The Royal College of Psychiatrists in Scotland response to the Independent Review into the Delivery of Forensic Mental Health Services – Call for Evidence

Introduction

The Independent Review has been tasked with looking at the current "delivery" of forensic mental health services in Scotland and making recommendation across the full range of services provided in the community, in hospitals and prisons. The terms of reference are daunting in their number and scope given the relatively short timescale in which to produce the report.

This response to the call for evidence in the Review of Forensic Mental Health Services in Scotland has been compiled from responses from members of the College. It takes a broad perspective rather than focusing at health board or service level and in doing so highlights areas of good practice and areas of possible development. The RCPsych in Scotland would like to thank Drs Johanna Brown, Jana de Villiers and Stuart Doig, the College representatives on the review group who undertook consultation exercises and assisted in the drafting of this response.

The Independent Review is to be commended for the proactive way it has sought evidence from a wide range of sources including patients, carers and support agencies. The Independent Review will approach the task of absorbing and analysing this evidence in its own way.

For the purpose of providing our evidence we have decided to frame the issues raised by our members in term of Realistic Medicine. We hope that by doing this we can help the Independent Review look at the same issues which will undoubtedly be raised by others in a different way.

We have decided to concentrate here on these aspects relevant to the consultation where there was strong consensus amongst the members of the College in Scotland.

The role of the Royal College of Psychiatrists

The Royal College of Psychiatrists in Scotland is the professional medical body for psychiatry in Scotland. We set standards and promotes excellence in psychiatry and mental healthcare. We lead, represent and

support psychiatrists nationally to government and other agencies, aiming to improve the outcomes of people with mental disorders, and the mental health of individuals, their families, and communities. We are a devolved nation and council of the Royal College of Psychiatrists. We have over 1,300 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland. The College in Scotland has several faculties dedicated to the specialities of psychiatry, including the faculties of Forensics and Intellectual Disability (ID).

Whilst all psychiatrists are acquainted with areas of the law that are related to their practice, forensic psychiatry can be described as comprising of two areas. The first is clinical and comprises of the similar clinical work as that found in general psychiatry but often in the context of a serious offence(s) and the additional negotiation of legal matters. The second area is that of legal psychiatry and concerns the association of law and mental disorder. This is perhaps more commonly seen observed in civil and criminal legal cases[1].

The patients managed by Forensic ID Services generally function in the 'Mild Learning Disability' range, and are held to be criminally responsible (that is, the behaviour is not better understood as 'challenging behaviour' as displayed by individuals with more severe cognitive impairments).

Individuals within secure Forensic ID services are often unfit for trial due to their cognitive impairments (that is they are unable to effectively participate in a trial). If the Court makes a finding that an individual is unfit for trial, an Examination of the Facts hearing will be held to determine whether or not the person has committed the alleged offences. If the person is found to have committed the offences, then the Court has a limited range of options regarding disposal, some hospital based and some community based (Learning Disability is included in the definition of mental disorder in the Mental Health (Care and Treatment) (Scotland) Act 2003 and the same sections of the Act are applicable as for other Mentally Disordered Offenders.

Some individuals with ID, even if fit to stand trial, find it difficult to cope within a custody setting due to being vulnerable and unable to maintain their own safety. Some will develop mental illness whilst in custody, or otherwise display high levels of distress (including suicide attempts). In specific cases the person may require specialist treatment programmes suitable for their level of intellectual functioning that is not available within a prison setting. In these situations, transfer to a hospital setting may be indicated and can be authorised under the Mental Health (Care and Treatment) (Scotland) Act 2003.

It is well recognized that people with ID who meet forensic criteria have the highest level of care needs in comparison to other forensic patients who do not have a diagnosis of ID (Lunksy et al 2011). In Forensic ID services 30% of patients will also have a co-morbid mental illness, and a similar proportion will have co-morbid personality disorder. In addition, there are high levels of co-morbidity with other

[1] Eastman *et al*., Forensic Psychiatry, Oxford Specialist Handbooks in Psychiatry, Oxford University Press, pp.7.

neurodevelopmental disorders (including Autism Spectrum Disorder, Foetal Alcohol Spectrum Disorder, genetic disorders and Attention Deficit Hyperactivity Disorder).

Physical health co-morbidities are common (for example epilepsy, cardiac abnormalities, obesity and sensory impairments). 95% of patients will have clinically significant communication impairments requiring adaptations by treating teams. Many patients will also have high levels of sensory impairments and/or sensory sensitivity. These differences in clinical presentation and co-morbidities highlights the need for specialist Forensic ID services.

The development of services for mentally disordered offenders

On 28 January 1999 the then Minister for Health and the Arts in the Scottish Office launched a policy governing health, social work and related services for mentally disordered offenders in Scotland. This became known as MEL99[2]. The overall aim of the policy remains largely relevant to services today. It describes a need for the co-ordination of care and support for the benefit of the individual and to ensure public safety through multi-agency and multi-disciplinary working to organise services which:

- provide care under conditions of appropriate security with due regard for public safety
- have regard to quality of care and proper attention to the needs of individuals
- where possible provide care in the community rather than institutional settings
- provide care that maximises rehabilitation and the individual's chance of an independent life.

MEL99 helped shape the current secure hospital estate and recommended the development of the Forensic Network. It gave less guidance about community, prison and criminal justice services which is perhaps in some respect why these are the areas which our members have identified as the main priorities for further development and allocation of resources.

Forensic mental health services and Realistic Medicine

In 2017 the Chief Medical Officer for Scotland, Dr Catherine Calderwood, published her second annual report titled "Realising Realistic Medicine"[3]. In this report the Chief Medical Officer said, "By 2025 everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine".

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[2] https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/Mel-5-99.pdf?x82981

[3] https://www.gov.scot/publications/chief-medical-officer-scotland-annual-report-2015-16-realising-realistic-9781786526731/

In her report the CMO is clear that the aims of Realistic Medicine are not for one profession alone, nor are the principles applicable only to healthcare professions. Delivering the best, high quality care in the complex environments that forensic mental health services work in can only be fully achieved through working together in teams, in networks and in partnership with people. The Royal College of Psychiatrists in Scotland is committed to understanding and valuing the contribution that health and social care colleagues can make for the individuals that require our services.

It is almost a quarter of a century since Evidence-based medicine was described by Sackett et al in 1996 as the "integration of best research evidence with clinical expertise and patient values"[4]. This approach has widespread acceptance in the NHS although it is perhaps not always implemented for a variety of reasons.

More recently the concept of Value-based healthcare has come to the fore and this underpins the aims of Realistic Medicine. Value Based healthcare has recently been defined in a paper from the Centre for Evidence Based Medicine[5] as

"the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person."

There is as much need for forensic mental health services to make optimal use of the resources we have to ensure the best possible outcome not only for our patients but the communities in which they live.

"Unwarranted Variations" in healthcare describe differences in resource allocation, resource use or outcomes in health that are not explained by patient preference or illness[6].

The secure hospital estate

In seeking the views of our members, we heard about challenges in all parts of Scotland with current service delivery due to problems in resource allocation and use of resources.

Patient flow and accessibility

Patient flow across the secure hospital estate has been highlighted as an issue which needs urgent attention. Additional resourcing to help with this has in the past been allocated to the State Hospital and regional medium secure units. Expansion in the medium secure estate was not mirrored by expansion in the low secure estate and community teams therefore any additional capacity created by the development of three medium secure units has been lost through delayed discharges. The State

[4] Sackett, D et al. Evidence based medicine: what it is and what it isn't. BMJ 1996;312:71

[5] Hurst L, Mahtani K, Pluddemann A, Lewis S, Harvey K, Briggs A, Boylan A-M, Bajwa R, Haire K, Entwistle A, Handa A and Heneghan C. Defining Value-based Healthcare in the NHS: CEBM report May 2019.

[6] Wennberg JE. Time to tackle unwarranted variations in practice. BMJ 2011;342:d1513.

Hospital has been able to close two mental illness wards but now finds it has an increasing pressure to accept patients under the exceptional circumstances arrangement due to lack of beds in medium security as well as low security.

Although the demand for mental illness beds at the State Hospital has reduced there has remained a particular capacity issues for the high secure Forensic ID service, which has been functioning at or just over the allocated bed numbers over recent years. This may in part be related to reduction in bed capacity with the development of the new State Hospital campus but may also reflect a greater demand for the service.

There is a particular issue in the West of Scotland with Rowanbank Clinic working at maximum capacity most of the time. This may be the result of a decision made not to progress with a larger medium secure estate in the West of Scotland that had been planned initially. The College recommends inpatient units aim for bed occupancy of around 80% most of the time. This is to accommodate surges in demand and recognises that services should not have their staff working under sustained stressful conditions for prolonged periods. This guidance relates to general adult services but there is no reason not to assume the same holds for forensic inpatient units.

Analysis by the Forensic Network suggests that provided patient flow improves significantly then there is likely to be sufficient capacity within the current medium secure estate. This however would be at a relatively high bed occupancy rate for most of the time which may not be sustainable, and a case could be made for progressing plans in the West of Scotland for additional bed capacity at Rowanbank Clinic.

The availability of low secure beds across the estate remains limited. Not all health boards have access to local low secure services. In addition, the need for low secure services for different patient groups can limit the use of available beds. There is a group of patients who will require long term low secure care and their needs are very different from those who are actively working towards discharge and remain in a low secure unit while progressing. The need for low secure access for patients on assessment orders and treatment orders is also important. Without enough capacity in low secure beds the bottleneck in the system pushes patients into other areas of psychiatric care.

There is variation in use across Scotland of Intensive Psychiatric Care Units (IPCU) beds for patients involved in the criminal justice system. Some areas admit patients who are facing serious charges or are serving lengthy sentences and spend long periods of time spent in the IPCU meaning these patients cannot access the full range of treatments available to other patients who can access low secure units with an acute admission function. This also has a direct impact on the availability of access to IPCU for non-forensic patients.

Problems accessing local and regional inpatient units therefore seem due to uneven capacity and flow through inpatient units as a result of variation in what services are offered between regions. Notwithstanding the comments above regarding the West of Scotland medium secure estate the

College supports an approach where greater emphasis is put on developing local secure units as part of discharge planning and increasing resource allocation to community services as a means to improve patient flow and accessibility for the whole estate.

The mechanism to appeal against excessive security is a welcome provision in Scotland, however, it is not always backed-up with the necessary provisions.

Lack of care pathways for certain groups

The care pathway for women in secure services in Scotland is a well-recognised problem. The Forensic Network completed an options appraisal on behalf of NHS Chief Executives. However, some of our members have expressed concern regarding the outcome of this options appraisal process. The College views it as important that the concerns expressed are carefully considered as service development plans progress.

The College support the view that women who require to be treated in conditions of high security should have this provided within Scotland and not have to cross the border to England. The Independent Review will have access to reports detailing the pros and cons of the current situation and the challenges of bringing back a high secure unit in Scotland. The College recognises that there is a need for significant investment into ensuring that high secure care for women meets the needs of this group whilst protecting the public from serious harm. It also notes that there should be a parity of provision for men and women in high secure psychiatric care which acknowledges differences in needs but ensures consistency in types of security (i.e. relational, physical and procedural). This parity should also be expected for individuals with an intellectual disability.

There are issues of the concept of same-sex accommodation and whether we should have such provision. Our members are aware that within female only wards, there has been many incidents of sexual assault that go unreported to staff at the time. In mixed gender clinical areas, the emphasis should be on managing the risk posed (whether by males or females), rather than presuming a single sex environment will be sufficient to safeguard vulnerable individuals.

Other groups of patients who are disadvantaged because of a lack of care pathways are individuals with:

- Acquired brain injury
- Neurodegenerative condition such as dementia

Overtreatment with excessive restriction and unnecessary loss of liberty

This concept is likely to be more familiar to people when physical healthcare is being considered. Examples include unnecessary investigations or treatments which bring little value for the patient. Not only is this a waste of limited resources but it also associated with a risk of harm to the patient.

The above examples are just as relevant to mental health care but for patient within forensic mental health services hospitalization in a secure unit *per se* is considered a therapeutic intervention. This is described in Kennedy's influential paper from 2002[7] which was operationalised for a Scottish context in the Forensic Network report published in 2004 titled *Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland*[8].

Forensic mental health services are high cost, low volume services. The higher the level of security, the higher the costs. This is because of the need for higher staff ratios and more "in house" facilities because patients cannot easily access the community. It is important that patients receive the right treatment, at the right time but it is also important this is delivered in the right place.

A delay in a patient moving to lesser security or delayed discharge from a secure unit should be seen as "overtreatment" in the context of Value based healthcare. Although a patient may be receiving good quality care, their continued detention in excessive security is an example of low value healthcare. Whilst they will still have access to treatments for their mental illness it is the wider rehabilitation opportunities which are not available or the ability to evidence that they no longer require to be detained in hospital.

Individuals with an Intellectual Disability

Within the Intellectual Disabilities sector of forensic services there are a small number of cases, but these are highly complex, so coordination is difficult, especially with female patients. There are issues of the concept of same-sex accommodation and whether we should have. Our members are aware that within female only wards, there has been many incidents of sexual assault that go unreported to staff at the time.

ID services sit within Health and Social Care Partnerships' (HSCP) remit, which has led to variations in the service provided. It has resulted in some Forensic services being aligned closely with ID services whilst others are aligned to Mental Health services. More consistent provision of Forensic ID services across Scotland is needed to improve standards within inpatient and community services.

Problems in ensuring a personalised approach to treatment of some patients who are unlikely to progress through the secure estate

There is a small group of individuals who our members identify find it difficult to progress through the secure hospital estate to the community. With the advent of appeals against being detained in excessive security they appear to become most often trapped in the medium secure / low secure units. They fall broadly into two groups:

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[7] Kennedy H.G. Advances in Psychiatric Treatment (2002), vol. 8, pp. 433–443

[8] https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/LevelsofSecurityReport.pdf?x82981

- The first group is individuals with a primary diagnosis of personality disorder who continue to present a risk of serious harm to others if in the community and are unwilling to engage in treatment or have been unresponsive to treatment. There is a mechanism for individuals to take their case back for a review of sentencing but the number of individuals who have taken this forward has been small.

The Royal College of Psychiatrists in Scotland published in 2018 a report which describes the current provision of mental health services for people with a diagnosis of personality disorder in Scotland and a consensus view on good practice for services providing care for people with a diagnosis of personality disorder[9].

When addressing the management of the risk, to self and others, the report concludes that there is no clear evidence that long-term hospital admission for treatment of personality disorder is helpful. The report then goes further and states that there is general consensus in the clinical literature that long-term hospital admission is likely to be harmful to the individual, as it may work against the long-term aims of developing skills to manage distress.

It is more common in forensic mental health services in Scotland for patients to have personality disorder as a comorbid condition to their primary mental illness. Services therefore have expertise in managing personality disorder and a recent position paper from the Forensic Network on psychological approaches to personality disorder highlighted minimum service requirements for all forensic settings[10].

However, there are currently a number of patients detained in hospital under a Compulsion Order Restriction Order for reasons other than providing medical treatment. This is because of what is commonly referred to as the "serious harm" test which appears in section 193 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and applies to all CORO patients.

The origin of the "serious harm" test is in the Mental Health (Public Safety and Appeals) (Scotland) Act 1999 where it was referred to as the "public safety" test. This was enacted as emergency legislation after the successful appeal by a patient at the State Hospital who had an untreatable personality disorder and had been convicted of culpable homicide.

The intention of the legislation was to enable preventative detention of patients who found themselves in a similar position of being originally detained in hospital for treatment of a mental illness and subsequently re diagnosed as having a personality disorder.

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[9] RCPsych (2018) Personality disorder in Scotland: raising awareness, raising expectation, raising hope. College Report CR214

[10] K. Russell , Psychological Approaches to Personality Disorder in Forensic Mental Health Settings, The Forensic Network, 2016.

The Independent Review will most likely view this as a matter for the Review of the Mental Health Act. However, this is not the first time this issue has been raised when reviewing mental health legislation in Scotland. The Millan Committee considered the matter and recommended that the "public safety" test as being unnecessary and that it should be abolished[11]. The then Scottish Executive decided to retain the test within the new Mental Health (Care and Treatment) (Scotland)Act 2003 and there is no guarantee that the Scottish Government will take a different approach if presented with similar recommendations by the Scott Review.

- The second group is individuals who have developed serious executive cognitive dysfunction, for whatever reason, and will continue to need a level of procedural and relational security to manage their risk of sexual or non-sexual violence which cannot be managed in a standard nursing home environment.

In anticipation of no change to the "serious harm" test there requires consideration as to how Scotland can develop resources for these groups.

The first group are likely to benefit more from a hospital environment which is designed to meet their treatment needs and quality of life issues and not have the destabilising effect of being accommodated with patients with acute mental illness. The Independent Review will be well placed to identify where such capacity may currently exist or could be developed if the issue continues to exist.

The second group overlap with a subgroup of elderly long-term sentence prisoners. Here a secure nursing home type facility may best meet their needs. This would most likely require a regional or national approach and again the College would welcome the Independent Reviews views on this approach.

The College supports the work done by the Forensic Network in the area of promoting service improvement but would like to take this opportunity to highlight the College Quality Network for Forensic Mental Health Services (QNFMHS) which covers both medium and low secure services and includes standards for female services as well as Intellectual Disability services. To date only NHS Tayside forensic mental health service has joined the network from Scotland and has been a member for eight years. They joined before the Forensic Network had launched its own peer review programme and have remained with the College network for several reasons. The QNFMHS promotes greater learning and innovation from the experience of visiting similar services across the UK which staff are not so familiar with. It is also more challenging to experience a review which has a patient reviewer who will give honest feedback on a service. The College looks forward to any comments the Independent Review may have on the QNFMHS as a means of promoting the aims of Realistic Medicine.

[11] New Directions: report on the review of the Mental Health (Scotland) Act 1984, Scottish Executive 2001

Limited service provision in lesser security

Other problems highlighted by our members across the country have been the lack of provision of specific treatments such as psychological interventions and occupational therapy in less secure hospital units. This is unwarranted variation as the need for non-pharmacological approaches to rehabilitation and safe discharged of patients is at least equal if not more important than the provision of these services in high security where patients may not have regular community access for a considerable length of time.

This, and the other problems highlighted above, are not unique to forensic mental health services and the impression can often be that forensic mental health services are relatively better off in terms of clinical environments, caseloads and staffing compared to other parts of mental health services. There may be some validity to these views when high and medium secure inpatient units are considered. However, when services providing for individuals in local low secure or locked units, the community or prison are looked at this picture is likely to be very different.

Across the estate there are concerns about the underinvestment in mental health services and forensic mental health services. This can often lead to frustrations about whether some services are better resourced in comparison with others. Consistently, identified is the lack of resources at community and low security as well as the lack of resources that prevent transition between high/medium and medium/low levels of security. Members have noted that the work of all parts of the forensic mental health system is dependent upon the good functioning of the other parts of the service.

The role of a Consultant Forensic Psychiatrist in Scotland is made more difficult to fulfil by pressures and service issues in forensic services. Limitations in these services often prevent patients from moving on in a timely manner at an appropriate point in their journey. This is not in the patients' interest or at times in keeping with the Millan Principles of the Act. Further, these pressures can result in difficult relationships between different parts of wider forensic mental health system.

Workforce issues

Our members have highlighted an increasing problem associated with insufficient number of suitably trained nursing staff to manage fluctuations in clinical acuity resulting in the inability to admit patients to hospital despite having bed availability. The reasons for this are likely to be complex but relatively high long-term sickness absence rates are often a feature of forensic mental health services. This should not be accepted as “normal” because whilst the nature of the work is often challenging the risk of staff burnout can be mitigated by adequate resourcing of staff support mechanism and leadership in promoting healthy workplaces.

Whilst territorial Boards have faced shortages in the nursing workforce for some years it now appears a similar problem is extending to the State Hospital.

The need for high levels of relational security makes the recruitment and retention of staff a patient safety issue. The Independent Review is well placed to have obtained the views of the current workforce and the College would support the making of recommendations which are focussed on improving the wellbeing of staff.

The issue of vacancy rates across psychiatry in Scotland has also hampered those that work within Forensic Mental Health services from fulfilling their role in the manner they wish. As of June 2019, Forensic Psychiatry has 5 WTE vacant consultant posts, two of which had been vacant for over six months. This constitutes a vacancy rate of 10% of the entire Consultant Forensic Psychiatrist workforce.

Psychiatry of Learning Disability has a consultant vacancy rate of 4 WTE, (2 of which have been vacant for over six months), which has led to an over 8% vacancy rate. The fill rates of Specialty Trainee places with Learning Disability Psychiatry rate should also be noted as they have been gravely concerning over the last few years; 0.00% (2017), 28.57% (2018) and 12.50% (2019).

The issue of vacancies can also be seen through geographical needs as well as through specialties. This has put a strain on RCPsych members as they work to cover these vacancy gaps, while continuing with their own demanding workloads. In order to deliver the best possible services to patients, There is a real need to not only retain current psychiatrists to stop a further decrease in filled posts, but also to focus on the recruitment of new psychiatrists to fill current vacancies and, with the likely increase in demand for mental health services, ensure the future of the workforce.

Currently, there is no specific Forensic ID curriculum available. Forensic Higher Trainees can arrange for placements within Forensic ID settings, and ID Higher Trainees can do so as well but the subspecialty would benefit from clear learning outcomes to ensure clinicians working in Forensic ID settings have the necessary knowledge and skills.

Variation in funding arrangements

Across Scotland, forensic mental health services are funded through a number of different means. The State Hospital is its own special health board. Regional services appear to have remained the responsibility of the territorial Board where they sit whilst other services are either aligned to Health and Social Care Partnerships or territorial Boards directly. A concern amongst our members is that this has resulted in services failing to be allocated the resources they require for service delivery and improvement which risk even further unwarranted variation in what service patients may receive and in some case resulting in longer hospital admissions for some patients.

Criminal justice services

Mental health services in prisons

In November 2011, the National Health Service (NHS) Scotland, took on the responsibility of providing healthcare to Scotland's prison population. This transfer of duty involved the Health Boards in Scotland taking on provision of healthcare staff for their local prisons. With fifteen prisons in Scotland, most health boards manage the care provided in one prison, if not more.

Health Board	**Prison**	**Number of Forensic Psychiatry Consultant Clinical Sessions per week (DCC only)**
NHS Ayrshire and Arran	HMP Kilmarnock[12]	2
NHS Dumfries and Galloway	HMP Dumfries	0.5
NHS Forth Valley	HMP Cornton Vale[13] HMP Glenochil[2] HMYOI Polmont[2]	3 3 4
NHS Grampian	HMP Grampian	4
NHS Greater Glasgow and Clyde	HMP Barlinnie HMP Greenock[2] HMP Low Moss	4 1 3
NHS Highland	HMP Inverness	1
NHS Lothian	HMP Addiewell[1] HMP Edinburgh	2 2
NHS Lanarkshire	HMP Shotts[2]	5
NHS Tayside	HMP Castle Huntly[2] HMP Perth	0.5 5

Table 1: Healthboards and corresponding Prisons

The total population of the prison estate is currently 8,159 with 388 women and 18 between the ages of sixteen and seventeen years[14].

In Scotland, each of the health boards provide input for mental health using forensic psychiatrists. It is worth noting that this is not the case in other parts of the UK. From the table above the variation in provision of psychiatric input is evident although we have not indicated the populations of individual prisons. Again, this area is seen as an area that is under-resourced. We have not commented on addiction psychiatry here.

[12] Denotes a prison operated by a private sector contractor
[13] Denotes a prison providing a national service
[14] https://www.sps.gov.uk/Corporate/Information/SPSPopulation.aspx Accessed 27th January 2020.

Anecdotally from psychiatrists providing sessions into the prisons there is a mixed workload. Many individuals with mental disorders that might in the community be seen by primary care nurses and/or GPs are often managed by a forensic psychiatrist. This reflects the high pressures on primary care staff within prison settings and a population seeking input. The system allows faster access to secondary mental health care and this can be seen as an inefficient use of a limited resource. It can result in those with more serious mental illnesses (e.g. schizophrenia and bipolar affective disorder) not being prioritised as they would be in secondary mental health services out with the prison.

Areas of Good Practice

- All prisons in Scotland provide consultant psychiatry input from local health boards
- Training is available for staff working in prisons about personality disorders
- Psychiatrists work closely with GPs in prison settings

Areas of Development

- A minimum standard of care that is provided in prisons that allows flexible delivery of services to patients with complex needs and those with less complex needs
- Greater opportunities for multidisciplinary input to treatment for prisoner. In particular moving away from models of care which because of team and skill mix are currently focused on pharmacological interventions for less serious mental disorders and increasing resources for implementing psychological and occupational therapy interventions.
- Enhancing input from primary care and empowering GPs to take more responsibility for managing mental conditions which would normally be dealt with by primary care in the community
- Consider establishing screening for neurodevelopmental disorders and provision of appropriate supports in prison settings

In 2015 the Royal College of Psychiatrists Centre for Quality Improvement launched a Quality Network for Prison Mental Health Services (QNPMHS)[15]. To date only one prison in Scotland, HMP Perth, has joined the network. As a member of this network the prison mental health team engage in an annual process of self and peer-review with the aim to ”Promote quality improvement, share best practice, encourage a culture of openness, help services plan improvements for the future and allow services to benchmark their practices against other similar services”.

If more prison mental health team were resourced to join this network, it is anticipated that would be less variation in standards of care between prisons and an increase in services offered to prisoners. The College asks that the Independent Review consider recommending that Health and Social Care Partnerships which have responsibility for delivering prison mental health services follow the example of Perth & Kinross HSCP and invest in this quality improvement programme. This approach is considered preferable to developing a new quality improvement network for prisons in Scotland, which would require considerable resources.

[15] https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/prison-mental-health-services

Transfer of prisoners to hospital

There are two situations where an individual might be transferred from prison to hospital for mental health care and treatment. The first occurs when an individual is on remand. In this case, a report must be provided to the court or to the Prison Governor detailing the reasons for transfer and that a bed is readily available within seven days. A report from a Mental Health Officer (MHO) is not required. The second occurs when an individual has been sentenced and requires care and treatment for their mental health in a hospital setting. In this case, arrangements must be made through the service local to the patient, i.e. their home health board, to review the patient and identify a suitable bed. The MHO local to the prison must review the patient. Reports must be provided from two doctors one of whom must be an Approved Medical Practitioner (AMP) under the act (Section 22 approved). The two doctors are usually either the GP or psychiatrist visiting the prison and the psychiatrist at the receiving unit.

In England and Wales, their waiting time for a secure bed is significantly longer than that here in Scotland. However, our times are dependent on local practices and bed availability.

When an individual is identified as requiring hospital admission consideration is given to appropriate placement and level of security required. Discussions must be had between the referring psychiatrist, a psychiatrist from the patient's home health board and the receiving unit. These may be three different people or the same one. This can result in prolonged assessment times and multiple assessments for the patient.

Areas of Good Practice

- Transfer between prison and hospital can take place at relatively fast speeds in Scotland when compared with other parts of the UK
- Multidisciplinary assessments from high secure and some medium secure services of individuals in prison.

Areas of Development

- A more consistent approach to assessing patients would be beneficial in reducing the time for patients to be seen; reducing repeat assessments; and result in patients being in hospital receiving care faster.
- The bottleneck in provision of care between medium/low security and low security/community results in the need for patients to be held in *Exceptional Circumstances* in an inappropriately high level of security. Improving patient flow across the estate would improve this.

Provision of professional and expert witness reports to Courts

Each health board has their own arrangements with their local court for the provision of professional and expert witness reports. This can be a fixed arrangement through contract or an understanding or agreement between the services. Reports can be requested at different stages in the court process. Generally, these are divided into two stages. The first is reports before trial where the focus is Fitness to Participate at Trial and/or Criminal Responsibility (or Diminished Responsibility in homicide cases) at the

time of the alleged offence. These are generally requested by the Procurator Fiscal. The second is reports before sentencing where the focus is on recommendations to be made to the court about appropriate disposal of the case. These are generally requested by the Sheriff.

It is often the case that where an individual is known to general adult services that the report is best completed by the general adult psychiatrist who knows the person. In forensic inpatient services these reports often run side by side with assessment of the patient. They provide an excellent training and supervision opportunity for trainees. Courts can request more specific reports e.g. risk assessment, but often this is not made clear with the request.

Individual psychiatrists make arrangements with defense solicitors for the provision of reports.

Relationships between services requesting reports and services providing reports are often tense. The demand for reports where no formal arrangement is in place for the provision of reports has resulted in situations where the Sheriff has demanded the presence of a psychiatrist in court and on one occasion has demanded the presence of health board managers. This can lead to deterioration in the relationship and reluctance to provide reports. It can be difficult for time constraints to be managed across the two services in the provision of reports.

The variation in the provision of Court liaison services versus police custody liaison services across the country can also result in demands for urgent psychiatric assessments from local forensic psychiatry services for individuals presenting as acutely unwell and/or suicidal. This variation results in mixed availability of services for patients and added disagreements between courts and local services.

Some areas have seen an increase in report requests from the courts for Witness Reliability. There are few psychiatrists who are available for this work.

Areas of Good Practice

- Court Liaison services are available in some parts of the country
- Forensic Psychiatry Trainees get more opportunity for supervised Court Reports than in other parts of the UK

Areas of Development

- Less variation in the provision of court liaison and police custody liaison would allow individuals to be identified at earlier stages in the process
- Some Health Board Area Forensic Psychiatrists do not provide any Court reports due to local employer stipulations. This can pose challenges when individuals are not already open to services but need to be considered for admission to an inpatient setting within such a service. As only the RMO for an inpatient service can offer a bed as part of a recommendation to Court, individuals may not be able to access services due to these practice issues rather than on the basis of clinical need

Prisoners with severe personality disorder

As already described, it is not common in Scotland to admit an individual to a forensic mental health unit with a primary diagnosis of personality disorder. There are however high rates of individuals with personality disorder in prison. Unlike in England, to our knowledge, there are no prisons in Scotland that provide specific services for this group of individuals. The Forensic Network provides training available to those working in the Scottish Prison Service and those from NHS Scotland who work in the prison settings[16]. The College would emphasise that training should be available for all staff working in prisons about personality disorders. Any consistency and minimum standards for Personality Disorder services within the Forensic estate should link with the work that the newly announced Personality Disorder Managed Network will be conducting.

Individuals with Intellectual Disability

Unless individuals are already known to services, it can be difficult to identify people with ID in custody settings. Forensic MH teams in prison often do not have any ID trained clinicians and tend to focus on psychotic illnesses. Research evidence indicates that a significant proportion of individuals in prisons have neurodevelopmental disorders (a recent paper noted 23% with ADHD, 7% with IQ scores below 70 and 1-4% with Autism in a UK prison). Neurodevelopmental disorders are associated with higher rates of mental illness and suicidal ideation/attempts. People with ID can be vulnerable in prison settings, with measures needed to be taken to ensure their welfare.

Women prisoners

The report from the Commission on Women Offenders identified a number of areas where provision for women in custody could be improved including a number of areas relating to mental health care. This report could be revisited, and provision reviewed again to compare. It is likely that there remain significant gaps that have not yet been addressed. There is no recommendation within this report that men or transgender people should be excluded from.

Prisoners with acquired brain injury and neurodegenerative conditions

Within the prison estate, there are no specific services that manage dementia or early onset dementia. These individuals are often not identified to mental health teams within the prison. There are different reasons as to why this might be including: prison regime helps manage/mask some symptoms; quiet presentations do not present at health care; no specific screening at admission. Forensic Psychiatrists providing input into the prisons may not be as up to date with investigation and management of this condition. Referrals to outside services may be appropriate but these can be challenging to arrange transfer to/from. There are anecdotally examples of individuals with dementias being supported by other prisoners on the halls. This can be a way of bringing things to the attention of others. There are also examples of individuals being exploited by other prisoners.

Community services

[16] RCPsych (2018) Personality disorder in Scotland: raising awareness, raising expectation, raising hope. College Report CR214

Community forensic mental health services in Scotland to date have received the least focus in terms of resources for service development and setting of standards of care. They also have the greatest variation in what services are delivered and how this is done. Larger Boards have dedicated forensic community teams, but these may not cover the whole geographical area. For example, in NHS Lothian the forensic community team only covers Edinburgh City and not East, West and Mid Lothian. Smaller boards often have identified a forensic clinician within their CMHT. This may be warranted given the size and nature of the Health Board area, but individuals should expect a similar opportunity to access services available in a dedicated forensic community team.

Issues highlighted by our members working in community teams are

- Patients who are delayed in their discharge from hospital for many months and even years due to lack of availability or allocation of suitable supported accommodation for patients in forensic mental health services and forensic ID services.

- Exclusion in some areas of patients being able to access community mental health resources because they are patients of a forensic mental health service or have been in prison having served a sentence for serious offences.

- There is no agreed process for equal allocation of restricted patients who cannot return to their original health board area because of victim safety, victim sensitivity or high media profile reasons. In these situations, the negotiation which is required between clinicians, health board managers and local authorities is often lengthy and relies upon good will and the promise of reciprocity. This is not a fair or appropriate way to manage these situations.

Forensic community mental health teams will usually offer case discussion and assistance with risk management planning for other subspecialties in the mental health service where they work. However, there is considerable variation which has developed between forensic community mental health teams to what extent they are willing to take on a public protection liaison role for patients usually with personality disorder or paraphilia who they would not normally case manage.

This reluctance can be a result of concern about expertise within a team but also concern about additional workload which is not resourced for within current budget and staffing level. Whilst it may be manageable initially because of small numbers of cases there is a risk the workload increases and then places at risk core functions, such as the safe community reintegration on inpatients.

The College believes that the further development of forensic community service is beneficial to patients and is necessary but to ensure sustainability and adequate allocation of resources there is a need for HSCP and Health Boards to be given clearer guidance on service specification.

Other evidence

Coming Home: A Report on Out-of-Area Placements and Delayed Discharge for People with Learning Disabilities and Complex Needs.

The experience of carer support and involvement within secure mental health services has influenced our views. Our members have had discussion with patients and those who have previously used forensic services to encompass their views into our response. This has been done through the Triangle of Care a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

We submitted evidence regarding the implementation of UNCRPD in the Independent Review of Learning Disability and Autism in the Mental Health Act. We recognise the ambition and reasoning behind that Review's initial choice in taking a purist interpretation of the UNCRPD. However, the College has concerns that this is not the best way to implement UNCRPD concepts, demonstrated by the fact that no other legislative area has been able to find a practical way to implement a purist interpretation. The UN model, given that it must suit the wide variations in worldwide health services, is not nuanced to the situation in Scotland. As well as our members experience, we look to the following research, which also acknowledges concerns of a purist approach of implementation:

Craigie, J., Against a Singular Understanding of Legal Capacity: Criminal Responsibility and the Convention on the Rights of Persons with Disabilities, International Journal of Law and Psychiatry, 2015:40.
Independent Review of the Mental Health Act, Modernising the Mental Health Act, 2018.
McCarthy, J, & Duff, M., Services for adults with intellectual disability in Aotearoa New Zealand, British Journal of Psychiatry International, 2018:16(3), 71-73.
Scholten M, & Gather J., Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward, Journal of Medical Ethics 2018:44, 226-233.
Stavert, J., The Exercise of Legal Capacity, Supported Decision-Making and Scotland's Mental Health and Incapacity Legislation: Working with CRPD Challenges, Laws 2015:4(2), 296-313.
Stavert, J., Paradigm Shift or Paradigm Paralysis? National Mental Health and Capacity Law and Implementing the CRPD in Scotland, Laws 2018:7(26).
The Essex Autonomy project report on Towards Compliance with UNCRPD Art. 12 in Capacity/Incapacity Legislation across the UK
United Nations, Convention on the rights of Persons with Disabilities, 2008.

References

- McCarthy J et al, Prisoners with Neurodevelopmental Difficulties: Vulnerabilities for Mental Illness and Self-Harm. *Crim Behav Ment Health.* 2019; 29:308–320.
- Mental Welfare Commission for Scotland, 2013. Corporate report: excessive security, April 2013.
- Mental Welfare Commission for Scotland, 2017. Visiting and monitoring report: medium and low secure forensic wards, August 2017.
- Mental Welfare Commission for Scotland, 2019. Report on announced visit to: Iona and Lewis Hubs, The State Hospital, 110 Lampits Road, Carstairs Junction, Lanark, ML11 8RP Date of visit: 12 February 2019.
- State Hospitals Board for Scotland, Annual Report and Accounts for the year ended 31 March 2019.