing.

People said that when social work professionals are embedded in the forensic team then services are more co-ordinated around the needs of the individual. In addition, Mental Health Officers and social workers frequently provide a degree of continuity and consistency as people move through the system. They can provide a longitudinal perspective to assessments and a balance in MDTs as they have the independence and ability to challenge clinical decisions. The Review was therefore disappointed to note that at present social workers were rarely embedded as core members of forensic MDTs.

It was highlighted several times that the Care Programme Approach (CPA) facilitated MDT involvement and communication. These meetings should include representation from all the professionals involved in a person's care, treatment and risk management in order to produce a multi-agency plan that addresses all of that person's needs. Several people also flagged the use of an Enhanced CPA as good practice for people within the forensic system.

Recommendations

Recommendation 22: There should be an equality of esteem between the professions in a high functioning forensic mental health service. This should be evidenced in practice and language used.

Recommendation 23: The new Forensic Board should consider how best to fund social work posts embedded within the multi-disciplinary teams (MDTs) in forensic mental health services, in order to maximise interdisciplinary working.

6.1.2 Participation and decision making

A commitment to person-centred practices means that people should be able to participate in decisions about their care and treatment as much as possible. As the interim report stated, there are people who feel involved in choices about their

treatment options, their medication and changes to the ward environment. However, other people do not feel listened to. They spoke about staff invalidating their advanced statement or producing reports about them that had not been discussed with them and with which they disagreed. Other people reported uncertainty or gaps in their understanding of parts of the mental health system. They felt that this information could be better communicated.

People must be given opportunities to access all the information they need to participate fully in their care and treatment. This information must also be communicated in ways that they can understand. This is important as Speech and Language Therapists and advocacy staff warn that the communication needs of the forensic population may be significantly underestimated.

Recommendations

Recommendation 24: People should be supported to participate as much as possible in decision-making about their care and treatment. Staff should proactively involve people in both formal and informal conversations about their care. Staff must communicate in a style that best enables people to understand what is happening and to voice their opinions.

Recommendation 25: Staff should proactively inform people about their right to request a copy of information held about them. People need to be supported to make such requests if desired and to express their wishes about what information they receive and how this is communicated to them.

- The person's wishes should be added to their healthcare record and staff should endeavour to fulfil them on an ongoing basis so long as that does not conflict with that person's wellbeing.
- If staff believe they have good reason to withhold information against the person's wishes, then that person should be afforded an opportunity to discuss this decision.

Recommendation 26: General information and advice for people within the forensic system should always be provided in accessible formats, including Plain English and Easy Read versions. Staff should ensure that any additional information required to ensure a person's understanding and ability to participate in decisions about their own care and treatment plans are converted to such formats as required.

6.1.3 Involving family and friends

As the interim report said, family members or close friends of people receiving forensic mental health services often felt like they were not sufficiently involved in decision-making processes. Experience varied between different units. People spoke of difficulties accessing information and feeling like staff failed to recognise their expertise. They told the Review of times when their warnings about a deterioration in their relative's mental health while in the community had gone unheeded – resulting in crises that might have been prevented. All of this limits their ability to input into their relative's care. It leaves them feeling more anxious and more likely to experience difficulties supporting their relative on discharge.

'Respect for carers' is one of the Millan principles upon which the Mental Health (Care and Treatment) (Scotland) Act 2003 is based. As such, the role and experience of carers must be respected. They should also receive appropriate information and advice and have their views taken into account.¹⁵ They can provide critical information about their relative and are an integral part of their support network throughout their time in forensic mental health services. Moreover, when people are discharged into the community, family members frequently play a lead role in their care. It is therefore vital that they have access to relevant information about their relative's care and treatment. While issues of confidentiality and consent must be respected, there is much that can be done to proactively support and engage family members. The Care Programme Approach (CPA) supports their involvement. Unfortunately, however, some family members told the Review they

¹⁵ Millan report (2001) *New Directions: Report on the review of the Mental Health (Scotland) Act 1984*. Available at: https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

had faced 'clinical defensiveness' at CPA meetings. The Review also heard that clinical teams could be inflexible about the timing of these meetings, making it difficult for family members to attend, especially if the person was being cared for out of area.

Family members spoke of how little they understood about forensic mental health services when their relative was first admitted. They wanted to be given more information right from the start. They spoke of having to 'pick things up as they went' and relying on peer networks to help them understand what was happening. While these peer networks were valued, family members wanted dedicated carer support staff or advocates to help them navigate the system. They also expressed a need for direct access to training to support them to look after their relative. It was felt that staff needed to be more aware of carers' rights and options, with carers' organisations emphasising the rights not only under the Mental Health (Care and Treatment) (Scotland) Act 2003 but the Carers (Scotland) Act 2016.

Carers' organisations said that their staff can also be unfamiliar with the forensic system and that this can be a barrier to family members getting the support they need. They felt they needed more information or training about forensic mental health services in order to support carers effectively. They also told the Review that sometimes their input can be actively resisted by some services. This is unhelpful and counter-productive.

There are people who are being cared for outwith their home Health Board area. The travel costs involved for families can often make it more difficult for them visit. The Review heard that financial support is available to family members of people who are detained in the State Hospital but not in other hospitals. This creates an inequality both for the families and for those being cared for at a distance as it makes it harder to maintain their social networks and contacts.

Recommendations

Recommendation 27: Each unit within the forensic mental health system must appoint a named staff member as a Carer's Contact. This person must have received training in carer's rights and have sufficient knowledge to answer a carer's initial questions and signpost them to further information and support services.

Recommendation 28: The new Forensic Board should be funded to establish an advocacy service for forensic carers. This service will provide expert support to help carers navigate the forensic mental health system, represent their views and find satisfactory resolution to complaints.

Recommendation 29: The new Forensic Board should work in collaboration with existing carer organisations and advocacy services to develop a) information targeted at new forensic carers, and b) information and training for organisations supporting forensic carers.

Recommendation 30: Until such times as the new Forensic Board is formed, individual Health Boards should put in place a system to reimburse travel expenses of those family members (or other carers) who have to travel to visit a person receiving forensic mental health services out of area. Once established, the new Forensic Board should continue to ensure financial support is in place.

Recommendation 31: Where a person receiving forensic mental health services has indicated their consent, family members (or other carers) should be actively supported to take part in the CPA process and their opinion recognised as that of an expert by experience. As part of this, their availability should be taken into account when scheduling these meetings.

Recommendation 32: Where a person receiving forensic mental health services has indicated their consent, family members (or other carers) should be proactively informed by the clinical team whenever a change is made to the person's care and treatment.

6.1.4 Complaints

People who are subject to compulsory powers are in a vulnerable position when it comes to raising any concerns they may have about their care and treatment.

People explained that they would not complain for fear of punishment. Others advised that in order to progress you needed to simply comply and 'keep your head down'. People and their families had experience of their complaints being dismissed as part of their illness or simply not responded to. The Review was contacted by two families who have felt it necessary to go to the media as they feel their concerns are not being listened to by the hospital system.

There needs to be a transparent and trusted way in which people and their families can raise concerns they have about their care and treatment. The development of a new Forensic Board provides an opportunity to design informal and formal feedback processes that address the specific vulnerabilities of people in forensic wards.

Recommendations

Recommendation 33: The new Forensic Board and people receiving forensic mental health services and their family members (or other carers) should co-design informal and formal feedback processes that address the specific vulnerabilities of these groups in the forensic system.

- This should include investment in the provision of collective advocacy for people in forensic mental health services.

6.1.5 Transfer of suspension of detention plans (SUS)

As explained in Section 5.3.3, restricted patients have to have any suspension of their detention (SUS) in hospital authorised by Scottish Ministers. In 2017, the Mental Welfare Commission asked for the processes for granting SUS for restricted patients to be reviewed to ensure that people were not unnecessarily subjected to greater restrictions when they transferred from one hospital to another. At the end of 2018, the Scottish Government issued guidance to all Responsible Medical Officers setting out how SUS plans could be transferred. This Review found these new guidelines seem to have made no discernible change in practice, nor was the

flexibility within the system to do this well known. When asked about their top priority for change by the Review, people still most commonly said that they would like their SUS plans to be able to transfer with them. People who had lost their SUS for sustained periods after their transfer to low security spoke of it feeling like they had gone 'backwards' or 'not achieved anything'. They spoke of waiting months to regain freedoms they had previously been granted elsewhere in the system.

Transferring to a new place and a new clinical team can be a period of increased risk for the person. As such there needs to be a period of time after transferring to any new setting to allow the person to settle in. It allows the person to get to know their new clinical team and for the clinical team to begin to understand them and their risk. However, the reduction of previously earned SUS, for any significant amount of time, undermines the principle of reciprocity. It also adds time to a person's rehabilitation path and therefore the time they are detained.

Recommendations

Recommendation 34: The Scottish Government should re-inforce the use of its guidance on transferring Suspension of Detention plans (SUS) issued in 2018 with clinical teams and identify any ongoing barriers (clinical, administrative or cultural) prior to refreshing and reissuing to all clinical teams, as part of its ongoing update of the Memorandum of Procedure on Restricted Patients.

Recommendation 35: At pre-transfer CPA meetings, it must be made clear to the person that the option to transfer existing SUS is available. Reasons for not carrying SUS forward should be clearly discussed with the person. Their own obligations for ensuring that their SUS is carried on as planned once transferred must also be clearly explained.

6.2 Social and environmental practices

The interim report highlighted the importance of the ward environment on people's experiences of comfort and safety. When someone spends a significant period of time in hospital, services should be provided in environments that respect the individual, provide a degree of privacy and encourage them to believe in and value

themselves. As mentioned earlier in this report, people can spend a number of years receiving inpatient forensic mental health care and treatment. Data from the Forensic Network's census in 2019 reported that women had been in their current hospital for an average of 1349 days (3.7 years) and men an average of 1641 days (4.5 years). Given these long stays, it is vital that the ward environments and social practices enable people to feel as 'at home' as possible and contribute positively to their rehabilitation.

People spoke to the Review about the importance of a therapeutic physical environment in forensic inpatient settings. Factors including levels of privacy, crowding and sensory stimulus (like noise and imagery) can all affect people's levels of stress. As such, the nature of the physical environment can work to exacerbate or mitigate aggression. This can then potentially affect the numbers of incidents in an inpatient environment. Evidence points to a more therapeutic environment being one that:

- ensures people have space to regulate their social relationships;
- uses design features to reduce noise; and,
- gives people access to daylight and opportunities to go outside.¹⁶

6.2.1 Physical infrastructure and fitness for purpose

Poor physical infrastructure has a negative impact on ward safety and security as well as care and treatment. Proper upkeep is therefore important not only to keep people safe and secure but also to support people to feel valued and at ease. Several responses to the Review from inpatient units highlighted concerns about the fabric of their buildings. Staff highlighted elements of their wards that are no longer fit for purpose. The Review saw examples of wards in many of the places they visited which, irrespective of age, were in need of more focused routine maintenance or were poorly decorated. A smaller number of wards did not meet the physical standards appropriate to that level of security.

The physical layout of some wards is interfering with their day to day functions. Several members of staff flagged up that older buildings lack dedicated spaces for

¹⁶ Ulrich (2018) *Psychiatric Ward Design can reduce aggressive behaviour* in 'Journal of Environmental Psychology' 57 pp.53-66. Available at: <https://www.sciencedirect.com/science/article/pii/S0272494418303955>

delivering interventions such as psychological therapies. This means that some people are unable to receive parts of their care and treatment in an appropriate setting. Similarly, many families identified that dedicated facilities for visitors are absent or unfit for purpose. The Review noted that the outdoor space available to wards on some units were limited in space. This restricts access to recreation, exercise and therapeutic activities. Some units have allowed these outdoor spaces to become overgrown with weeds and moss. This may discourage people from using it and does not support people feeling valued.

The nature of communal and social spaces affects the atmosphere of a ward and can have a significant impact upon the experiences of people living there. The Review was concerned by the limited size of free circulation and socialising space in many areas it visited. A person's access to personal space must be balanced with risk management requirements. However, grouping people together in small areas for prolonged periods of time is likely to have a detrimental effect on mental wellbeing and distress levels.

Recommendations

Recommendation 36: The poor state of repair of current forensic inpatient environments, including outside space where it is provided, should be addressed by individual Health Boards to ensure they are therapeutic spaces which demonstrate a value being placed on the people detained there.

Recommendation 37: Evidence-based design of therapeutic environments should inform the planning stages of all renovations and new developments within the forensic estate.

6.2.2 Person-centred practices

Access to personal and private space is important to support individual dignity. It also allows people to self-regulate their exposure to potentially stressful social situations. The right to respect for private and family life is set down under Article 8 of the European Convention on Human Rights (ECHR). It is not an absolute right but forensic mental health services need to ensure that any limitations placed on a

person are proportionate and can be justified in terms of managing a person's risk. As noted in the interim report, the Review found considerable variations in social practices and restrictions related to this within inpatient environments. These variations were often not explained by the differences in security levels. Blanket rules are also applied in some areas rather than person-centred approaches. These fail to support the individual autonomy and decision making necessary to ensure the service is recovery focused and rehabilitation orientated.

People highlighted the following variations as having a particularly significant impact on their wellbeing:

- freedom of access to their bedrooms and belongings;
- opportunities for private conversations; and,
- access to technology.

These concerns resemble those highlighted to the Mental Welfare Commission when it visited the low and medium secure estate in 2017.¹⁷

The Review was disappointed to find people in one area were required to share rooms, including some in four bedded dormitory accommodation. Individual bedrooms themselves were of variable standards with different rules being applied across the same levels of security, by different clinical and managerial teams. There are still some low and medium secure wards preventing everyone accessing their bedroom for large parts of the day. Staff explain this is to encourage participation in ward activities and discourage isolation. However, other wards are taking a more person-centred approach where bedrooms are kept open. If there are concerns about someone's isolating behaviour, they are then encouraged and supported to spend time in the communal areas as part of their care plan.

It is important to people that they have some choice about the belongings they can keep on wards. However, people spoke critically about the different rules in different services about the number and type of belongings they could have. People worried about having to reduce how many belonging they had or no longer being allowed certain items due to different restrictions in different hospitals. This was not only

¹⁷ Mental Welfare Commission (2019) *Visiting and monitoring report: Medium and low secure forensic services*. Available at: https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf

confusing for people, but added to the stress they felt about transferring between services. As the interim report set out, people receiving care felt that decisions around these restrictions were not always based around an assessment of their need. They felt decisions were made arbitrarily or depended more on the staff's ability to keep track of belongings or available space on the ward. The Review recognises the risk element related to the number and type of personal possessions a person has in their room, however, this should be balanced with a consistent, person-centred approach to the issue.

In addition to the lack of appropriate visitor's facilities in some parts of the forensic estate, in several units people highlighted that ward layout or practices prevented them from conducting private telephone conversations with family or friends. This lack of privacy was identified as a barrier to maintaining personal relationships.

The Review team witnessed other restrictive practices during its visits to inpatient units. For example, people on a number of wards said that they were not allowed to use the kitchen to make their own cups of tea. It is the view of the Review that such restrictions are infantilising and contrary to the principles of person-centred practice, rehabilitation and the least restrictive option. As the interim report highlighted, people particularly appreciated when there were more opportunities use the kitchen, for example, to plan and prepare meals for staff and others on their wards. In some areas the Review found evidence of professional silos further restricting access to kitchens and indicating a less than whole team approach to rehabilitation. During a number of the Review's visits, the kitchen was described as the 'OT kitchen' with its use restricted to sessions with occupational therapists. This suggests that other members of staff were not involved in or were reluctant to support people to use these facilities. Rehabilitation should not simply be the domain of one profession.

There are inconsistencies in the level of access that people have to technology including laptops, mobile phones, the internet and games consoles across and between security levels. The Scottish Government the Forensic Network to set up a Communications and Specified Persons Short Life Working group to look at the use of communication and technology in mental health settings. It initially reported to the Scottish Government in November 2018, but the Forensic Network has now been asked to update further in light of developments in the use of technology since then, including as a result of the coronavirus pandemic.

Technology is now a fundamental part of active participation in society. It allows people to more easily access education, shopping, banking, benefits and the job market, as well as staying in touch with friends and family. Ensuring that people have opportunities to learn the skills and knowledge to use technology safely and confidently as part of their rehabilitation pathway is critical, therefore, if they are not to be disadvantaged on discharge. People the Review spoke to on forensic wards wanted staff to receive IT training in order to support them to develop these skills and also inform the development of less restrictive practices.

There should be a consistent, positive risk taking approach to the access of technology for people, supported by trained staff and educational programmes, across all levels of security.

Recommendations

Recommendation 38: Everyone subject to detention within the forensic system should have their own single room.

Recommendation 39: The new Forensic Board should, under the direction of the Nurse Director, establish multi-disciplinary 'Best Practice' standards to guide least restrictive practices. These must have the principle of person-centred practice at their core and should be applied consistently across all forensic inpatient settings.

The standards must include guidance around enabling people to:

- access privacy to support relationships with family and friends;
- access bedrooms;
- access personal belongings; and,
- access technology – this should be accompanied by staff training to ensure they can confidently support a positive risk approach related to technology.

Recommendation 40: The Scottish Government should respond timeously to the Technology and Communications Group's updated report, which the Review hopes will reflect an enabling, rather than a risk averse approach in its recommendations.

6.2.3 Community placements

As part of a safe and successful rehabilitation programme, a person needs to have access to meaningful, structured activities. These promote skills development, social inclusion, structured routine and employability prospects. In the early stages of a person's journey, when they are subject to greater restrictions, these will primarily be provided by inpatient services. However, as they progress, people need to access community placements or vocational opportunities. By providing these, consistently in both inpatient and community settings, the aim is that people gain more ownership over the activities they are involved in and recognise for themselves the benefit of having a routine in its own right. This can then be a protective factor once a person is discharged and has to adjust to the loss of the constant support and routine that was previously provided by the ward environment. There is also an expectation that people will be able to demonstrate that they have successfully engaged in, and have in place, structured community activities to support any application for conditional discharge.

The Review heard that in some areas there is a worrying decline in the number of community projects capable of accommodating placements for people from the forensic system. People reported community resources closing down or just a lack of availability. Providing services to people with a forensic background can incur additional management, reporting and staff training obligations which all add to costs for the service providers. For some providers the reputational risk of doing so is just considered too great. In addition, changes to commissioning for some funded placements that were designed to increase accessibility have actually reduced accessibility for people from forensic mental health services. For example, the Review heard that a number of structured community placements now require their users to use self-directed support. This is not available to inpatients and so these placements cannot be accessed until a person is discharged. Any reduction in the availability of placements is not only an issue in terms of providing the structured activity required to allow a person to rehabilitate successfully to the community, but reduces the ability of services to get an activity or placement that matches a person's individual goals and interests.

In terms of reciprocity, as long as people in the forensic system are expected to take part in structured activities, there is a requirement on authorities to provide the

appropriate services. The Scottish Government therefore has a responsibility to ensure that suitable, skilled placements are available to support the rehabilitation of people back into the community.

Strong working relationships between statutory and third sector organisations are vital for successful activities and placements. These need to be underpinned by appropriate information sharing protocols as well as highly skilled staff to deliver an appropriately, person-centred experience. Third sector organisations have asked for more support to navigate the legislative requirements around disclosure when looking to work with people with a forensic background. Allied Health Professionals have identified this as a wider need for anyone supporting someone with mental health issues and criminal convictions. They have shared a draft guidance document with the Scottish Government to fill this gap.

Recommendations

Recommendation 41: The Scottish Government, together with forensic mental health services, should monitor the availability of placement providers to ensure there are sufficient available to support the rehabilitation of people in forensic inpatient services and to sustain them for people discharged back into the community.

Recommendation 42: The Scottish Government should re-engage with Allied Health Professionals to finalise their draft guidance aimed at supporting people with criminal convictions and mental health conditions into work, volunteering or education.

7 Specific populations

7.1 People with learning disabilities

People in forensic mental health services who have a learning disability have specific and sometimes highly complex needs. This should not have any discriminatory impact on how they are treated or the services they receive. The Forensic Network's annual census data shows that, on average, people with a learning disability spend a longer time in secure forensic services than people with a mental illness. In 2019, people with a learning disability had spent 6.7 years in their current hospital, while people with mental illness had spent 4 years. This raises human rights concerns because it suggests that people with a learning disability are likely to be subject to restrictions for a longer time than other people. When in hospital, staff said that people with a learning disability are sometimes placed in conditions of greater security than are required to manage their risks. They are also disproportionately affected by delayed discharge because of challenges finding appropriate support and accommodation in the community. These delays are contrary to the principles of reciprocity and the least restrictive option because they keep people in conditions of excessive security.

The Review heard that people with a learning disability should be given more choice about what happens to them, like what accommodation they will return to in the community. They should also be in environments that are adapted to their needs.

7.1.1 Supporting people to go through the criminal justice system

The Review heard concerns that people with a learning disability are diverted to secure inpatient settings for offences that might not have been severe enough to receive a prison sentence in the criminal justice system. It also heard of people being subject to these restrictions in hospital for longer than any prison sentence that may have been imposed for a comparable offence.

Professionals agreed that people with a learning disability who are accused of offending should, by default, be supported within the criminal justice system. This was endorsed by people with lived experience who spoke to the Review. One person in medium security said they would have been able to stand trial if they had had a little more support to understand what was going on. They also believed that had they gone to prison, they would have served their sentence long ago and been

back in the community. People with a learning disability should only be diverted to hospital if they are unable to participate in the criminal justice system despite reasonable support being provided. Some people also said that people with a learning disability should receive 'parity of disposal'. This means that they should not be placed on criminal orders that last longer than for other people.

This Review is aware of the reports by the Equality and Human Rights Commission (2020) and the Law Society for Scotland (2019) that offer guidance on supporting vulnerable people within the criminal justice system.¹⁸ These make clear that people with a learning disability require support to effectively communicate and participate in criminal justice processes. Appropriate Adults services are there to ensure vulnerable people are helped to understand what is going on and supported during police procedures. It is likely that Appropriate Adult or equivalent support will be required throughout the criminal justice process in order to allow people with a learning disability to fully participate.

Recommendations

Recommendation 43: There must be a presumption that people with a learning disability who are accused of an offence will be supported to go through the criminal justice system. They should only be diverted to hospital where this has not been possible.

Recommendation 44: The Scottish Government should commission a study to examine the experiences of offenders with a learning disability compared with offenders in the general population and offenders with a mental illness. This study should compare court 'disposals' for similar offences, including whether people are given prison sentences or diverted to hospital for treatment. It should also explore what kind of restrictions are associated with these 'disposals' and the length of time people are subject to them.

¹⁸ Equality and Human Rights Commission (2020) *Inclusive justice: a system designed for all*. Available at: <https://www.equalityhumanrights.com/en/publication-download/inclusive-justice-system-designed-all>
Law Society for Scotland (2019) *Report – Vulnerable Accused Persons*. Available at: <https://www.lawscot.org.uk/media/362501/vulnerable-accused-persons-report-final.pdf>

7.1.2 Hospitals

Care and treatment

People in forensic mental health services should be managed in the least restrictive environment possible whilst meeting their care and treatment needs and risk management requirements. Some professionals raised a concern that this does not always happen for people with a learning disability. In particular, there was a feeling that the seriousness of a person's offence could lead to incorrect assumptions about the level of security required to manage their risks. Clinicians emphasised that the rehabilitation pathway for people with a learning disability is different to that for people with mental illness and that decisions about their care and treatment should not necessarily be made in the same way. No specific change of procedure is required to address these concerns but there should be a culture of considering a person's needs holistically when responding to a referral, alongside information about their offence.

The care and treatment of people with a learning disability requires a different approach to that for people with mental illness. In settings where these populations may be cared for on the same units and/or by the same staff teams it is critical that staff are equipped with the skills to manage both groups effectively, and to switch between different approaches to care and communication as appropriate. In Section 8.3, it is recommended that standards for staff skillsets and training should include best practice in relation to the care and treatment of people with learning disabilities.

Whilst all inpatient units should be designed as therapeutic environments (see Section 6.2.1), it is particularly important that services caring for people with learning disabilities are designed to accommodate different sensory needs.

Management of low secure and community forensic learning disability services

People with learning disabilities within the forensic system are relatively small in number. The Forensic Network's census of people in inpatient forensic services in 2019 identified 75 people with a learning disability and four with a learning disability and a mental illness. Reflecting this, there are fewer forensic learning disability services than forensic mental health services and some areas do not have this specialist provision. The Review heard that this had resulted in differences in

practice and levels of expertise across Scotland and that there was a need for a more consistent approach.

The State Hospital provides the national high secure services for men with learning disability. The National Medium Secure Intellectual Disability Service for men and women is hosted by Rowanbank. Outwith these high and medium secure services, the management structures for forensic learning disability services vary. Some low secure learning disability units sit under forensic mental health whilst others are located within generic learning disability services. Similarly, the Review's survey of community forensic mental health services found that some are managed by Health Boards whilst others are located within Health and Social Care Partnerships.

There is a concern that people with a learning disability in the community are not always able to access specialist forensic provision. It is believed they are more likely than people with mental illness to be offered generic rather than specialist forensic services.

People with a learning disability have different rehabilitation needs to people with mental illness. Clinicians felt that guidance provided for forensic mental health services overall did not always reflect these differences. However, it is important that the needs of people with a learning disability are met throughout their journey within the forensic system, and particularly so when preparing for life in the community. The Review heard that generic learning disability services have significant expertise in helping people with learning disabilities transition from inpatient to community services.

Reflecting the existing management structures of many low secure and community forensic learning disability services and the location of professional expertise about this group, the Review believes it may be preferable for forensic learning disability services to be managed by generic learning disability services rather than transfer to the management of the new Forensic Board.

Recommendations

Recommendation 45: Low secure and community forensic learning disability services should be managed under the local Health Board/Health & Social Care Partnership generic learning disability services. This arrangement should be reviewed within 3-5 years of the new Forensic Board being established.

Recommendation 46: The new Forensic Board should collaborate with generic learning disability services to develop appropriate standards for forensic learning disability services.

Recommendation 47: In areas without forensic learning disability services, generic learning disability services should be supported to embed professionals with forensic training and expertise within their workforce.

Recommendation 48: The new Forensic Board should establish mechanisms to provide consultation, advice, and professional supervision for all staff involved in the care and treatment of people with learning disabilities who have forensic needs.

Delayed discharge and restrictions

People with a learning disability appear to be more severely affected by delays in discharge into the community than other groups. This issue has been highlighted before in both the *Coming Home* report, published by the Scottish Government in 2018, and the Mental Welfare Commission's *No through road* report in 2016.¹⁹ The delays are attributed, in part, to the complexity of the support and accommodation packages that are often required. However, the Review heard concerns that severely delayed discharges can be an 'accepted' part of this group's experiences.

¹⁹ MacDonald, A. (2018) *Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs*. Online: Scottish Government. Available at: <https://www.gov.scot/publications/coming-home-complex-care-needs-out-area-placements-report-2018/> and Mental Welfare Commission (2016) *Visit and monitoring report: No through road: People with learning disabilities in hospitals*. Available at: https://www.mwscot.org.uk/sites/default/files/2019-06/no_through_road.pdf

This represents a human rights concern that people remaining in hospital without clinical need are being held in conditions of excessive security.

The Review team recognises that it can take some time to arrange a community package for people with a learning disability. In recognition of this, planning for a person's community transition should begin when they first enter services, not simply within low secure services. Forensic professionals in low secure should continue to work closely with colleagues in forensic community services, local authority housing officers, and community support providers to identify accommodation and support options appropriate to that individual. As recommended in Section 5.3.1, delayed discharges within the forensic system should be subject to the same monitoring and standards as in acute health services and plans should be submitted to the Scottish Government which address the outstanding needs of anyone who has been delayed for over six months.

As noted above, people with learning disabilities have different rehabilitation needs to people with mental illness. They should not be expected to follow the same discharge pathways. Some people with learning disabilities may never be in a position to take unescorted leave or live independently, but this should not prevent discharge into the community where their risk can be managed with supervision.

Community accommodation

There is a need for high quality community accommodation for people with learning disabilities. Community accommodation should be designed or adapted to offer a therapeutic environment that meets people's sensory needs. People should be given some choice over the accommodation that they are discharged to. Whilst single person units may be suitable for some people, others may prefer shared accommodation options. Those responsible for commissioning community accommodation for people with learning disabilities should also be mindful of offering 'different solutions for different stages' of a person's rehabilitation in the community.

Recommendations

Recommendation 49: Health and Social Care Partnership commissioners must ensure community accommodation can be adapted to meet the sensory and other needs of people with a learning disability

Recommendation 50: Health and Social Care Partnership commissioners must ensure that people with a learning disability have a choice about whether to move into single person or communal accommodation in the community.

7.2 People with neurodevelopmental disorders

There are people who have neurodevelopmental disorders, alongside co-existing mental illness or a learning disability, who are receiving care and treatment in the forensic system. It is not possible to say how many people because no data is collected on this group.

As the interim report highlighted, there is no specific provision or forensic pathway for people with a sole diagnosis of Autism Spectrum Disorder (ASD). It is criminal justice services, rather than forensic mental health services, that have the primary responsibility for addressing the offending behaviour of people who have ASD, but no mental illness or learning disability. There are concerns that this arrangement means people with ASD, and people working with them, are not able to access specialist forensic mental health expertise and support when it is required.

The Review was made aware of two NHS Board areas where existing forensic mental health services sought to address this gap. They both set up assessment and consultation services for people in criminal justice and other agencies working with people with ASD who would benefit from forensic mental health input. The project in NHS Fife did not continue past its pilot phase. However, there continues to be a multi-disciplinary team within NHS Greater Glasgow and Clyde's, Specialist Treatment Addressing Risk (STAR) service. It takes referrals from, and provides specialist support to, NHS colleagues, criminal justice social work, community mental health teams and others working with people with ASD.

After the publication of the interim report, the Review heard additional concerns about the lack of services for people with Attention Deficit Hyperactivity Disorder (ADHD) and/or Foetal Alcohol Syndrome Disorder (FASD). Emerging research suggests that people with FASD may be overrepresented, unrecognised and vulnerable in the justice system.²⁰ Staff identified that the needs of these people are not being met in custody or recognised early enough in the community. Clinicians in forensic mental health services argued that the needs of people with FASD need to be better understood and addressed, not only to ensure that they receive the correct level of support but as part of any overarching prevention of offending strategy.

Recommendation

Recommendation 51: The new Forensic Board should undertake a needs assessment related to neurodevelopmental disorders and forensic mental health services. This should inform future service provision.

7.3 Children and young people

The interim report highlighted the lack of general or specific forensic mental health services for children and young people in conflict with the law. In the community, only NHS Greater Glasgow and Clyde have a Forensic Child and Adolescent Mental Health Service (FCAMHS), and the in-reach of general Child and Adolescent Health Services into secure care was reported to be variable. A lack of low secure inpatient care can result in young people being placed in adult Intensive Psychiatric Care Units (IPCUs). Young people requiring medium secure care, including those with a learning disability, are currently placed in specialist provision in England which inevitably takes them away from their support networks.

The building of a new National Secure Adolescent Inpatient Service (NSAIS) was approved around the same time as this Review was commissioned. The Review did not seek to review this decision. The NSAIS will be a 12 bed unit situated within

²⁰ Flannigan et al (2018) 'Fetal Alcohol Spectrum Disorder and the criminal justice system: A systematic literature review' *International Journal of Law and Psychiatry* 57 pp.42-52. Available at: https://canfasd.ca/wp-content/uploads/2018/02/Flannigan.etal_.2018.FASD_justice_review.pdf

NHS Ayrshire and Arran for young people up to the age of 19. It is a medium secure unit with some low secure provision to allow for step down. Within its planning, there is capacity for three beds for young people with a mild to moderate learning disability that require secure care. A national four-bedded unit for young people aged 12-18 years with moderate, severe or profound learning disability and co-morbid mental health disorder is also planned; this will be in NHS Lothian.

People had suggested to the Review that the 12-bed NSAIS unit may not meet current needs. Recent needs assessment suggest there may have been a fall in previous demand as some of the young people are now in need of adult services. It was also made clear to the Review that the unit would not address the known lack of intensive psychiatric care provision for young people, more generally.

The Review is pleased that work is underway to address some of the gaps in secure provision for young people in Scotland. The new NSAIS represents a significant investment in inpatient care and the team in NSAIS have a vision for the shortest possible stay. However, there will need to be clear pathways out of this unit. These require, first, a corresponding commitment to investment in community mental health provision to support these young people to return to and thrive in their local communities. The National Child and Adolescent Mental Health Service (CAMHS) specifications say local CAMHS teams must have access to forensic specialist expertise.²¹ Community FCAMHS expertise can be found in NHS Greater Glasgow and Clyde and will develop within the new adolescent units.

Second, there must be a clear pathway for young people to transition to adult forensic mental health services if required. The Review heard that FCAMHS clinicians have previously struggled to move young people into adult forensic mental health services. This is because the risk assessment for adult services are based around offending histories, which meant that these young people were 'not forensic enough'. The Review agrees with the families we spoke to that this is counter to a proactive preventive health promoting approach. Nonetheless, it is important to emphasise that the NSAIS should not be seen as an extension of, or stepping stone to, adult forensic mental health services. For this reason, the Review does not

²¹ Scottish Government (2020) *Child and Adolescent Mental Health Services: national service standards*. Available at: <https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification>

consider it to be appropriate for the service to be managed under the new Forensic Board.

The latest estimates provided to the Review are that the building work for the NSAIS would start in April/May 2021, with the first young person admitted in April 2022. The Learning Disability CAMHS unit in NHS Lothian should open in 2022/3. In March 2020, the Mental Welfare Commission recommended that clear protocols be developed in the interim for young people who require forensic or learning disability inpatient facilities to address the current gap in provision.²² The Review was not made aware of any such protocols being under development and clinicians remained concerned about the lack of provision meantime.

Recommendations

Recommendation 52: The Review recommends that the National Secure Adolescent Inpatient Service does not fall under the remit of the new Forensic Board. This position should be reviewed within 5 years of the National Secure Adolescent Inpatient Service opening to ensure this continues to provide the best pathway for young people.

Recommendation 53: The National Secure Adolescent Inpatient Service should set up a service to provide access to forensic specialist expertise for local CAMHS teams to support clear pathways into and out of the National Secure Adolescent Inpatient Service.

Recommendation 54: A clearly defined pathway should be agreed between the new Forensic Board and the National Adolescent Secure Inpatient Service for young people who do need to transition to adult forensic mental health services.

Recommendation 55: Clear interim arrangements need to be put in place for young people in Scotland who require forensic or learning disability inpatient facilities prior to the National Adolescent Secure Inpatient Service facility being opened. This should be actioned by the end of 2021.

²² Mental Welfare Commission (2020) *Young People Monitoring Report, 2018-19*. Available at: https://www.mwccot.org.uk/sites/default/files/2020-05/YoungPeopleMonitoringReport_2018-19.pdf

7.4 Older adults

The forensic population is ageing and the Review heard that there is an increase in older adults entering the system for the first time as a result of historic offences. The Scottish Government's census found 9% of people receiving forensic mental health services in NHS Scotland facilities in March 2019 were 65 or older.²³ The Forensic Network's annual inpatient census data indicates that the number of over-65s has risen by 50% in the years from 2013-2019, from 14 to 21 individuals in total. Over the same time period, the number of people aged 56-65 has risen by 27%, from 48 to 61 individuals. The number of older adults under the care of forensic community services is unknown.

At present, there is no upper-age limit for admission to forensic mental health services. Decisions to admit are made on a case by case basis and clinicians emphasised that they would not refuse a referral for someone with forensic needs on the basis of age alone. This is because it is possible to manage the needs of some older adults well within inpatients units, with some preferring to live, and indeed thriving, in a mixed-age environment. Where older adults are cared for in forensic mental health services, it was felt that it is good practice to work with old age psychiatry and old age medicine colleagues to identify and support them with any additional mental and physical health needs. However, there is a gap in specialist provision for people who have more significant age-related physical or cognitive difficulties who also require a secure care setting. This remains manageable while the number of people involved are low but, as with the general population, this cohort of people within the forensic system is likely to increase.

It was highlighted to the Review that people in forensic mental health services can have an older 'biological age' than their 'chronological age'. This means they can face age-related difficulties earlier than the general population. These include cognitive deterioration through dementia, physical frailty, and communication difficulties through hearing loss. Some staff in the forensic system told the Review that they do not feel equipped to recognise and respond to these issues. They also felt that existing forensic units are not currently set up for an ageing population.

²³ Scottish Government, *Inpatient Census 2019*. Available at: <https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/>

There is a need to make adaptations to accommodate this group, but staff said that the physical make-up of some buildings can make this challenging.

The lack of a specific forensic pathway for older adults with additional age-related health needs means they can remain inappropriately in mixed-age inpatient units due to a lack of alternative provision. These settings are not always best-placed to meet these needs, nor to support the individual to live well as these needs increase. It was also not clear whether older adults who have additional mental or physical health needs should be cared for within forensic mental health services at all. In particular, people identified a lack of clarity around which part of the health service should have lead responsibility for the care of adults with a diagnosis of dementia.

There is a second distinct cohort of forensic patients who require age-related care. This is people who could be considered for discharge to the community if appropriate accommodation was available. Moving older adults on from forensic inpatient services is challenging. Risk management issues and the stigma associated with forensic mental health services can make it difficult or inappropriate to discharge this group of older adults into general older adult mental health services or care homes in the community. Where people experience deterioration in cognitive ability they may also require further risk assessment. Care homes may feel unable or unwilling to take in people with restriction orders and to manage their risks. This is a particular issue for people with a history of sexual offending.

Clinicians considered that the creation of bespoke solutions was the most appropriate course of action for older adults who were ready to be discharged into the community where numbers remain low. This was felt most likely to enable people to reside in their local area or near to friends and family. If this option is adopted the new Forensic Board would need to consider facilitating arrangements between community forensic mental health teams and individual care homes on a local or regional level, to support care homes to accommodate people from forensic inpatient services and to safely manage their risks.

As the number of people requiring secure age-related care increases there may be a business case for developing specialist provision such as a secure nursing home(s) at a national or regional level. Research into secure services for older adults has identified they would require a specialised multi-disciplinary approach. It was also suggested that older adults within forensic mental health services may have

overlapping needs with older adults in the prison population who are on longer sentences and unlikely to be discharged.

Recommendations

Recommendation 56: The new Forensic Board should make an assessment of age-related needs across all forensic mental health services and, based on current and projected demand, develop an older adults' pathway that reflects the care and risk management needs of this group.

- The new Forensic Board should work with the Scottish Prison Service to consider whether older adults in prison would also benefit from age-related care in an alternative secure setting.

Recommendation 57: The new Forensic Board should conduct an assessment of staff training gaps around the age-related health needs of older adults, particularly around dementia, and make provisions to improve staff skills and confidence in this area.

7.5 Northern Ireland

There is no high secure forensic provision in Northern Ireland. High secure services for men from Northern Ireland are currently provided through an arrangement with The State Hospital. Northern Ireland has a relatively small population requiring high secure care. There has been an average of six men from Northern Ireland in the State Hospital between 2015 and 2020. Overall numbers have reduced over this time from 10 to four.

Officials in Northern Ireland reported that this cross border arrangement works well and is supported by good relationships with The State Hospital and the Scottish Government. The current legislation in Northern Ireland and Scotland works relatively well together, but transfer between jurisdictions requires very robust information that must be reviewed against legal tests. The information gathering process can cause some delays. The Review was also told that on occasion legal issues have made it difficult for people to return to Northern Ireland.

Whilst Northern Ireland is in the process of developing its forensic infrastructure for people with mental illness or learning disability, officials told the Review that there is no long term plan to provide high secure services, although consideration might be given to developing this in the future. However, it would take some years to develop and represent a very high cost given the small numbers involved. As such, they do not have the resources, expertise or facilities to provide high secure care locally at the moment.

The current arrangement is acknowledged to be less than ideal in respect of the distance placed between people and their families. However, both parties to the arrangement consider that continued access to the specialist therapeutic input available in the secure environment of the State Hospital is in the best interests of the small population requiring this care. The Review agrees that this arrangement should continue, as capacity allows, until a high secure alternative is available in Northern Ireland.

The State Hospital does not charge Northern Ireland for these high secure services. The Review found this surprising given the length of time some people have been cared for in the State Hospital, the current out of area and exceptional circumstances cross-charging taking place internally across NHS Scotland, and the charges NHS Scotland pay for women's high secure care in England.

Recommendation

Recommendation 58: The Review recommends that the State Hospital introduces charges for the care and treatment of people from Northern Ireland. These costs should be benchmarked against the costs incurred by NHS Scotland for the high secure care and treatment currently provided to women from Scotland at Rampton Hospital.

8 Sharing information and expertise

High quality care is multi-disciplinary in nature. Professionals from multiple backgrounds, including clinicians and support workers need to be involved in needs assessment, care planning, risk assessment and risk management planning. These assessments and plans should also be developed in liaison with the person, their family and supporting professionals from external agencies. The ability to effectively share relevant information is critical in this endeavour.

There are increasing requests for specialist forensic support from people in the wider health, social care and criminal justice systems who are managing or caring for people with forensic needs. Different decisions are being reached at a local level about how to respond to these needs. This has created instances of inconsistency and uncertainty about such provision across the country. There is a need for more co-ordinated or strategic approaches to sharing forensic expertise with partners.

The Review also heard about training and development needs for staff working in the forensic system as well as those in partner agencies.

8.1 Sharing information about people in forensic mental health services

Existing forms of multi-disciplinary working embedded in forensic mental health services, including multi-disciplinary team (MDT) meetings and Care Programme Approach (CPA) meetings, were consistently highlighted as facilitating good collaboration and information sharing between all the professionals involved in a person's care. High quality information sharing is also integral to clinical risk management. The interim report highlighted that the different electronic record keeping systems across forensic units and security levels did not support good information sharing. These differences were associated with difficulties, delays and the unnecessary repetition of assessments.

Staff asked for a shared electronic health records system and consistent electronic formats for assessments to support information sharing across the forensic system. It was felt these would reduce the need for duplicating or redrafting assessments, as well as prevent the loss of information when a person moves between different forensic settings. Increasing the ease of access to relevant information in this way

could make it easier to access care and treatment in an appropriate setting and help to reduce waiting times. It could also support forensic mental health services to develop protocols for sharing information, where appropriate, with external organisations involved in a person's management or care. These organisations include generic mental health services, social work and criminal justice services, and third sector community providers.

Recommendations

Recommendation 59: The new Forensic Board should have a single electronic health records system. All staff in forensic mental health services should use the system and the Board should ensure that staff have access to technology of an appropriate quality to support their work.

Recommendation 60: The new Forensic Board's single electronic health records system should include a facility to clearly record where a person does, and where a person does not, consent to their information being shared with family members and certain partner organisations.

- Clinicians should proactively seek consent to share information with appropriate family members.
- People should be given a regular opportunity to update their wishes about how their information is shared.

Recommendation 61: The new Forensic Board should develop a procedure for sharing information with external organisations to support consistent practices across forensic mental health services that balance the rights of the individual and the protection of the public.

8.2 Provision of forensic mental health expertise to external agencies

There is demand for forensic professionals to share their expertise with other individuals or agencies whose work involves care and treatment and/or risk management of people with major mental disorders and offending histories. This work may involve advising colleagues in generic mental health services as well as external partners, such as agencies in the criminal justice system. In particular, there has been a call for greater input from forensic mental health services into the Multi-Agency Public Protection Arrangements (MAPPA).

8.2.1 Multi-Agency Public Protection Arrangements

MAPPA is a set of arrangements to manage registered sex offenders, restricted patients and people who are assessed as presenting a serious risk of harm to the community. It is made up of four responsible agencies: Police Scotland; local authorities (justice social work services); the Scottish Prison Service; and NHS Health Boards. Each takes the lead for different populations, with health as the lead responsible authority for restricted patients. Restricted patients, however, represent only a very small proportion – approximately 4% – of the people managed under MAPPA.

The clinical service available to the criminal justice agencies in MAPPA and the offenders they manage is inconsistent across the country. Many of these offenders have a primary diagnosis of personality disorder and can find it difficult to access mental health services even when they have secondary diagnoses of mental illness. MAPPA requires input from mental health professionals, particularly clinical psychologists, in order to develop appropriate risk management plans for these people. There is a specific need for forensic mental health professionals to undertake this work because practitioners in generic mental health services do not always feel they have the right expertise for working with people who have offending histories. At present, however, there is no consistent route or resourcing to support the volume of forensic input MAPPA require.

The Review heard from a number of Health Boards that have developed some form of consultation and advice service to ‘plug the gap’ for people with mental disorders and an offending history who fall outside the typical remit of forensic mental health services. Included among these are the Serious Offender Liaison Service (SOLS) at NHS Lothian and the Specialist Treatment Addressing Risk (STAR) service at NHS

Greater Glasgow and Clyde. However, such services are not available in all parts of the country, nor do they operate under a consistent remit.

Criminal justice agencies involved with MAPPA have expressed a desire for more consistent access to forensic mental health expertise across Scotland. As reflected in the Review's interim report, a number of people suggested there should be a national service following models such as SOLS and STAR. There was also feedback that access to a national forensic consultation service would be of benefit to health colleagues working in generic mental health services and in remote or rural areas.

Recommendation

Recommendation 62: The new Forensic Board should develop a consistent way of providing consultation and advice to MAPPA and other external individuals or organisations (including other NHS services) that may benefit from access to forensic mental health expertise.

- The Scottish Government should work with the new Forensic Board to ensure that this consultation and advice service is adequately funded.

8.2.2 Court reports

Provision of psychiatric and psychological reports to the courts are critical to the smooth running of the criminal justice system. Requested by the Crown Office and Procurator Fiscal Service (COPFS) or the courts, these reports inform decisions such as whether to bring a person to trial and the appropriate 'disposal' for someone found to have committed an offence. As such, timely provision of reports not only impacts on fair process but also on access to appropriate care and treatment for people accused of offences.

For such a vital part of the criminal justice system, however, there is no national agreed process for the courts or COPFS to obtain psychiatric and psychological reports. There is no agreed fee structure for these reports, no statutory obligation on anyone to provide them and no approved list of providers. This lack of governance has resulted in regional variations and sometimes ad hoc arrangements which are

associated with uncertainty and frustration on the part of the courts and COPFS, as well as clinicians. Current practice is also associated with delays that can mean courts fail to meet their own statutory requirements and accused persons have to wait longer to access appropriate care and treatment. The number of reports required by Scottish courts averages in excess of 1000 each year. This is associated with costs of over £555,000.

There is no statutory duty on the NHS to provide court reports and this activity is not included in NHS clinicians' job descriptions. However, difficulties can occur when courts rely on independent providers, who can lack relevant knowledge of available service and treatment options and be unable to facilitate hospital admissions when required. Independent reports can also negatively impact on a person's care and treatment as the NHS teams who ultimately take on the care and treatment of the person do not always have access to them. This can lead to assessments being repeated and consequent concerns about practice effects in psychological tests. As such, there was general consensus that court reports would ideally be provided by the NHS.

There needs to be a clear and consistent procedure for requesting reports that allows for equitable provision across Scotland. People suggested this could include a single point of contact to request them, specified timescales for their provision and a more standardised approach to the reports themselves. There were several calls for levels of remuneration to better reflect the cost of provision and for the creation of an administratively straightforward method of payment.

Dame Elish Angiolini's Commission for Women Offenders report recommended in 2012 that a national service level agreement for the provision of psychiatric reports should be developed between the NHS and the courts, with the aim of increasing access and timeliness of such reports to assist the courts with sentencing decisions.²⁴ This Review is aware of other scoping exercises aimed at reaching solutions at both national and local levels, which have been conducted since the publication of the Angiolini report, but none have resulted in any changes.

²⁴ Angiolini report (2012), *Commission on women offenders*. Available at: <https://www.webarchive.org.uk/wayback/archive/3000/https://www.gov.scot/Resource/0039/00391828.pdf>

There needs to be a co-ordinated solution to the provision of these court reports and calls for such a solution are not new. Their provision should not be left to ad-hoc arrangements across the country nor impacted by different parts of the public sector having to argue over appropriate levels of remuneration.

Recommendations

Recommendation 63: The Scottish Government should bring together the NHS, the Scottish Courts and Tribunals Service and the Crown Office and Procurator Fiscal Service to agree an appropriately funded national framework to ensure the timely provision of court reports by psychiatrists and psychologists for assessment and sentencing purposes. This should be actioned within one year of the publication of this report.

Recommendation 64: The Scottish Government, together with the new Forensic Board and the relevant criminal justice agencies, should review the current limitations about which disciplines can complete court reports. They should consider what professional qualifications and training are necessary for the completion of these reports, including whether a change of law is required.

8.3 Research, education and training

The forensic mental health community is well supported in its training and development needs by the School of Forensic Mental Health. This is a virtual school hosted by the Forensic Network. It was established in 2007 to address concerns about education and training of professionals in the forensic system, to promote research and to build an evidence base for services. It has developed a suite of 'New to Forensic' programmes alongside NHS Education for Scotland, and academic courses in collaboration with the University of the West of Scotland and New College Lanarkshire. It also delivers a range of short courses to meet the training needs of forensic mental health professionals and partner agencies. These learning and development opportunities and the work of the School overall was highly praised by staff working in forensic mental health services.

Some staff working in forensic mental health services felt they lacked the necessary skills to work with certain groups, including older adults and people with learning disabilities as well as other neurodevelopmental disorders. A number of people emphasised that forensic staff caring for people with learning disabilities should have access to training on Positive Behavioural Support and be given the power to implement this approach within their work.

People also felt there was a need for more access to forensic specialist support, training and development opportunities for staff in generic services who may encounter people with forensic needs. People specifically spoke about needing this support in remote or rural areas. They also identified a need for early-intervention training to help GPs pick up early warning signs of people who are at risk of offending due to their mental illness or learning disability.

Criminal justice services said that they do benefit from training from forensic mental health professionals, including via the Forensic Network. But they want more in-reach to support their work with offenders living with mental illness or learning disability. Advocacy staff highlighted that they would benefit from proactive training about forensic mental health issues, rather than 'waiting until times of crisis'.

Third sector providers play an important role in the safe discharge of people from forensic inpatient services into the community. It was widely acknowledged that the staff working in these community services require good quality training in working with people with forensic backgrounds to support their work, and that a lack of training was linked to the breakdown of support packages and people being readmitted to hospital. There is no systematic training for community providers. One community forensic mental health team described offering it in the past but had to stop. It was not part of their official remit and it had become unsustainable, in part because the high turnover of staff in the support services meant it needed to be frequently repeated. Where such training can be provided, it is valued. One third sector organisation, praising the joint working they have experienced with their CFMHT, also considered themselves 'very lucky to be provided with training opportunities with one of the Forensic Psychologists within the team'. This all suggests efforts must be made to retain forensically-experienced staff in these third sector organisations.

People spoke more generally of difficulties accessing training opportunities due to limited resources or inflexible shift patterns. Education and training opportunities should be made as accessible as possible. This means that training should be delivered at regular intervals, at times when the most staff can attend, flexibly in small groups, or using online and video-link technology where appropriate.

Recommendations

Recommendation 65: The new Forensic Board must support the work of the School of Forensic Mental Health to continue developing and progressing education, training and research activities within Scotland's forensic mental health services.

Recommendation 66: Working with the School for Forensic Mental Health and wider stakeholders, the new Forensic Board should set evidence-based standards for staff skillsets and training, that include best practice in caring for and treating people with a learning disability.

- The new Forensic Board may consider the development of a specialist training programme for professionals entering forensic services including shadowing opportunities and rotation through services at different security levels in order to build up an expert skillset.

Recommendation 67: The new Forensic Board should work with community providers and partner agencies to develop skilled staff teams who are confident and empowered to provide support to people from forensic mental health services.

9 List of Recommendations

Strategic governance and oversight

Creating a single system

1. It is recommended that a new NHS Board should be created for forensic mental health services in Scotland.
 - All forensic mental health services, including both inpatient and community services, should be brought under the management of this new Forensic Board.
 - Forensic learning disability services at high and medium security should also be brought under the management of this new Forensic Board. The Review considers, however, that forensic learning disability services at low security and in the community should remain under the management of, or transition to management by, generic learning disability services (see Section 7.1).
 - The new Forensic Board should not be based in the State Hospital. To do so would be to further alienate and disenfranchise clinicians and managers across the country who already perceive there is significant power, resources and focus sitting inappropriately at the high secure level. The new Forensic Board must demonstrate practical engagement with all of its new service areas. Serious consideration should be given to basing the Board outwith the central belt, or as a minimum not within Edinburgh or Glasgow.
 - The new Forensic Board will supersede the role of the Forensic Network in providing strategic oversight of the forensic system. However, care should be taken to ensure that the Forensic Network's valuable role in advancing governance and professional networks within the forensic system is not lost during this transition, and is incorporated into the governance framework of the new Forensic Board where appropriate. The School of Forensic Mental Health should also be retained: its role is discussed further under Section 8.3 of this report.

Defining forensic mental health services

2. The definition and purpose of 'forensic mental health services' should be reviewed by the Scottish Government at a multi-disciplinary, multi-agency level to help inform the establishment of the new Forensic Board.

Women's pathways

High security provision

3. A high secure service for women should be opened in the State Hospital within nine months of the publication of this Review.
 - The design and staffing model for this unit must be able to appropriately flex to meet the care and treatment needs of both women with mental illness and women with a learning disability.
 - It will be for the new Forensic Board to review and determine appropriate arrangements for high secure provision for women in the longer term.

Women's pathways in forensic mental health services

4. The Short Life Working Group set up in response to the Forensic Network's report on the Women's Service and Pathways should reform to complete its work related to women's pathways across medium secure, low secure and community forensic settings.
 - The Short Life Working Group should initially report to the NHS Chief Executives' Group pending the formation of the new Forensic Board.
 - Its work must ensure a pathway for women to transfer from prison for forensic mental health care and treatment when required.
 - It should also consider the care needs of the group of women who may not meet the definition of 'forensic', but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services. While it is important not to draw these women inappropriately into forensic mental health services, there needs to be clear pathways around their longer term care and treatment. As such, representatives from the independent sector must be invited onto the Group.

Capacity and Transitions

Data collection and reporting

5. The Scottish Government should commission the Information and Statistics Division (ISD) of NHS National Services Scotland to develop a data management system to accurately collect, monitor and report on performance across forensic mental health services, including on service capacity and the timeliness of people's transitions.
 - This report identifies a number of further recommendations for specific data that should be collected, monitored and reported on within this system (see recommendations 7, 8, 20).

Pressures on medium secure services

6. NHS Greater Glasgow and Clyde plans to extend medium secure provision at Rowanbank Clinic should be progressed.
7. The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland should collect, monitor and report delays incurred by people assessed as ready to transfer to a different level of security. Any delay of four months or over must be reported to the Scottish Government.

Delays affecting discharges into the community

8. The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland must collect, monitor and record delayed discharges in a way that is as transparent as data collected in the acute (physical health) sector.
 - This should include delayed discharges and delays in progress towards conditional discharge as a result of waiting for accommodation or support packages. The 'clock' should start when the clinical team and the person agree that clinically they are ready to move to the next stage of their rehabilitation journey.
9. The management bodies of all forensic mental health services must identify anyone waiting for accommodation or support packages in the community to the extent that their discharge from these services - or their eligibility to start the

process towards conditional discharge - has been delayed for six months or more.

- Management bodies here refers to the relevant Health Board, Health and Social Care Partnership or independent provider providing care and treatment for the person.
- Within six months of this Review being published, these bodies must submit plans to the Scottish Government to address the outstanding needs of anyone it has identified as being delayed in this way.
- These bodies must continue to record, monitor and report on these delays on an ongoing basis until this responsibility is assumed by the new Forensic Board.

10. The new Forensic Board must work with social work teams and local authority housing departments to ensure that the commissioning process in each area provides appropriate support services and accommodation options for people with the need and risk profiles typical of individuals within the forensic mental health system.

11. The new Forensic Board must work with social work teams and local authority housing departments to develop an accommodation strategy that ensures individuals have access to community accommodation so that they can begin the discharge process in a timely manner when clinically appropriate.

12. Commissioners of community support and accommodation services should ensure that remuneration for people working in these services reflects the complexity of the forensic cohort and the need to retain skilled staff.

13. We recommend that people in low secure units should be given the right to make an application to the Tribunal where they are being detained in conditions of excessive security. This right should be equivalent to the one which people in high and medium secure units have under the Mental Health (Care and Treatment) (Scotland) Act 2003. It should apply to anyone in low secure services, allowing them to be moved into conditions of lesser security, including into the community. People in secure units whose plans for discharge into the community are being delayed as a result of the non-provision of the necessary facilities for a phased move to the community should also be given a right to

make an application to the Tribunal for an order that a relevant authority make the necessary provision.

- Where a Tribunal is satisfied that a person in low secure is being detained in conditions of excessive security, then it should make an order for the discharge process to begin. Where the person is to be discharged to the community, an order must also be placed on a relevant authority to provide the appropriate accommodation and support.
- An order from the Tribunal that a person in low secure is being detained in conditions of excessive security should provide for the same time frames as the equivalent orders at high or medium secure. This would mean the relevant authority is to make the necessary provision for the person to begin the discharge process within three months of the order being made.

14. A legal duty must be put on a relevant authority to provide appropriate accommodation, services and support for people who are due to be discharged from a secure hospital into the community. The Review considers the relevant authority should be the local authority.

15. The Scottish Government should review with clinicians in both inpatient and community teams, as well as MAPPA and police representatives, the current discharge planning process for restricted patients to identify any aspects that can be streamlined while continuing to protect the public and supporting the best chance of a successful and sustainable discharge for people.

16. The update of the Scottish Government's Memorandum of Procedure on Restricted Patients should be available in an accessible format to increase transparency around the processes and the flexibility within it, and the role of Scottish Ministers more generally. This work should be prioritised.

17. The Scottish Government and the new Forensic Board need to identify funding to ensure that no one leaving forensic inpatient services has to go into debt for housing costs to complete overnight stays to accommodation as part of their required pre-discharge plan.

Community forensic mental health teams

18. The new Forensic Board should define the service remit of Community Forensic Mental Health Teams (CFMHTs).

- This service remit should specify the population that CFMHTs may work with. The new Forensic Board may consider that CFMHTs should have a broader remit than forensic inpatient services but this must be clearly defined in order to support consistency of provision across the country.
- The service remit should also specify the expectations for its multi-disciplinary team (MDT) composition, including a requirement for social work representation, and appropriate staffing ratios for CFMHTs.

19. CFMHTs should be appropriately resourced based on future projected demand as bottlenecks in low and medium secure services are eased.

- Using available figures together with any improvements in data from increased monitoring activity, the new Forensic Board should estimate demand for CFMHTs over the coming years. This should inform what additional resources may be required by CFMHTs to meet projected demand and be factored into its planning.

Prison issues

20. The data management system developed for forensic mental health services by the Information and Statistics Division (ISD) of NHS National Services Scotland must be able to collect, monitor and report on transfers and delays to transfers into forensic mental health services from prisons.

21. The system of multiple assessments to facilitate transfers from prison should be reviewed with the aim of streamlining the process to the benefit of the person in need of forensic inpatient services. At the latest this should be reviewed by the new Forensic Board, however the Review considers that this could be reviewed sooner than that.

Person-centred practices

Care and treatment

22. There should be an equality of esteem between the professions in a high functioning forensic mental health service. This should be evidenced in practice and language used.

23. The new Forensic Board should consider how best to fund social work posts embedded within the multi-disciplinary teams (MDTs) in forensic mental health services, in order to maximise interdisciplinary working.
24. People should be supported to participate as much as possible in decision-making about their care and treatment. Staff should proactively involve people in both formal and informal conversations about their care. Staff must communicate in a style that best enables people to understand what is happening and to voice their opinions.
25. Staff should proactively inform people about their right to request a copy of information held about them. People need to be supported to make such requests if desired and to express their wishes about what information they receive and how this is communicated to them.
- The person's wishes should be added to their healthcare record and staff should endeavour to fulfil them on an ongoing basis so long as that does not conflict with that person's wellbeing.
 - If staff believe they have good reason to withhold information against the person's wishes, then that person should be afforded an opportunity to discuss this decision.
26. General information and advice for people within the forensic mental health system should always be provided in accessible formats, including Plain English and Easy Read versions. Staff should ensure that any additional information required to ensure a person's understanding and ability to participate in decisions about their own care and treatment plans are converted to such formats as required.
27. Each unit within the forensic mental health system must appoint a named staff member as a Carer's Contact. This person must have received training in carer's rights and have sufficient knowledge to answer a carer's initial questions and signpost them to further information and support services.
28. The new Forensic Board should be funded to establish an advocacy service for forensic carers. This service will provide expert support to help carers navigate the forensic mental health system, represent their views and find satisfactory resolution to complaints.

29. The new Forensic Board should work in collaboration with existing carer organisations and advocacy services to develop a) information targeted at new forensic carers, and b) information and training for organisations supporting forensic carers.
30. Until such times as the new Forensic Board is formed, individual Health Boards should put in place a system to reimburse travel expenses of those family members (or other carers) who have to travel to visit a person receiving forensic mental health services out of area. Once established, the new Forensic Board should continue to ensure financial support is in place.
31. Where a person receiving forensic mental health services has indicated their consent, family members (or other carers) should be actively supported to take part in the CPA process and their opinion recognised as that of an expert by experience. As part of this, their availability should be taken into account when scheduling these meetings.
32. Where a person receiving forensic mental health services has indicated their consent, family members (or other carers) should be proactively informed by the clinical team whenever a change is made to the person's care and treatment.
33. The new Forensic Board and people receiving forensic mental health services and their family members (or other carers) should co-design informal and formal feedback processes that address the specific vulnerabilities of these groups in the forensic system.
- This should include investment in the provision of collective advocacy for people in forensic mental health services.
34. The Scottish Government should re-inforce the use of its guidance on transferring Suspension of Detention plans (SUS) issued in 2018 with clinical teams and identify any ongoing barriers (clinical, administrative or cultural) prior to refreshing and reissuing to all clinical teams, as part of its ongoing update of the Memorandum of Procedure on Restricted Patients.
35. Recommendation 35: At pre-transfer CPA meetings, it must be made clear to the person that the option to transfer existing SUS is available. Reasons for not carrying SUS forward should be clearly discussed with the person. Their own

obligations for ensuring that their SUS is carried on as planned once transferred must also be clearly explained.

Social and environmental conditions

36. The poor state of repair of current inpatient environments, including outside space where it is provided, should be addressed by individual Health Boards to ensure they are therapeutic spaces which demonstrate a value being placed on the people detained there.
37. Evidence-based design of therapeutic environments should inform the planning stages of all renovations and new developments within the forensic estate.
38. Everyone subject to detention within the forensic inpatient services should have their own single room.
39. The new Forensic Board should, under the direction of the Nurse Director, establish multi-disciplinary 'Best Practice' standards to guide least restrictive practices. These must have the principle of person-centred practice at their core and should be applied consistently across all forensic inpatient settings. The standards must include guidance around enabling people to:
 - access privacy to support relationships with family and friends;
 - access bedrooms;
 - access personal belongings; and,
 - access technology – this should be accompanied by staff training to ensure they can confidently support a positive risk approach to technology.
40. The Scottish Government should respond timeously to the Technology and Communications Group's updated report, which the Review hopes will reflect an enabling, rather than a risk averse approach in its recommendations.
41. The Scottish Government, together with forensic mental health services, should monitor the availability of placement providers to ensure there are sufficient available to support the rehabilitation of people in forensic inpatient services and to sustain them for people discharged back into the community.
42. The Scottish Government should re-engage with Allied Health Professionals to finalise their draft guidance aimed at supporting people with criminal convictions and mental health conditions into work, volunteering or education.

Specific populations

People with learning disabilities

43. There must be a presumption that people with a learning disability who are accused of an offence will be supported to go through the criminal justice system. They should only be diverted to hospital where this has not been possible.
44. The Scottish Government should commission a study to examine the experiences of offenders with a learning disability compared with offenders in the general population and offenders with a mental illness. This study should compare court 'disposals' for similar offences, including whether people are given prison sentences or diverted to hospital for treatment. It should also explore what kind of restrictions are associated with these 'disposals', and the length of time people are subject to them.
45. Low secure and community forensic learning disability services should be managed under the local Health Board/Health & Social Care Partnership generic learning disability services. This arrangement should be reviewed within 3-5 years of the new Forensic Board being established.
46. The new Forensic Board should collaborate with generic learning disability services to develop appropriate standards for forensic learning disability services.
47. In areas without forensic learning disability services, generic learning disability services should be supported to embed professionals with forensic training and expertise within their workforce.
48. The new Forensic Board should establish mechanisms to provide consultation, advice, and professional supervision for all staff involved in the care and treatment of people with learning disabilities who have forensic needs.
49. Health and Social Care Partnership commissioners must ensure community accommodation can be adapted to meet the sensory and other needs of people with a learning disability

50. Health and Social Care Partnership commissioners must ensure that people with a learning disability have a choice about whether to move into single person or communal accommodation in the community.

People with neurodevelopmental disorders

51. The new Forensic Board should undertake a needs assessment related to neurodevelopmental disorders and forensic mental health services. This should inform future service provision.

Children and Young People

52. The Review recommends that the National Secure Adolescent Inpatient Service does not fall under the remit of the new Forensic Board. This position should be reviewed within 5 years of the National Secure Adolescent Inpatient Service opening to ensure this continues to provide the best pathway for young people.

53. The National Secure Adolescent Inpatient Service should set up a service to provide access to forensic specialist expertise for local CAMHS teams to support clear pathways into and out of the National Secure Adolescent Inpatient Service.

54. A clearly defined pathway should be agreed between the new Forensic Board and the National Adolescent Secure Inpatient Service for young people who do need to transition to adult forensic mental health services.

55. Clear interim arrangements need to be put in place for young people in Scotland who require forensic or learning disability inpatient facilities prior to the National Adolescent Secure Inpatient Service facility being opened. This should be actioned by the end of 2021.

Older Adults

56. The new Forensic Board should make an assessment of age-related needs across all forensic mental health services and, based on current and projected demand, develop an older adults' pathway that reflects the care and risk management needs of this group.

- The new Forensic Board should work with the Scottish Prison Service to consider whether older adults in prison would also benefit from age-related care in an alternative secure setting.

57. The new Forensic Board should conduct an assessment of staff training gaps around the age-related health needs of older adults, particularly around dementia, and make provisions to improve staff skills and confidence in this area.

Northern Ireland

58. The Review recommends that the State Hospital introduces charges for the care and treatment of people from Northern Ireland. These costs should be benchmarked against the costs incurred by NHS Scotland for the high secure care and treatment currently provided to women from Scotland at Rampton Hospital.

Sharing information and expertise

Sharing information about people receiving forensic mental health services

59. The new Forensic Board should have a single electronic health records system. All staff in forensic mental health services should use the system and the Board should ensure that staff have access to technology of an appropriate quality to support their work.

60. The new Forensic Board's single electronic health records system should include a facility to clearly record where a person does, and where a person does not, consent to their information being shared with family members and certain partner organisations.

- Clinicians should proactively seek consent to share information with appropriate family members.
- People should be given a regular opportunity to update their wishes about how their information is shared.

61. The new Forensic Board should develop a procedure for sharing information with external organisations, to support consistent practices across forensic mental health services that balance the rights of the individual and the protection of the public.

Provision of forensic mental health expertise to external agencies

62. The new Forensic Board should develop a consistent way of providing consultation and advice to MAPPA and other external individuals or

organisations (including other NHS services) that may benefit from access to forensic mental health expertise.

- The Scottish Government should work with the new Forensic Board to ensure that this consultation and advice service is adequately funded.

63. The Scottish Government should bring together the NHS, the Scottish Courts and Tribunals Service and the Crown Office and Procurator Fiscal Service to agree an appropriately funded national framework to ensure the timely provision of court reports by psychiatrists and psychologists for assessment and sentencing purposes. This should be actioned within one year of the publication of this report.

64. The Scottish Government, together with the new Forensic Board and the relevant criminal justice agencies, should review the current limitations about which disciplines can complete court reports. They should consider what professional qualifications and training are necessary for the completion of these reports, including whether a change of law is required.

Research, education and training

65. The new Forensic Board must support the work of the School of Forensic Mental Health to continue developing and progressing education, training and research activities within Scotland's forensic mental health services.

66. Working with the School for Forensic Mental Health and wider stakeholders, the new Forensic Board should set evidence-based standards for staff skillsets and training, that include best practice in caring for and treating people with a learning disability.

- The new Forensic Board may consider the development of a specialist training programme for professionals entering forensic mental health services including shadowing opportunities and rotation through services at different security levels in order to build up an expert skillset.

67. The new Forensic Board should work with community providers and partner agencies to develop skilled staff teams who are confident and empowered to provide support, including positive risk taking, to people from forensic mental health services.

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Annex A: Terms of Reference

Context

Forensic mental health services specialise in the assessment, treatment and risk management of people with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings. Some other people are managed by forensic mental health services because they are deemed to be at a high risk of harming others or, rarely, themselves under civil legislation.

The level of secure service a person is accessing (high, medium, low, or community) is determined by the level of risk a person is thought to pose. Although a large majority of forensic mental health services are run by NHS Boards, Scotland also has a few independent sector secure inpatient forensic mental health services.

In recent years there has been a significant adjustment in the delivery of forensic mental health services. The annual ministerial review of the State Hospital in January 2019 examined a number of issues, not least how the Board responds to a decline in the number of people detained in high security and the development of medium secure services elsewhere. There has also been the introduction of excessive security appeals for people detained in medium security and a continuing move towards community services. More recently, there have been further developments such as a planned new Child and Adolescent Mental Health Service secure unit and an ongoing review of the needs of women who require secure care, particularly high security.

In order to enable forensic mental health services to be delivered as effectively as possible, we are instigating a review more widely into the delivery of these services in recognition of these changes and new developments.

The principal aim is to review the delivery of forensic mental health services in hospitals, prisons and the community, including:

- the demand for forensic mental health services, including bed availability and use in hospitals across the levels of security and in the community across Scotland
- the delivery of forensic mental health services in prison
- the delivery of high secure forensic services in hospital, given the decline in the number of patients at the State Hospital

- the capacity of medium secure services to deliver forensic mental health services for all patients who require such services
- the impact of excessive security appeals at medium security on low security
- the availability of specialist open i.e. unlocked forensic rehabilitation services
- the movement of patients from low or medium security into the community

The review will include the make-up of the forensic estate and the patient flow for male and female patients, as well as those with additional intellectual support needs.

The review will include representation from:

- people with lived experience of forensic mental health services, their relatives, carers and representatives
- organisations commissioning, delivering and monitoring forensic mental health services as well as those providing support services
- staff-side and professional organisations
- organisations involved in legal and court proceedings

The review will take a human rights based approach to its work. It will use the PANEL principles of participation, accountability, non-discrimination, equality, empowerment, and legality to support this approach.²⁵

Scope and terms of reference

The specific methodology of the review is at the discretion of the chair but will involve consideration of:

Strategic direction for the delivery of forensic mental health services

- the arrangements for the strategic direction and ongoing oversight and governance of the delivery of forensic services across Scotland, including the roles of the Scottish Government, Integration Authorities and NHS Boards as well as the role, functions and reporting structures of the Forensic Network

²⁵ Community Health and Social Care Directorate (2015) *National health and wellbeing outcomes framework: Embedding a human rights based approach*. Available at: <https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/pages/9/>

Demand, capacity and availability across the forensic secure estate

- an evidence review of bed availability and capacity at high, medium and low security hospitals, in intensive psychiatric care units, and at open forensic rehabilitation inpatient facilities
- any evidence of people being unable to move between hospitals and its causes, taking into account patients' human rights and the principles in section 1 of the Mental Health (Care and Treatment) (Scotland) Act 2003
- the demand for medium secure services from across Scotland and the deliverability of such services in the current forensic estate
- the ease of movement of patients both down and up through levels of security
- the impact of appeals against conditions of excessive security across the mental health system, including demand for low secure services and the extent to which this can be met by the current forensic estate
- alternatives to cross-border transfers to specialist services far from patients' home areas and families

High secure provision

- the arrangements for the governance and delivery of high secure services, given the decline in patient numbers, and whether there are alternatives to more efficiently deliver such services including any options for the re-provision of unused bed capacity at State Hospital for care of other patients
- the appropriateness of continuing to provide high secure care for people on behalf of Northern Ireland and any recommendations for future service delivery

Forensic mental health services to client groups with particular needs

- the delivery of services for intellectual impairment / learning disability and neurodevelopmental disorder / autistic spectrum disorder
- the availability, demand and delivery of forensic mental health services to women
- the availability, demand and delivery of forensic mental health services to children and young people
- the availability, demand and delivery of providing forensic mental health services to elderly people

Community forensic mental health services

- the movement of people from low or medium secure services to the community; any delays and the causes of them
- the support and services that are needed to successfully treat people in the community and any difficulties providing or accessing such services
- the provision of forensic mental health services to support the ongoing assessment and management of high risk offenders (violent and sexual) managed under MAPPA in the community
- processes by which people can resettle in a different territorial health board area within Scotland e.g. for victim sensitivity reason.

Forensic mental health services and the justice system

- an evidence review of the delivery of forensic mental health services in prisons
- the ease of movement of people between prison and hospital
- the impact any lack of provision has on sentencing decisions, for example for women requiring high secure care
- the provision of professional and expert witness psychiatric and psychological reports to Scottish Courts and the impact any delays may have on people awaiting sentencing
- the availability and provision of forensic mental health services generally, in the context of the investigation and prosecution of crime, including, in particular, to persons accused of crime.

How the review is undertaken is a matter for the Chair but the views of people receiving forensic mental health services, their families and representatives will be central to the work of the review.

Definitions of key terms

Forensic Mental Health Services are services that provide assessment, care, treatment and all forms of support (including reintegration into the community) to:

- people in high, medium and low secure hospitals or hospital units
- people accused of offending or who have offended and are in intensive psychiatric care hospital units or open rehabilitation inpatient facilities
- people not in hospital who are at risk of offending, accused of offending or who have offended and have a mental illness, personality disorder or learning disability (this includes people who develop a mental illness while in prison)

Previous and ongoing work around forensic mental health services

The review should consider previous and ongoing work around forensic mental health services, including:

- the findings of the Forensic Estate Review group
- the Mental Welfare Commission's Visiting and Monitoring Report relating to medium and low secure forensic wards (August 2017), including actions planned by Health Boards in response to its findings
- 'Coming home: complex care needs and out of area placements 2018', Scottish Government, November 2018
- the findings of the short life working group on female pathways in forensic mental health
- the (emerging) findings of the review of learning disability and autism under the Mental Health (Care and Treatment) (Scotland) Act 2003
- the findings of the review of Mental Health Services at HMP YOI Polmont
- the inquiry by the Equalities and Human Rights Commission into the question of whether people with mental health conditions, cognitive impairments and conditions including autism are experiencing discrimination in the criminal justice system

Review outcomes

The review is expected to:

- make recommendations for changes or improvements to the Scottish Government and delivery bodies
- should anything of immediate concern be identified these should be escalated to the respective Chief Executive and/or Scottish Government
- suggest any legislative issues that arise out of the enquiry
- suggest any further reviews that arise out of the enquiry

This review will be presented to the Cabinet Secretary for Health and Sport and the Minister for Mental Health and be published by the end of June 2020. Quarterly updates on progress and any emerging findings are required. *[A revised date was subsequently agreed with the Minister for Mental Health due to impact of the coronavirus pandemic].*

Annex B: Working group members

Hospital Working Group Members

No.	Body	Rep
1	Allied Health Professionals Forensic Leads Group	Cheryl McMorris
2	British Psychological Society	Jillian McGinty
3	Carers Trust	Karen Martin
4	Forensic Network	Lindsay Thomson
5	Healthcare Improvement Scotland	Belinda Robertson
6	Integrated Joint Boards	Claire Smith
7	Mental Welfare Commission	Paul Noyes
8	NHS Chief Executives	Alex McMahon
9	NHS Forensic Services - General and Service Managers	James Meade
10	NHS National Services Scotland	Louise Wilson
11	Mental Health Tribunal Service for Scotland	Pradeep Pasupuleti
12	Royal College of Psychiatrists	Stuart Doig Jana de Villiers
13	Scottish Government	Ian Dewar
14	Scottish Human Rights Commission	Sarah Booth (Cathy Asante until July 2020)
15	Scottish Independent Advocacy Alliance	Ben Baldock (Ann Morton until November 2019)
16	Scottish Learning Disabilities Nurse Leads	Helen Eunson
17	Scotland's Executive Nurse Directors	Mark Richards
18	Scottish Group of Forensic Clinical Psychologists	Heather Laithwaite
19	Social Work Scotland	Drew Lyall
20	State Hospital Board for Scotland/ NHS Chief Executives.	Gary Jenkins
21	UNISON	Tom Hair
22	VOX (Scotland)	Wendy McAuslan
	National Autistic Society of Scotland	Nick Ward until December 2019
	Prison Officers Association	Andy Hogg until March 2020

Criminal Justice Working Group Members

No.	Body	Rep
1	Allied Health Professionals Forensic Leads Group	Christine Breslin
2	British Psychological Society	Claire Ogilvie
3	Care Inspectorate	Jane Kelly (Ray Jones until July 2020)
4	Community Justice Scotland	Keith Gardner
5	Crown Office and Procurator Fiscal Service	Anthony McGeehan
6	Forensic Network	Lindsay Thomson
7	Her Majesty's Chief Inspector of Prisons for Scotland	Wendy Gieben-Sinclair
8	HM Inspectorate of Constabulary in Scotland	Gill Imery
9	Integrated Joint Boards/Social Work Scotland	Diane Dobbie
10	Inspectorate of Prosecution in Scotland	Laura Paton (Karen Nicol until August 2020)
11	Mental Health Nursing Leads	David Thomson
12	National Prisoner Care Network	Linda Stark
13	NHS Forensic Services - General and Service Managers	Iain MacKenzie
14	Parole Board for Scotland	Karen Richard
15	Police Scotland	Jim Evans (Barry Blair until October 2020)
16	Prison Officers Association	Karen Ewen (Mick Gratton until March 2020)
17	Risk Management Authority	Elaine Ferguson (Geoff Taylor until September 2020)
18	Royal College of Nursing	Eileen McKenna
19	Royal College of Psychiatrists in Scotland	Johanna Brown
20	SACRO	John Kennedy
21	Scottish Appropriate Adult Network	David Calderwood
22	Scottish Courts and Tribunals Service	Elaine Walker
23	Scottish Independent Advocacy Alliance	Clare Gallagher
24 25	Scottish Prison Service	Lesley McDowall Emma Christie

Community Working Group Members

No.	Body	Rep
1	Allied Health Professionals Directors Scotland Group	Catherine Totten
2	Association of Clinical Psychologists - UK	Judi Bolton
3	Coalition of Care and Support Providers in Scotland	Stephen McLellan
4	COSLA	Nicola Dickie (John Wood until February 2020)
5	Criminal Justice Voluntary Sector Forum/ Turning Point Scotland	David Whitters
6	Forensic Network	Helen Walker
7	Health and Social Care Alliance Scotland	Lucy Mulvagh
8	MAPPA Co-ordinators Group	Bob Thomson
9	NHS Forensic Services - General and Service Managers	Shona Hendry
10	Police Scotland	Tim Ross
11	Royal College of Nursing	Stuart McKenzie
12 13	Royal College of Psychiatrists	Stuart Doig Jana De Villiers
14	Scottish Independent Advocacy Alliance	Shaben Begum
14	Serious Offenders Liaison Service	Elizabeth Flynn
16	Social Work Scotland	Elaine Davison
17	SOLD Network	Tony Bowman
18	Support in Mind Scotland	Frances Simpson
19	VOX (Scotland)	Mahmud Al-Gailani

Annex C: Responses to calls for evidence

The Review received 103 responses to its call for evidence that ran from 14 October 2019 until 31 January 2020.

Fifty six organisations provided a written response:

1. Allied Health Professions Directors Group
2. Borders Health and Social Care Partnership
3. Care Inspectorate
4. Carers Trust Scotland
5. Centre for Youth and Criminal Justice
6. Circles Advocacy
7. Crown Office and Procurator Fiscal Office
8. Deaf Scotland
9. Families Outside
10. Forensic Network
11. Friends and Family Conference 2019 Delegates
12. Healthcare Improvement Scotland
13. HM Inspectorate of Prisons for Scotland
14. Mental Welfare Commission
15. National Police Care Network
16. National Prison Care Network
17. NHS Ayrshire and Arran
18. NHS Dumfries and Galloway
19. NHS Eileanan Siar/ Western Isles
20. NHS Fife
21. NHS Forth Valley
22. NHS Forth Valley Disability Services
23. NHS Grampian
24. NHS Greater Glasgow and Clyde
25. NHS Highland
26. NHS Lanarkshire
27. NHS Lothian
28. NHS Lothian Forensic Community Mental Health Team
29. NHS National Services Scotland
30. NHS Orkney
31. NHS Scotland Acquired Brain Injury Network
32. NHS Shetland
33. NHS Tayside
34. Orchard Clinic Psychology Department
35. Patients Advocacy Service
36. Parole Board for Scotland
37. Partners in Advocacy
38. Rohallion Users Group
39. Police Scotland
40. Royal College of Nursing
41. Royal College of Psychiatrists
42. Royal Edinburgh Hospital Patients Council
43. Scottish Appropriate Adult Network
44. Scottish Association for Mental Health (SAMH)
45. Scottish Courts and Tribunals Service

- | | |
|--|---|
| 46. Scottish Group of Forensic Clinical Psychologists | 52. Support in Mind Scotland |
| 47. Scottish Independent Advocacy Alliance | 53. The State Hospitals Board for Scotland |
| 48. Senators of the College of Justice | 54. The State Hospital Medical Advisory Service |
| 49. Sheriffs Principal | 55. Volunteer Edinburgh |
| 50. Social Work Scotland Mental Health Sub-Committee | 56. VOX (Scotland) |
| 51. Speech and Language Therapists working in Forensic Mental Health Service | |

The Review received 47 responses from individuals either in writing or over the phone. It received:

- 14 from people with lived experience of receiving forensic mental health services (or people advocating their behalf).
- 15 from family and friends supporting someone who had received, was receiving or who they felt should be receiving forensic mental health services.
- 15 from people working in forensic mental health services.
- Three from people with another interest in forensic mental health services.

The Review received 20 responses to its call for feedback on its interim report that ran from 28 August 2020 until 31 October 2020.

Eight organisations provided a written response:

- | | |
|---|--|
| 1. Allied Health Professionals Group | 6. Royal College of Occupational Therapists |
| 2. Forensic Lead Nurses Forum | 7. Royal College of Psychiatrists |
| 3. Heads of Forensic Clinical Psychology | 8. Scottish Group of Forensic Clinical Psychologists |
| 4. NHS Forth Valley and the Forensic Matrix Group | 9. Step Up Ltd. |
| 5. NHS Tayside | |

The Review received 11 written responses from individuals:

- One from a person receiving forensic mental health services.
- Five from family members supporting someone who is receiving forensic mental health services
- Four from people working in forensic mental health services.
- One person with another interest in forensic mental health services.

Annex D: Engagement activities supporting the work of the Review

The Chair of the review met with people to gather their views and experiences. Details of the visits, meetings and events he attended are listed below.

Visits

The Chair visited the following places where he met with groups of staff, people with lived experience and their families:

- The State Hospital – 5 August 2019
- Woodland View Hospital, NHS Ayrshire and Arran – 23 October 2019
- Rohallion Clinic, NHS Tayside – 30 October 2019
- Rowanbank Clinic, NHS Greater Glasgow and Clyde – 14 November 2019
- Leverndale Hospital, NHS Greater Glasgow and Clyde – 20 November 2019
- Orchard Clinic, NHS Lothian – 27 November 2019
- The Ayr Clinic – 9 December 2019
- Lynebank and Stratheden Hospitals, NHS Fife – 15 January 2020
- Bellesdyke and Falkirk Community Hospitals, NHS Forth Valley – 22 January 2020
- Royal Cornhill Hospital, NHS Grampian – 29 January 2020

During these visits he met:

- 88 people with lived experience
- 16 people who were friends or family of people with lived experience
- 188 members of the multi-disciplinary teams working across hospital and community settings in these areas.

Meetings

The Chair met with the following people to hear their views and experiences:

- John Crichton, Chair of Royal College of Psychiatrist – 25 June 2019
- Colin McKay, Chief Executive, Mental Welfare Commission – 26 June 2019 and 19 February 2020

- Cathy Asante, Legal Officer, Scottish Human Rights Commission – 17 July 2019
- Shaben Begum, Director, Scottish Independent Advocacy Alliance – 17 July 2019
- Ian Dewar, Principal Medical Officer (Forensic Psychiatry), Scottish Government – 17 July 2019 and 12 February 2020
- Mike Winter, Director, NHS National Services Scotland – 24 July 2019
- Rose Fitzpatrick, Chair, National Suicide Prevention Leadership Group – 27 July 2010
- Elish Angiolini, Chair of Independent review of complaints handling, investigations and misconduct issues in relation to policing – 1 August 2019
- Wendy Sinclair-Gieben, Chief Inspector of Prisons – 2 September 2019
- Family member of person with lived experience – 2 September 2019
- Lindsay Thomson, Medical Director, The State Hospital and Forensic Network and Lindsey McIntosh, Forensic Network Manager – 3 September 2019; and Lindsay Thomson – 12 February 2020
- Lewis Macdonald, Convener, Scottish Parliament Health and Sport Committee – 18 September 2019
- Police officer – 12 October 2019
- Nancy Loucks, Chief Executive, Families Outside – 12 October 2019
- Community Justice Scotland members – 4 December 2019
- Gary Jenkins, Chief Executive, NHS State Hospitals of Scotland – 27 December 2019
- Members of Scottish Government’s Restricted Patients Team – 19 February 2020
- Clinical staff, NHS Lanarkshire (video conference) – 22 July 2020
- Iona Colvin, Chief Social Work Adviser (conference call) – 23 July 2020
- Mary Donaghy, Northern Ireland Health and Social Care Board and Ian McMaster, Medical Adviser, Department of Health (video conference) – 5 August 2020
- Eileen Bray and Stuart McKenzie, on behalf of National Secure Adolescent Inpatient Service – 4 September 2020; Helen Smith on behalf of National Secure Adolescent Inpatient Service – 17 November 2020
- Jim Crabb, Associate Medical Director for Mental Health, NHS Forth Valley – 23 September 2020

- Members of NHS Forth Valley's clinical team – 4 November 2020
- Representatives of the Royal College of Occupational Therapists – 4 November 2020
- Representatives from Forensic Clinical Psychology – 18 November 2020
- Specially convened meeting of clinical and third sector representatives of learning disability services – 25 November 2020
- Sarah Booth, Legal Officer, Scottish Commission for Human Rights – 4 December 2020

The review's secretary met with the following people to hear their views and experiences:

- Family with lived experience – 6 February 2020
- Group from People First (Scotland) – 10 February 2020
- Tommy MacKay, Visiting Professor (Autism Studies) at the University of Strathclyde and Clinical Director of the National Diagnosis and Assessment Service for Autism Spectrum Disorders (telephone call) – 26 February 2020
- Members of Scottish Government's Restricted Patients Team and Litigation Team – 11 March 2020
- Person currently receiving forensic mental health services – (phone calls) – 23 and 30 September 2020, 2 and 23 October 2020 and 20 November 2020

Events

The Chair accepted invitations to speak and take questions about the work of the review at the following events and meetings:

- Family and Friends Conference for anyone supporting people in Forensic Mental Health Services – 20 September 2019
- Royal College of Psychiatrists' Scottish Forensic Faculty Conference – 25 October 2019
- Forensic Network's Intellectual Disability Clinical Forum – 29 October 2019
- Adult Protection and Support Strategic Forum – 2 September 2020
- Scottish Executive Nurse Directors' Meeting – 23 October 2020
- NHS Chief Executives' Meeting - 11 November 2020

Annex E: Forensic mental health inpatient provision

The current configuration of forensic mental health services for inpatients developed from principles set down by the Scottish Executive in its letter HDL(2006)48 to NHS CEOs in 2006. There are three different levels of secure hospital provision as described by the Forensic Network in its Security Matrix and each has been developed at a different national, regional or local level. In general:

- High secure is provided at a national level;
- Medium secure services are provided at a regional level; and,
- Low secure services are provided at a local level.

This section provides an outline of the information provided to the review about the available provision at each level across Scotland.

High Secure

There is one national high secure unit in Scotland located in the State Hospital. It has 144 high beds for males requiring maximum secure care and treatment. There are 12 beds specifically for people with a learning disability. It also provides high secure care and treatment for men from Northern Ireland. Data from the Forensic Network's annual inpatient census indicates a reduction in the number of men receiving high secure care between 2013 and 2017. From 132 people in 2013, numbers have remained at around 110 since 2017.

There is no high secure unit for women in Scotland. Women who require high secure care and treatment are referred to Rampton Hospital in Nottinghamshire, England.

Medium Secure

There are three regional medium secure units in Scotland.

Rowanbank Clinic, Stobhill Hospital, Glasgow - NHS Greater Glasgow and Clyde

Rowanbank is a 74 bed unit providing a number of different services. It provides male mental illness medium secure care for the West of Scotland (NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Ayrshire and Arran, NHS Dumfries and

Galloway and the 'Argyll part' of NHS Highland). There is a 12 bed admission ward and 44 rehabilitation beds across four wards.

It has six female medium secure beds for Greater Glasgow and Clyde patients and can consider female patients from across other regions on a case by case basis.

The National Medium Secure Intellectual Disability Service is also hosted by Rowanbank, providing eight male and four 4 female beds.

The Orchard Clinic, Royal Edinburgh Hospital – NHS Lothian

The Orchard Clinic is a 40 bed unit. Based in Royal Edinburgh Hospital it is the regional medium secure unit for male mental illness within NHS Lothian for the East of Scotland (NHS Lothian, NHS Borders, NHS Fife and NHS Forth Valley). It is a 40 bed unit with one admission/acute ward and two rehabilitation wards. Rooms can be adapted to provide male and female beds. For reporting on available beds, the Forensic Network works on a configuration of seven female and 33 male beds.

Rohallion Clinic, Murray Royal Hospital, Perth – NHS Tayside

The North of Scotland regional medium secure unit for male mental illness is provided by NHS Tayside at the Rohallion Clinic based at the Murray Royal Hospital in Perth. It has 32 male beds split between one admission ward and two recovery wards. In practice not all beds are available and the functional capacity is 30 medium secure beds. It provides care and treatment for NHS Tayside, NHS Grampian, NHS Highland (non-Argyll), NHS Orkney and NHS Shetland.

Low Secure

As low secure provision has developed locally, the provision across the country is varied. The precise numbers of forensic beds available is harder to identify as a number of Board have no specific low secure provision and manage any forensic patients in general wards. In addition, where there are low secure wards, they can often be treating forensic and non-forensic patients. In its report on medium and low secure provision in 2017, the Mental Welfare Commission highlighted low secure wards were in effect catering for two distinct groups of people: people detained under criminal orders who may have committed serious offences and people detained under mental health act orders who are there because general adult

services have been unable to manage their care safely. For the report, they visited 32 low secure wards identifying 293 low secure beds, 63 of which were for people with a learning disability.²⁶ In its 2019 annual census figures, the Forensic Network found 215 forensic inpatients in low secure wards, 23 of whom were in independent provision. There were also 11 people in locked learning disability wards, six in IPCUs, nine on open rehabilitation wards and two in other facilities. In some services the use of IPCU beds is part of planned pathways, for example, for people transferred on assessment or treatment orders from court or custody, to assess restricted patients, or for women. In others, IPCU beds are managed alongside other forensic wards to manage populations or because of limited capacity in the forensic wards.

The table below presents the information that was provided to the Review on low secure provision by each NHS Board, as well as independent providers.

Provider	Low secure services MI = mental illness LD = learning disability
*NHS Ayrshire and Arran	Woodlands View, Ayrshire Central Hospital, Irvine <ul style="list-style-type: none"> • 8 bed low secure ward • 10 bed open forensic rehabilitation ward • Also use IPCU for people under assessment or treatment orders.
NHS Borders	No specific low inpatient provision. Dependent on availability from other NHS Boards or private sector.
NHS Dumfries and Galloway	No specific low inpatient provision. Midpark, Hospital <ul style="list-style-type: none"> • Enhanced rehabilitation unit • Use of IPCU

²⁶ Mental Welfare Commission (2019) *Visiting and monitoring report: Medium and low secure forensic services*. Online: MWC. Available at: https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf

Provider	Low secure services MI = mental illness LD = learning disability
*NHS Fife	Lynebank Hospital, Dunfermline <ul style="list-style-type: none"> • Daleview: 10 male LD beds – regional facility for NHS Fife, NHS Lothian, NHS Borders and NHS Forth Valley. • Levendale: 8 bed male LD low secure unit Stratheden Hospital, Cupar <ul style="list-style-type: none"> • 10 male beds. 1 bed held for recalls from step-down unit • 4 bed male step down unit. • Use of IPCU and rehabilitation ward
*NHS Forth Valley	Bellsdyke Hospital, Falkirk <ul style="list-style-type: none"> • 6 female MI beds • 18 male MI beds • Also use IPCU for initial assessment of all restricted patients.
*NHS Grampian	Blair Unit, Royal Cornhill Hospital <ul style="list-style-type: none"> • 8 bed male acute forensic ward • 16 bed male forensic rehabilitation ward • 8 bed LD male forensic close supervision unit • 8 bed IPCU has provision for 2 female beds • 8 bed male MI step down facility
*NHS Greater Glasgow and Clyde	Leverndale Hospital, Glasgow <ul style="list-style-type: none"> • 53 low secure beds • 30 male MI across two admission/rehabilitation wards • 9 male close supervision ward LD unit • 9 male pre-discharge MI and LD ward • 5 low secure female beds
NHS Highland	No specific forensic inpatient provision. All low provision currently provided by independent sector. New Craigs Hospital <ul style="list-style-type: none"> • 8 bed IPCU use for forensic patients when appropriate (also serves Argyll and Bute) Community rehabilitation facilities have been used as step-down unit for forensic patients.
NHS Lanarkshire	Beckford Lodge, Hamilton <ul style="list-style-type: none"> • Iona: 15 male low secure beds • Gigha: 12 male and female open forensic rehabilitation unit. Kirklands Hospital, Bothwell <ul style="list-style-type: none"> • Kylepark: 10 bed unit for assessment/treatment and low secure LD beds.

Provider	Low secure services MI = mental illness LD = learning disability
*NHS Lothian	There is no specific MI low secure unit within Lothian. Glenlomond - 6 male LD beds locked forensic unit in the community. William Fraser Centre – male and female LD provision (numbers vary). IPCU at St John’s Hospital can admit short-term remand patients.
NHS Orkney	No specific provision. All forensic mental health services provided by NHS Grampian via a service level agreement
*NHS Tayside	Rohallion Clinic, Murray Royal Hospital, Perth <ul style="list-style-type: none"> • 25 male MI beds across two wards; <ul style="list-style-type: none"> ○ Esk: mixed admission/rehabilitation ward ○ Lyon: rehabilitation ward with self-contained flat. • IPCU can be used for females requiring care in a locked environment. Strathmartine Hospital, Dundee <ul style="list-style-type: none"> • 8 bed LD low secure forensic ward
NHS Shetland	No specific provision. All forensic mental health services provided by NHS Grampian via a service level agreement.
NHS Western Isles	No specific provision. Contract these on an ad-hoc basis when required.
Surehaven, Glasgow, Shaw Healthcare	Independent provision available. <ul style="list-style-type: none"> • 15 bed male low secure ward • 6 bed female low secure ward
*Priory Ayr Clinic, Ayr	Independent provision available. <ul style="list-style-type: none"> • 12 bed female low secure admission unit • 12 bed male low secure admission unit • 12 bed mixed low secure rehabilitation • 8 bedded male step down community house (not restricted patients) • 10 bed female step down community house (not restricted patients).

* Review Chair visited the inpatient wards in these Board areas.



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