

# **Independent Review into the Delivery of Forensic Mental Health Services**

**What people told us**

**August 2020**



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## Message from the Chair of the Review

This report is a summary of the experiences, opinions and observations that people shared with the review either face-to-face or by responding in writing during our call for evidence. Under a series of themes, it reflects what people receiving, delivering and supporting others within forensic mental health services felt was important that the review knew. It also includes some of the many the ways in which people felt these the services could be improved.



I want to thank everyone who has taken the time to share their experiences. I have found everyone willing and eager to share their experiences, both good and not so good. I'd like to say a particular thank you to people with lived experience who spent time with the review team and shared their stories. We have tried to ensure your voices are heard in this interim report. Family members also deserve our thanks for coming along to various sessions specifically to speak to the review team. Thank you for your passion and for sharing your experiences with us.

Before reading this report I think it is important to note that this interim report does not seek to provide solutions, it aims to share what we were told and what was sent to us. The issues that people raised with us will be the foundation on which the review will now start to work towards making its recommendations. However, the report also lets me see the areas where we need to take some time to gather further evidence to allow us to make informed decisions and meet our terms of reference.

As everyone is well aware coronavirus (COVID-19) has come upon us during the period of the review. This led to a cessation of the work while we all contributed to the national effort to fight the virus. The pandemic has led to a revised timetable with a projected date of January 2021 for the publication of the final report.

Thank you to everyone who has contributed.

A handwritten signature in black ink that reads "Derek T Barron". The signature is written in a cursive, flowing style.

**Derek T Barron, Chair of the Review**

## Acronyms

AA	Appropriate Adult
AHP	Allied Health Professional
CMHT	Community Mental Health Team
CFMHT	Community Forensic Mental Health Team
CORO	Compulsion Order and Restriction Order
CPA	Care Programme Approach
GDPR	General Data Protection Regulations
GP	General Practitioner
IPCU	Intensive Psychiatric Care Unit
IRMHA	The Independent Review of Learning Disability and Autism in the Mental Health Act
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team
MHO	Mental Health Officer
NHS	National Health Service
SUS	Suspension of Detention

# 1 Introduction

## 1.1 Background to the review

In March 2019, the Minister for Mental Health announced an independent review into the delivery of forensic mental health services in Scotland.<sup>1</sup> Derek Barron, Director of Care at Erskine, was named Chair of the review later that year in May.<sup>2</sup>

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 themselves or others under civil legislation. The review was set up in recognition of changes and developments in the delivery of these services over a number of years. The changes include 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 secure National Adolescent Secure Inpatient Service for Scotland.

The review's remit and purpose is set out in its terms of reference which can be found at Annex A: Terms of Reference. Under these terms, the review has to consider the following parts of the forensic mental health system:

- 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.

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<sup>1</sup> See the Minister's announcement: Directorate of Health and Social Care (2019) *Improving mental health services*. Available at: <https://www.gov.scot/news/improving-mental-health-services-1>

<sup>2</sup> See the Announcement of the Chair: Forensic Mental Health Review (2020) *Forensic mental health services: independent review*. Available at: <https://www.gov.scot/groups/forensic-mental-health-services-independent-review>

The client groups named in the terms of reference are: people with a learning disability or a neurodevelopmental disorder; women; children and young people; and older adults.

The review is supported by a secretariat team that started work in July 2019 and three working groups that were established over the summer of 2019. Over 60 people are on these working groups, from more than 45 organisations. Together they represent: people with lived experience of forensic mental health services; their relatives, carers or representatives; organisations commissioning, delivering and monitoring forensic mental health services and those providing support services; staff-side and professional organisations; and organisations involved in legal and court proceedings.<sup>3</sup>

The review is expected to make some recommendations for change. These will be published in its final report, which was originally expected in June 2020. The review was suspended from 17 March until 20 July 2020 to allow the Chair and its working group members to focus their efforts on responding to the COVID-19 pandemic. The review now expects to publish its final report in January 2021.

## 1.2 Background to this report

The review opened with a 'listening' phase. This was to give as many people as possible the opportunity to share their experiences of forensic mental health services in Scotland.

The review provided two ways for people to share their views. Firstly, people could respond to the review's formal call for evidence which ran from 14 October 2019 until 31 January 2020.<sup>4</sup> Responses could be made online, by email or over the phone. The review received 103 responses to this call: 56 were from organisations and 47 from individuals. The organisations that responded are listed at Annex B: Responses to call for evidence.

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<sup>3</sup> See all working group members: Forensic Mental Health Review (2020) *Forensic mental health services independent review: working group membership*. Available at: <https://www.gov.scot/groups/forensic-mental-health-services-independent-review-member-organisations>

<sup>4</sup> See the Review's Call for Evidence: Forensic Mental Health Review (2019) *Call for evidence*. Available at: <https://fmhr.citizenspace.com/forensicmentalhealthreviewscot/call-for-evidence>



Secondly, the Chair met face-to-face with people. He visited 10 secure hospital sites between August 2019 and January 2020. The Chair met with groups of people with lived experience, their family members and members of staff to hear about their experiences and understand the range of services being delivered. In total, 88 people with lived experience, 16 family members and 188 staff shared their views during these visits. Advocacy workers helped to amplify the views of people with lived experience at a number of these meetings. The Chair also met with some people individually and spoke at a number of conferences. He had a meeting with one staff team via video conference in July 2020 because a visit to their hospital site was not possible due to COVID-19. The review's engagement activities are listed in Annex C: Engagement activities supporting the call for evidence.

The review also considered over 200 supplementary documents including reports, articles and guidelines. These documents were attached as additional information to people's written responses, provided by members of our working group or identified by the review team as relevant to the terms of reference.

This report is a summary of what people told the review during this 'listening' phase. It provides an account of the key themes and related issues people described within the forensic mental health system. It draws on supplementary material to add further information where necessary. This report does not make any value judgements about different points of view or decisions about what should happen next.

### 1.3 How the analysis was done

The call for evidence did not have set questions that people had to answer. A series of prompt questions were provided to help people shape their responses, if needed. The content of the visits and meetings was also led by what people wanted the review to know. Therefore, the data analysed in the report is mainly qualitative: it captures a range of organisational perspectives and personal experiences. These were sometimes shared in great depth and detail. To make the most of the richness of this data, each written submission, comment from the face-to-face meetings and piece of supplementary evidence was coded and thematically analysed with the support of qualitative analysis software, NVivo.

The content of this report reflects the themes which emerged most clearly from the data and some of the suggestions for change. Care was taken to ensure that quieter

voices and more marginalised points of view were not lost. Appropriate weighting was applied to evidence which provided an alternative perspective, identified an issue of particular importance or addressed an element of the terms of reference. Many of the issues raised are relevant to more than one theme. These issues are discussed under the theme they relate to most closely.

#### 1.4 A note on terminology

There are many terms that are used to describe people who use mental health services including 'patients', 'users', 'clients' and 'experts by experience'. The term 'carer' can sit uncomfortably with family and friends who support people in the system.<sup>5</sup> The range of professionals who work across forensic mental health is extensive, covering a diverse range of specialisms. The review spoke to service managers and a wide variety of clinicians across multi-disciplinary teams.

In all cases, the review aims to use language which emphasises the humanity of the people who responded to the review, whilst accommodating the need for consistency, brevity and anonymity. For people who have received or are receiving forensic mental health care and treatment, this report uses the terms 'people with lived experience' or 'people receiving care'. The terms 'family' and 'staff' or staff 'team' are used to describe the other major perspectives. If a point came from one professional group in particular then this is specified. 'People' is used when the same point had been raised from multiple perspectives or from more than one person with lived experience. The term 'learning disability' used in the report reflects the wording in Scottish mental health legislation. However, the review recognises that 'intellectual disability' is the preferred terminology among clinicians and other groups.

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<sup>5</sup> See Ridley, J., McKeown, M., Machin, K., Rosengard, A., Little, S., Briggs, S., Jones, F. and Deypurkaystha, M. (2014) *Exploring Family Carer Involvement in Forensic Mental Health Services*. Edinburgh. Available at: <https://www.supportinmindscotland.org.uk/exploring-family-carer-involvement-in-forensic-mental-health-services>; Mental Health Foundation *Terminology*. Available at: <https://www.mentalhealth.org.uk/a-to-z/t/terminology>

# Themes

## 2 Underpinning themes

Two aspects of the forensic mental health system seemed to underpin the issues that people raised. First, the effectiveness of the system is hampered by limited capacity. NHS secure units and wards lack beds in the right places and there is not enough suitable accommodation in the community. Second, Scotland's forensic mental health system is characterised by variations in both provision and practice. These can be experienced as unfair or inconsistent by people receiving the service. The impact of both limited capacity and inconsistency is evident in many of the themes described in the rest of this report.

### 2.1 Capacity within the forensic mental health system

Staff spoke about NHS services within the forensic mental health system as functioning 'at capacity'. Managers said that services should optimally be operating at 80% to enable clinical responsiveness. However, most services reported running at full capacity most of the time. Resourcing issues affect the availability or quality of provision in some areas. Getting an inpatient bed at an appropriate security level can involve long waits and out of area placements. When services operate at capacity for long periods of time it is said to have a negative impact on the care and treatment people receive. It can also affect staff retention and welfare. Lack of suitable accommodation in the community is having a negative impact on individuals awaiting discharge and knock-on effects for the system overall. One team described people 'being placed where there is a bed rather than where fits their needs'.

#### 2.1.1 Funding

People said that specialist forensic services represent a high cost for a relatively small number of people. They also felt, however, that the system is under-resourced. This is delaying progression and discharge and some people said it is increasing the threshold for access to services. Variations in funding arrangements are associated with concerns that some services are not allocated the resources they need for service delivery and improvement. This can cause unwarranted variations in people's care and length of hospital stay. Some providers felt that the integration of forensic services into Health and Social Care Partnerships places them

at risk. They feared decreases in understanding, funding and prioritisation of the specialism.

Some people queried whether resource allocation reflects population and need across different parts of the forensic system. A number of people felt that the 'beds are in the wrong places'. Some suggested that resources had not moved with the forensic population following the reduction of people in high security after appeals against conditions of excessive security were introduced. People also expressed frustration about the lack of resources in low secure services and in community services. This theme was consistently brought to the review's attention.

Differences between NHS Boards' funding models were said to pose challenges when arranging people's transitions. People spoke of 'wrangling' over who should pay for specialist support. Boards that rely on services in other areas expressed frustration about difficulties accessing them when demand is high.

To function effectively, forensic mental services rely on appropriate funding for other services. These include advocacy, education, structured community activities, work placements and support workers or befrienders. People raised concerns about 'patchiness' and reductions in third-sector provision. They said that the short tendering and commissioning cycle for such services contributes to uncertainty about their future.

Some services highlighted the need for new investment into the fabric of their forensic units. This was needed to bring lower secure facilities up to low secure standards and to improve ageing units.

### 2.1.2 Availability of NHS forensic beds

Frustration about a lack of beds was a consistent theme. The system relies on people being able to move – or 'progress' – from high security provision, through medium secure units, into conditions of lower security. The ultimate aim is for people to be discharged back into the community, with support from forensic community mental health teams (CFMHTs) or general adult community mental health services (CMHTs). This progression relies on beds being available when needed so that people can move through the system in a timely way and be at a security level with the least restrictive conditions necessary to manage their risk.

The review was repeatedly told about waiting lists for low secure services and two of the three medium secure units. This means people remain in inappropriate levels of security because of lack of beds at the appropriate level. One team said that this means 'people are here for much longer than they need to be'. People talked about a 'bottleneck' in low secure services and the review heard of people waiting months or years for places in lower security to become available. A lack of suitable accommodation or support packages in the community means people are not being discharged when they are ready. This reduces the ability of low secure units to accommodate people referred from conditions of higher security or general mental health services such as intensive psychiatric care units (IPCU).

The pressure on beds means a small number of people continue to be admitted to the State Hospital under the Exceptional Circumstances Clause.<sup>6</sup> It also increases the reliance of NHS Boards on independent or out of area provision, especially for women.

There are no high secure beds for women in Scotland and the number of beds for women in medium and low secure settings are reported as being too few to meet demand. High and medium secure provision for men with learning disabilities is provided on a national basis and is nearly always full, with high secure running at or above its occupancy rate in recent years. More details on the provision for women and people with learning disabilities are given in section 7. There are high secure beds available in the State Hospital for men with mental illness.

There is consensus that having people in an inappropriate security level limits their access to appropriate care and treatment. Managers were keen to address this but there was a sense of frustration in their efforts. One team was concerned that even if the problem was solved for their own unit, it would not address the overall constraints on beds and could exacerbate inequalities across the system. Another team who had tried to propose wider system changes spoke of not being able to get the agreement needed from other areas.

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<sup>6</sup> People who do not meet the criteria for high secure care and treatment can be admitted to the State Hospital under Exceptional Circumstances if there is no medium secure facility available. The Mental Welfare Commission must be notified of these admissions. See Forensic Network (2019a) *Guidance on patient referral to or within Scottish high and medium secure services*. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Guidance-on-Patient-Referral-to-High-Medium-Security-FINAL.pdf>

One Health Board recommended a needs assessment of the whole forensic estate including an examination of funding structure, trends in population flow and provision of services at regional and national levels. NHS Greater Glasgow and Clyde has proposals for extending both its medium and low provision. Other suggestions included: developing more specialist forensic rehabilitation or step-down units or low secure units; reinstating high secure provision for women within Scotland; greater clarity and collaboration around the processes for accessing secure beds across the forensic estate; and increasing resources in the community.

### 2.1.3 Out of area placements

Lack of beds means that some NHS Boards rely on placing people out of area, including with independent providers. People can therefore find themselves far away from their support networks. People said this makes it harder to maintain connections with family and friends. Family members highlighted that financial support for visiting out of area services is only available at the level of the State Hospital.

Placing people out of area is associated with significant costs for the 'home' Health Board. Funding arrangements between areas usually operate on a 'per case' basis. The National Services Division provides national risk share funding to resource and co-ordinate referrals outside Scotland. People felt there was a gap for similar coordination between NHS Boards in Scotland.

### 2.1.4 Community resources

Community Forensic Mental Health Teams (CFMHTs) play an important role in helping people to 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 care. They can provide intensive home care treatment or refer people to general adult mental health wards or IPCUs as required.

CFMHTs said they feel like the 'poor relations' in terms of resources within the forensic mental health system. They feel that less priority is given to, for example, their service development or setting standards of care, than for inpatient services. CFMHTs are often small and there is a lack of guidance about appropriate staffing ratios. Teams spoke of having to manage increasing workloads within existing or

reducing staff numbers. Some teams are looking to address gaps in their service, for example in governance and leadership, skillsets and referral routes and pathways. Lack of resource in these teams was also said to contribute to difficulties in arranging accommodation and support for people ready for discharge into the community. In rural locations, CFMHT staff felt there was insufficient recognition of the resource impact of working in the community where they have to spend significant periods of time travelling to meet with people and conduct assessments.

The majority of people come under the care of a CFMHT after being discharged from hospital but some CFMHTs also take referrals from CMHTs. However, some CFMHTs who had accepted non-forensic referrals said this had created expectations and resulted in CMHTs being more likely to escalate people's care into forensic services. This placed additional strain on CFMHT resources.

Some CFMHTs highlighted that they provide training for support staff who will be working with people coming out of the forensic system. However, high staff turnovers and limited CFMHT resources make it difficult to build up that skillset or for the training offer to be sustainable over the longer term.

## 2.2 Variation across the forensic mental health system

Despite the review receiving a number of documents relating to guidelines and standards for forensic service provision, people spoke a lot about the way that provision varies in practice. They highlighted that this variation means that people's experiences and outcomes can be affected by factors that are not related to their care needs or risk management requirements. People receiving care consistently raised concerns about these variations in the system.

People said that a person's journey through the forensic system can depend on the nature of local provision and individual working relationships. They spoke of differences in referral criteria and service-specific approaches to information sharing. People also spoke widely about variations in governance, protocols and practice, as well as differences in service ethos and experiences of care.

People felt that flexibility to respond to local need is important but that there should be a national approach to guidance and resourcing rather than a 'postcode lottery' affecting care and treatment.

### 2.2.1 Variations in forensic services in secure hospitals

At the highest level, variation is a consequence of forensic mental health services being a specialism for a relatively small inpatient population.<sup>7</sup> There is one national high secure service based at the State Hospital, three medium secure units providing services on a regional basis, while lower security and community services have been developed at local Health Board level. This creates inequalities of access to care and treatment depending on where a person lives. A significant number of people called for equal access to services across the forensic estate.

People spoke widely about variations in governance, protocols and practice, as well as differences in service ethos and experiences of care. Diversity within a system can provide the potential to respond in a more flexible and person-centred way to individual need. However, people more often framed differences as examples of inconsistency and inequalities within the system. Clinical teams, for example, spoke of the frustration of knowing that the different approaches taken in different units could benefit some people more than others but that there is no option to 'choose' which unit to refer someone to.

There are different risk management approaches in different clinical teams and areas. People with lived experiences see this as inconsistent, unfair or making little sense. It also makes it harder for them and their families to know what to expect in different places. People who had moved through the system spoke of ways in which practice differed, even between wards in the same units. They spoke of variations in restrictions, rates of progression, opportunities for activities and ward culture. Some people with lived experience felt there were different rules for different people. Advocacy organisations noted that differences in ward culture affected how their workers were received.

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<sup>7</sup> The Scottish Government's Inpatient Census counted 488 people receiving forensic services in NHS Scotland facilities in March 2019 and 37 people whose care was funded by NHS Scotland in a facility elsewhere. See Population Health Directorate (2019) Inpatient Census 2019: parts one and two. Edinburgh. 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> The Forensic Network's Inpatient Census identified 510 people accessing forensic mental health services in Scotland in November 2018.



### 2.2.2 Variations in community forensic mental health services

Many people commented on the lack of a consistent community pathway for people within forensic services. CFMHTs operate on a range of models. They have differing staff compositions, remits and terms of access. They are also not available in all parts of the country. Consequently, people spoke of an inequity in service provision across the country.

People felt there was a need for clearer guidance around CFMHT service specifications. They said variations in practice include whether teams were willing to accept restricted patients who cannot return to their home health board or take on public protection liaison roles for people they would not normally look after. Any reliance on negotiation and good will to access these services rather than clear guidelines was not thought to be an appropriate and equitable way to work.

### 2.2.3 Oversight and governance

People called for a more standardised approach to the provision of forensic mental health services. One clinician lamented that the service was missing 'a central brain'. People suggested more steering from government guidance, more detailed service specifications or the creation of a national body for the oversight and coordination of forensic services across Scotland. A key point was that any such oversight body would need to have operational control, allowing it to direct actions.

The Forensic Network was set up in 2003 to bring a pan-Scotland approach to planning of services, pathways and strategic planning, as well as teaching, training and research. It is hosted by the State Hospital. People spoke positively of the learning, development, networking and training opportunities that it provides. But some people felt that it was not as inclusive as it could be and that this meant it struggled to get consensus around some of its work. It was felt this would always be a problem if the Network 'is hosted by one Board'.

Staff felt that inter-organisational relationships could be improved. People spoke of absences of inter-organisational arrangements and instances where formally agreed service arrangements had been reviewed or discontinued because of lack of resources. People called for: regional joint working; a greater use of service level agreements; and a more coherent strategy between NHS Boards and their partner

agencies. A number of services spoke of trying to make regional or national arrangements but being unable to bring everyone required on board.

People recommended that forensic pathways should be reviewed and that legislative, procedural and administrative processes should be streamlined. They hoped this would increase efficiency and reduce timescales for people moving through the system. In particular, several recommendations were about the transition pathways to lower security, rehabilitation and community care. People requested co-ordinated development plans, earlier referrals and a standardised approach to identifying accommodation and support in the community. They also asked for clearer specifications for community forensic services and criteria for people with lived experience moving back to general adult mental health services.

## 3 Transfers and transitions

The lack of NHS beds available within the forensic system creates delays in transferring people up and down security levels. The majority of people raised this as an issue and it causes frustration for everyone affected: people receiving care, clinicians and management.

Delays in transfers can lead to differences between 'actual' and 'intended' ward populations. Staff at medium secure units may have to meet the needs of people waiting for discharge to low secure or referrals to high security, alongside people with needs appropriate to that security level. Placing people with diverse needs and levels of acuity in the same ward can have adverse consequences on their mental well-being. The challenge of managing and caring for a mixed population contributes to staff shortages due to stress and illness. Staff shortages were also linked with greater restrictions of people's freedoms because escorted leave and activities may be reduced.

Some staff felt services were prioritising beds for people in their own area. They said this was understandable but that it made it more difficult to transfer people when needed. There was widespread consensus that clarity over referral pathways and processes would support decisions about the appropriateness of referrals. One Health Board said that a national framework for referrals would be helpful.

### 3.1 Transfers and transitions to NHS secure hospitals

#### 3.1.1 Transfers to conditions of lower security

A person's transfer to conditions of lower security is a critical time in their care, treatment and risk management. People saw strong joint working relationships as being critical to a successful transition. Variation in provision and bed availability in local low security units causes delays when people are assessed as ready for transfer. The review heard that two of the medium secure units and some low secure facilities are operating waiting lists. However, individual circumstances vary considerably. A small number of people said their transfers happened quickly, while many others spoke of waiting months or years for a place in their local low secure facility.

When transfers to lower security are delayed, people's progress is hampered. They can be subject to conditions of excessive security and are at increased risk of becoming institutionalised or losing motivation. Such practice is also felt to constitute 'over-treatment' and so represent low-value healthcare. In addition, the sense of reciprocity in the system is lost, leaving people feeling they have done all that has been asked of them but then not progressing as they should.

Delayed discharges, which impact on waiting lists in low secure settings, were consistently blamed on a lack of suitable and available accommodation or support packages in the community.

### 3.1.2 Transfers to conditions of higher security

Staff working in low and medium secure settings reported difficulties or delays in referring people to conditions of higher security. They felt such delays compromise the care and treatment they can provide to that individual and to others on the ward.

Some clinical teams involved in referrals to higher levels of security described the process as 'sluggish' and inconsistent. They suggested that referral criteria varied between units, with one team feeling like they have to follow 'unwritten guidelines'.

There was a call for the referral criteria to be reviewed. People said that requirements for multiple assessments took time and that referrals were often refused. One clinician felt that 'pragmatism' had been lost from the system.

However, another argued that it was appropriate for decisions that restrict a person's freedoms not to be rushed or made lightly. In one instance, where a referral had been accepted by a unit, lack of an available bed meant more assessments had to be done for a second referral to another unit.

While waiting for transfers to higher security to be agreed, staff felt they had to manage the person's high levels of distress without the staffing numbers or aspects of physical security needed to provide appropriate care and treatment. They felt this placed a strain on everyone on the ward. People with lived experience explained that when additional observations are required for one person, it reduces the amount of time staff are available to provide ward activities and escorted leave for others. They also said it changed the atmosphere on the ward.

There is a conflict resolution system available when clinicians disagree about whether to transfer someone to higher security. People raised questions about its length, cost and transparency. The Forensic Network reported that the full process has only been used twice since 2005. There is also a shortened version of the process that has been used three times.

Two teams highlighted the absence of formal arrangements or practical processes for transferring people subject to civil detention orders between secure settings. One unit explained that the lack of a national contract or process meant they had to 'ring around' colleagues to find out how to do it. As no transport could be identified in Scotland, a secure ambulance was brought up from England.

### 3.1.3 Transfers between prison and secure hospitals

People in prison can be transferred for mental health treatment in hospital. Prison populations can straddle more than one Health Board. Referring clinicians explained that this can make it difficult to refer people to the forensic system because there are different processes and thresholds for access to services in each area.

Transfers from prison were generally felt to take place relatively quickly, with positive comparisons often made to the time taken elsewhere in the UK. The Forensic Network established a system for monitoring transfers from prisons to forensic mental health services in 2018. By November 2019, the Network had received information on 50 transfers, three women and 47 men. The average time for transfer for urgent referrals was 11.3 days.

Some people did raise concerns about the transfer of women. The lack of forensic hospital beds for women was felt to contribute to difficulties in transferring women from prison when they need secure hospital treatment. This in turn was linked to the number of women remaining in prison despite experiencing complex and enduring mental health problems. There were reports of women who courts had identified as requiring assessment in hospital but who had to return to prison to await a hospital place because no beds were available. One person with lived experience commented on the absence of women in Scotland's forensic system and wondered if this was because they are disproportionately accommodated in prisons.

These concerns align with the findings of the European Committee for The Prevention of Torture and Inhuman or Degrading Treatment when it visited

Scotland's prisons in 2018. It found that while transfer to high and medium secure facilities was possible for men in prison, 'for female prisoners the situation [was] entirely different'. They highlighted a number of women who should not have been in a prison environment as they required psychiatric hospital care and treatment. The Committee felt that the absence of a high security mental health facility for women in Scotland appeared to play a key role in decisions to keep these women in segregation in prison rather than transfer them to hospital.<sup>8</sup>

## 3.2 Transfers and transitions in the community

### 3.2.1 Discharge into the community

Conditional discharge into the community is recognised as a high risk transition point. The intense support that people receive in hospitals cannot be replicated in the community. There are different models of community provision across the country offering different levels of support. This means that the approach to transitions from low secure to community services varies significantly between areas. Staff felt people's expectations needed to be managed better around what support would be available in the community as well as how much freedom they would have.

Strong and lasting relationships with professionals, support workers or befrienders can help people gain confidence and familiarity with new environments prior to returning to the community. They also help people to maintain their mental health and reduce their risk of reoffending once there. Staff and family members felt that when discharged people should have integrated support from social and healthcare professionals who know them and who know about the recovery opportunities in the local community. The inclusion of allied health professional (AHP) staff in the CFMHT teams was, for example, seen as supporting smooth discharges and sustainable living in the community by working with people while they were still in hospital to help them establish regular routines and activities prior to moving. Family

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<sup>8</sup> See Council of Europe Anti-Torture Committee (2019) *Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 17 to 25 October 2018*. Strasbourg. Available at: <https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-report-on-the-united-kingdom-focusing-on-police-and-prisons-in-scotland>

members stressed the importance of involving the person's own social support system in discharge planning from an early stage.

Staff highlighted the importance of joint working with third sector organisations to support long-term, successful discharges. People need to engage in structured activities as a key part of the discharge process. Staff raised concerns that it is becoming more difficult to access appropriate vocational activities and placements in the community. These are also often time limited, which is an issue when discharge is delayed.

There is no agreed process for managing the discharge of people who cannot return to their original health board area because of victim safety, victim sensitivity or high media profile reasons. As such, negotiation between clinicians, health board managers and local authorities can be lengthy and rely on 'good will and the promise of reciprocity'. It was felt that this was not a fair or appropriate way to manage these situations.

### 3.2.2 Delayed discharges and their impact

Delayed discharges are frustrating and disappointing for everyone but difficulties in arranging appropriate support packages and accommodation in the community are widespread.

People said that the lack of suitable community accommodation and appropriately trained support staff is leading to some discharges being excessively delayed, sometimes for years. These problems particularly affect people with more complex needs, including co-morbidity or learning disabilities. There is a feeling that no one is taking responsibility for this. As one family member said, 'social work blame the NHS and vice versa'.

Keeping people in hospital after they are deemed ready for discharge can leave them vulnerable to further mental health issues or setbacks. As well as providing rehabilitation, staff are having to find ways of maintaining people's progress and keeping them motivated. They explained how they need to develop interventions to address issues that would not have occurred if a person had been discharged when they were first deemed ready.

Staff in some areas spoke of their frustration when people being assessed for discharge had to then meet additional ‘tests’ in order to get access to accommodation and support packages in the community. For example, one low secure ward felt that social work services asked for ‘testing’ of people that went beyond the risk assessment requirements. Another team said it seemed like it was local authorities that were dictating the level of risk. This was seen to be inappropriate and unnecessary because there is ‘only so much testing you can do’.

Mental Health Officers (MHOs) complete an Assessment of Needs for community care services as part of the multidisciplinary discharge planning process. People said this is a ‘massive’ piece of work. A couple of social workers described frustration at having no control over the funding for people’s supported accommodation. They spoke of having to apply to different funding lines within a local authority or to one department that considers all requests for supported accommodation, not just those from forensic services. For a small number of people in hospital, it is the criminal justice social worker who is responsible for accessing accommodation.<sup>9</sup>

### 3.2.3 Rehabilitation and ‘step down’ facilities

A number of areas have rehabilitation wards or ‘step down’ facilities in the community. These support people’s progress from low secure, through rehabilitation and onwards to the community. People who have transferred to these facilities appreciated them. Staff in areas with these units see them as valuable assets that can support smoother and more successful discharges. They called for the role of ‘rehabilitation’ to be formally recognised as a distinct forensic service because it is about ‘more than just cooking and waiting for a house’.

### 3.2.4 Moving between forensic and general services

There are challenges moving people between forensic and general mental health services. It was felt that the pathway for leaving forensic services is not well defined:

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<sup>9</sup> A small number of people who received a life sentence in court have subsequently been transferred to hospital for treatment and rehabilitation. When they are assessed as ready to transfer to the community, they are considered for release on licence by the Parole Board of Scotland rather than for conditional discharge by the Mental Health Tribunal for Scotland.



a number CFMHTs described difficulties moving people back into general mental health services. One member of staff spoke of feeling that they had to 'jump through hoops' to do so. Although some people do move to CMHTs over time, others never leave forensic care. Difficulty discharging people to CMHTs was felt to put additional pressure on the capacity of CFMHTs. However, some teams also keep people on their caseload even after they have transferred to general services, so they can easily return to forensics if required.

There was a sense that general healthcare professionals do not have consistent access to training about forensic services and that stigma around the 'forensic' label can exclude people from accessing CMHTs and general health resources. Staff talked about feeling responsible for trying to demystify 'forensic' care to help prevent people being kept inappropriately within forensic services. The stigma can also be a barrier to people in the community accepting help from this service when it is offered. One person described their initial worry about transferring to 'forensic' from general mental health services. Once in forensic services, however, they felt they received improved care, including more intensive support when unwell, which had prevented them returning to hospital. They reported that their family also felt much more supported.

It was suggested that people under multi-agency public protection arrangements (MAPPA) who have mild to moderate mental health problems, or people assessed as 'at risk' of offending but who do not meet other criteria, can struggle to access the mental health services they need in the community. There are concerns that these groups can miss out on provision because they are seen as 'not risky enough' for CFMHTs but 'too forensic' for CMHTs.

### 3.3 Role of Scottish Ministers

People in hospital under a compulsion order with restriction order (CORO), a hospital direction or a transfer for treatment direction are subject to special restrictions. For these 'restricted patients', particular stages of their progression need to be 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 Procedures (MoP). Clinical teams reported using similar procedures for non-restricted patients (minus the need to seek Ministerial approval).

These procedures were often blamed for delays in people's progression or seen to be incompatible with person-centred care. Some of these concerns seemed to be based on a lack of understanding about the degree of flexibility that the MoP permits. For example, one team complained that the MoP was the reason people recalled from the community had to be admitted to medium secure facilities. The MoP does not state this and the expectation is that conditions of lower security would be more appropriate. There can, however, be delays in reaching decisions when the required professional reports are not submitted to the Scottish Government or do not include up-to-date information. For example, the review was told of one instance in which a clinician had resubmitted a previous year's report without changing any details including the date. Ongoing communication between clinical teams and the Scottish Government was felt to be important to support efficient decision-making at key points in the process.

The MoP is a complex document. The Scottish Government is working to revise and update it to make it more user-friendly, while ensuring it continues to both meet the needs of the people it supervises and maintain appropriate public safeguards.

Advocacy felt that there should be more transparency around the Scottish Government's involvement. One person queried whether the Scottish Government was best placed for this role in the risk management of restricted patients.

### 3.3.1 Transfer of 'SUS' plans

Many people in low secure wards spoke of losing existing plans for authorised leave when they transferred from medium secure units. These plans are called 'SUS' plans as they authorise a suspension of a person's detention in hospital. People spoke of having to be 're-tested' in the new setting in order to regain freedoms they had previously earned elsewhere in the forensic system. This is frustrating. One person in low security said that it can take months after being transferred to 'get back out again'. People spoke of feeling like they were going 'backwards' or like they had 'not achieved anything'. One person felt that this re-testing was because the culture in forensic system is overly risk adverse.

In response to the same issue being raised by the Mental Welfare Commission in 2017,<sup>10</sup> the Scottish Government issued guidance to all Responsible Medical Officers setting out how a person's SUS plan could be considered for transfer from medium to low security. This flexibility within the system was not well known among people with lived experience or some staff. Indeed many people receiving care identified allowing SUS to transfer as the most important change that the review could recommend. The review met only one person who said their SUS plan had transferred with them.

Professionals across the system acknowledged these frustrations. They agreed that reducing SUS plans for a significant period of time can be detrimental to a person's mental health and motivation. However, they explained that they do also need some time to understand a person's presentation and risk issues after transfer.

### 3.3.2 Discharge planning processes

Some clinical staff and people with lived experience felt that the pre-discharge process for people on COROs could be streamlined. The review's attention was drawn to the MoP's expectation that people need to undertake four months of overnight stays, building from one night per week up to four on a monthly basis. Some felt this was not responsive enough to individual needs and left some people 'treading water'. The requirements also leave beds empty on wards for significant periods of time. One person with lived experience did say that they had benefitted from this staged approach because they had been in hospital for a long time.

A number of people raised concerns that housing benefit is not available at the earlier stages of the overnight testing process. This risks people getting into debt at this critical point in their rehabilitation.

Some clinical teams wait until the successful completion of the four month staged overnights before applying for a conditional discharge tribunal. The Scottish Government issued guidance to Responsible Medical Officers about the process for

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<sup>10</sup> See Mental Welfare Commission for Scotland (2017) *Visit and monitoring report: Medium and low secure forensic wards*. Available at: [https://www.mwscot.org.uk/sites/default/files/2019-06/medium\\_and\\_low\\_secure\\_forensic\\_wards.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf)

requesting an expedited Tribunal hearing. If the requirements are met, a hearing can take place within six weeks of the staged process ending, instead of 12 weeks.

### 3.4 Other issues

There was a general feeling that there could be better communication between tribunals, MAPPA, local forensic teams and others involved in people's care and treatment. It was suggested that some procedures rely too heavily on written documents sent through the post and face-to-face meetings at predetermined intervals and that this can delay people's progression. People felt more use could be made of electronic communication methods such as email or video links to facilitate meetings. People also recommended streamlining discharge processes, including identifying appropriate accommodation and meeting MAPPA requirements.

People with lived experience gave examples of other ways in which time had been added to their stay including: a change of consultant; a person being recalled taking their place in the lower secure setting; the closure of the ward they were due to go to; and the correct paperwork not being submitted.

## 4 Information sharing and working relationships

People wanted more coordination and consistency between the different services and individuals supporting people in forensic services. Family members in particular talked about difficulties in accessing information and providing advice about their relative's care and treatment.

People spoke of the different processes and pathways are used across different NHS Boards, Health and Social Care Partnerships and local authorities. The way information about mental health and risk is presented and the quality of links between different services was seen as inconsistent. Multi-disciplinary teams (MDTs) were often identified as areas of good joint working practice within services but some staff felt that there was room for improvements in communication between colleagues with different specialisms. Some services have struggled to adapt to changes in the relationship between health and social work.

Some people recommended that more resources or more formal guidance should be provided to support joint working between different parts of the forensic system, other statutory services and third sector partners.

### 4.1 Family members

Family members noted variations in units' willingness to include them in decision making. Many felt that their expertise about their relatives was not recognised and that staff failed to use them as a resource in decisions about care and treatment. They felt that while they are relied on by the system to support their loved ones when they are in the community, their warnings about risk factors or deterioration of the person's mental health can go unheeded, resulting in crises that could have been avoided. A couple of family members felt that if services had listened to them then their loved one would not have committed the offences that they did. They said this could have prevented harm to others. There was a specific call for the perspectives of young carers to be valued.

Access to information and communication was one of the issues family members talked about the most. Limits on information shared with family left them feeling more anxious, less able to input into their relatives' care and more likely to experience difficulties in supporting people upon discharge. Staff spoke of a tension between wanting to be open with family members and the legal and procedural

barriers to sharing personal information without a person's explicit permission. Some family members felt the regulations protecting personal information are inappropriate in forensic care. They called for new legal rights to allow them to access information about a family member's care, especially at the point of discharge. When a person gives their consent, family members want this to be recorded centrally to prevent them from being 'locked out' of communications. Family members want more information at the start of the forensic journey, as many currently have to rely on peer networks.

There was a call for the appointment of dedicated carer support staff. Some services have set up services for carers but even those admitted they could be a bit 'ad hoc' and did not always operate in a consistent fashion. Staff in one ward reported that events organised for family members were not usually well attended.

## 4.2 Social work

People recognised the specialist roles of social work and mental health officers (MHOs) within the system. Where there is a lack of social work input this was felt to have a negative impact on people's care.

People's MHOs and social workers can provide a degree of continuity and consistency as they move through the system. They can provide a longitudinal perspective to assessments and have the ability and independence to challenge clinical decisions. Families and people with lived experience recognised the importance of building a good relationship with the MHO but they said it takes time to develop this trust. People had experienced varying degrees of contact and consistency with MHOs. For example, one person's MHO had followed them throughout their time in the forensic system. Another family spoke positively of a social worker who had travelled some distance to see them and gather the initial family history. Others, however, spoke of how their MHOs 'chop and change', of having an MHO 'in name only' or only seeing them a month before their CPA (Care Programme Approach) meetings.

There are a variety of models for social work provision to the forensic hospital estate and only two NHS Boards said they have dedicated social work resources on site. People are more likely to be able to access social work services if they are in hospital in their 'home' area and people placed out of area can be put at a

disadvantage. Social work services are supplied out of area when required but often on an ad hoc basis and 'based on goodwill' rather than any formal arrangement.

People also described times when social workers would not travel out of area to see people in regional units. There was a call for nationally funded posts, more resource for MHOs and more consistency and clarity about provision across the system.

People said social work needs to be better integrated with the MDTs in hospitals. Hospital staff in one area felt that social work had 'backed off' since health and social care integration. Joint funding from local authorities for a dedicated post in a regional unit had subsequently been withdrawn. Without dedicated social work posts, others working in the system were unsure how to access social work supports, benefits and housing support. For example, nurses described feeling pressured to help people make benefits applications. They did not feel trained to do this and were anxious about 'making a mistake'. They also said that time spent on tasks previously undertaken by social workers negatively impacts other areas of work, such as the ability to staff escorted leave. Without a social worker on their team, one area was aware they were also relying on MHOs to do social work tasks that were not really within their remit.

### 4.3 Assessments in the forensic mental health system

Information sharing is an integral part of clinical risk management. Multi-disciplinary ways of working, including MDT meetings, were felt to support this. Co-locating services was felt to support integrated and collaborative working practices. People associated failures in MDT working with negative outcomes such as people not receiving the services they require. A number of teams requested more social work input. Specific requests were made for dedicated resources to maintain MDTs, including national funding for social work posts to ensure equality of access to the service.

Staff spoke about how different record keeping systems across units and security levels cause difficulties, delays and unnecessary repetition of assessments. They recommended the creation of a centralised system to support information sharing and a consistent electronic format for risk assessments. Recording risk information on a single electronic document would allow it to move with a person at points of transition, be updated and edited as risks change and decrease the risk of repeating complex assessments. Similarly, a more consistent approach to multidisciplinary

assessments could reduce waiting times, reduce repeat assessments and make it easier to access hospital care.

The quality of referral processes for advocacy services was seen to be variable. Even when they work well they are often informal, meaning referrals tend to depend on good relationships rather than the consistent application of policies.

People said that risk assessments for people in forensic mental health services vary between regions and organisations. The same risk assessment tools are used but the formats of risk reports vary. This means that reports may need to be rewritten when people move from one unit to another. Some staff wanted to standardise risk reports into one key document reviewing all risks and laying out an integrated management plan.

Advocacy organisations raised concerns about transparency in the risk assessment process. A small number of people with lived experience and their family members suggested that information recorded in reports did not reflect their whole story or was inaccurate. One family member felt that people should have access - and time to respond – to clinical reports before they are presented at Tribunals.

Prompt assessments at or before the point that someone enters the criminal justice or forensic system were highlighted as being critical for identifying the right pathway for an individual and planning appropriate care. Considered assessments require sufficient time, an appropriate and safe environment and skilled multi-professional staffing. Thorough psychological assessments when people enter the forensic system were felt to lead to more comprehensive formulations and treatment plans for people. There was a call for adequate resource for these wherever a person entered the system.

Difficulties accessing information for people in the community mean that risk assessment and management of this group can also be variable. One Health Board said that it is not always easy to acquire a detailed forensic history for people who are not managed by MAPPA. People wanted better ways to share information about risk and needs outside of the MAPPA process. Organisations that need access to this information include the police, local authorities, the NHS and the Crown Office and Procurator Fiscal Service.



#### 4.4 Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) operate between health services, local authorities and the police to assess and manage the risks of restricted patients in the community. People reported that the quality of relationships between MAPPA partners varies regionally. Some reported strong links. In one area the co-location of MAPPA with other forensics services allows for closer joint working and information sharing. In other areas, however, there was concern that some of the staff operating in the Health Liaison role at MAPPA meetings had insufficient clinical or forensic expertise or insufficient seniority to ratify and resource multi-agency risk management plans.

There were calls for national or regional guidance to support greater consistency of MAPPA provision across Scotland. The Serious Offender Liaison Service and the Specialist Treatments Addressing Risk service were both proposed as models for a national service. They both provide case consultations, representation at MAPPA meetings, offence-focused psychological treatment and complete risk assessment and management plans for people who are high-risk.

## 5 Care and Treatment

People spoke widely about the care and treatment they received in forensic mental health system. They offered mixed responses about the use of medication within their care and the balance struck between the medical model, access to psychological interventions and the delivery of person-centred care. Relationships with staff were key to how individuals and their family members experienced care and treatment. There is consensus around the need for person-centred care. People's opinions varied about whether the system supports this or achieves it in practice.

People in the forensic mental health system experience poorer physical health and earlier morbidity than people in the general population. Some people expressed concern that physical health is not taken sufficiently seriously and felt that more could be done to address this.

### 5.1 Mental health care

#### 5.1.1 Service ethos and person-centred care

Many services reported that person-centred, recovery-focused, holistic care are core parts of their ethos. Others spoke of evidence-based, rights-based, strength-based and trauma-informed approaches, the maintenance of a positive therapeutic milieu and 'least restrictive' practices. Services connect these values with MDTs operating in an integrated and collaborative way to ensure that people receive appropriate and timely interventions.

People want services to be flexible and to respond to the unique needs and rights of each individual within the system. People and their family members expressed frustration with services that failed to respond in this way. Some staff are concerned that the medical model may encourage a 'one-size-fits-all' approach which can get in the way of holistic person-based treatment.

#### 5.1.2 Medication and the medical model

Some people expressed concerns about the continued dominance of the medical model. It was criticised for not reflecting evidence about the most effective first-line treatments and legitimising the denial of hospital treatment to people who do not

respond to medication. One family member felt the system should be more open to less traditional pharmacological interventions such as cannabidiol (CBD).

People's experiences of medication were mixed. At its best there were some who had been provided with good information to inform their decisions and reported benefits to their mental health with no side effects. At its worst, people experienced medication as a form of control that had no positive changes but created dependencies. People described medication being withheld when they needed it in both secure hospital and police custody settings. Family members spoke of people being discharged from secure care without sufficient supplies of their medication. Community teams described variations in GPs' willingness to prescribe anti-libidinal medication, explaining that this can affect the implementation of MAPPA clients' risk management plans.

People and their family members stressed the importance of clinical staff providing full information on any medication, including its potential side-effects and long-term impact and the rationale for prescription. It was felt that the long-term physical side-effects of medications are not always made clear, nor other option discussed.

### 5.1.3 Psychological interventions

The majority of people said access to psychological interventions was very helpful. Some felt that first-line treatments ought to be weighted more towards these than medication. Advocates argued for a shift towards psychological services in care packages and for support to focus on recovery rather than risk management. However, some people said they found it difficult to engage with psychological interventions and others observed that those who do not or cannot engage with them are 'left to float around', as alternative interventions are limited.

People said that less secure hospitals do not have parity of access to psychological interventions and occupational therapy. These non-pharmacological approaches were seen as particularly critical for people in lower security because they support rehabilitation and safe discharge. Once discharged, people can struggle to access appropriate psychological services in the general adult mental health system in areas without a CFMHT.

#### 5.1.4 Supportive relationships

People with experience of the forensic system emphasised that the quality and consistency of their interactions with the staff delivering their care and treatment makes a significant difference to their experience and recovery. Their satisfaction with services depends on feeling listened to, valued and understood.

There were significant variations in the relationships people have with staff and the support they receive from them. People who had positive relationships with staff talked about the benefits of staff who were approachable, non-judgemental and genuinely interested in listening to them and maximising their potential. Negative experiences included 'personality clashes' or individuals spending a long time in hospital before they found a supportive member of staff. Some people raised issues about abuses of power, unnecessary restrictions and bullying behaviour. People can share their concerns more freely when they have access to one-to-one sessions with nursing staff they know well. When units are short-staffed or reliant on nursing banks the quality and continuity of care can be negatively affected.

Family members said that when their relationships with staff break down it negatively affects people's recovery and progression. Some family members had particularly negative experiences related to disputes with senior clinicians and interactions with the police.

## 5.2 Physical health care

Professionals are acutely aware of evidence that people in the forensic system die earlier than the general population. This difference in health outcomes is larger for women. The main causes of death are cardiovascular or respiratory disease. It is common for people with a learning disability to also have other physical health issues, such as epilepsy, cardiac abnormalities and obesity.

Staff raised concerns about an increase of health conditions amongst the people under their care. These conditions include diabetes, ulcers and heart attacks. The number of people being admitted to general hospitals is increasing as a consequence. Obesity remains a significant challenge. Weight gain is a side-effect of some psychiatric medications and people spoke of wanting and needing to lose weight but it being 'difficult here'. It was felt that people could be supported to make healthier choices. However, this is difficult as one person complained that they

never got enough vegetables and were not able to order more. Others simply said how much they appreciated any increase in the degree of choice they could have over what they could eat. Access to physical activity was also identified as critical to sustaining good mental and physical health.

Women's physical health needs are different from men's and they affect their mental health and well-being in specific ways. People suggested that women's physical health issues are not always taken seriously. Women seeking healthcare are often accused of manipulation or 'attention seeking'. Failures to address these needs were said to add to women's experiences of trauma and detract from their rehabilitation.

Access to GPs, pharmacies and dietetic services are important to help people maintain good physical health. Services also spoke of providing well-being clinics, health checks and access to general screening programmes. People's experiences suggested there is less access to dentistry.

### 5.3 Participation and decision-making

Submissions from NHS Boards recognised the importance of encouraging and enabling people and their family members to participate in decisions about care and treatment at an organisational level as well as for individuals. People highlighted the importance of staff relationships in facilitating their participation. Some people spoke of being involved in making choices about their medication or changes to the ward environment. Negative experiences included lack of access to clinical staff; not being listened to; invalidating an advanced statement; and finding staff had produced reports with contents that had not been discussed with them and which they disagreed with.

People talked about the importance of advocacy in supporting participation. Advocacy services can help people to understand information they are given and to exercise their rights.

#### 5.3.1 Access to information

People can only effectively participate in decision about their care and treatment if they are given the opportunity and have access to all the relevant information.

People and their family members said that their access to information and communication with clinical staff and social workers was variable.

Some people spoke of staff who go out of their way to speak with them and keep them informed, while others had experienced staff as not wholly honest or forthcoming in their communication. Examples of breakdowns in communication included: not receiving updates from MDT meetings; not being informed of key developments in care such as arranged transfers; and not being informed of errors such as failures to carry out MAPPA checks at the appropriate time. Some people felt that there was a culture of secrecy amongst staff.

People reported uncertainty or gaps in their understanding of parts of the mental health system where information could be better communicated. These include confusion about what treatment orders they are on and what these mean, the roles of staff members and 'the rules' of their unit. People felt services ought to be more proactive in their communication. For example, while they were informed of their rights (e.g. to appeal), they were not provided with enough information about how to exercise them. One person suggested that care-related decisions ought, by default, to be communicated in letters addressed to them directly rather than relying on hospital staff to relay information.

### 5.3.2 Language and communication

Advocacy and Speech and Language Therapists warned that the communication needs of the forensic population may be significantly underestimated. This is a problem because resources, information and rehabilitative programmes aimed at people in the forensic system are typically language-based. This means they are inaccessible to those with communication difficulties. Provision for people with different language and communication methods is variable. Rather than making people apply for adjustments under equalities legislation, a call was made to adopt the social model of disability and build more accessibility into the forensic system. Speech and Language Therapists want resources translated into accessible versions as standard. They also recommended that visual aids or other technologies such as 'talk mats' should be used more to help people understand their care and the restrictions placed upon them.

### 5.3.3 Complaints system

People who become subject to compulsory powers are in a vulnerable position. It is essential that there is a way for concerns and complaints to be dealt with quickly and transparently to protect against abuses within the system. Some people said they would not complain for fear of punishment, saying it is better to comply and 'keep your head down' in order to progress. For those who did raise concerns, experiences were mixed. Staff who were open and receptive to feedback from people were appreciated and one family member said that their complaint had been processed well. More often, people described staff reacting poorly to being challenged, concerns being dismissed as part of their illness or receiving no response. Advocacy organisations reported that the processes around disclosure of abuse for people with learning disabilities can be delayed by professionals as they consider the 'validity of the claim'. This can delay initiating investigative adult support and protection, placing this group at a disadvantage.

People felt that more should be done to lower the barriers for raising issues with staff. One person thought that senior staff could make it more explicit that people can come to them if they are unhappy about anything or think there is something wrong with their care.

## 6 Social and Environmental Conditions

Experiences of the hospital environment were a particularly important theme for people with lived experience of the forensic mental health system, who can spend long periods of time living in wards. Opportunities for activities and outings are important for people in hospital as a means of alleviating boredom, developing their skills and fulfilling progression requirements. Access to placements is uneven, which can delay people's progress.

Ward infrastructure and policies affect the degree to which people can retain a sense of privacy and personal space and maintain their personal relationships. Facilities for visitors vary and are inadequate in some units. People's control over their environment, including access to their bedrooms and retention of their belongings, influences their experiences of comfort and safety in a ward environment. A number of concerns were raised about ward safety. Weaknesses in this area are linked to poor staff retention.

Restrictions in forensic services are rightly higher than elsewhere in the mental health system but they vary in degree, even between different units of the same security level. Restrictive practices highlight the tension between measures to ensure everyone's safety and attempts to maximise people's freedom. People find some restrictions dehumanising and unhelpful for their recovery.

### 6.1 Activities and community placements

Opportunities for activities and outings are highly valued. People described activities on the ward as essential to alleviate boredom, to give a sense of purpose and achievement and to develop skills. Many people with lived experience commented on the difficulties of boredom and frustration when faced with long periods of time without structured activity, particularly on evenings and weekends. Gaps in services' ability to provide a range of activities that appeal to everyone are associated with dissatisfaction and demotivation.

Access to activities and regular routines outside of the ward is integral to a person's progression through the secure estate to the community. However, people with lived experience reported activities and escorted leave off ward being cancelled as a result of staff shortages.



### 6.1.1 Activities on the ward

In terms of ward activities, people with lived experience were particularly positive about opportunities to prepare meals as a means of giving meaning and structure to their days. Some wards provide people with a budget to plan and prepare the week's meals for staff and others people on the ward. This was seen as an example of good practice which enabled them to learn or maintain a number of skills. At the other end of the scale, one person in a low secure ward felt he was treated like a 'wee boy' as people were not even allowed to make their own cups of tea.

Several services discussed attempts to provide educational opportunities for people receiving care. They highlighted that while high and low secure services have access to core funding for adult education, medium secure services do not. Positive partnerships with local colleges have been made in some areas to provide education on wards. But there are also instances of these opportunities being withdrawn due to lack of interest.

Staff and people with lived experience commented on the importance of exercise. One person receiving care felt that people should be encouraged to do more physical activity. It was felt to be good practice for hospitals to make access to gym facilities easy. People who had gym facilities on their wards liked them. This was because they did not need a leave pass to use them.

### 6.1.2 Community placements and disclosures

People require access to meaningful and structured community placements or vocational opportunities in order to meet criteria for a discharge referral. These are used to promote skill development, social inclusion, employability prospects and structured routine within supportive and trusted environments.

A number of staff spoke of an increasing shortage of community projects capable of accommodating placements for people in the forensic system. This limits people's rehabilitation and opportunities for progression. One service said there should be a review of the interface with and capacity of community placements and the resources available to forensic services.

Disclosure of an individual's personal information must be carefully managed when on community placements in order to minimise risk whilst retaining privacy and

discretion. Although there are organisations who have developed expertise in these matters, some third sector organisations expressed a need for more support to navigate them. Occupational therapy staff have developed some guidance on disclosure and are working with the Scottish Government to publish it.

Reports from advocacy confirm that people want paid employment to provide the dignity of some financial freedom alongside meaningful activity. People spoke of barriers to this. One person in the community explained that a clinical recommendation to his potential employer that he be supervised in the early months of employment meant the job offer was withdrawn. Other people had concerns about finding work due to stigma and fear of being worse off in employment than on social security benefits.

## 6.2 Privacy and personal space

### 6.2.1 Personal relationships

Inconsistent approaches to privacy affect people's ability to maintain relationships with their friends and family when they are in hospital.

On some wards, people complained that phones are poorly situated and do not allow for private conversations. For example, people in one ward said that the only phone they could use was located at the staff base. One person described a member of staff listening into conversations. An example of preferable practice was access to a portable ward phone which could be used in side rooms to ensure complete privacy.

Several family members commented on a lack of suitable facilities for visitors on wards. One explained that their visits had to be done with the door open at all times and two members of staff outside. Another said that a staff member stood so close during their visit that they felt they needed to include them in the conversation. This lack of privacy inhibited communication between people and their loved ones.

One person commented that wards do not seem to have any provisions for them to engage in intimate relationships whilst in hospital and that little support was given to prepare people for healthy relationships on discharge.

### 6.2.2 Bedrooms

People's access to their bedrooms is variable across the forensic estate and the variation is not explained by security levels. In some wards, people cannot access their room for long periods of time during the day. Staff said that this discourages isolation and encourages participation in ward activities. On others wards, bedrooms are kept open, people retain possession of their own key and are encouraged and supported to spend time in communal areas. Privacy in bedrooms is also variable. Some wards have peep screens that the people in care cannot close, others have no en-suite facilities and a small number of people do not have their own room.

Reflecting the length of time that they may spend in hospital, people expressed a desire for more 'homely' furniture and welcomed opportunities to personalise their space. In one low secure setting, people had complained about how uncomfortable the mattresses were but staff had simply told them they were standard 'forensic mattresses'.

### 6.2.3 Belongings

People talked about the importance of retaining their belongings during their journey through the forensic system and the distress they can experience when the system breaks down.

Several people relayed experiences of losing all of their belongings because they lost their accommodation in the community when they were admitted to hospital. This loss has both a sentimental and financial impact. People expressed frustration around a lack of clarity about where their belongings are meant go when they are admitted to hospital and who is responsible for this. Other people described spending significant sums of money to keep their possessions in storage. People also spoke of their belongings being lost when they moved within the secure estate. There can be significant delays in recovering belongings after a move.

It is important to people that they have some choice about the belongings they can keep on wards, given the extended period of many stays. The restrictions about the number and types of personal items that people are allowed varies. People receiving care felt these restrictions were not decided based on their needs. They

felt decisions were made arbitrarily or depended on the staff's ability to keep track of belongings or available space on the ward.

### 6.3 Access to technology

Staff and people in the forensic system recognise that technology is a growing part of everyday life. Access to it is important for therapeutic, educational and financial purposes.

Access to technology and communication devices is restricted in forensic inpatient settings but the extent of these restrictions varies. People find this frustrating. Some policies do not allow people to access technology or only let them use basic mobile phones whilst supervised. Other policies permit use of smart phones. People want mobile phones or technology such as Skype to keep in touch with their support networks, especially if they are placed out of area. Staff reported that variations in access to technology across wards led to difficulties managing people's expectations at times of transition.

People with access to mobile phones and the internet said this was helpful. One ward was using this technology to help family members to join ward rounds. People on wards with more restrictive practices found the experience of digital inequality very difficult. The experience of moving between units to different levels of restriction caused frustration and anxiety. Lack of practice using technology left some people feeling unprepared and fearful of making mistakes in the future. Some AHP staff advocated for monitored access to technology to help people to carry out therapeutic work between sessions.

Some forensic services said that they are waiting for the Scottish Government to issue updated guidance on this. Some also suggested that the regulations on a specified persons' access to technology are severely outdated and require urgent review.

### 6.4 Ward safety and security

A small number of people receiving care spoke of feeling unsafe on their wards. They gave examples of being subjected to bullying, sexist, racist or homophobic behaviour from others. People felt that rather than addressing the issues with the bully, it was often the victim who was moved.

Issues around staffing levels were raised by a number of people. The relational security involved in forensic settings means that recruitment and retention of sufficient staff is a matter of safety for everyone in the ward. The review was told there are insufficient mental health nurses to meet the demand in forensic care. Staff spoke of being overworked due to staff shortages as a result of and resulting in long term absences due to stress and burnout. Difficulties with recruitment were associated with the perception that assaults are commonplace in forensic wards.

Staff shortages compromise ward safety. A small number of staff spoke about being physically and verbally abused on a daily basis. Some felt they were placed in dangerous situations and not provided with enough support. One person spoke of 'patients running the wards' and bullying by management. Some nursing assistants spoke of feeling undervalued by the system. In one area, they spoke of being left on the wards alone to manage people exhibiting extreme distress and being 'the ones getting bruises on our legs'.

A number of units operate as 'locked wards' because they do not meet low secure standards. The review witnessed smashed glass in wards, windows that could have items passed through and doors that were not robust enough. Staff recognise that these environments can be unsuitable for caring and treating people when their level of acuity rises. However, the difficulties in transferring people to higher security means they often have to be managed there where they are. This was felt to compromise the safety of staff and people receiving care on the ward. These concerns were exacerbated in wards that had no seclusion facilities.

Family members commented on different physical approaches to risk management between units operating at the same security level. One person, for example, was surprised at the airport style security at one medium secure unit having previously been to another where that level of security was not in place.

## 6.5 Seclusion and restraint

Use of restraint was a difficult issue for all respondents. It was observed that a culture of restraint for one person can change the ethos of a whole ward. Several family members reported instances where they felt that their relatives had been restrained inappropriately or excessively. People have found the experience 'terrifying'. However, there were also examples of restraint being used to prevent

serious harm and many wards have started to use of 'Safety Pods' as a more trauma-informed practice than taking people to the floor.

There was widespread awareness of the Mental Welfare Commission's guide on the use of seclusion as alternative to physical restraint.<sup>11</sup> Staff felt seclusion facilities allowed for better care and treatment for someone in hyper-distress and could potentially prevent the need to transfer them to higher security levels. On wards without specialist seclusion facilities, staff felt the management of people in their rooms was inappropriate and unsustainable.

Some staff reported difficulties managing people who became more acutely unwell and associated this with poor ward safety and injuries amongst colleagues. Concerns from people with lived experience tended to be about the length of time seclusion could be used: stays of more than two weeks in seclusion were reported.

## 6.6 Other issues

Given the length of time people are spending in hospital, wards effectively become their homes. Issues that made things more difficult for people were the lack of consistent application of smoking policies between and within hospitals. Many people suggested that the smoking policies on forensic wards were more restrictive than on general wards. The heating on wards was also difficult to get right, with people on almost all the wards the review visited complaining it was either too hot or too cold and took too long to make changes.

Communal space was felt to be important in bringing connection and normality into people's lives. Staff highlighted a growing need for adequate spaces for therapeutic work given the greater emphasis on psychological therapies in current practice than when the forensic estate was originally designed.

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<sup>11</sup> See Mental Welfare Commission for Scotland (2019a) *Use of seclusion: Good practice guide*. Edinburgh. Available at: [https://www.mwscot.org.uk/sites/default/files/2019-10/Seclusion\\_GoodPracticeGuide\\_20191010.pdf](https://www.mwscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf)

## 7 Populations of particular interest

### 7.1 Women

The Forensic Network's Inpatient Census reported 65 female inpatients receiving forensic services in November 2018. There was widespread agreement that current arrangements for women's forensic care in Scotland are inadequate and that there is a lack of 'joined-up thinking' and coordination at both national and local levels. The lack of high secure provision for women within Scotland is seen as unacceptable. Discharge planning for women is particularly challenging because of the lack of agreed pathways for access to low secure, rehabilitation and discharge into the community. There are also fewer opportunities for 'testing'. There was a broad consensus that this gender inequality is a human rights concern. People wanted parity of provision for men and women that ensures consistency in security but acknowledges differences in needs. Most people supported the provision of discrete services for women.

People felt there is need for a national strategy or nationally commissioned forensic services for women, with agreed pathways in and out of secure care and service-level agreements defining working relationships between NHS Boards. Working with NHS Board Executives, the Forensic Network review of the female pathway in 2019 made recommendations that included exploring the possibility of a co-located high secure development, the development of single sex accommodation in the Orchard Clinic and for NHS Boards to work regionally to determine the best solutions for low secure provision for women.<sup>12</sup>

#### 7.1.1 High secure provision

There is no high secure provision for women in Scotland. Women needing high security care and treatment are referred to Rampton Hospital in Nottinghamshire. That referral pathway is challenging. It includes different legislatures, delays in accessing placements and difficulties repatriating people moving back down security levels. All these challenges detract from delivery of care. Transfer to Rampton is

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<sup>12</sup> See Forensic Network (2019b) *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>

not available to women who are on remand awaiting court proceedings as they are not allowed to be transferred outside Scotland. They are therefore unable to access high secure care.

Women in need of high secure care may inappropriately remain in – or be admitted to – medium security units. This places additional pressure on medium secure facilities because of the heightened risk of violence and aggression and the staffing levels required to support prolonged enhanced observations.

There was agreement that high security provision should be made available for women within Scotland. There is a lack of consensus around how this should be offered. Some people support the Forensic Network report's recommendation to co-locate of women's high secure facilities within existing medium secure units. Others voiced concerns about the time and costs that this would involve. An alternative suggestion proposed was re-opening female high secure beds at The State Hospital.

### 7.1.2 Access to medium and low security

There is a shortage of women's beds at medium and low security. Women's experiences of secure care in Scotland were characterised as involving frequent transfers between inpatient locations. Medium secure beds are available for women in NHS Lothian (in the Orchard Clinic) and NHS Greater Glasgow and Clyde (in Rowanbank). These can be purchased by other areas on a 'spot purchase' basis but these arrangements are dependent on a bed being available. All the medium secure female beds are within mixed wards: the Orchard Clinic ward is mixed-sex and Rowanbank's ward accommodates women with mental illness and learning disability.<sup>13</sup>

### 7.1.3 Inappropriate, independent or out of area placements

Lack of local low secure forensic provision for women means that women are more likely to be placed in services which do not best meet their care needs or do not aid their recovery, such as IPCUs. It also prevents those other services from being used for their intended purpose. In addition, it increases the reliance of NHS Boards on

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<sup>13</sup> See Mental Welfare Commission for Scotland (2017) *Visit and monitoring report: Medium and low secure forensic wards*. Available at: [https://www.mwccot.org.uk/sites/default/files/2019-06/medium\\_and\\_low\\_secure\\_forensic\\_wards.pdf](https://www.mwccot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf)



independent or out of area provision. Out of area placements, especially in independent provision, are reported to be more common for women, placing them further away from their social networks. In one area, the development of a secure female ward has allowed women to be brought back into area from independent provision.

Women's accommodation in secure 'mixed wards' is a source of concern for some. There were requests for discrete services for women on a variety of grounds, including the different care needs of women.

## 7.2 People with learning disabilities

The Forensic Network's 2018 census of people accessing forensic services identified 78 people with a learning disability and seven with a learning disability and a mental illness. The Scottish Government recorded 55 people on a forensic learning disability ward in 2019.<sup>14</sup>

People with learning disabilities are small in number within the forensic system but their needs are highly complex. They have different needs to the general forensic population including different presentations and co-morbidities. Meeting these needs requires significant coordination across health, social care and criminal justice professionals. Speech and language therapy and advocacy support is also important to ensure the voice of this population is heard, allowing their wishes and needs to be met.

It was reported that there is an 8% vacancy rate in Learning Disability psychiatric posts. Further concerns were raised about the low number of people taking up trainee places and the lack of a specific forensic learning disability curriculum.

There were calls for more consistent provision of forensic learning disability services in order to improve standards within inpatient and community services. It was also felt that forensic learning disability services would benefit from having closer links with forensic services in general.

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<sup>14</sup> See Population Health Directorate (2019) Inpatient Census 2019: parts one and two. Edinburgh. 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>

The Independent Review of Learning Disability and Autism in the Mental Health Act (IRMHA) recommended that existing low, medium and high secure forensic wards and units for people with a learning disability should become 'habilitation' units.<sup>15</sup>

### 7.2.1 Hospital provision

Capacity issues across the wider forensic estate are replicated for learning disability hospital beds. It was reported that there are often no beds available to admit urgent cases. High and medium secure provision for men is provided on a national basis and is nearly always full. Lower secure care is variable across Scotland and can sit within either mental health or learning disability structures. Some areas operate regional or local low secure purpose built units. Others are working with locked wards that do not meet low secure standards.

There are significant gaps in forensic provision for women with learning disabilities. One staff member questioned the appropriateness of women with learning disabilities being in the forensic system at all.

There is no high secure provision for women with a learning disability and only four medium secure beds. There is no specialist forensic low secure service. As a result, women with a learning disability tend to be treated in IPCUs, general mental health wards or independent provision. If a woman does have high secure needs, specialist provision in England or bespoke arrangements have had to be made, both at a high cost to the Boards.

People expressed concern that people with learning disabilities spend longer in hospital. It can be harder for them to demonstrate that their risk has lowered and many experience severe delays while awaiting suitable accommodation in the community. The review was told of someone who has been waiting for eight years, and that one ward could be closed if everyone who was ready for discharge had a place to go to. One person who had been waiting on a place since 2016 said they

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<sup>15</sup> 'Habilitation' is described as 'a process of supporting disabled people to attain, keep or improve skills and functioning for daily living'. See The independent review of Learning Disability and Autism in the Mental Health Act (IRMHA) (2019) *Final report*. Available at: <https://webarchive.nrsotland.gov.uk/20200313213229/https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf>

'just wanted out'. The IRMHA noted that delays in discharge for people with learning disabilities may amount to a breach of their human rights.<sup>16</sup> Delays in discharge also mean that beds are not available for people with learning disabilities when they need to step-up from the community. The result is that they are placed in general wards. People said this population can be vulnerable when inappropriately placed in mental illness forensic wards and general wards.

### 7.2.2 Community provision

Community management for people with learning disabilities helps to widen people's social networks, minimises negative peer influence and offers opportunities to gradually reduce supervision levels. There was a feeling that there are insufficient forensically aware community services for people with learning disabilities. As in mental health, people with learning disabilities have difficulty moving from forensic community services back into general community care.

Forensic learning disability community services vary across Scotland. Community services, in the main, are part of learning disability services rather than forensic mental health. However, some do have separate specialist forensic teams. Staff highlighted that people with learning disabilities in the community were more likely to be provided with general services and interventions than specialised forensic ones. Co-located, dedicated multi-disciplinary community forensic learning disability teams were felt to improve the pathway between inpatient and community forensic services.

There is a lack of community accommodation and support packages to meet the needs of people with learning disabilities. In some areas, suitable accommodation simply does not exist.

A good relationship must be developed with the 'right' support worker in order to support successful and long-term community discharge. Staff spoke of support packages breaking down because a community support worker was not sufficiently

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<sup>16</sup> See The independent review of Learning Disability and Autism in the Mental Health Act (IRMHA) (2019) *Final report*. Available at: <https://webarchive.nrsotland.gov.uk/20200313213229/https://www.irmha.scot/wp-content/uploads/2020/01/IRMHA-Final-report-18-12-19-2.pdf>

skilled or empowered to manage difficulties that may only have been temporary, resulting in people being recalled back to hospital. It was also highlighted that people who receive 24 hour supervision can find it intrusive or experience increased loneliness. This happens because the constant presence of support staff reduces opportunities to make new connections, leading to greater dependence on care.<sup>17</sup> There are calls for more creative solutions to meet people's needs.

### 7.2.3 Criminal justice

People with learning disabilities who spoke about police interviews said that the environment was intimidating. Having consulted with lawyers prior to the interview, they spoke of having trouble retaining the information during the actual interview. One person had been unclear what the role of their Appropriate Adult (AA) was in the interview and did not feel they had helped them. By contrast, another spoke positively of an AA who was engaged, took time to build rapport and supported them to advocate for their own needs. They felt that it was important that an AA was proactive. In most areas, AAs no longer support witnesses or the accused in court. The proposals to create a statutory AA service do not suggest that they should.

People with experience of court proceedings, and staff teams that work with them, said there are gaps in the support available for people in court. Support is needed to help people understanding the proceedings and the consequences of sentencing decisions. People recommended more staff training to address these gaps, as well as mechanisms to help courts identify people who need additional support. A number of people with a learning disability felt they could have stood trial if they had received more support. They also felt that this would have been a preferable option that would have seen them return to the community sooner. People raised concerns that the threshold for people with a learning disability being sent to hospital for offences is lower than that for the general population.

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<sup>17</sup> More generally, two Supreme Court decisions (*Welsh Ministers v PJ* [2018] UKSC 66 and *Secretary of State for Justice v MM* [2018] UKSC 60) highlighted issues with packages of 24/7 care that involve a level of restriction, supervision and monitoring that amount to a deprivation of liberty. Available at: <https://www.supremecourt.uk/cases/uksc-2017-0212.html> and <https://www.supremecourt.uk/cases/uksc-2018-0037.html>

### 7.3 People with neurodevelopmental disorders

The only neurodevelopmental disorder people spoke about was autism spectrum disorder. There were reports of increased numbers of people with autism coming into contact with criminal justice. Identifying autism during police and court processes can be difficult, which can result in failures to provide an AA. The review was told that for a person with autism to receive just outcomes, people interviewing them need to be aware that they could have verbal fluency exceeding comprehension; speed of processing and working memory deficits; a desire to please and conform to authority; and poor emotional control when under stress. False confessions are also among the dangers of failing to identify autism when someone is in police custody.

There are no central reports currently available to say how many people with autism are receiving care and treatment in the forensic system. There is, however, a known lack of specific provision and forensic pathways for people with autism. Forensic services are mainly set up for those with a mental illness or learning disability.

Most staff groups acknowledged a lack of expertise about autism. Psychologists do have the necessary skills and use these to assist with risk assessments and treatment plans in inpatient, community and criminal justice settings.

The family members of one person with autism within the forensic system said that their relative received good medium secure care but that the 'staff had to learn fast' about autism. They highlighted the particular importance of involving family in discussions about care and treatment of people with autism as they can be the person's 'emotional voice'. The same family members expressed disappointment in the level of care provided in the community as it has not delivered what was promised. One parent spoke of her decade-long struggle to get her son appropriately diagnosed prior to his subsequent decline into drug addiction, leading to a custodial sentence.

### 7.4 Children and young people

There is a lack of access to general or forensic mental health services for children and young people in conflict with the law. In the community, NHS Greater Glasgow and Clyde is the only Health Board with a Forensic Child and Adolescent Mental Health Service. Young adults and their family members feel that some of the

problems that they are experiencing now are the result of not getting appropriate help when they were younger.

Specific concerns were raised about the unmet mental health needs of young people in secure care. The in-reach of general Child and Adolescent Mental Health Services to secure care was reported to be variable. There can also be tensions and disputes across Health Board and local authority boundaries in relation to the funding and provision of secure care.

Mental Welfare guidelines on the admission of people under 18 to general adult wards are applied to forensic mental health services.<sup>18</sup> In general, no one under 16 should be admitted and the admission of young people aged between 16-18 should be exceptional. Consideration of admitting anyone under 18 to higher secure settings requires particular scrutiny and national oversight. The lack of low secure inpatient care can result in young people being placed in adult IPCUs. Young people requiring medium secure care, including those with learning disabilities, are currently placed in specialist provision in England. There are concerns that out of area provision can lead to a breakdown in young adults' support networks.

Plans for a secure National Adolescent Secure Inpatient Service for Scotland have been approved. It will be located within NHS Ayrshire and Arran and provide care and treatment for male and females up to the age of 19. However, one person suggested no one under 25 should be placed in an adult medium secure unit. People also questioned whether the planned 12 bed facility will be sufficient to meet current needs.

Difficulties were highlighted around provision of court reports when a child is remanded in secure care outwith their home area. The review of mental health services in HMP YOI Polmont indicated that greater inter-agency communication and

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<sup>18</sup> See Forensic Network (2019a) *Guidance on patient referral to or within Scottish high and medium secure services*. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Guidance-on-Patient-Referral-to-High-Medium-Security-FINAL.pdf>

information exchange is needed around young people in the criminal justice system, including those transitioning into and out of secure services.<sup>19</sup>

## 7.5 Older adults

The Scottish Government's Inpatient Census found 9% of people receiving forensic services in NHS Scotland facilities in March 2019 were 65 or older.<sup>20</sup> The forensic population is ageing and there is an increase in older adults entering the system as a result of historic offences. There is no upper-age limit for admission to forensic services, nor is there a distinct older adult forensic services or an older person's forensic pathway. Decisions on whether to admit people over 65 to forensic wards are made by adult and forensic services on a case by case basis.

The forensic population faces difficulties associated with old age comparatively early. Staff have a desire to 'get ahead of the game' to prepare for age-related needs. Forensic units are not currently set up for an ageing population and people felt that consideration should be given to creating special wards or units for this group. It was suggested that the needs of this population may overlap with those of some elderly prisoners and that a national or regional approach may be required.

Staff in the forensic system acknowledged their lack of expertise in recognising and dealing with issues associated with old age such as dementia, frailty, and hearing loss. They identified a growing need to understand how these issues relate to effective risk management strategies. The lack of expertise leaves a gap in information available to MAPPA, which affects its ability to plan for this population and their needs in the community. People also raised concerns that dementia is not picked up early enough by police or social work in the community and that, even if it was, there would be no healthcare pathway to address it.

Older adults can remain inappropriately placed in secure settings due to a lack of alternative provision. The risk or stigma associated with forensic services makes it

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<sup>19</sup> See HM Inspectorate of Prisons for Scotland (2019) Report on an expert review of the provision of mental health services, for young people entering and in custody at HMP YOI Polmont. HMIPS. Available at: <https://www.prisoninspectorescotland.gov.uk/publications/report-expert-review-provision-mental-health-services-hmp-yoi-polmont>

<sup>20</sup> See Population Health Directorate (2019) Inpatient Census 2019: parts one and two. Edinburgh. 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>.

difficult or inappropriate to return this population to general services or nursing homes in the community. In some cases, people have been placed in specialist provision in England.



## 8 Criminal justice

### 8.1 Mental health care and assessment in police custody

Police are responding to a demand for mental health related services which they do not feel best placed to meet. People often come to police attention when out of hours mental health services have failed to respond to their needs. The review was told that 41% of people in police custody self-disclose previous mental health issues, with 31% disclosing previous attempts of suicide or self-harm. Lack of access to or coordination with mental health services when responding to a person exhibiting mental health problems can create substantial demands on police time. For example, one officer described spending whole shifts escorting and waiting for people to be assessed at A&E. They also said they did not receive enough training in mental health issues but had been 'self-taught' through the experience of working with people in crisis.

Police aim to conduct a full physical and mental needs assessment when someone enters custody. This assessment is usually done by a duty healthcare professional such as a GP or nurse. It can happen on-site in police custody or off-site at a hospital, depending on the area. Referral processes are in place for when further assessment by a mental health professional is needed. These vary between different NHS Boards and custody centres. People may, for example, need to be taken to hospital or a professional may attend the custody suite.

People supported the development of Liaison and Diversion Services to help identify people with mental health problems earlier and divert them away from further interactions with the police and criminal justice system. Many NHS Boards are using the Scottish Government's Mental Health Strategy Action 15 funding to increase mental health nursing provision in custody and improve the pathways.

People with lived experience spoke of times the police had not responded to their mental health problems effectively and family members described a lack of support. Negative experiences included failures to keep family members informed, acting against family members' advice, denial of medication while in custody and releasing people without ensuring that they accessed mental health services. One family member said she did not pursue complaints about the police because she did not believe they would have an impact.

People said the availability and quality of support for people with mental health issues in police custody needs to be examined. Guidance to local authorities issued earlier this year says that AAs should attend requests with minimum delay and ideally within 90 minutes.<sup>21</sup> Advocacy services felt it would be challenging to meet this target. People described previous instances where no AA was available and interviews needed to be rearranged. There were also concerns that information from AA reports is not held centrally or easily retrievable.

## 8.2 Court proceedings

People want more consistent joint working arrangements between forensic mental health and criminal justice services. These are needed to support timely, high quality assessments and reports in the criminal justice system.

### 8.2.1 Assessments and reports for the courts

Timely access to high quality mental health assessments and reports is vital to the smooth running of the criminal justice system. It affects access to fair process and appropriate care and treatment for people who are accused of offences. At present, there is no nationally agreed process for conducting mental health assessments in the criminal justice system. Regional variations in practice contribute to uncertainty, delays and frustration. People linked this with poor working relationships and lack of quality assurance of the assessments and reports provided. Multiple submissions called for the introduction of stronger governance to remedy the difficulties which arise from inconsistent practices.

People noted significant issues in arranging both initial and formal mental health assessments and reports for people subject to court proceedings. The availability of medical practitioners for initial assessments can be restricted to narrow time frames. This means people have to spend additional time in custody whilst awaiting initial assessment. Some people said places available in custody and courts were not always conducive to making mental health assessments. In some areas, initial assessment is conducted by 'paper triage' based on available medical records.

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<sup>21</sup> See Justice Directorate (2020) *Appropriate Adults: guidance for local authorities*. Edinburgh. Available at: <https://www.gov.scot/publications/appropriate-adults-guidance-local-authorities>

Some felt that this creates a risk that no medical practitioner will attend an individual in custody with mental health issues.

The absence of a framework for obtaining formal psychiatric reports causes difficulties. It is the Crown Office and Procurator Fiscal Service who need to arrange them prior to and during hearings and the Scottish Courts and Tribunal Service when they are required to inform court disposals. Although some local arrangements are in place, NHS psychiatrists are not generally contracted to provide court reports. There is also no standardised system of payment for reporting services. They must either do it as 'private work' or the courts must source independent provision. Some people felt that clinicians' reluctance to do this work could be linked to the comparative low rate of pay. This all means that courts sometimes have to make requests to multiple requests before someone accepts, adding to delays that can be well in excess of the statutory requirements. Even where a psychiatrist agrees to prepare a report, it takes time to provide it. Delays in obtaining reports cause disruption in the court system. They incur additional costs and cause delays in accessing care and treatment for accused persons, who often have their cases continued whilst reports are prepared.

Difficulties obtaining reports mean that courts often rely on trainee psychiatrists, non-forensic psychiatrists or independent (non-NHS) provision. This raised concerns about consistency and quality. It also means the reporting psychiatrist may not be able to source suitable hospital provision, if required. Independently produced reports may not be made available to the NHS or may not be accepted by them. This risks repetition of complex assessments for the individual concerned, which is not thought to be in their best interest.

The absence of governance around provision of court reports causes tensions between the justice and health services. People in criminal justice sought the creation of a national framework or even a statutory duty on NHS Boards to manage report provision. Healthcare professionals noted soured relations with the courts as a result of 'requests' that feel like demands, and gave the example of Sheriffs demanding that health staff appear in court.

Courts said that they did not have issues obtaining social work reports. However, MHOs wanted a more consistent and robust process for managing these reports at a national level. In particular, they asked for courts to inform local authorities more

promptly of decisions that require an MHO to be appointed. This would allow them the maximum time available to fulfil their statutory reporting duties.

People questioned whether clerks in court have sufficient training about the types of assessments and reports available, as often the requests were not clear. Some people felt that decision about whether to request a psychiatric or a psychological reports may be based on how easy each is to get, rather than consideration of which is more appropriate. One family member observed that Sherriff courts may send people to locked wards for assessment, even where they have an established history of mental health problems.

### 8.3 Mental health services in prisons

Responsibility for healthcare services, including mental health services, in prisons transferred to the NHS in 2011. One of the aims of the transfer was to ensure that people in prison received the same level of care as the general population. The Scottish Prison Service has a Memorandum of Understanding in place with the NHS Boards areas in which there are prisons. These Boards are responsible for providing all primary care services in prison, including mental health input. One group felt that the Memorandum of Understanding was in need of updating to better balance issues around confidentiality, risk and public protection.

#### 8.3.1 Forensic mental health services in prisons

Psychiatric provision in prisons is provided by in-reach sessions by forensic psychiatrists. However, this provision varies significantly, from five to 0.5 forensic psychiatry sessions per week. Out of hours psychiatric support is not always provided by someone who is forensically trained. Psychiatric provision was reported not to have increased in line with increases in prison populations within Health Board areas, leaving it under-resourced. Feedback from psychiatrists suggested that most of the work they do in prisons relates to mental health conditions like depression and anxiety, which would not typically be referred to forensic specialists.

The Parole Board recommended that the burden of producing psychiatric reports should be shared more evenly across the health services, so that it does not fall disproportionately on clinicians whose Health Board includes multiple prisons.

Forensic and clinical psychologists are providing psychological interventions in prisons. They are also providing training and supervision of staff. However, the level of provision is variable and in some areas there is no formal provision. It is also felt to be under-resourced. Psychologists said that the demand for highly specialist psychological interventions cannot be met by the current resource allocated. The Scottish Prison Service do employ some forensic psychologists directly but this is for a very specific roles such as offender behaviour treatment programmes.

### 8.3.2 General mental health services in prisons

Concerns were raised about the numbers of nursing staff in prisons. One person said that the current mental health care model is not sustainable, with demand outstripping resource. They suggested that if mild to moderate mental health issues could be moved to primary care, the mental health teams could function as a more specialist service focusing on the people with the most complex needs. Another group said that people often feel they need to see a specialist about their mental health but that if they presented with these issues in the community they would be managed by primary services.

One organisation noted a contrast in the services available to people who are treated under the mental health legislation in hospital, compared to those with significant mental health problems but who do not meet the criteria for transfer for treatment and remain in prison. It argued that people detained in hospital under the mental health act have greater access to mental health specialists, whereas those in prison experience less scrutiny of symptoms, less access to treatment and less access to aftercare when they return to the community.

### Joint working

Frustrations about inconsistency in mental health services within the prison system echo the concerns expressed within the forensic system. NHS Boards described variation between prison establishments as a challenge. Some prisons discharge a national function, meaning the Health Board in which they sit must liaise with all territorial NHS Boards and local authorities across Scotland. Each authority has its own unique systems and processes, which prevents a consistent approach to communication. Information sharing between prisons and both community and forensic mental health teams was general felt to be good but hampered by different

IT systems. Some people noted failures to take account of GDPR and issues regarding the balance of risk management with confidentiality. At the highest level, NHS Boards want greater consultation on proposed changes to the prison estate because new prison populations have knock-on consequences for NHS provision in the relevant area.

Joint working is associated with positive outcomes for people in prison. The majority of people who discussed multi-disciplinary working in prisons said it needed to be better understood and operationalised. Constraints on mental health staff resources impact on multi-disciplinary working. Psychiatrists are only in prison for limited times and mental health nurses in prison can struggle to protect time for meetings, so there are limited opportunities to discuss more complex cases. One group recommended creating service level agreements between prison managers, health services and local authority social work departments to support a continuous and integrated multi-disciplinary health package. Another suggested that dedicated, rather than visiting, psychiatric provision would allow for greater integration of psychiatry into the multi-disciplinary team.

The Parole Board for Scotland (the Parole Board) relies on the provision of mental health reports to help it reach decisions about release of people from prison. Absence of information sharing between clinicians and the Parole Board means that reports may come too late for a given Tribunal. Prisoners may also be transferred between prisons as a Tribunal approaches and the report requests are not necessarily communicated to the next prison.

The process of ensuring people in prison receive mental health referrals when they are transferred between prisons or the community lacks clarity and consistency. Referrals are reported to be more common if the person has previous contact with mental health services. The quality of transitional arrangements into the community was also queried. Gaps in communication between prison staff, CMHTs and third sector organisations can affect the support given to people liberated into the community.

One advocacy organisation commented on good experiences around contacting the transferring prison when a person has been admitted to hospital. This helps in locating missing property and acquiring useful information.

## Care and treatment

There is variation in the delivery of mental health care in prisons, including processes and pathways to access care from the point of referral, the composition and expertise of prison mental health teams, selection and delivery of treatment and the degree of mental health training given to prison officers.

People who have experienced prison custody can find it very difficult to get mental health support and experience delays in seeing a mental health nurse. Families spoke about a general lack of professional input and access to medication. When accessed, people's experience of mental health care in prison can be different to experiences in their home health board, including changes to proposed treatments. Family members said they can have difficulty accessing information or participating in decision-making about their relative's care in prison and may not be notified of any changes. This can create problems when people are released because family members are typically their main source of support.

Provision of psychological therapies was said to be inconsistent. Improvements have been reported following the creation of some prison-based psychology posts and the introduction of Low Intensity Psychological Interventions (LIPI) but there is still significant unmet need. This particularly affects people with personality disorder, for whom there is a growing evidence base of the efficacy of psychotherapy. A number of staff recommended enhancing resources for psychology. One argued that prisons should adopt a consultant psychiatrist-led community mental health model in order to improve access to care and treatment.

One prison has joined the Royal College of Psychiatrists Quality Network for Prison Mental Health. It was suggested that if more prisons were to join the network there would be less variation in standards of care between prisons and an increase in services offered to prisoners. Psychologists also felt that the targets for referral times for people in the community should equally apply to people in prison.

There is inconsistent access to other services in prisons, including AHPs, advocacy and other third sector organisations. AHPs reported challenges establishing relationships and developing their roles, which they associated with high prison staff turnover. They also noted difficulties in continuing care when people are transferred or liberated and felt that there are opportunities to develop pathway working in this

area. One group said there is no strategy to coordinate access to services from third sector organisations and no clear efforts to direct resources in the most appropriate ways. The provision of independent advocacy within prisons was described as ‘tokenistic and very poorly funded’. Advocacy services also commented on gaps in the referral process, noting that the majority of referrals to their services were by people detained in prison themselves or through word of mouth.

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### Remand

A number of people raised the issue of remanding people in prison whilst they wait for assessment or treatment in a secure inpatient unit. These prison placements are often made due to lack of hospital beds. They are said to be particularly common for women due to lack of female provision in the forensic mental health system. Professionals acknowledged that this practice can be traumatic and delays people’s access to treatment. Family members described it as ‘unacceptable’ and ‘devastating’ for those affected. An additional concern is that prisons share information about inmates with the DWP but do not adjust their systems to reflect individual circumstances. This means that people remanded in prisons awaiting mental health assessments may have their social security benefits – including Housing Benefit – stopped automatically.

### 8.3.3 Conclusion regarding forensic mental health services in prisons

In seeking to look specifically at the ‘forensic’ aspects of mental health services in prisons it became clear that there was little specialist forensic provision. In the main forensic psychiatrists were providing an in-reach service, delivering a primary care adult psychiatrist role, for example treating depression, anxiety and stress disorders. Nursing input does not come from a forensic specialism but rather from a community mental health nurse perspective. It has a focus around primary care nursing, both



for physical and mental health, with little or no learning disability nursing input that the review has been made aware of.

The provision of general mental health provision in prisons falls outwith the terms of this review. However, the evidence outlining issues with mental health provision in prisons does indicate that it is an area which would benefit from further examination and it is hoped that the Scottish Government will identify an appropriate body for such work.

## 9 Who should be – and who is – in forensic services?

People expressed varying views about who should be on forensic wards, suggesting that the definition of ‘forensic’ is not clear cut. Some felt that the bar for accessing forensic services has been raised as a result of budget constraints, meaning some people who require specialist forensic care and treatment are not getting it. Others felt that bar has been lowered, with other services now expecting forensic services to accept people with non-forensic challenging behaviour and less serious offending histories. A 2017 Mental Welfare Commission report found that many of the people receiving care in medium or low security are there because they cannot be cared safely for in non-forensic (general) wards. About half the people receiving care in low secure were on mental health orders, not criminal orders, indicating two distinct groups of people receiving care.<sup>22</sup>

People questioned the appropriateness of forensic mental health services for people with acquired brain injuries, cognitive executive dysfunction and diagnoses of personality disorder. They also recognised the lack of readily identifiable alternatives for these groups.

People talked about the ongoing use of forensic services to care for people who are unlikely to be able to progress to the community.

### 9.1 Acquired Brain Injury with offending or violence

There is no service in Scotland for people with acquired brain injury who exhibit offending or violent behaviours. People with such injuries and offending histories do not meet the mental illness criteria for forensic services and acquired brain injury units are reticent to take them due to their forensic history. When referrals are made, lack of bed availability on forensic wards means that people who are already in the forensic system are prioritised. However, it is also argued that forensic wards are not the right place for people with these injuries. While they may require conditions of security, it was argued they need neurological input rather than forensic. They may be transferred to specialist services in England.

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<sup>22</sup> See Mental Welfare Commission for Scotland (2017) *Visit and monitoring report: Medium and low secure forensic wards*. [Online]. Available at: [https://www.mwscot.org.uk/sites/default/files/2019-06/medium\\_and\\_low\\_secure\\_forensic\\_wards.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/medium_and_low_secure_forensic_wards.pdf)

One person with an acquired brain injury who spoke to the review said he did not want to be in the forensic ward. Other people who had shared wards with people with such injuries, while sympathetic to their situation, felt they took up too much staff time and that this affected the care that could be given to others.

## 9.2 Personality Disorders

A report by the Royal College of Psychiatrists in 2018 concluded that there is no clear evidence that a long-term hospital admission for the treatment of personality disorder helps to address the risk management issues associated with this diagnosis. Moreover, such an admission may be harmful by working against the long-term aim of developing skills to manage distress.<sup>23</sup> Guidelines for admission to medium and high secure forensic services recommend that people with a primary diagnosis of personality disorder are not admitted. The criminal justice services is seen as the primary agency responsible for their risk assessment and containment.<sup>24</sup> People pointed to the increased evidence base for treatment of personality disorder in the community using specialist psychological therapies. Given the high prevalence of personality disorders within the prison population, it was argued that this treatment should also be considered in prison settings.

Staff working in forensic mental health services do care for and treat people with personality disorder. This is because people in the forensic system often have a personality disorder but it is not their primary diagnosis. It was also reported that a small number of people with a primary diagnosis of personality disorder remain detained under the 'serious harm' test in section 193 of the Mental Health (Scotland) Act. The Forensic Network has made recommendations for minimum standards of staff training and support within services that manage or care for offenders who have a personality disorder. There was consensus among professionals that people with personality disorders require a different approach to treatment, formulation and risk management compared with people with psychotic illnesses. It was also

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<sup>23</sup> See Royal College of Psychiatrists (2018) *Personality disorder in Scotland: raising awareness, raising expectations, raising hope*. (College Report CR214). Available at: <https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr214.pdf>

<sup>24</sup> See Forensic Network (2019a) *Guidance on patient referral to or within Scottish high and medium secure services*. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/Guidance-on-Patient-Referral-to-High-Medium-Security-FINAL.pdf>

acknowledged that treatment for personality disorders is resource intensive and takes time.

A number of NHS Boards have placed people with personality disorders out of area in independent low secure provision. The majority of these people are women and it can be difficult for these providers to move them to conditions of higher security. In these circumstances placements are sought in England. It can then be difficult to repatriate people.

It was said that forensic clinical psychologists can play a key role in supporting criminal justice colleagues involved in the MAPPA process by sharing risk management and rehabilitation expertise about people with personality disorders.

### 9.3 People who are unlikely to progress to the community

There are a small number of people whose risk is unlikely to ever be considered manageable in the community. These people are reported to be 'trapped' in medium and low services.

Many people saw the role of hospitals as progressing people. When people are not doing so, this can cause exasperation and impact on the therapeutic milieu of the ward. For example, one person complained that 'this is meant to be a rehab ward but some people have been here for 20 years'.

#### 9.3.1 Progressive neurological diseases

The review was told that it can be difficult to rehabilitate people with forensic histories back into the community if they have or develop progressive neurological disease. As long as they present a risk of sexual or non-sexual violence, they will not be accepted into community nursing care. However, it was suggested that people with neurological conditions could be destabilised by living alongside those with mental illness. There was a call for specific resources to be developed for this group if they are to remain in the forensic system despite their conditions not being treatable.

## 10 Legal issues and rights

People raised issues about the legislative framework within which forensic services work.

A number of individuals and advocacy organisations raised issues around the legal rights of people in the forensic mental health system. People with lived experience and their family felt that they suffered from a lack of clarity in this area. The role of advocacy in safeguarding and protecting the rights of people receiving care was identified as particularly important. People felt that without advocacy they would not get a full explanation of their rights or receive complete information about their situation.

Advocacy groups argued that forensic services infringe on the human rights of the people who use them. They said that people have no choice about their use of forensic mental health services and that, once in that system, they lose their liberty and many other rights, without reciprocity. They suggested that coercive control still exists in the forensic system and some felt this to be at odds with the United Nations Convention on the Rights of Persons with Disabilities.

### 10.1 Appeals against conditions of excessive security

People should not be kept in conditions of security that are higher than clinical requirements or unnecessary for the protection of the public. People in high and medium secure units have the right to appeal if they feel they are being held in conditions of excessive security. These provisions are seen as welcome but are thought to have added to the pressure on beds in medium and low secure settings.

The primary cause of detention in conditions of excessive security is the lack of a bed at the right security level. This means that few appeals are made without merit and many are made with clinical support. This creates pressure to hold tribunals that would not be necessary if beds were available to enable timely progression. As successful appeals do not solve the capacity issue, people may also still face considerable delays before the decision is enacted. People in the forensic system are well aware of this. One person explained that he decided not to appeal because, even if he won, it was not as if a bed 'would magically appear'. Another suggested successful appeals only placed people further up a waiting list they were already on.

Not everyone uses the appeal system. There are people who lack capacity to appeal, are concerned about being moved out of area or who do not have confidence in the system. Some are reticent to appeal, knowing that if they were successful, they would be bumping someone else further down the queue. One person said he had not appealed against his conditions because he kept being told he was 'just about to be moved'. People who do not appeal appear less urgent and are potentially disadvantaged.

There were widespread calls to create an equivalent right of appeal for people detained in 'excessive conditions' in low security, for instance because their discharge has been delayed as they wait for accommodation in the community. The review was warned that without such a right, it is likely that a person held inappropriately in low secure services could successfully raise an appeal based on breach of the European Convention on Human Rights. However, it was also recognised that extending the right of appeal to people in low security would not be sufficient and that it is likely to lead to people to being transferred to 'lower' conditions of security such as IPCUs rather than being discharged.

What was common across all responses was agreement that there needs to be some mechanism or legal redress to resolve the issue of people's discharge being delayed by a lack of community resources. People said any successful solution would require the support of local authorities and general mental health services. A number of people suggested that there could be a clearer duty on local authorities to provide services to people who are ready to begin rehabilitation in the community.

## 10.2 Other legislative issues

In addition to calls for more governance, there was a clear appetite for legislative change within some submissions to the review. The following issues were identified by one or more people:

- One person raised questions around the legitimacy of any form of detention on the grounds of a person's mental health condition, arguing that compulsion and force due to a person's disability is contrary to the rights conferred under the United Nations Convention on the Rights of People with Disabilities.
- There is no requirement for a risk assessment when court disposals place people on a CORO. People felt that a risk assessment should be in place before a

CORO is considered. As restriction orders are of unlimited duration, people thought the quality of that assessment should be particularly high.

- Advocacy recommended that there should be legislative clarification regarding the length of detention for treatment in order to avoid the appearance of arbitrary detention. They argued that no order should be ‘without end’.
- There was thought to be a gap in sentencing options for people whose mental illness, learning disability or autism played a part in their offending but for whom long-term inpatient care would not be recommended.
- One family member felt that it is unacceptable that a person can be transferred to prison while waiting for a hospital bed to be sourced for a psychiatric assessment for the courts. These placements in prison were said to be potentially devastating for the person affected. Admission to prison can also cause DWP benefits to be stopped, potentially leading to rent arrears.
- One Responsible Medical Officer highlighted that there was no mechanism for them to return to a Mental Health Tribunal if they are unable to fulfil aspects of a treatment plan for people on criminal orders. They felt that the availability of ‘recorded matters’ (which can currently be specified by Mental Health Tribunals in respect of people subject to compulsory treatment orders) should be extended to people who are subject to criminal orders.<sup>25</sup>
- Family members called for a change in law to allow those who will be supporting people at the point of discharge access to basic information, even if they are not the nominated person.
- Advocacy raised the issue that people lose their right to vote under the current legislation, calling this a ‘civil death’. They wanted to see the vote given to all people within the forensic mental health system.

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<sup>25</sup> The use of ‘recorded matters’ by Mental Health Tribunals is intended to ensure the provision of elements of care and treatment where a specific need has been identified for people of Compulsory Treatment Orders. If any recorded matter cannot be provided, the Responsible Medical Officer must report this back to the Tribunal. See Mental Welfare Commission for Scotland (2019b) *Visit and monitoring report: Updated Survey of Recorded Matters*. Edinburgh. Available at: [https://www.mwscot.org.uk/sites/default/files/2019-06/updated\\_survey\\_of\\_recorded\\_matters\\_2.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/updated_survey_of_recorded_matters_2.pdf)

## 11 Other observations

### 11.1 Early intervention and prevention

Many people felt that a preventative approach to mental health care is needed. Family members felt that they are relied upon to fill gaps in care and treatment in the community but are not listened to when they offer advice or need help. They spoke of health services failing to respond to their warnings about deterioration in a family member's mental health and of people only gaining access to services once they had committed an offence. They argued that a reactive approach is a false economy and that earlier interventions would not only reduce victims but reduce the need for specialist care in the future. There was support among staff for embedding preventative models into mental health care.

### 11.2 Scepticism about change

There were people with lived experience, family members and staff who held out little hope that this review would result in any change. It was noted that several previous reviews have not led to the substantial and co-ordinated change that people feel is needed. People with lived experience and their family members said they had been telling people about the same issues for years and nothing had changed. Staff also said that plans to address known issues, such as lack of capacity, were talked about for years but never came to fruition. Some felt that this was because plans were made without the right people around the table.



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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.<sup>26</sup>

### 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

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<sup>26</sup> 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 areas 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.



## Annex B: Responses to call for evidence

The review received 103 responses to its call for evidence.

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's 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 NHS Shetland
32. NHS Tayside
33. Orchard Clinic Psychology Department
34. Police Scotland
35. Patients Advocacy Service
36. Parole Board for Scotland
37. Partners in Advocacy
38. Rohallion Users Group
39. Royal Edinburgh Hospital Patients Council
40. Royal College of Nursing
41. Royal College of Psychiatrists
42. Scottish Appropriate Adult Network
43. Scottish Association for Mental Health (SAMH)
44. Scottish Court and Tribunal Service
45. Scottish Group of Forensic Clinical Psychologists
46. Scottish Independent Advocacy Alliance

- |   |   |
|---|---|
| 47. Senators of the College of Justice  | 52. The State Hospitals Board for Scotland      |
| 48. Sheriffs Principal  |   |
| 49. Social Work Scotland Mental Health Sub-Committee                          | 53. The State Hospital Medical Advisory Service |
| 50. Support in Mind Scotland  | 54. Volunteer Edinburgh                         |
| 51. Speech and Language Therapists working in Forensic Mental Health Services | 55. VOX   |

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.
- 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.
- 3 from people with another interest in forensic mental health services.

## Annex C: Engagement activities supporting the call for evidence

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 2020
- Woodland View Hospital, NHS Ayrshire and Arran – 23 October 2020
- Rohallion Clinic, NHS Tayside – 30 October 2020
- Rowanbank Clinic, NHS Greater Glasgow and Clyde – 14 November 2020
- Leverndale Hospital, NHS Greater Glasgow and Clyde – 20 November 2020
- Orchard Clinic, NHS Lothian – 27 November 2020
- 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 multidisciplinary 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
- Video conference with clinical staff, NHS Lanarkshire – 22 July 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

## Events

The Chair accepted invitations to speak at the following events:

- 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







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