Forensic Mental Health Services Managed Care Network

Care Standards Working Group

Care Standards for Forensic Mental Health Inpatient Facilities in Scotland

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Membership of the group

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Terms of reference

Following the launch of the Forensic Mental Health Services Managed Care Network (the Forensic Network) in September 2003, a number of expert groups were commissioned to aid the strategic planning of forensic psychiatric services in Scotland. This group was set up in August 2004 and has been financially supported by the Scottish Executive. The primary purpose of the group's work was to contribute to a strategic national planning document which will draw together the conclusions from the various Forensic Network working groups. Phase I group reports were consulted on in 2004 (women's services, learning disability services and definition of levels of security) Phase II and III group reports are planned to go out for consultation in June 2005.

The purpose of the group was to define multidisciplinary standards of care for in-patient forensic services for use by commissioners, planners, registration (private sector), inspectorates and those involved in clinical governance.

High, medium and low forensic care standards were to be defined, developing the work of the Levels of Security group report (Crichton et al, 2004) and incorporating standards for physical, procedural and relational security.

Given the current state of the medium secure provision we were asked to prioritise medium secure care standards.

Low secure care standards were to be considered in the light of both the current service provision and their future role in the spectrum of forensic services.

The expert group was multi-professional, with contributors with experience of nursing, security, the Mental Welfare Commission, the Care Commission, psychiatry, social work, occupational therapy, a relatives' support organisation, psychology and Quality Improvement Scotland. After the group's first meeting the group decided to extend membership to Susanna Paden, Morag Slesser and Crawford Little.

Summary of the work of the group

The group first met on 14th October 2004 in Edinburgh and subsequently met in full on 4 occasions including a final meeting on 5 May 2005. Additionally, the chairman and the group facilitator met regularly and the entire group was regularly updated and asked for comment between meetings via e-mail. We have informally consulted colleagues widely about the approach we have taken.

The Scottish Development Centre for Mental Health was commissioned to complete a piece of work designed to elicit user perspectives on forensic standards. Unfortunately this work could not be completed prior to our deadline and will be published to complement this report on the Forensic Network internet site, when it is available. We comment later on the importance of user consultation, the difficulties which we have encountered and how they may be avoided in the future.

A body of background information was prepared by the group facilitator and distributed to the group; a bibliography is at the end of this report. Large amounts of helpful material were felt to be of use to readers but too long to be included in the report. We had considered including them in appendices, but with the development of the Forensic Network website they will instead be available there. The documents of particular reference available in full on the Forensic Network website are listed at the beginning of the bibliography.

The report was submitted to the Forensic Network Board in June 2005. The Chairman will give an oral presentation on the work of the group at the Forensic Network Board on 10 June 2005. Following approval by the Board, a consultation period will then commence. It is planned to present this report, modified by the consultation process and in liaison with the group, at a special meeting organised by the Forensic Network on 4th October 2005 at the Edinburgh International Conference Centre. On that occasion we expect the Scottish Executive to announce an updated Mentally Disordered Offender policy, having considered all the Forensic Network reports and feedback.

CHAPTER ONE

Introduction to the report

1.1 Introduction

This report aims to set standards for in-patient forensic mental healthcare; however, relevant standards are already in operation. What has driven this report is a perceived gap in the current standards available, especially in relation to the commissioning of three new medium secure units, the introduction of private forensic healthcare in Scotland and other proposed developments in forensic care, including services for women, the learning disabled population, adolescents, those with personality disorder and the development of community services.

This chapter will summarise the policy context of the report. The Scottish Executive have set important standards by endorsing policy in the area of health, social care, mental health and the care of Mentally Disordered Offenders (MDO).

The regulatory and standards context, which follows, contains the warning that setting a top-down standard, with periodic examination of whether a standard is fulfilled, has not proved to be a fully successful strategy to drive quality improvement in healthcare. This argument is further explored in chapter 2. Local ownership and a bottom-up approach, is more successful with the continuous monitoring of performance indicators and incorporation of standards into local Integrated Care Pathways (ICP). This then can be the basis of reports to Clinical Governance Committees and the identification of Key Performance Indicators for a Health Board's Accountability Review.

Chapter 3 gives a broader view of standards from the perspective of users, carers and victims.

Chapter 4 reviews those standards that currently have particular bearing on forensic mental healthcare in Scotland. The chapter does not comprehensively review standards relevant to healthcare, but does include reference to forensic standards from elsewhere, particularly England, which may be of relevance. Rather than reproduce lengthy extracts from other documents the full text is available on the Forensic Network website.

An important outcome following any untoward incident is proper review of what went wrong and what remedies should be put in place. Chapter 4 also suggests development of current Critical Incident Review procedures.

Chapter 5 proposes new standards to fill a gap in the current standards available; the secure care standards for medium security, including relational security. Following consultation, should this approach be supported, secure care standards for high and low secure care will be proposed using the same format. The first three secure standards are relevant to all levels of security. This section also includes standards for risk assessment; although this is an evolving area in that standards set by the Risk Management Authority likely to be influential across all of forensic mental healthcare.

Chapter 6 draws upon the standards reviewed earlier in the report and other specific building standards to propose a model medium secure unit design guide. This is put forward to be of specific assistance to those involved in commissioning new medium secure facilities in the north and west of Scotland. Some of the guidance will also be of assistance to those planning the reprovisioning of the State Hospital and low security facilities.

Chapter 7 concludes the report with a series of recommendations including the approach local services should adopt in relation to building systems which drive quality improvement. A difficulty with a "top-down" standards approach is variation in quality of acceptable service. This can partly be addressed by benchmarking certain performance indicators and identifying others as mandatory. Even for mandatory performance indicators there will still be local discretion about how they are knitted into Integrated Care Pathways and routine data collection.

The Forensic Policy Context

1.2 The Mentally Disordered Offender Policy

On 28th January 1999 the Minister for Health in Scotland launched the Policy Document *Health, Social Work and related services for Mentally Disorder Offenders in Scotland* (NHS MEL (1999) 5, Scottish Office 1999) (the MDO Policy). The policy statement examined the provision of mental health and social work services for MDOs (and others requiring similar services) in the care of the police, prisons, courts, social work department, the State Hospital, other psychiatric hospitals and community services.

The MDO Policy endorsed certain recommendations made, in the English context, by the *Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services* (the Reid Report, Department of Health 1992). The same set of guiding principles was adopted; that MDOs should be cared for:

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

MDO Policy has subsequently been adopted by the devolved administration and continues to be Scottish Executive policy.

1.3 The Framework for Mental Health

The MDO Policy was complementary to the *Framework for Mental Health Services in Scotland* (Scottish Office 1997) (the framework). The Mental Health Reference Group had been established in 1996 to assist the Scottish Office in the first drafting of the framework, which tasked Health Boards and Local Authorities to jointly organise comprehensive integrated local mental health services, based on sound interagency agreements and protocols. Priority in the provision of care and support was to be given to those with severe and/or enduring mental health problems. Core provision included a range of inpatient facilities; from the general psychiatric to more specifically forensic, short and longer term inpatient care and a range of community options.

A central principle of the framework was that no patient should be discharged from hospital unless services and accommodation were in place and available. The framework anticipated the concept of the "managed clinical network" as described by the Acute Services Review Report (Scottish Executive, 1998). This highlighted the need for a formal relationship between components of a service based on standards of service, quality assurance and seamless provision of care.

1.4 The Risk Management Report

Following its contribution to the framework, the Mental Health Reference Group established four subgroups, one of which was tasked with producing guidance on the management of risk across mental health. In October 2000 the *Risk Management Report* (Scottish Executive, 2000) (the RMR) was published, which was endorsed by the Scottish Executive as guidance (HDL (2000)16). The RMR focused on personal rather than corporate risk and made reference to lessons to be learned from homicide inquiries in England linked to mental health services. There was, therefore, relevance to forensic mental health. The role of Critical Incident Reviews (CIR) following adverse incidents or near misses was described and a model policy recommended. This included the importance of agreeing what incidents merited initiation of the procedure, decoupling the processes of a CIR from any consideration of disciplinary action, and the need for an organisation as a whole to take up and respond to any findings. The RMR is further reviewed in Chapter 4.

1.5 The Care Programme Approach

The RMR recommended: that all care organisations should have a proper programme to identify personal risks; that there should be clarity regarding lines of responsibility and accountability; and that procedures should be in place which allow staff to identify and improve the management of risk. The Care Programme Approach (CPA) was recommended to help manage the personal risks posed in complex cases. The CPA had been introduced as a mandatory operational development in mental health services in England and was endorsed in Scotland in 1996 (Care Programme Approach for people with severe and enduring mental illness including dementia 1996 SWSG 16/96). The RMR rehearsed the arguments for and against the CPA and noted its variable uptake in Scotland.

Nevertheless the CPA was endorsed as it:

- formalised communication between agencies and multidisciplinary colleagues;
- was explicit about the roles of each professional;
- gave clarity to service user and carer;
- did not need to be bureaucratic;
- when properly working avoided duplication; and
- in particular could be used to manage risk.

1.6 Care Pathway Document

A review of progress of the implementation of the MDO Policy was commissioned from the Scottish Development Centre for Mental Health. Each local agency involved in the provision of services for MDOs received a digest report on progress in their area. The Scottish Executive Department of Health in 2001 published a Care Pathway Document (Scottish Executive 2001a) on the care components required in any local service, which was one part of the Scottish Development Centre report. The Care Pathway Document describes the range of health and social care interventions and services that should be made available at each stage of the criminal justice process. Joint agency, multidisciplinary MDO forums or steering groups were established on the basis of Health Board areas. Their role was to consider and advise locally on how best to advance implementation of the MDO Policy and report to the Scottish Executive by the end of September each year. This reporting mechanism has not been linked to the process of Accountability Review (see below).

1.7 Creation of the Forensic Network

In the autumn of 2001 a review group was set up to consider the governance and accountability of the State Hospital's Board for Scotland. A consultation paper

resulted from that review: "*The Right Time, The Right Place*" (Scottish Executive 2001b). Following consultation, the Forensic Mental Health Services Managed Care Network was created in 2003. The Forensic Network has the task of overseeing the development of services for mentally disorder offenders across Scotland. It is to provide a strategic overview and direction for the planning and development of forensic services.

1.8 The Memorandum of Procedure on Restricted Patients

After several years of consultation the revised *Memorandum of Procedure on Restricted Patients* (the MoP) was published by the Scottish Executive (2002). It sets out, in 108 pages, the formal responsibilities of professionals within health and social work services in relation to those MDOs who have been subject to special restrictions by the court. This includes the statutory duties of psychiatric and social work supervision.

As of 7 April 2005, 240 restricted MDOs were in hospital and 49 were on Conditional Discharge in the community. Of the inpatients, 137 (57% of the total) were at the State Hospital making up 61% of the population in high security. The Orchard Clinic had 7% of the total restricted inpatient population (making up 49% of the medium secure population), with the remaining 36% of inpatient restricted MDOs in low secure settings across Scotland.

The MoP endorses the use of the Care Programme Approach and the Care Pathways Document. There is also guidance on the frequency and content of reports to Scottish Ministers. Scottish Ministers must approve a move to lower security or any Suspension of detention for a restricted patient. As Ministers expect the MoP to be followed before allowing such progression, there is a high degree of professional compliance with the guidance. So, in contrast to much of Scottish mental health, the Care Programme Approach is operational at the State Hospital and Orchard Clinic.

The MoP requires thorough reviews following any untoward incident involving a restricted patient and endorses the use of Critical Incident Reviews as proposed by the RMR.

1.9 Mental Health (Care and Treatment) (Scotland) Act 2003

In January 2001 the review of the Mental Health (Scotland) Act 1984, chaired by the Right Honourable Bruce Millan, reported to the Scottish Parliament (Scottish Executive 2001c). The Millan Committee devoted a chapter to high risk patients and recommended that patients should have a right of appeal to be transferred from the State Hospital or a medium secure facility to conditions of lower security. That proposal was adopted in the form of a general right of appeal against the level of security of detention in hospital, in the Mental Health (Care and Treatment) (Scotland) Act 2003, Part 17, Chapter 3 and is due to be implemented in May 2006; this date was set in the Act itself (section 333).

One consequence of the appeals against levels of security is that there requires to be equivalence in the standard of security across Scotland's medium secure estate. If there is an imbalance in the security provided, patients may successfully appeal a move to high security for a move to another medium secure unit, if that unit could meet the particular security needs. This is one reason why security standards need to be specified. If there is no direction at this stage then there will still, as a result of the legislation, be a pressure for the medium secure units to conform to a similar security standard. In the absence of guidance, that unplanned standardisation may yield to pressures to adopt the highest level of security in the medium secure estate thus creating a higher, and perhaps unnecessary, norm of medium security.

Whilst some aspects of mental health law relating to Mentally Disordered Offenders may appear to be similar to the 1984 Act, in fact the 2003 Act introduces significant changes in practice and procedure. All Compulsion Orders, with or without restriction, will be managed by the Mental Health Tribunal for Scotland. A far greater degree of consultation and participation will be required, including taking proper account of the role of the Named Person and Advance Statements. There is a greatly enhanced role for Mental Health Officers (MHO), and all those subject to an order will require a designated MHO. Also all remands to hospital will be automatically restricted, significantly increasing the number of patients who will be subject the standards set in the MoP. The Act also creates principles which have to be taken into account when making any decisions pursuant to the Act.

The Regulatory and standards Context

1.10 Clinical Governance

The concept of clinical governance was introduced to NHSScotland in *Designed to Care (SEHD 1997),* the White Paper on improving Scotland's healthcare. Further guidance was provided in MELs (1998) 75, (2000) 29 and HDL (2001) 74. It was described as 'corporate accountability for clinical performance' and has more recently been described as the system for making sure that healthcare is safe and effective and that patients and the public are involved. (*Draft Clinical Governance and Risk Management Standards, NHS QIS 2005).* In addition, *Building a Better Scotland (2001*) identifies that NHSScotland needs to 'improve the health and quality of life of the people of Scotland and the delivery of integrated health and community care.'

NHS Boards are statutory bodies and have clearly defined governance arrangements in place to cover clinical, staff and corporate governance and this is collectively described as healthcare governance. Performance Management Division at the Scottish Executive Health Department (SEHD) receives information on the three areas of governance. Staff governance information is scrutinised by Audit Scotland, whilst corporate governance information is subject to internal and external financial audit. Clinical Governance is the responsibility of NHS Quality Improvement Scotland. Every Health Board must have a standing committee on each of the three areas of governance, chaired by a non-executive board member and have the Chief Executive in attendance, in their role as Accountable Officer.

As described a number of bodies are involved in assessment and monitoring of healthcare governance arrangements within NHSScotland. In order to minimise duplication and to develop comprehensive profiles of NHS Boards, the Scottish Executive Health Department (SEHD) is establishing a national governance reference group and all bodies involved in monitoring governance will be represented on this.

The themes of clinical governance are:
- clinical effectiveness
- patient focus
- risk management
- information management
- professional/staff development.

These themes are underpinned by effective systems of organisational learning and development.

The elements of governance which NHS QIS has a responsibility for are the assessment and monitoring of clinical governance and risk management. Prior to the establishment of NHS QIS, the Clinical Standards Board for Scotland (CSBS) developed Generic Clinical Governance Standards and conducted two rounds of self assessment and peer reviews against these standards. CSBS was subsumed in 2003 into the new organisation, NHS Quality Improvement Scotland. NHS QIS published draft Healthcare Governance standards in January 2004. After an initial consultation and interim review, these have been redrafted as Clinical Governance and Risk Management Standards (second consultation until June 2005). Peer review visits will commence in 2006.

In addition to the systems of governance currently in place, the overall performance of NHS Health Boards is assessed on the basis of the annual Accountability Review by the Scottish Executive.

Aspects of Clinical Governance are considered through the Performance Assessment Framework (PAF) and its key clinical performance indicators. In 2004, The State Hospital adopted 26 Key Performance Indicators for Clinical Governance. A selection of these is included in the PAF along with indicators for the other governance strands. There is a necessary hierarchy of performance indicators with a broader reporting of data to the Hospital Management Team and operational managers. In addition to the PAF being part of the Accountability Review, quarterly results are presented to the Board. These Clinical Governance KPIs, together with their provenance are at Appendix 1. There is a close relationship between standards set by national bodies and these KPIs. One challenge is to have in place the information technology to support the necessary data gathering. Given that similar information is also gathered by the English Special Hospitals, there is the opportunity to benchmark certain data.

Other Health Boards must include in their PAF, data on delayed discharges from the State Hospital and their progress in fulfilling the Mentally Disordered Offender policy detailed in MEL(99)5. From 2005, the Forensic Network has been tasked with drawing up Key Performance Indicators (KPI) in relation to MDO policy for the PAF and commenting to the SEHD on the relevant sections of every Health Board's Accountability Review.

In response to the Accountability Review, the SEHD issues a letter, which should be published in the Board's annual report. Also from 2005, Accountability Review meetings are to be held in public in the presence of the Health Minister.

1.11 Clinical Standards and NHS Quality Improvement Scotland

On 1 January 2003, NHS Quality Improvement Scotland (NHS QIS) was created as a Special Health Board, as an amalgamation of the Clinical Research and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), the Health Technology Board for Scotland (HTBS), the Nursing and Midwifery Practice Development Unit (NMPDU), and the Scottish Health Advisory Service (SHAS). Subsequently NHS QIS has assumed responsibility for the Scottish Intercollegiate Guidelines Network (SIGN).

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards, monitoring performance, and by providing NHS Scotland with advice, guidance and support on effective clinical practice and service improvements.

Products from NHS QIS include Best Practice Statements and standards (e.g. *Admissions to Adult Mental Health In-Patient Services*, April 2004). NHS QIS continues to review and publish (*National Overview: Schizophrenia,* April 2003

and June 2004) the performance of NHS in Scotland in meeting the standards set out in the CSBS publication *Clinical Standards – Schizophrenia* (2001).

Simply setting a standard, however, does not ensure quality improvement and NHS QIS has encouraged the development of other drivers of quality improvement such as the use of Integrated Care Pathways (ICP) with systems to analyse – and remedy - variance from those pathways. NHS QIS propose in their mental health strategy (Improving Mental Health Services in Scotland: developing a strategic framework for quality improvement, Draft 2005) that they will have a role in accrediting examples of good practice for ICPs (as it does at present for Managed Care or Clinical Networks). However, an essential principle in the development of an ICP is that local practitioners are central to their design and implementation. Such a 'bottom-up' approach helps ensure local ownership for the product. There can be national guidance on what might be in an ICP for a particular clinical process; the local partners must have their say in what, and how, they will deliver. NHS QIS asserts that, to be useful, ICPs need to be supported by service 'information mindedness', and a determination to improve outcomes for individual patients by meeting their assessed needs.

When assessing whether a service has met certain standards, it can be difficult to confirm whether the systems designed to monitor performance accurately reflect performance on the ground. The aim should be to create a system that accurately reflects actual clinical practice and delivery of care. This is an important element to support the improvement of quality and to ensure that the improvement is sustainable. Part of that process identified by NHS QIS, is to collect meaningful data consistently. The "McNamara fallacy" is often referred to in this context, to paraphrase: to make the important measurable and not the measurable important. One difficulty in the mental health context is the establishment of meaningful outcome measures. NHS QIS proposes a proxy way of measuring outcome as serial measures of need and thus how well identified needs are met through time.

The approach of NHS QIS moves away from total reliance on "traditional" standards to a broader agenda identifying drivers of quality improvement. In contrast, in the English context, *Standards for Better Health* published in July 2004 (Department of Health 2004) identifies key standards, set by ministers, and monitored by the Healthcare Commission.

One potential area of work of NHS QIS, which may have an important role in forensic services, is the investigation of serious service failures. Their guidance (NHS QIS 2004) makes it clear that investigations will not be carried out if the Mental Welfare Commission (MWC) would be the more appropriate body. A group from NHS QIS and the MWC are currently considering how the two organisations dovetail their work in this area.

1.12 Mental Welfare Commission

There has been a body in Scotland charged with the protection and welfare of people with mental disorder in existence from 1859. The Mental Welfare Commission succeeded to its predecessor, the General Board of Control, by virtue of the Mental Health (Scotland) Act 1960. Its constitution powers and duties have, or are being, adapted following legislative change in 1984 and 2003. The Queen appoints Commissioners, and these appointments have become increasingly multi-professional and begun to include user and carer involvement in recent years. There is a full time Medical Director, Chief Executive and a secretariat and will move from Edinburgh to Falkirk next year.

The MWC has a statutory general duty to protect those with mental disorder in a wide variety of circumstances by exercising its powers to inspect, report matters of concern to others with a regulatory function (such as the Public Guardian), and ultimately to discharge from detention non-restricted patients. Under the Mental Health (Care and treatment) (Scotland) Act 2003 the MWC has a duty to monitor the performance of the Act, promote best practice and promote the observance of the principles of the Act (see below). It also has the power to hold an inquiry, issue citations and hear evidence on oath or affirmation.

The MWC is required to present an annual report to the Scottish Parliament and to hold local meetings with Health Boards, both of which provide sources of guidance and potential standard setting. The annual reports from 2000 contain a cumulative practitioners' index of topics covering the preceding 4 or 5 years. The MWC has also published occasional good practice guidance such as "*Restraint of residents with mental impairment in care homes and hospitals: principles and guidance on good practice in caring for residents with dementia and related disorders and residents with learning disabilities"* (MWC 1998). The MWC website has been developed as a resource for practitioners, patients and carers and is also a source of advice.

1.13 Care Commission

The Care Commission was established by the Regulation of Care (Scotland) Act 2001 (RoCA 2001). It has four key regulatory roles: registration, inspection, complaints investigation and enforcement.

There are also regulations (Scottish Statutory Instruments) which relate to specific roles and responsibilities for service providers, which must be adhered to.

The Care Commission regulates many different types of care service, such as Independent Healthcare Services, this includes Independent Hospitals some of which provide mental healthcare. The Independent Healthcare Division has responsibility for these services, in terms of ensuring that all regulatory activity is carried out appropriately, but also in ensuring that the quality of care provided is appropriate for the needs of the service user.

RoCA 2001 gives Scottish Ministers the power to publish National Care Standards which must be taken into account by services. These standards are underpinned by the principles of privacy, dignity, choice, safety, realizing potential and equality and diversity. The National Care Standards for Independent Hospitals are in the main generic but there are two specific standards which relate to mental health (see the Forensic Network website).

While the Care Commission does not administer specific standards for Forensic Mental Healthcare Services, the policy position paper '*Regulating the Independent Healthcare Sector*', (Scottish Executive, 2001) set out the establishment of the Independent Healthcare Division and the requirement to ensure that all clinical standards which apply in NHS are adopted in the independent sector.

1.14 The Scottish Social Services Council, NHS Education Scotland and other professional organisations

The RoCA 2001 also created the Scottish Social Services Council which has a duty to promote high standards, conduct and practice among social services workers. The council has four main tasks: to establish registers of key groups of social services staff; to publish codes of practice for all social services staff; similarly for their employers; and to regulate training and education for the work force.

NHS Education Scotland (NES) has the responsibility for training and education for NHS employees in Scotland and it is currently closely working with one of our sister groups examining forensic training and research. Individual employees working in forensic services will also usually be members of professional organisations some of which are statutory, and as individuals will also be subject to standards set by those organisations.

CHAPTER TWO

Standards and other drivers for quality improvement

2.1 Quality

Quality has been defined by the International Standards Organisation (1986) as "the totality of features and characteristics of a product or service that bear on its ability to satisfy specified or implied needs". This implies that quality improvement necessarily may involve scrutiny and possibly change to all aspects of the system or service in question, as they all may affect quality. However the existence or perception of quality cannot be separated from an understanding of the purpose of the system or service. Ducks are hardly ever seen lined up neatly in row – each component of the service has an effect on the others, too much effort focused on one may allow the others to move out of focus, and the emphasis always has to be on "good enough" as defined at that moment. That "good enough" will change over time; the needs of those using and operating within the service change continually, and the satisfaction of those needs – central to the definition above – will require adaptation over time.

2.2 Quality Improvement

Quality improvement does not happen spontaneously in many circumstances, and the last half-century has seen a huge increase effort to make quality improvement happen in health-care systems. It is not immediately clear that the results achieved have been proportional to the input. This says much about the resistance of systems to change, the varied perceptions of people and groups, what is needed and how it should be done, and the tendency to focus over-much on one of the ducks to the exclusion of the others, thus on only part of the solution required to make a lasting difference.

There are a variety of sets of principles/pointers/steps to quality improvement. Juran (2004) describes ten, emphasizing work by people in groups and an approach focused on the organisation's purpose:

- Build awareness of need and opportunity for improvement
- Set goals for improvement
- Organize to reach the goals
- Provide training
- Carry out projects to solve problems
- Report on progress
- Give recognition
- Communicate results
- Keep a score
- Maintain momentum by making annual improvements central to the organization's activities

Most people working in a NHS Scotland environment would recognize the importance of at least some of these. At the same time there might be a bit of a struggle to specify exactly how they might be fitted into day-to-day practice. One person's perception may not be another's. Some means has to be found to link the general to the particular healthcare problem, to bring about a systems approach, to allow the good to flourish, so that individuals wish to contribute, while ensuring that it all goes as well as it should on the bad days, as well as the good. This means some form of what is now known as governance.

2.3 Clinical Governance

As previously discussed, in NHS Scotland there are three strands governance, corporate, staff and clinical. The current emphasis in service quality improvement is upon clinical governance. This is defined as the system for making sure that healthcare is safe and effective, and that patients and the public are involved. Thus improvement can be brought about in the health and quality of life of the people of Scotland, through the delivery of integrated health and community care. NHS Boards, as statutory bodies, are accountable to the Scottish Executive for the realization of these matters.

The themes of clinical governance are:

- Clinical effectiveness
- Patient focus
- Risk management
- Information management
- Professional/staff development

All of these are inter-dependant, and none can be developed satisfactorily in isolation. The organization has to learn from its experience as it goes along, dealing with an issue arising in one area by looking across the others to make any necessary changes. In this way it can respond adaptively to the lessons it has learned. Positive organizational responses to these tasks can be recognized if there is:

- A clear understanding of the organisation's purpose, particularly the outcomes for service users, (and those who care for them at home)
- Effective performance apparent in explicitly defined functions and roles
- Values deriving from good governance permeating the organisation's practices, visible in all its activities, with real accountability
- Risk management through accessing and assessing the necessary information, and the basis for subsequent decisions is clear
- Continuing development of the capacity and capability of the organization to be effective in achieving its purposes
- Positive involvement of stakeholders

Practically, there are five linked key functions which need to operate to improve quality:

- Standard setting
- Reviewing and monitoring performance, (which means collecting the necessary activity data only once, and using it for different purposes to best advantage)
- Sourcing advice and guidance on effective practice
- Supporting staff in their efforts to improve services
- Listening to the user and the public, and translating their concerns into the organization

2.4 Care Standards

Standards are usually based on the patient's journey as he or she moves through the service. They need to be clear and what is described has to be measurable. The evidence base, ideally, will derive from reputable and well conducted clinical trials, of treatment or management of a similar illness to the population to whom the standard will apply. Such evidence may not be available, and a consensus on what is good practice may have to suffice. Taking into account other recognized standards or clinical guidelines from elsewhere is always good practice. The language should be simple, the focus should be on clinical issues, and other

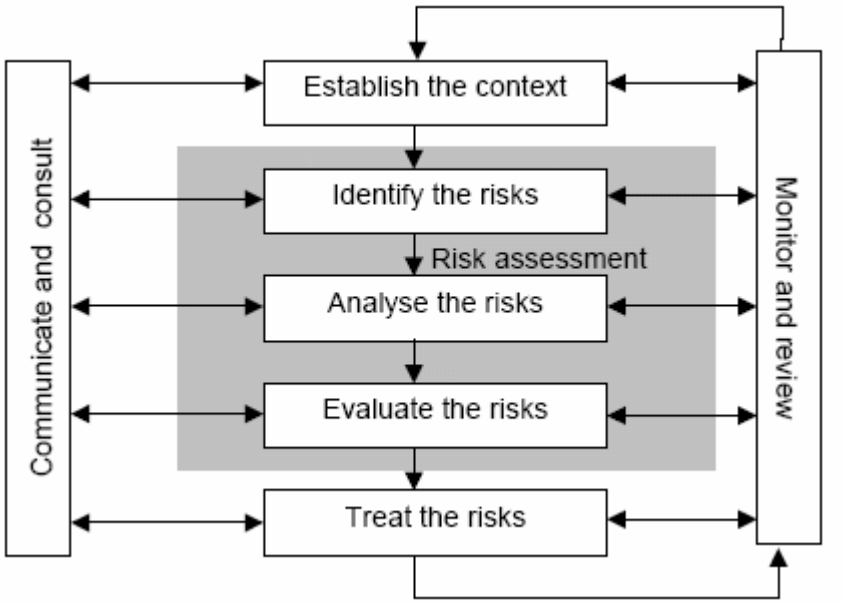
matters should only be included if they impact on clinical care. Healthcare professionals may develop the first draft of a standard, but it is better to have service users, those who care for them at home, workers from partner organizations and members of the public involved from a very early stage. There is no getting away from wide and lengthy consultation before they are finalized. Even then regular review, updating and revision will be required. "Achievable, but stretching" is one way of describing the level of difficulty which a standard should aim for. Enlightened leadership is required matched by a willingness on the part of staff to be led. This does not develop instantaneously and has to be earned over time.

2.4 Risk Management

Risk Management is defined as "the culture, processes and structures that are directed towards realizing potential opportunities whilst managing adverse effects" *(Australia/New Zealand Risk Management Standards 4360:2004).* To be most effective, risk management must become part of an organisation's culture, embedded into its philosophy, practices, and business processes. Any tendency to view it as a separate activity may be dangerous in a real sense. As part of the culture, everyone in the organization becomes involved in the management of risk. It is mandatory that NHS Boards have systems and processes in place to manage risk.

The healthy risk management culture is proactive, takes active steps to identify, and then reduce identified risk to acceptable levels. Assessment and prevention take priority over reaction and remedy. By informed decision-making, a safe and secure environment can be provided for patients, staff and visitors, often at a lower cost, through efficient and effective use of resources. In Scotland NHS QIS has responsibility for overseeing the standard setting and assessment processes associated with this for NHSScotland. It is also supporting a national standard methodology within NHS Scotland for the management of risk, building on the Australia/New Zealand Risk Management.

The Australia/New Risk Management Standards define the generic risk management processes as follows:



2.6 Clinical Governance and Risk Management Standards

In January 2004, *Draft Standards for Healthcare Governance: Working towards Safe & Effective, Patient Focussed Care* were issued by NHS QIS for consultation. The key messages received back from the service were that NHS QIS should reclaim the patient and clinical focus of the standards. Therefore the draft has been revised and reissued (April 2005) for further consultation *(Clinical Governance & Risk Management – achieving safe and effective, patient-focussed care* consultation on draft national standards NHS QIS 2005). These will help everyone concerned in these areas not only to understand and apply common principles of good clinical governance, but also to assess the strengths and challenges of current practice and improve it. All aspects of clinical governance are mutually supportive. Good clinical governance encourages public trust and participation that enables services to improve. Bad clinical governance fosters low morale and the adversarial relationships that lead to poor performance, a raised risk of critical incidents and ultimately to producing the dysfunctional organization which is so difficult to turn around.

The standards will be supported by a self assessment framework, it will contain the operational detail, measurable criteria and outcome indicators which will be used to assess performance.

Further Reading

International Standards Organisation (1986) *ISO 8042: Quality Vocabulary.* Geneva: ISO

Juran: Quality and a Century of Improvement (2004) Kenneth Stephens ed. Book Series of the International Academy for Quality Vol 15. American Society for Quality, Wisconsin USA

AS/NZS 4360 (2004) Standards Australia International Limited, Melbourne

For a general discussion, see *What makes a Good Healthcare System – comparisons, values and drivers* (2003) Alan Gillies (ISBN 1 85775 921 4) Radcliffe Publishing, Oxford

CHAPTER THREE

Users', Carer's and Victims' perspectives on forensic mental healthcare standards

3.1 Users' perspectives

Patient Focus and Public Involvement (Scottish Executive 2001) recognises that it is no longer good enough to simply do things ***to*** people; a modern healthcare service must do things ***with*** the people it serves. It aims to achieve:

- a service where people are respected, treated as individuals and involved in their own care
- a service where individuals, groups and communities are involved in improving the quality of care, in influencing priorities and in planning services
- a service designed for and involving users.

The framework, which has four broad themes: building capacity and communications; patient information; involvement; and responsiveness aims to make this change in culture a reality. Success in achieving the aims of *Patient Focus and Public Involvement* will ensure that the health service is responsive to these needs and is focused on action to meet those needs. It is an important part of the quality agenda of continuing service improvement.

Our National Health: A plan for action a plan for change (Scottish Executive 2001) states that a patient-focused NHS, will:

- maintain good communications, including listening and talking to patients, public and communities;
- know about those using the service and understand their needs;
- keep users of the service informed and involved;
- have clear, explicit standards of service;
- maintain politeness and mutual respect;
- have the ability to respond flexibly to an individual's specific needs;
- ensure effective action is taken to improve services; and
- talk with users, the wider public and communities.

These characteristics need to be kept at the forefront of delivering change in the NHS.

The Health White Paper, '*Partnership for Care*' (Scottish Executive, 2003), requires the public, including users of a service, to be involved in discussions about the changing pattern of healthcare services with decisions taken in an open, honest and informed way. This means seeking the public's views from the earliest stages, defining issues clearly, exploring possible options, and examining these in an open way with good evidence.

It is therefore firmly established that proper account must be taken of user views in any development of mental health services, and that this is a necessary part of improving quality in services.

Within a forensic patient population there are particular difficulties in securing the views of users. One problem is the power differential between professionals and patients caused by compulsory detention. All patients in secure settings are detained under a section of either the Mental Health or Criminal Procedures Act. Also, a large proportion is likely to be restricted. For a detained patient to participate in a group with professionals is made problematic by perceptions that their contribution might be biased or tempered to curry favour or at least avoid opprobrium. There are also problems with ensuring confidentiality and avoid press interest in any published document, focusing solely on one of the authors and not the content.

We decided to commission the Scottish Development Centre for Mental Health (SDC) to independently perform an exercise designed to elicit the views of users about standards in a variety of inpatient settings. However, it was deemed necessary for this exercise to be scrutinised by the relevant Medical Research Ethics Committee.

This raises the important question of the role of research ethics committees in such work. User involvement is neither the same as consulting a professional group nor is it medical research. We should be engaged in user consultation but full ethics committee scrutiny of every consultation exercise is at best going to delay the stage at which patients or users are involved or consulted on developments. At worst, this hindrance will reduce the amount of consultation. However, the consultation process is with a potentially vulnerable group whose rights require protection.

We hope to subsequently publish the results of the user consultation, but it would obviously have been much more desirable for this contribution to be part of the drafting of this document rather than be effectively part of the wider consultation process.

We invite the Scottish executive to review guidance on user consultation and specifically those occasions which also require Research Ethics Committee application.

3.2 Carer's Perspective

A Carer's Perspective
by Crawford Little

Introduction

As the only non-professional member of the Forensic Network Care Standards Group, I have been invited to add some personal comments to the Care Standards document. I should stress that while I was nominated by the National Schizophrenia Fellowship (Scotland), I did not attend the Group as NSF (Scotland)'s representative, but as an individual with experience of caring for a family member, and the following comments are entirely my own.

Previously, I was asked to prepare a document outlining concerns about care standards that I, as a carer, thought should be addressed. Some have been considered, while others have not. Perhaps this reflects the gulf between what health professionals describe as care standards, and what others might perceive as standards of care. It is my hope that at some time in the future a working group will be set up to report on the standards of care that a service user (and their carer or carers) might expect in various levels of security - in which respect for a patient's privacy, care during attendance at court, acceptable levels of restraint, the control of bullying and intimidation, complaints procedures, provisions for adolescent patients, suitable visiting arrangements, continuity in staffing, informed compliance with medication and similar issues would receive closer scrutiny than, say, the siting of man-hole covers.

Best Intentions

Leaving all that aside, my main concern was and is about how "best intentions" might be brought to fruition. In this, I find myself echoing the concerns expressed in the Scottish Executive's An Introduction to The Mental Health (Care and Treatment) (Scotland) Act 2003, which acknowledges that the objective of making sure people with mental disorder can receive effective care and treatment "depends on more than what the Acts says. It also depends on the policies, practices and actions of a wide range of organisations and individuals, and on how well they work together." And what is true of that Act will be equally true of these Care Standards.

Any gap between setting standards and ensuring their implementation could be mitigated by a concerted effort to avoid ambiguity - and clearly defining which organisation or individual is responsible and ultimately accountable. I say this in light of recent (mid-December 2004) statements in the press and parliament that reveal a confusion over such fundamental issues as who makes a risk assessment - hospital staff or local police force - and who takes ultimate responsibility for approving unescorted visits - political, medical or managerial. Certainly, it raises questions about how well these individuals and authorities will or can work together…

A Carer's Perspective

Early Intervention

To return to the beginning of care standards, it is surely important to acknowledge that many admissions to secure units are precipitated by a failure in primary care. A failure to diagnose, treat and make a proper risk assessment (a failure prompted by the policies, practices and actions of an organisation or individual) can lead to the confinement of an individual who, if treated, might not have posed a risk to the public or to themselves - or demand confinement in a higher level of security than would otherwise have been deemed appropriate.

If the standards of care and the "policies, practices and actions of the wide range of organisations and individuals," with responsibility for early intervention, diagnosis and treatment were concerned with achieving standards of excellence in how well they work together, there would be far fewer admissions to secure mental health facilities via the criminal justice system.

Regarding the team approach to early diagnosis and treatment, greater efforts could be made to identify high risk groups - with the provision of appropriate early standards of care for same – possibly including what some describe as an early warning system for mental illness to pre-empt violence. This would require the patient to be seen without delay by that member of the clinical team who is professionally qualified to make a diagnosis and initial risk assessment. As well as possibly reducing the number of admissions to medium and high secure units; such early intervention would clearly serve to protect the public and the patient's family.

This touches on how professionals will discharge their specific functions under the Mental Health Act. While acknowledging the need to respect an individual's rights and an understandable reluctance to jump to conclusions or apply labels, in those cases where a failure to diagnose and treat at an early stage leads to injury or worse to a third party, and a long period of confinement and restriction for the patient, it might be concluded that it would have been better to be safe than sorry, to use a layman's expression. There again, it is relevant to consider why so many professionals are reluctant to make a definitive diagnosis – other than the obvious explanation that they are undecided. Might it be that they are very aware that while it is one thing to get a patient into the secure mental health system, it is quite another matter to get them out of it?

A Unique Position

In preparing care standards, setting levels of security, denying basic freedoms, or simply ignoring or responding to sensationalist headlines in the press – do we remember that many service users are confined in a secure environment not for committing a crime, but because they are judged to have the potential to do so? One is tempted to compare society's acquiescence in this with outpourings in the liberal press when an individual is confined on suspicion that he has the potential to commit acts of terrorism.

A Carer's Perspective

If I might be excused for suggesting the ridiculous in order to illustrate the sublime - statistics show that the highest risk of violence is from young men under the influence of drink and-or drugs. Should all weekend revellers be confined to prison for an indefinite period on the basis of a professional assessment of what they might do, in the sure and certain knowledge that they will be in that same condition of intoxication on many nights in the year?

I would not wish it to be assumed that I am objecting to the confinement of individual's with serious mental health problems - following proper diagnosis and risk assessment. Instead, I am endeavouring to highlight the unique position of those with mental health problems, and therefore the importance of making full and proper risk assessments - and subsequently to conduct full and regular case reviews – and that any decision on a stepping up or down in security levels should be made on the basis of medical opinion, rather than to satisfy the requirements of political expediency. In regard to restricted patients, might we consider how standards of care could be improved by achieving a better balance between care and treatment, on the one hand, and the reaction of politicians to media and other pressure, on the other? A reaction which seems to involve increasing the level of restriction on patients across the board – irrespective of the individual's medical and social progress. A system in which tabloid journalists may have more influence than consultant psychiatrists…

Early Confinement

Regarding people with mental disorder within the criminal justice system immediately following arrest and interview, if the medical opinion is that the individual is vulnerable and should not be transferred to a prison, surely alternative facilities must be available? Might the precautionary principal of automatically placing the patient in a high security environment – perhaps until they have proved they don't need it – be applied? Will this decision be made in accordance with the needs of the patient, or on the availability of beds? In either case, how does this fit with the provisions of the new Mental Health Act, regarding the minimum restriction of the patient that appears to be necessary in the circumstances?

As more alternative (low and medium secure) facilities are provided, courts will surely be obliged to make better informed judgements on what level of security is required for an individual – rather than accepting that some security is required and the State Hospital is the only option. This will require early risk assessment – before rather than after admission. Within medium and low security units, still to be built throughout the length and breadth of Scotland, will there be dedicated facilities for making full and proper risk assessments? One is aware that in the State Hospital, such an assessment is made only after weeks or months of intense observation and enquiry. Compare that with the current situation in courts, where a psychiatrist may be required to make a diagnosis and risk assessment on the basis of one short interview.

A Carer's Perspective

Regarding Assessment, Treatment and other Orders as introduced by the MHA, will they differentiate between diagnosis and risk assessment? Will it be within the scope of an assessment to consider whether a patient being judged as a risk to others or to themselves might, at one and the same time, be at risk from others? If so, then might it be possible to avoid, say, mixing adolescents with paedophiles. Or placing one adolescent into an otherwise adult patient group. Or mixing vulnerable psychotics with manipulative psychopaths, if you will excuse the phrase and implication.

Defining the Risk

Some definitions may leave things open to individual interpretation, and therefore to appeal. For example, the working group was presented with a document setting out various criteria on which appropriate levels of security might be decided. These included one of the primary concerns of those committed to secure units (and their carers and families), which is the risk of violence from other patients. Surely, the system has a duty of care to ensure that such a risk is at least minimised?

The document stated that "Medium or high risk of life-threatening in-patient violence" demands high security, but "Medium or high risk of serious, but not life-threatening, in-patient violence" suggests medium security. But some might ask how a high risk of serious violence can ever be described as not being life-threatening. And therefore some might apply the precautionary principle of stating that either risk – medium risk of life-threatening or high risk of serious - demands a high security response. However, the Act sets out a principle requiring "the person discharging the function to do so in a way which … involves the minimum restriction of the patient that appears to be necessary in the circumstances." And so the judgement must be made.

Of course, it can be justifiably argued that the risk of in-patient violence is not the only criteria on which a decision is based. But this argument assumes that those other considerations do not demand equally subjective judgements on shades of grey, rather than black or white.

Quality of Support

Returning to the Scottish Executive's concerns regarding the policies, practices and actions of a wide range of organisations and individuals, and on how well they work together, their document went on to acknowledge that it also depends, in part, on, "how service users and carers are supported and encouraged to participate in their care and treatment."

Part of that support and encouragement must involve a determination to provide service users and carers with full, clear and reliable information. Should this principle be enshrined in Care Standards? And not simply so that somebody can place a tick in the inclusion box … Many carers feel that their role is that of the Victorian child - seen, but not heard. It is one thing to create Care Standards, but something altogether different to ensure that professionals will listen, as well as hear… Will this happen? Will service users and carers be supported and encouraged to participate in their care and treatment - remembering that the Mental Welfare Commission's report in to the care and treatment of Noel Ruddle found it necessary to make the recommendation that "Responsible Medical Officers in the State Hospital should have all security, medical and other information relevant to patients in their care made available to them"? If that reflects the position for RMOs just a few years ago, then what hope for service users and cares today? But perhaps we have progressed a very long way in a very short time…

The Provision of Facilities

As already discussed, the Scottish Executive have acknowledged that the objective of making sure people with "mental disorder" can receive effective care and treatment "depends on more than what the Acts says. It also depends on the policies, practices and actions of a wide range of organisations and individuals, and on how well they work together." Of course, this includes themselves and the various Scottish Health Care Trusts who have responsibility for the provision of the full range of suitably designed and properly staffed secure mental health facilities…

The MHA gives patients (and others on their behalf) the right to appeal against detention in conditions of excessive security. This begs a question …What if the appeal is successful, but no beds are available in units with lower security? In planning and designing medium and low secure units, it would be better to over rather than under estimate requirements. It would be better if such units always had a few empty beds, rather than waiting lists. The alternative is that patients will inevitably spend time in levels of security that are excessive. The State Hospital will remain, in part, a high security transit camp for patients waiting for a place in medium or low security units.

I express these concerns in the belief that original estimates for the number of beds required in a proposed medium secure unit in the West of Scotland have been cut to the bone, and then some. At the same time, I am aware of plans to close a rehabilitation unit, which many regard as a vital step between a secure environment and the community.

Mental health professionals and court officials may be forced to decide whether a patient requiring a low secure environment, when a bed in such a unit is not available, should be transferred to or kept in a medium or high security alternative. Public safety might suggest the latter, but the patient and his family (and legal representative) might choose to differ.

A Carer's Perspective

As anybody who has experience of the State Hospital, Carstairs, and the Orchard Clinic, Edinburgh, will probably agree: the higher the security, the more the balance shifts away from treatment and toward confinement and protecting the staff (and other patients, and the public). As the level of security falls, then the more the balance shifts toward treatment, rehabilitation and eventual repatriation to the community. But the rehabilitation work of medium secure units will be confounded if there is an inadequate provision of local, low secure facilities as that final and vital step toward rejoining the community. Will decisions on provision or maintenance of such facilities be made by clinicians or accountants?

A very significant proportion of the current patient population in the State Hospital does not require confinement in a high security facility. Estimates seem to vary, but it was reported in The Sunday Times that the State Hospital's Chief Executive, Andreana Adamson, has told ministers that 100 patients are being held in inappropriate accommodation. In recognition of this, in the past there has emerged what might be described as a transitional stage, somewhere between high and medium secure, neither one nor the other, but within a high security setting. However, as that part of the patient population which does not require high security is transferred to medium secure units, then the transitional stage might fade and finally disappear, leaving an exclusively high security environment. A glimpse of the future was presented by Adamson in a fairly recent statement to The Scotsman. "People eligible for unescorted leave shouldn't be in the State Hospital in the first place". But they will be, until such time as there are more beds than patients in dedicated medium secure units. And the need will still exist for that transitional environment within a high security setting. Perhaps this introduces the question of whether the level of security should be defined on a hospital or ward basis.

There are two sides to the coin of maintaining "the minimum restriction of the patient that appears to be necessary in the circumstances." Another very real concern arising out of any shortfall in bed numbers is that standards of care would be compromised if pressure for admissions was transmitted into a pressure for the premature release of patients to units with inadequate security, or into the community which, for some, will be a return to their family homes. In this regard, the rights and safety of the family and carer, as well as public safety, might need to be highlighted.

A carer's desire to see progress should not be translated as volunteering to act as part of an unpaid work force - though they might not complain openly, because to do so could sour their relationship with a friend, partner or family member. There does seem to be a naive assumption in the Mental Health Act, in regard to the Mental Health Tribunals, that the carer will always be seeking to have the patient's restrictions reduced. However, one can picture circumstances in which a carer might wish to object to a reduction in security – or even seek to have it increased. The establishment may be happy enough to talk about assessment in terms of public safety, but the statistics reveal that it is "the family" who are at a very much higher risk. At the same time, there is an assumption that a carer or carers will be on hand to fulfil the function dictated by the establishment. This ignores (while creating) one of the major concerns faced by the ageing parents of those with mental health problems.

A Carer's Perspective

A Caring Environment

The Care Standards Group has spent considerable time discussing building standards, but surely environments are shaped by people rather than fixtures and fittings? I am talking here about the patients and staff. Rights and restrictions, and attitudes and atmospheres within wards, rather than razor wire on perimeter fences, surely make the real difference between low, medium and high security unit in terms of standards of care – certainly from the patient's point of view. Within a ward setting, the attitude of just one member of staff might mean the difference between a high and medium secure environment. Or the difference between a sense of harmony, however fragile, and conflict or threat. Equally, the presence of one patient might demand change, irrespective of the rest of the patient group. I think we should be cautious in defining what is high, medium or low secure simply in terms of whether or not there are motion detectors on the perimeter fence and which way the windows are facing.

There may be many ways in which standards of individual care, rather than simply conditions of confinement, could be improved by achieving an appropriate balance between the two. In suggesting standards of care, if we are talking about individuals within a ward rather than patient groups within a hospital, we surely need to be very careful in suggesting a "one size fits all" approach in regard to confinement and security arrangements.

Can staff as well as patients show symptoms of institutionalisation and resistance to change and if so, what can be done in order to ensure that medium secure standards of care will be applied from the outset in new-build, medium secure settings? There is a possibility that as medium secure facilities become available, mass transfers of patients from the State Hospital, accompanied by those staff who are no longer required due to the reduction in patient numbers, might conceivably result in high security policies and practices being transferred directly into a medium secure setting. For example, staff in high security units are reassured that they can be differentiated at a glance from the patient population and by putting the nursing staff in uniforms, this allows the patients to suit themselves. However, this raises a question about the patients' perception of the nurses. Equally, it might raise questions about the nurses' perception of themselves. On the other hand, in one low security unit where there are no guidelines on clothing, there have been complaints from some patients who feel intimidated by staff members wearing the colours of football clubs with a sectarian history.

What constitutes "reasonable force" in restraining patients? What "disciplinary measures" are acceptable in reference to high, medium and low security units? Let us not pretend that they do not exist … Again, as part and parcel of standards of care, we might need to consider the role of nurses in this. Not least, how does it effect the patients' perception of the nursing staff when they witness "the caring profession" involved in physical restraint and disciplinary measures?

A Carer's Perspective

The day-to-day life of a patient in a secure environment may involve nothing more than sleep, television and eating - leading in a fairly short time to institutionalised sloth, or worse. It may be a manifestation of negative symptoms, and otherwise it might be argued that you can take a horse to water … But the fact is that some patients, seeking specific courses or activities, find there are long waiting lists - though this is often denied. In setting standards of care, should we highlight the need for the provision of more activities with wider appeal, and that such activities might be suited to individual needs? For example, a patient admitted from an art college might not be too enthusiastic about colouring in by numbers with felt tip pens.

Aspects of physical health might also be addressed. For example, while respecting the right of an individual to choose not to exercise, smoke excessively and eat a defective diet, how is this balanced against the inevitable deterioration in their physical health over a prolonged period?

If medium and low secure units are the means to the end of recovery, rehabilitation and return to a more normal life, then the goal may be defined as care within the original home, or with the close support of the individual's family. In relation to these eventual standards of care, might we consider solutions to those cases where the service user's insistence on confidentiality impinges on their carers' ability to function effectively? As I mentioned earlier, I think it would be a mistake to assume that carers will only seek to have security and restrictions reduced. If we accept the possibility that sometimes the carer might seek to have these maintained, or even increased – despite the wishes of the patient - then providing the carer with full and proper information might create a very knotty problem indeed… At the same time, might we consider, as part of overall standards of care, what levels of knowledge and-or training are required by those on who society places the burden of eventual care?

I have far exceeded the space I was allowed, so shall close with one final concern. It may be understandable that in the short term the catalyst in providing low and medium secure mental health facilities is the threat of legal appeal from the large number of patients currently held in inappropriately high levels of security. In the longer term, however, perhaps the balance will shift more towards recognising the basic human rights of those who, through no fault of their own or their family, develop a mental health problem or disorder which is defined as requiring a period of confinement within a secure environment. A recognition that legal expediency isn't the only reason for ensuring the minimum restriction of the patient that appears to be necessary in the circumstances…

3.3 Victims' perspectives

It is logical to follow the section on carers with that of victims as the most common victim of offending behaviour involving an MDO is a family member or carer. Users and carers may also identify themselves as victims of inadequate past health or social care. Victim issues in Criminal Justice have broadly developed in Scotland and internationally. When the injured party has been hurt by a MDO there are particular difficulties principally because of medical confidentiality and because traditionally forensic services only liaised with victims who had an ongoing relationship with the patient.

In jurisdictions such as Canada, the court may consider a victim impact statement prior to sentencing (International Association of Forensic Mental Health Services Conference 2005) In New South Wales, victims have the right to make representations to mental Health tribunals considering the release of MDOs (International Association of Forensic Mental Health Services Conference 2005) In England the Zito Trust has campaigned for similar victim involvement (written evidence to the Joint Committee on the Draft Mental Health Bill). In Scotland, the MoP expects victim issues to be addressed when considering a restricted patient's move to lesser security, leave or conditional discharge. No systems are in place to specifically support victims of MDOs and clinical teams are dependant on the patient's consent to liaise with victims. Patients may only consent because they know this will speed up their clinical progress. In such a potentially coercive situation the validity of that consent could be challenged. Victims may be contacted many years after the offending behaviour without much warning or organised subsequent support.

There is therefore a need for this particular area to be subject to further examination and the establishment of an expert group.

CHAPTER FOUR

Current Clinical standards applicable to forensic psychiatry in Scotland and those to become applicable following the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003.

4.1 Introduction

A bewildering array of standards applies to forensic mental healthcare, but they vary in how specific they are in terms of the speciality and how authoritative they are in the Scottish context. The items referred to in this chapter are selected because they have particular relevance to the day-to-day practice of forensic mental healthcare in Scotland. There is therefore inclusion of specific forensic mental healthcare material which has a range of authoritative importance. Health and Safety legislation, employment law and financial management are examples of authoritative and relevant material but their scope would effect many public and private organisations and so are not included here. This section is therefore far from exhaustive in terms of the responsibilities on forensic healthcare services.

The more specific and authoritative the standards the more influential they are in forensic practice. The most authoritative material is that enacted by parliament. There is an almost absolute standard to comply with legislation. Included in this chapter is information on the Mental Health (Care and Treatment) (Scotland) Act 2003 which is currently in the process of implementation.

Certain para-statutory material approaches statutory authority, the clearest examples of which are Codes of Practice to legislation. Whilst not legally binding in themselves, if there was a case of negligence considered by the court the provisions of a Code of Practice are likely to be seen as authoritative and if referred to in a judgement may then form part of the common law. Lack of awareness of the provisions of the Code or resource constraints is unlikely to reduce the obligation or requirement to comply. It is likely that a practitioner or service would have to demonstrate that an aspect of the Code is not followed for good reason by a body of practitioners or a relevant aspect of the Code is inconsistent with some other statutory provision.

If a court was considering whether clinical conduct amounted to a reasonable clinical standard in a negligence case, other documents are also likely to be authoritative. Official guidance from the Scottish Executive in the form of Health Department Letters or other official publications would be a good example. Adherence to such guidance would also be a managerial matter monitored in the NHS by mechanisms of clinical governance. Standards set by NHS QIS, its predecessors and professional bodies could also be seen as similarly important. The Schizophrenia Standards referred to below and the Adult Mental Health Standards are clearly applicable to forensic mental healthcare. Although some items do not apply, the vast majority do and where these standards are comprehensively implemented, they would by themselves ensure a high standard of clinical care in forensic settings. Guidance from other similar jurisdictions, such as England, may also be seen as influential.

Finally, this chapter identifies gaps in the current standards which will then be addressed in the following chapter.

4.2 Principles in Mental health Legislation

Any recommendations regarding care standards for forensic psychiatric services must take account of the principles laid down in relevant legislation. The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 underpin any decision made relating to a detained patient in Scotland and therefore pertain to the vast majority of forensic mental healthcare inpatients (The Mental Welfare Commission has given guidance that voluntary inpatient status is inconsistent with any patient care in a locked environment). The principles are:

- **Non-discrimination** – People with mental disorder should, wherever possible, keep the same rights and entitlement as those with other health needs.

- **Equality** – All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national, ethnic, or social origin.

- **Respect for diversity** – Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds.

- **Reciprocity** – Where an obligation is imposed on an individual to comply with a programme of treatment or care, an obligation is also imposed on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

- **Informal care** – Wherever possible, care treatment and support should be provided should be provided to people with mental disorder without the use of compulsory powers.

- **Participation** – Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully.

- **Respect for carers** – Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

- **Least restrictive alternative** – Service users should be provided with any necessary care, treatment and support both in the least invasive and least restrictive way, and in a place that allows the delivery of safe and effective care, taking into account the safety of others, where appropriate.

- **Benefit** – Any intervention under the Act should be likely to produce a benefit for the service user.

- **Child welfare** – The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.

The Mental Health (Care and Treatment) (Scotland) Act 2003 will be implemented in 2005. The Act will introduce: Mental Health Tribunals; a right of access to independent advocacy; a requirement to encourage participation by users and carers; and the need to take account of Advance Statements and the views of

Named Persons. There are also enhanced duties for Mental Health Officers in the provision of reports and opinions which will mean a substantial expansion of their role in forensic mental healthcare.

For those patients incapable of decision making there are also the additional safeguards of the Adults with Incapacity (Scotland) Act 2000. Although most mental health treatment decisions with a forensic population will be subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 the AI(S) A 2000 is relevant to decision making in relation to physical treatment, welfare, and management of finance of Mentally Disordered Offenders, if incapacity is an issue. Any intervention pursuant to the AI(S) A 2000 is also subject to the principles of that Act, which have some similarity to those of the MHA 2003 Act.

The adoption of guiding principles that underpin Scottish mental health legislation has been widely welcomed. In the context of this report, however it is their translation into meaningful standards which would yield measurable indicators of clinical performance and drive quality improvement that is the challenge. The same can also be said of another piece of legislation founded on principles: The Human Rights Act 1998

4.3 Human Rights Act 1998

The Human Rights Act is a wide-ranging piece of legislation which adopted the European Convention on Human Rights into Scottish law as Scotland regained its Parliament. All new legislation and all working of public bodies must be consistent with the Human Rights Act. Within the Act, there are Absolute Rights i.e. those which are set out without reservation or qualification where interference is unjustifiable and there are Qualified Rights where interference with individual rights is permitted (for example where this is necessary to protect the rights and freedoms of other people) subject to safeguards.

The Absolute Rights are: - Article 2 – Right to Life, Article 3 – Prohibition of Torture, Article 4 – Prohibition of Slavery and Forced Labour, Article 7 – No Punishment without Law.

Qualified Rights include Article 5 – Right to Liberty and Security, Article 6 – Right to a Fair Trial, Article 8 – Right to Respect for Private and Family Life.

Forensic mental health services require to examine their practice in light of many articles of the Human Rights Act.

Article 3 – Prohibition of Torture states, “No one shall be subjected to torture or to inhuman or degrading treatment or punishment” has implications regarding treatment and conditions of detention of patients. In determining whether a breach has occurred, a number of factors will be considered including the nature and context of the treatment, how it is carried out and its physical and mental effects.

Article 5 – Right to Liberty and Security is a Qualified Right. “No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law”. The Article then goes on to list specified permitted interferences with the Right to Liberty and Security including in Sub-section (e) “the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants”. Under Article 5, “Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall

be decided speedily by a court and his release ordered if the detention is not lawful".

Article 6 – Right to a Fair Trial includes access to independent advocacy and legal counsel. This Article implies that patients should have the right to a fair hearing, access to an independent and impartial court or tribunal. In addition, they should have the right to be heard within a reasonable time, the right to representation, the right to disclosure and the right for the evidence to be tested in an adversarial process.

Article 8 – Right to Respect for Private and Family Life and Correspondence

- Everyone has the right to respect for his private and family life, his home and his correspondence.
- There shall be no interference by a public authority with the exercise of the right except such as is in accordance with the law and is necessary in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Any interference with human rights must be justified on the grounds of lawfulness, a legitimate aim and proportionality.

Darjee and Crichton (2005) have reviewed legal judgements within the scope of the Human Rights Act 1998 and forensic mental healthcare. They concluded that, in those cases which have been tested in Court, there has been less impact on various practices thought potentially to be non-compliant than was at first thought likely.

However, the European Convention on Human Rights and the subsequent Act are "living instruments" and are responsive to the state of society; a practice which is judged now to be compliant could in the future be judged to contravene the Act.

4.4 Health, Social Work and related services for Mentally Disordered Offenders in Scotland NHS MEL (1999) 5

NHS MEL (1999) 5 is the key policy document regarding Mentally Disordered Offender and the provision of forensic mental healthcare in Scotland. The policy adopted a set of guiding principles, summarised in chapter 1.2 above, which have influenced the principles in the legislation described in chapter 6.2 above.

4.5 National Care Standards for Independent Hospitals

The standards which apply to independent hospitals in Scotland are described in section 1.13 and include specific standards for mental health. Full details can be found on the website.

4.6 Clinical Standards for Schizophrenia

The majority of patients receiving treatment in forensic psychiatry services suffer from schizophrenia. Therefore the *Clinical Standards for Schizophrenia* produced by the Clinical Standards Board for Scotland in January 2001 are particularly relevant (CSBS, 2001). What is striking, is the extent to which the standards embody the principles outlined above. A full copy of the standards can be found at the Forensic Network website. There is detail about how the standards can be met and information about certain of the standards which do not apply in a forensic setting. The Forensic Network website also reproduces the NHS QIS national overview of how well Health Boards met certain of the standards – the

State Hospital performed well and the results from the State Hospital are also available. The schizophrenia standards can also be broadly applied to other psychotic disorders such as schizoaffective disorder, bipolar affective disorder and unipolar psychotic depression. They are therefore relevant to over 90% of the likely inpatient forensic population.

The standards have the following headings:

- Information on Populations and Individuals
- Initial Diagnosis
- Initial Assessment and Care Planning
- Ongoing Assessment and Care Planning
- Transferring Care – Admission to Hospital
- Transferring Care – Discharge from Hospital
- Information and Support for Carers
- Prescribing Anti-Psychotic Drugs – General Principles
- Prescribing Anti-Psychotic Drugs – Special Circumstances
- Social and Psychological Approaches to Care
- Misuse of Alcohol and Illicit Drugs

4.7 QIS Standard: Admissions to Adult Mental Health In-Patient Services

This best practice guide produced by QIS is divided into 6 sections covering various aspects of treatment. This is available on the Forensic Network website and is applicable to forensic mental healthcare in Scotland.

The six sections are:

- Risk assessment and management.
- Pre-Admission/Initial Assessment Need.
- Admission to Hospital
- Assessment and Care Planning.
- Assessment of Psychosocial Needs
- Discharge Planning.

4.8 Occupational Therapy in Forensic Residential Settings

This guidance was published by the College of Occupational Therapists in January 2003 and has applicability to the United Kingdom. It sets standards of particular relevance to OT activities, the OT role in the forensic MDT and therapeutic interventions. The standards specify how criteria are to be evaluated and give references supporting why a standard has been set, including much information from the Scottish policy context. The text of the standards can be found on the Forensic Network website and are applicable in Scotland to a wider range of professionals than Occupational Therapists.

4.9 Social Work Services for Medium Secure Care.

In August 2001 the Social Services Inspectorate of the Department of Health issued *National Standards for the Provision of Social Care Services to High Security Hospitals.* (These can be viewed on the Forensic Network website, www.show.scot.nhs.uk/forensicnetwork) This document incorporated many of the recommendations of *The Lewis Report, the Review of Social Work in High Secure Hospitals*.

As part of their work members of the Lewis Committee visited South Lanarkshire Council to inquire about the arrangements for the provision of social work services to the State Hospital.

The report identified standards for the arrangement and provision of such services including the important partnership required between local authority and health services, to ensure high quality and effective services. The report also identified core tasks to be delivered by such services. Key performance indicators have since been developed in relation to these activities.

While the standards formally apply principally to the High Security Hospitals in England, this approach is being considered in relation to its possible applicability to set consistent standards for medium secure care in England. The report was also subsequently circulated to local authorities in Scotland, by Social Work Services Inspectorate of the Scottish Executive.

A similar process of identifying core tasks that reflect the statutory duties and essential activities required of the social work service has been adopted in the development of a service specification for the State Hospital social work service.

It is proposed that the following standards and core tasks may provide a template for the arrangement and provision of social work services to medium secure care.

It is understood and acknowledged that there are certain essential core activities that are a requirement in the arrangement and provision of such social work services. These include the provision of assessment and care management services; Mental Health Officer services; criminal justice social work services; and effective child protection services.

4.10 Standards for Social Work Services for Medium Secure Care

Social work services to medium secure care should seek to provide the following core activities:

4.10.1 Pre – Admission

- Social Work / MHO Assessments in relation to all referrals.

4.10.2 Admission

- Allocation of a named social worker and designated MHO for all admissions.
- Provision of a comprehensive social work assessment for all admissions
- Provision of a MHO assessment and opinion in relation to all admissions.
- Ensure all families and carers are offered assessment and support as required.

4.10.3 Through Care

- Social work attendance at all patient reviews.
- Liaison with local services as required.
- Support on-going family carer contact.
- Provision of statutory mental health and criminal justice reports as required.
- Provision of MHO assessments, reports and opinions as required in relation to all reviews of compulsory powers.

4.10.4 Transfer and Discharge Planning

- Provision of comprehensive community care assessments to identify and address patients needs.
- Liaison with family / carers and arrange assessments and services as required.
- Liaison and collaborate with local services to support the arrangement of care packages as required.

4.10.5 Mental Health Officer Service

Provision of a comprehensive Mental Health Officer service to meet the statutory requirements of the Mental Health (Care and Treatment) (Scotland) Act 2003 and AWI Act 2000.

4.10.6 Mental Health Officer Service Standards

As all patients in medium secure care will be subject to powers of detention, the Mental Health Officer Service will have a significant role in the provision of care to patients and families.

In addition to the specific statutory duties arising from the Act, the standard and practice of Mental Health Officer Services will be shaped by the Mental Health Act Codes of Practice and associated regulations and guidance.

The Mental Health Officer Service will also have to meet the requirements of the National Standards for Mental Health Officer Services [See attached at appendix?] formally issued to Local Authorities and Health Boards by the Scottish Executive in March 2005.

4.10.7 Child Protection

- Provision of social work assessments in relation to all proposed child / patient contact.
- Management of child protection referrals in relation to disclosure or suspected abuse, in accordance with the requirements of the local inter-agency Child Protection Committee.

4.10.8 Child Visiting Policy / Family Visiting Facilities

The Medium Secure Care Service will require to have a child visiting policy, and dedicated off ward family visiting facilities.

The Medium Secure Service will require to have established formal links to the local Child Protection Committee.

Child visiting policies and family visiting arrangements will need to meet the requirements of the local inter-agency Child Protection Committee.

4.10.9 Risk Assessment and Management

Risk assessment and management planning will be addressed in the preparation of all social work reports.

4.10.10 Monitoring, Audit, and Performance Indicators

The core activities described above can be easily incorporated into monitoring and audit frameworks.
Currently many of the above activities are reflected in the State Hospital ICPs and subject to variance reporting. These activities can also contribute to the development and reporting of KPIs for senior managers and other appropriate bodies and organisations.

4.10.11 Commissioning and Management of Social Work Services

The arrangement of social work services for medium secure care may be supported through the development of service level agreements negotiated with the appropriate local authority(ies).

Further Reading
Social work services will carry out duties in accordance with responsibilities under the following legislation:

- Social Work (Scotland) Act 1968
- Mental Health(Scotland) Act 1984
- National Health Service and Community Care Act 1990
- Criminal Procedures (Scotland) Act 1995
- Carers Act 1995
- Children's Act 1995
- Mental Health (Detention) Act 1991
- Mental Health (Patients in the Community) Act 1995
- Mental Health (Public Safety and Appeals) (Scotland) Act 1999
- Prisoners and Criminal Proceedings (Scotland) Act 1993
- Sex Offenders Act 1997
- Adults with Incapacity Act 2001
- Mental Health (Care and Treatment) (Scotland) Act 2003

4.11 National minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments

In England, the Department of Health in May 2001 commissioned the PICU Policy Research and Development Group based at North East London Mental Health Trust to produce national PICU and low security standards. The group produced the above paper. A PICU and Low Secure Practice Development Network was formed which consisted of a multi-disciplinary group of professionals and user representatives from around the UK. Although these standards apply to the English context and also to general adult PICUs they are useful to consider in the Scottish forensic context and can be found on the Forensic Network website.

4.12 Critical Incident Reviews

The *Memorandum of Procedures on Restricted Patients* requires Responsible Medical Officers (RMOs) to report any serious incident involving a restricted patient to the Scottish Executive and Mental Welfare Commission (Scottish Executive 2002). The definition of serious incident would include any major breach of security. However, there is no collation of this information distributed to RMOs or Multidisciplinary Teams working in secure settings. The Mental Health Reference Group for the Scottish Executive (2000) published guidelines on how to conduct critical incident reviews following security breaches but again there has been no collation or central repository of incident reviews in secure settings.

In England there has been a radical change in the way adverse incidents in the NHS are investigated following Sir Liam Donaldson's *An Organisation with a Memory* (publish, date). This marked a deliberate shift away from a 'blame culture' to one which encouraged openness and learning from mistakes. As a result of *An Organisation with a Memory,* the National Patient Safety Agency was formed, and they are developing systems of adverse incident review based on Root Cause Analysis.

Within the Scottish context, both QIS and MWC have a role in investigating untoward incidents and are currently deciding how their activities can be organised to avoid overlap.

4.13 Risk Assessment and Management Standards

The last ten to fifteen years have seen a great change in the approach to the clinical assessment of risk of violence. There has been a move from a position of a poor evidence base and operating on the clinician's "gut" instinct, to good quality research and knowledge on those factors that predict risk of future violence at a level significantly better than chance. There is a vast literature on the "science" of prediction, longitudinal studies looking at what predicts violence in different populations and a movement towards the use of this information and knowledge to clinically manage risk.

This has benefits not only for society in terms of better identification of those patients who may be violent in the future but also for individual patients. The latter should have detailed and rigorous assessment and a considered opinion given as to whether their risk can be managed outwith a high security environment. In the past "gut" instincts have often led to errors on the side of caution: to over predict violence (Monahan, 1981). This led to significant numbers of “false positives”; patients being detained who were unlikely to represent a future risk to others.

Anyone becoming involved with patients where the assessment and management of risk of future violence is important should be aware of the following:

- There is good agreement about what risk factors are most predictive of violent and sexually violent offending. The risk factors for mentally disordered offenders are the same as those for other offenders.

- Although statistical (or actuarial) tools have the best predictive validity in statistical terms, these assessment tools are of little utility when it comes to making an individual plan of treatment or care for a patient.

- There exist a number of protocols which use a system of Structured Professional Judgement to help guide a clinician’s judgement about risk (Historical, Clinical and Risk Management for risk of Violence, (Webster et al, year); Risk of Sexual Violence Protocol (Hart et al,2003) Psychopathy Checklist Revised (Hare et al, 1991), Risk Matrix 2000 (Thornton et al.,2000).

- Much of the research to date has been carried out in North America and this creates problems for a Scottish population. However, what studies have been carried out in other countries suggest that the risk factors are likely to be similar. What is different is the base rate of violence for different countries. Scotland, for instance, has a relatively low base rate for violence, and very low use of firearms, compared to North America, so the same level of violence cannot be predicted from a similar score on the same protocol in Scotland.

- Risk assessment is never an end in itself but should lead to a risk management plan that outlines how the risk factors identified can be managed, what treatment or interventions will help the person to reduce any risk they may continue to pose to others and what services or systems need to be put in place to ensure that the risk continues to be managed.

4.14 Recommended Standards in Risk Assessment and Management

A risk of violence (or sexual violence) assessment should be carried out in cases where an individual is considered to present a risk to others and that as a result of this his or her liberty is at threat. There should be formal procedures and protocols for carrying out an assessment of risk.

4.14.1 Protocols and assessment tools

Risk of violence assessments should be carried out using protocols or assessment tools that have proven validity for the category of people that the assessed person falls into (e.g. mentally disordered offenders, prisoners, sex offenders). Where no specific assessment tool exists to fit the person being assessed, it is most valid to use a variety of assessments. In most cases where mental disorder is also at issue, the assessment should consider not just statistical (or actuarial) assessment but attempt to place the risk the person presents in the context of his past history and his current offending.

More specifically this means:

- Personal and family history
- Criminal History and violent history
- Substance misuse
- Psychiatric history
- Assessment of personality disorder
- Other relevant risk factors for the population group the person falls into (e.g. sex offender risk factors)

4.14.2 Historical Factors Summary Document

On entry into forensic healthcare a summary document should be produced which is sufficiently detailed so that collection of data for the PCL-r or historical factors of the HCR20 does not have to be collected de novo in the future. A summary document should be designed which can be passed on to different forensic healthcare providers and can be updated as new information is made available.

4.14.3 Information sources

At no time in an assessment of risk of violence should judgements of risk be made on information collected entirely from the person himself. Practitioners should be aware of large volumes of notes which simply reiterate self-report from interviews with others. Strenuous attempts should be made to source collateral information from family members, police reports, criminal records and contemporary accounts of previous violent incidents that may be contained in other records (e.g. nursing notes of past violent incidents).

Protocols should be in place for ensuring that collateral sources of information are checked and that a summary of these are included in the summary document mentioned at 4.14.2 above.

4.14.4 Categorisation of risk

A good assessment of risk should never define a person simply in terms of high / medium or low risk. Although these terms may reasonably be used, such assessment should also include an attempt to characterise the nature of the violence the person may perpetrate in the future. For example this would included:

- The kind(s) of violence the person is capable of perpetrating.
- The likely level of physical or psychological harm.
- The situation(s) the person is most likely to be violent in.
- The likely victim(s) of that violence.
- The warnings signs that the person may be at risk of being violent.
- The management strategies that need to be put in place to mange the risk of violence in the short term.

Any assessment of risk should include a full description of the nature of the risk that the person presents. This should include both inpatient and outpatient risks, the level and nature of the potential harm, who the victims could be and what situations would aggravate the risk.

4.14.5 Warning signs and protective factors

Assessments of risk should include a list of those warning signs that indicate that the patient may be becoming more at risk of committing a violent act.

Assessments of risk should include a list of those protective factors that can help to reduce the person's risk of committing a violent act.

4.14.6 Multidisciplinary working and information sharing

Clearly such an assessment will need the involvement of a multi-disciplinary team and once formal assessments have been carried out by the professionals involved in the Multi-Disciplinary Team (MDT), Mental Health Officers and Responsible Medical Officers should be encouraged to hold MDT risk management meetings to consider the risk an individual poses. These meetings should form a formal part of any care planning process.

Protocols should be developed for multi-disciplinary discussion of risk where the results of standard risk assessment are communicated to the multi-disciplinary team and the implications in terms of the individual patient is discussed. This process should include clear risk management planning as part of the treatment management process. Interventions should be designed to help reduce the risk the person presents as well as recording what systems or procedures are required to manage that risk.

Protocols should be developed which outline who the risk assessment and management plans should be communicated to.

Further Reading
In addition to the above there exist a number of useful guidelines and guidance that practitioners can turn to for advice on risk assessment and risk management. We would particularly commend the following.

Specialist Working party on the Clinical Assessment and Management of Risk (Council Report 53, April 1993). The Royal College of Psychiatrists,

Assessment and Management of Patients Presenting Risk to Others. CORE Mini Guides (1998). The British Psychological Society: Centre for Outcomes, Research and Effectiveness.

The Sex Offenders Act 1997 Guidance for Agencies. Scottish Executive year

Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland. Scottish Executive, 1999.

We have noted that the RMR (see section 1.4) produced by the *Mental Health Reference Group- Risk Management* (October 2000) makes a number of useful points. However, many of its premises, particularly in relation to their review of the literature and comments about existing practice have now been superseded. Chapter 5 proposes a set of new secure healthcare standards including the need to carry out risk assessment and management. Also included are some recommendations to further give guidance on risk assessment and management which should replace the Executives endorsement of the RMRs report in relation to these areas.

CHAPTER 5

Index

Introduction
Overarching Principles

Generic Secure Care Standards

Standard 1	**Assessment and care planning**
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Level Specific Secure Care Standards - Medium Secure Environments

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Standard 7	**Excluded Items**
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5.1 Introduction:

These standards have been written for forensic mental health organisations providing care and treatment in conditions of high, medium and low security, as defined by the "matrix of security". This matrix was designed by a previous working group of the Forensic Mental Health Services Managed Care Network (FMHSMCN) on Levels of Security (*Definition of security levels in psychiatric inpatient facilities in Scotland*, FMHSMCN, 2004)

The standards are written to complement other standards applicable to mental health (see chapter 4). Duplication or contradiction has been avoided when possible by focusing on areas that are specific, if not unique, to forensic mental health services.

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

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

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

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

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

However, in developing standards for forensic services, it is essential that relational security is included, albeit those standards may not differ significantly throughout the levels of security.

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

5.2 Overarching Principles

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

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

Further reading
In addition, there is a range of further reading which will prove useful in understanding the context in which these standards have been written
Matrix,
SNAP
kennedy,
MEL 5,
Tilt,
Directions
NHS QIS Mental health Strategy

5.2.1 Governance & Risk Management

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

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

5.2.2 Quality Improvement

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

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

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

For each standard the following evidence is suggested

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

5.2.3 Policies and Procedures

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

For each standard the following evidence is suggested

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

5.2.4 Links, Liaison and Joint Working

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

For each standard the following evidence is suggested

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

Standard 1 Assessment and care planning

Standard 1.1 Statement:
Organisations will have in place systems and processes, from the pre-admission stage through to aftercare, that ensure the multi-disciplinary assessment of the health and social care needs of patients, and the risk of harm posed by them to themselves and others. Assessments will then be used to inform the treatment plan and enhanced Care Programme Approach.

Standard 1.2 Rationale:
The aim of forensic mental health services is to deliver the right care, at the right time, to the right patient. These aims should be delivered through a system of:

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

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

- All of the multi disciplinary team caring for the patient, the patient themselves and their carers should be able to share information regarding the identified needs, risks, objectives, interventions and treatments.

- Each should understand decisions that are being made and have reasonable expectations of what should be delivered and when.

- The multidisciplinary team should be able to use the assessment and planning structure to avoid duplication in their work, identify any gaps and to prioritise the interventions, treatment and support they provide.

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

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

The key objectives of the RMA are given as being:

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

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

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

Standard 1.3 Criteria

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

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

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

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

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

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

Standard 1.4 Suggested Evidence
These specific pieces of evidence are suggested in addition those at 5.2

Standards, Governance & Audit	
• Risk assessment tools	• Treatment plan templates

Policies & Procedures
• Referrals and admissions policy • Clinical risk assessment policy and procedure • Treatment planning procedure • Care Programme Approach policy • Needs assessment framework

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

Standard 2.1 Statement:
Organisations will have in place an infrastructure that delivers a range of generic and specialist treatments, interventions, and support for recovery, appropriate to the health and social care needs of patients and fulfilling the multidisciplinary treatment plan.

Standard 2.2 Rationale:
Patients in forensic services are more likely to have complex needs, including resistant psychotic illness, disadvantaged socioeconomic background and comorbid substance abuse problems, compared with the patient population of general adult mental health services. They are also more likely to be living with the consequences of previous institutional care.

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

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

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

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

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

Standard 2.3 Criteria
The organisation is able to demonstrate evidence of audit of delivery of planned interventions, treatments and support.

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

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

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

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

Standard 2.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 3.1 Statement:
Organisations will have sufficient staff numbers and skills available to deliver effective treatment and maintain a safe environment.

Standard 3.2 Rationale:
The wide ranging variety of needs within a forensic mental health patient population mean that in order to assess, plan and deliver care, treatment, intervention and support for recovery, the teams which care for them have to be truly multidisciplinary. Organisations should therefore have in place mechanisms to assess the need of the populations they serve and to ensure availability, numbers and skills of staff required to meet those needs.

Standard 3.3 Criteria
Strategies should exist on three levels:

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

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

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

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

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

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

Standard 3.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 4 Maintenance of Detention

Standard 4.1 Statement:
Medium Security Forensic inpatient services will have in place a range of appropriate physical and procedural security measures to manage the risk of escape and subsequent adverse consequences. These should be proportionate to the level of risk posed by the patient population and take account of the impact these measures have on the rights of patients, visitors & staff, and on patients' quality of life.

Standard 4.2 Rationale:
Medium security forensic inpatient units must maintain the detention of their patients as part of their duty of care to the patient, staff members and the public in general, including carers, previous and potential victims.

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

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

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

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

Patients assessed as requiring a medium security environment:

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

Standard 4.3 Criteria

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

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

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

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

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

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

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

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

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

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

Standard 4.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 5 Suspension of Detention (previously Leave of Absence)

Standard 5.1 Statement:
Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk of absconding and subsequent adverse consequences proportionate to the level of risk and effect of the measures on the rights of patients, visitors and staff, and on patients' quality of life.

Standard 5.2 Rationale:
Suspension of detention is a term used to describe any movement by a patient outside the hospital providing detention.

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

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

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

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

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

Standard 5.3 Criteria
In addition to the over arching principles the following criteria exist in this standard.

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

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

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

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

- Vehicle
- Mobile Phones
- Radios

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

Standard 5.4 Suggested Evidence
These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 6 Management of Violence

Standard 6.1 Statement:
Medium security forensic inpatient services will have in place appropriate physical and procedural measures to manage the risk of harm to persons through aggression or violence.

Standard 6.2 Rationale:
Patients in forensic settings may have a previous history of violence, and may have been admitted to forensic services because of violence or aggression. Patients in forensic settings may also have an increased incidence of mental illness combined with substance abuse, thus increasing the risk of violence. Offending behaviours & previous histories may include serious & sustained violence and use of weapons.

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

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

Standard 6.3 Criteria
Approaches to minimising violence and aggression must recognise the wide range of causative factors and minimisation techniques.

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

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

RCPsych emphasise:

- ***Ward design & organisation***
  - Calming features & ensuring a secure environment
  - Activities
  - Day accommodation
  - Protocols for effective care environments
  - Policies for effective care environments

- ***Anticipating & preventing Violence***
  - Responsibilities of staff and management
  - Risk assessment and action to anticipate and de-escalate violence
  - Reasons for using restraint
  - Training for restraint
  - Protocol for seclusion (as the last resort)
  - Policy issues relating to restraint and seclusion

- ***Use of medication***
  - Rapid tranquilisation & protocols for use
  - Avoiding high doses & polypharmacy
  - Auditing emergencies

NICE emphasise:

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

The "Zero tolerance" campaign (HDL reference, year) is endorsed by the organisation and publicised, including notices to patients and visitors

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

- CCTV
- Handheld Metal detectors
- PA Alarms

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

Standard 6.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 7 Excluded Items

Standard 7.1 Statement:
Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk associated with the introduction of potentially harmful items or substances proportionate to the level of risk & the effect of the measures on patients, visitors & staff rights, and the effect on patients quality of life

Standard 7.2 Rationale:
Excluded items are excluded because their makeup or properties are hazardous. This may be because:

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

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

Standard 7.3 Criteria

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

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

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

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

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

Standard 7.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 8 Control of Restricted Items

Standard 8.1 Statement:
Medium security forensic inpatient services will have in place appropriate procedures to manage the range of items and substances that require controls on their availability, use and storage in order to manage the risks they may present. These measures will be proportionate to the level of risk presented and the effect they have on the patients, visitors and staff rights, and patient quality of life.

Standard 8.2 Rationale:
Similar to excluded items, restricted items are those that are restricted because their makeup or properties are hazardous. This may be because they could be used to harm others, or be used in attempts to escape. As a number of patients within forensic units may have histories that include offending or exploitative behaviours, restrictions may include items used to trade & encourage criminality such as pornography. The potential for patients or carers to be coerced into bringing restricted items in may also exist and need to be addressed.

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

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

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

Standard 8.3 Criteria
Forensic services must have measures in place to assess the risk from items both generally in relation to the item, and specifically in relation to individual patients. Measures taken and policies & procedures must demonstrate proportionality, balancing realistic assessments of risk with the therapeutic benefits of the item.

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

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

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

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

Standard 8.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

Risk Management	
• Risk assessments of restricted items and individuals	
Policies & Procedures	
• Use of tools • Cameras • Recording equipment	• Cutlery • Sewing equipment • Sharps

Standard 9 Communication and Technology

Standard 9.1 Statement:
Medium security forensic inpatient services will have in place appropriate physical and procedural security measures to manage the risk of criminality or harm to persons through communication media (physical, electronic, verbal communication) proportionate to the level of risk and the effect of the measures on the rights of patients, visitors and staff, and the patient's quality of life.

Standard 9.2 Rationale:
Communication media is a rapidly expanding field, with technological advances creating more ways of communicating and more complex communication devices. Items & technologies considered include, but are not limited to,

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

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

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

Standard 9.3 Criteria
Forensic services must have measures in place to assess the risk from items and technologies, both generally in relation to the subject, and specifically in relation to individual patients. Measures taken and policies & procedures must demonstrate proportionality, balancing realistic assessments of risk with the therapeutic benefits of these technologies & items.

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

Standard 9.4 Suggested Evidence

These specific pieces of evidence are suggested in addition those at 5.2

Risk Management
Risk assessments of communication media & technology
Policies & Procedures
• Telephone policy • IT policy • Video game policy (broader definition??) • New technology policy

Standard 10 Movement of Personnel

Standard 10.1 Statement:
Medium security forensic inpatient services will have in place appropriate procedures to manage the risks created by the movement of patients, visitors and staff proportionate to the level of risk posed, and the effect of those measures on the rights of patients, staff and visitors, and the patients quality of life.

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

Standard 10.2 Rationale:
Medium security services will exercise a level of control to ensure that risk is minimised when individuals move around the unit. This may be associated with risk of self-harm, escape, movement of items, hostage taking, concerted activity, criminality or violence.

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

Standard 10.3 Criteria
The organisation has in place the necessary equipment and systems to minimise risks associated with movement of personnel. These may include:

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

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

Standard 10.4 Suggested Evidence
These specific pieces of evidence are suggested in addition those at 5.2

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

Standard 11 Contingencies

Standard 11.1 Statement:
Forensic inpatient services will have in place appropriate contingency plans to manage the impact of a range of events, which although low likelihood, can be expected to occur at some time in the life of the service. Many of these plans will be drawn up in collaboration with other agencies (e.g. fire service, police)

Standard 11.2 Rationale:
All services are vulnerable to incidents that may interrupt normal business; Forensic services are vulnerable to some types of incident that would be unlikely in services that do not combine detention with other objectives.

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

Standard 11.3 Criteria

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

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

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

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

Standard 11.4 Suggested Evidence
These specific pieces of evidence are suggested in addition those at 5.2

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

CHAPTER SIX

Medium Secure Unit Building Standards Specification

6.1 Introduction

The majority of current published guidance for the provision of medium secure psychiatric facilities is obsolete. This guide is intended as background reading and is based on the practical experience gained from the design process undertaken for the Orchard Clinic.

Many of the documents noted in the bibliography provide further background; however, many of the specific technical solutions are now not regarded as good practice and should therefore be avoided. The documents serve to highlight issues and the history of the development of facilities.

It is important to understand the context in which buildings of this type are created. Clear evidence exists that a non clinical or homely atmosphere improves the life experience of patients and subsequently improve patient outcomes.

While the care of patients is the primary issue in the design of psychiatric units, the ability to manage the unit by staff and the safety of patients and staff are also to be considered. The ability to accommodate the needs of other involved people (such as patients' families, some with young children, visiting care and legal professionals) are also to be taken into account, as are the needs of the community in which the unit is sited.

The scale of the ward is also a critical early decision. It is anticipated that each ward should accommodate more than 15 patients (see clause 6.5.4)

External landscaping is of particular value in psychiatric facilities as it provides views and recreational possibilities for patients. Care should be taken to ensure the security and safety of such spaces.

Designers have the problem of reconciling two potentially conflicting requirements:

- to preserve patients dignity and privacy
- to provide staff with the ability to observe/care/supervise patients at all times

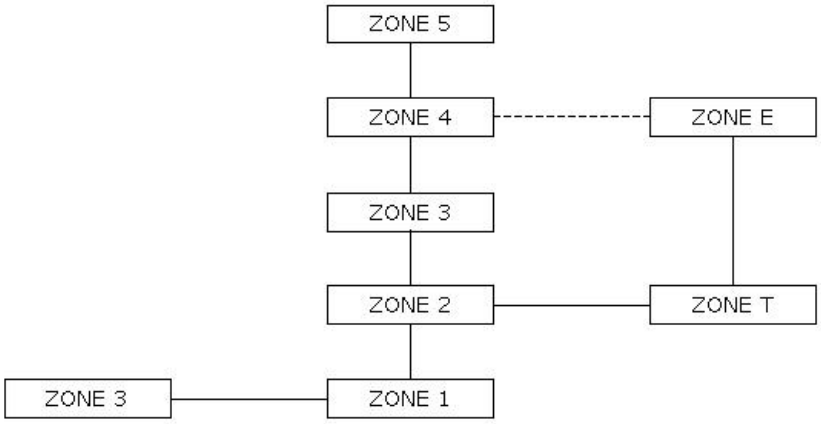
Therefore, this document should be taken as general guidance for building standards, however, text in ***bold italics*** should be regarded as a firm recommendation of good practice.

6.2 Hierarchy of Spaces and Planning

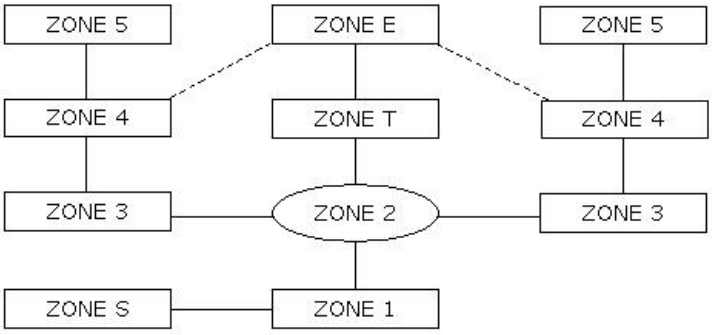
6.2.1 Typical Zoning

Zone	Description	Staff / Visitor Population	Patient Population
Zone 1	Entry / Waiting	Semi public	Patients at entry/ egress
Zone 2	Links	"At risk" patients Staff Professional Visitors Patients' visitors	Supervised patients
Zone 3	Ward Entry	Escorted professional visitors Escorted patients visitors?	Supervised patients
Zone 4	Day Activities	Nursing/Activities/Medical staff	Supervised and unsupervised patients
Zone 5	"Private" Spaces	Nursing/Medical staff	Unsupervised and supervised patients
Zone T	Therapies	Nursing/Medical/Activities staff Escorted professional visitors	Supervised patients
Zone E	External Secure Spaces	Nursing/Medical/Activities staff	Supervised patients
Zone S	Staff/Administration	General staff Professional Visitors	None

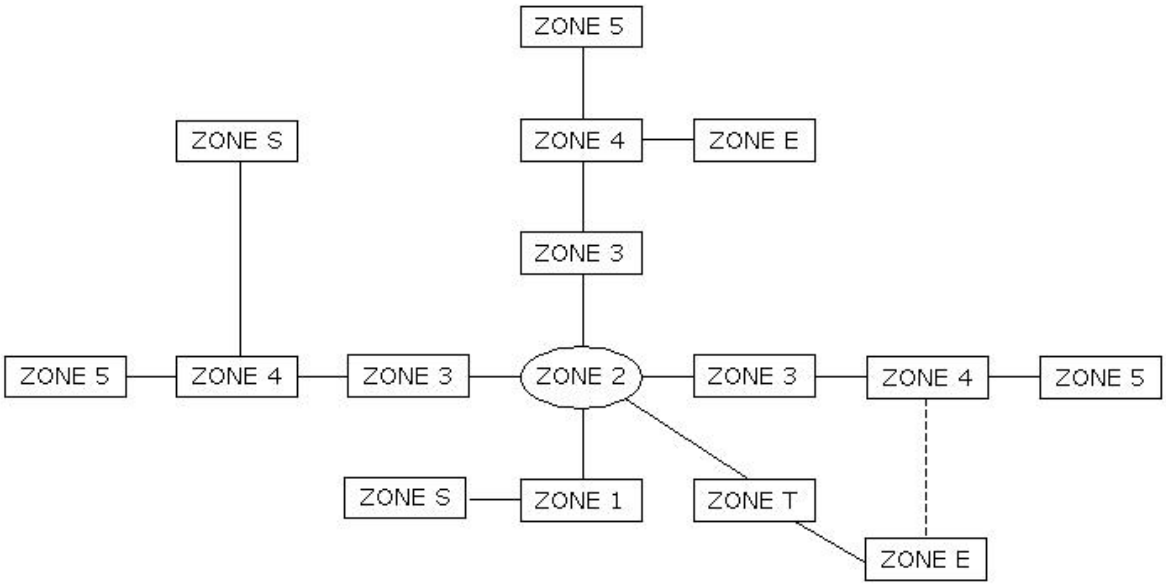
6.2.2 Single Ward Diagram



6.2.3 Double Ward Diagram



6.2.4 Triple Ward Diagram



6.3 SPECIAL ASPECTS

6.3.1 Nurse base

Generally staff will be based within the ward/public interface. This allows supervision of the ward entry. The nurse base should provide supervision of the ward circulation and main day spaces, however, it should be recognised that nursing staff will generally work in “day areas” therefore good supervision of the entrance from these areas is also required.

A second "night time" nurse base may be incorporated within the ward bed space zone.

Flexibility may include the need to physically isolate the bed space zone from the day space zone in order to maintain the patient group within one single zone. This aspect would be a management policy decision.

6.3.2 Fire

The unit should comply with the latest Building Standards (Scotland) Regulations.

Management policy will probably involve the escort of patients from the unit to designated safe zones. These may be within other fire compartments within the unit or within secure external spaces.

In one previous project, staff external to the unit where the fire is located are required to assemble at the final exit point (on the external side of the door(s)) with a key for the unlocking of the final exit door(s).

The staffing levels together with external key holder policy will be required in an application to differ from the Building Standards (Scotland) Regulations to allow the locking of the final exit doors. Discussion with the relevant statutory bodies will be required in order to consider a risk assessment of the locked escape policy.

As staff will guide patients to agreed zones or compartments depending on circumstances to hand, the use of fire escape signing is not recommended.

The fire management statement, therefore, will also be required in order to apply for an agreement to differ from the Building Standards (Scotland) Regulations relating to the provision of fire escape signage.

Portable fire fighting appliances should be provided in consultation with the NHS Trust Fire Officer. However, these appliances should be secured from patient access. Several strategies are available to achieve this:

- Siting of appliances in locked housings with keys held by staff.
- Siting of appliances in "staff only" areas such as the units office.

Fire alarm activation buttons should be provided in the normal locations for a care building. However, these should be key operated for staff operation only.

Fire detectors should be deployed to a level as appropriate to the function of the room served and the Building Standards (Scotland) Regulations.

Care should be taken in patient areas to prevent abuse of the system and policy agreed if smoke or heat should be used as the activation. In addition, illicit smoking may take place in rooms.

It should be stressed that the type of patient occupying this type of unit will not be "confined to bed" therefore the application of the combination of Regulations and of the Building Standards Scotland Regulations should not be applied. An application to differ will be required.

6.3.3 Illicit Substances

Measures should be employed to prevent the passing of illicit substances from the outside to within the unit.

6.3.4 Self Harm

Care should be taken to minimise opportunities for anchor points for tourniquets in patient areas.

Overhead door closers should not be used in patient areas.

While curtain rail systems designed to fail when weight is applied are available, these may provide a weapon to an agitated patient. Rails fixed hard back to surfaces are preferred, secured using security headed screws.

General design should consider all items which could be broken up and used to self harm or improvise into a weapon.

Specific checks must be made prior to the completion of the building to establish that the project is free from builder's tools, blades and the like. In particular, floor layers work is a possible source of discarded blades and all building voids must be verified as "clean".

While distortion provides less of a feeling of normality, metallic mirrors have been deployed in areas where misuse may occur; other (plastic or laminated glass) mirrors may be acceptable after a risk assessment.

Lighting should be flush or recess mounted. ***Pendant lighting is to be avoided.*** Specification of light fittings should be made in consideration of anti self harm or potential weapon sources. Security/anti vandal fittings should be considered.

6.3.5 External Spaces

Risk assessments should be made to designate levels of security to external spaces.

In high risk areas the spaces should be designed to prevent escape:

- This may be a courtyard or fenced area.
- The space should provide a perimeter with at least a 5m continuous height.
- Rainwater pipes, doors, window openings, fixed external furniture and all other elements should be specified and located to prevent assistance to climbing.

Systems deployed should be discrete or covert where possible. Use of obvious security fences should be limited to where these are unavoidable.

Rainwater goods should be fixed hard to wall surfaces and be secured using concealed fixings. It is likely that cast aluminium goods will be required to meet this standard.

6.3.6 Staff Security

Care should be taken within the layout design to prevent:

- Opportunistic areas for concealment with a view to surprise.
- "Blind" unsupervised areas.
- Division walls, platforms or desks which may provide "launching" points for attack.

6.3.7 Dining

Dining areas should be able to be isolated from patient areas while not in use. However, in the event of the unit being planned with open dining areas where supervised use is anticipated throughout the day then this approach will not be applicable.

Consideration may be given to the possibility of isolating servery areas if dining rooms are to have a multi function use.

Thought should be given to the method by which dining facilities are serviced. Dining/ portering staff may not have the same level of training as dedicated unit staff therefore unsupervised contact with the patient group should be avoided.

Dining rooms may be shared over scheduled time arrangements.

If deliveries are made outwith the main entrance route, the service access doors should be configured with an air lock.

Early consideration should be given to the method of serving food. The ability to serve food rather than distribute plated meals is preferred; however, modern plated meal services may be able to provide the variation and flexibility required.

6.3.8 Dispensing

A stable door with integral shelf arrangement has been successful in allowing the safe dispensing of medication. The door would be located to the treatment room to allow dispensing from the treatment room to the patient area.

Thought should be given to the security of medication and staff, including agreement on the policy of providing warning lights on the opening of dangerous drug cupboards.

Medication trolleys are generally not used.

6.3.9 External Boundary

Where garden areas, which do not have patient access, form the perimeter of the site, consideration should be given to lighter duty/landscape fencing to provide a pleasant visual barrier rather than physical containment. The fence should be designed to prevent views in to patient areas from surrounding public areas and windows.

The design should prevent the ability of people outwith the service observing patients or patients activities. This should be in the form of buffer landscaping and/or screen fencing. The strategy of omitting windows to external facades will provide an inappropriate and aggressive “face” to the facility.

Fencing should be provided to prevent the escape of patients from external areas

Security fencing generally provides an aggressive image to both the patient group and the facilities’ neighbours.

Use of the building form may assist in easing the harshness of the fence requirement, however, care should be taken to prevent climbing around fence ends and eaves.

The integrity of the fence system must include the prevention of climbing opportunities which require care in locating such items as windows near corners, rainwater downpipes, and the consideration of threat from moveable garden benches and similar items.

The use of security fencing to form sports pitches (with roofs and airlocks) has been used to form an effective perimeter fence.

An area with a boundary obstacle of 5m where patients can have access to is generally regarded as a minimum standard. However this area can be made up of fence or building as long as the feature is designed to prevent scaling of the obstacle.

Where ball sports are undertaken externally, consideration should be given to a roof to the court to prevent loss of balls.

Measures should be taken to prevent the ability to approach patient areas (windows in particular) by unauthorised people.

6.3.10 Flexibility

Secure systems can be used to reconfigure corridors to allow variation in gender mix in bedroom areas. However, consideration of patients' routes to dining, day and therapies areas as well as effective overnight nursing supervision must be considered.

6.3.11 Wheelchair WC/Disabled Facilities

Normal Disability Discrimination Act provision should be incorporated; however, items such as grab rails should be installed in patient areas only on identification of an actual need. The facilities should then be removed on discharge of the particular patient. This is to prevent the opportunity for self harm in areas of infrequent use.

6.3.12 Costs

For comparison and indexing costs of the Orchard Clinic updated to Q1 2005 are:

Substructure:	£131.59/m^2 (typical £85 - £150/m^2)
Superstructure:	£1393.84/m^2
External Work and Drainage:	£337.14/m^2 (typical £200 - £400/m^2)

The external works were expensive due to additional drainage requirements.

Contractors Prelims should be added to the above.

6.4 Components

6.4.1 Opening Windows

Opening windows with an aspect on to semi-private space should include a system to prevent the passing of substances (as small as a razor blade) through the window. Options available include hoppers or installing fixed windows.

6.4.2 Windows in Patient Areas

Windows should appear as close to a "non secure" environment as possible. Bars should not be employed.

Windows should comply with the standards set down in the Building Standards (Scotland) Regulations.

The glass used should prevent easy escape (by determined breaking) as well as preventing the use of fragments as weapons.

For this reason, a laminated heavy-duty inner leaf glass should be used within the double or triple glazed unit.

Care should be taken to provide adequate depth of stop for the fixing of glazing units, which should be applied from the outside. If timber, these should be glued and screwed (with security head screws).

It is unlikely that aluminium systems will provide the strength to resist determined attack. UPVC windows should not be considered.

Window to structure fixings should also be considered to resist determined attack from the inside. Traditional Scottish detailing would assist in this area.
If windows are designed as opening, the mechanisms and design must:

- not allow anchor sites for tourniquets,
- allow staff to mechanically deny use by the patient,
- not fail on multiple cycle abuse.

Use of plastic “glass” is not advised due to scratching, limited strength and flexibility leading to failure at stops.

Due to the need to prevent escape, it is unlikely that natural ventilation will provide sufficient capacity to service rooms adequately. In any event, abuse of the opening window or ventilator system may cause staff to "lock off" the facility. This, of course, could be in the open or closed position. In view of this, mechanical ventilation will probably be required but it is unlikely that this will need to be air conditioned, and care should be taken in designing ventilation grilles to prevent abuse or unauthorised removal.

6.4.3 Doors

Doors in patient areas should be solid core heavy duty.

It is likely that the layout of the unit will require patient area doors to open into the room. If this is the case, then a system of opening the door "outwards" must be available to staff in the event of emergency.

This can be achieved by using a removable door stop on the lock case side of the door frame. Such a system should be secured by staff operated allen key headed screws and remain attached to the door frame by a piano hinge.

Simple single point "push in" stops may be abused.

These systems work well with pivot hinges and can allow closer operation and friction to be applied to the opening and closing of doors**.**

Bedroom doors should have vision panels to allow discrete observation of patients from the corridor. In particular, the patients upper body and head should be visible from outside the room through the vision panel at all times.

The vision pane should be in laminated glass.

Doors should be designed to allow agitated patients being escorted by two staff to pass.

6.4.4 WC Fittings

While anti vandal fittings are available, these provide a harsh environment in which to live. The care organisation is giving an aggressive signal by adopting the use of stainless steel fittings.

Robust chinaware ***rimless WC pans should be specified,*** with normal seats.

Cisterns should be concealed and all access to pipe and cisterns should be fixed using security headed screws. ***Care should be taken to prevent improvised concealment of illicit materials and substances.***

6.4.5 Bathroom Areas

Bathroom/shower room doors should open outwards.

Management policies should be deployed to manage abuse of bathroom/shower room facilities or provide a "private" area where self harm may occur.

Several approaches have been used:

- One option may be to simply "lock off" bathroom areas where abuse is predicted or has occurred. This approach requires that alternative supervised provision is included.

- A second option is to allow staff to be able to supervise bathroom/shower rooms through a vision panel. This may be regarded as an intrusion on the dignity of the patient.

- A third option is to design bathroom doors to allow them to be fixed "flush" to the wall in the open position allowing easy supervision from the room when required.

- The final option prevents the need to be able to isolate water service in the event of potential abuse.

Showers should be an anti vandal/anti tourniquet site type with push button operation.

WC flushing mechanism should be proximity activated or push button flush operated.

Taps should be specified which limit the opportunities for self harm and consider infection control requirements.

Wash hand basin wastes should be avoided, or be of a captive type or be a "spinning dish" type. Plugs with chains are to be avoided.

Overflows in wash hand basins are to be avoided.

Shower wastes should be able to allow rodding from above but use security fixings. It should be noted that deliberate blocking of shower wastes may occur. However, the final appearance of the shower should be non-institutional.

In previous projects, the diameter of WC wastes has been increased on passing the floor slab in previous projects. This is to try to prevent blocking with towels or similar items. Consideration should be given to a weir on the main foul drainage line to prevent large solid objects from entering the main sewer system.

6.4.6 Security Systems

Consideration should be given to proximity detection in order to allow staff to detect persons approaching the building.

All exit doors should be able to be alarmed to give a signal on opening.

CCTV should be deployed to allow observation and supervision of external spaces, the main entrance and entrances to wards.

The main entrance should be able to be supervised by staff with a video entry system. This should be able to be "passed" by authorised staff.

A staff personal alarm and call system should be deployed. Reception nodes and indicator lights for the system should be discrete. Locations for all warning and repeater panels should be agreed to facilitate management response.

6.4.7 Heating

Underfloor Heating Systems

Advantages:

- Is safe for patients.
- Can give a good temperature gradient for comfort.
- Can have local control.

Disadvantages:

- Care required to co-ordinate with floor fixings and may limit flexibility (for instance bed fixings).
- Limits structure/systems to concretes/screeds/
- Requires control manifolds with access from within the unit.

Flush Ceiling Mounted Radiant Panels

Advantages:

- Is safe for patients.
- Can have local control.
- Maintenance can be designed to be undertaken from outwith patient areas (above).

Disadvantages:

- Can appear "institutional".
- Temperature gradient may not provide best comfort conditions.
- Higher surface temperature used.

Warm Air Heating System

Advantages:

- Is safe for patients.

Disadvantages:

- May provide a dry atmosphere unless conditioned.
- Maintenance requirements.
- Local control is difficult.

6.4.8 Ironmongery

Door handles in areas where patients may be unsupervised for periods of time should be of a flush type. In order to facilitate this, heavy duty roller ball latches may be deployed together with independent dead locks.

If patients are allowed to lock rooms, by thumb turn operated locks for instance, designs should include clutch operation within the lock to facilitate the overriding of the lock by staff with a key from the outside.

Signage is important for the safe and appropriate use of the facility, but has the potential to contribute to an institutional look to the living areas of the wards. Care should be taken when choosing signage for these areas to maintain a non-institutional appearance.

6.5 Space Standards

6.5.1 Typical Schedule Excluding Therapy Areas

Zone 1
- Entry
- Waiting Area
- Search/Interview Room
- Visitors WC
- Staff Changing Facilities *[1]
- Reception

Zone 2
- Airlock
- Interview Room/s
- Seminar/Meeting Room
- Family / Child Visiting facilities

Zone 3
- Ward Entry
- Staff Office
- Staff Base
- Interview Rooms
- Dining Room and Servery
- Disposal Store

Zone 4
- Day Activities Spaces
- Quiet Room/s
- Interview Rooms

- Smoking Room
- Treatment Room
- Recovery Room
- Toilets

Zone 5
- Bed Spaces with En-suite Facilities
- Sluice Room
- Assisted Bathroom
- Disabled Persons WC
- Staff WC
- Overnight Nurse Base
- Pantry Facilities

*[1] may be in Zone 2
Stores should be provided throughout as necessary**.**

6.5.2 Typical Therapy Areas

Internal
- Art Room
- Gym (Multi Gym)
- Multi Purpose Hall - Drama/Sports
- Training Kitchen
- Seminar Room
- Library
- Stores
- Staff WCs
- Patient WCs
- Disabled WC

External
- Five-a-side Football/Basketball Pitch
- Gardening Facilities
- Stores

6.5.3 Circulation

When comprising the schedule of accommodation the following allowances should be included/added over the total area of rooms required:

5 - 7%	for walls
30 - 35%	for circulation/corridors etc.

Plant spaces should be scheduled areas and not included in the circulation allowance. This principle should also be applied to waiting areas and general toilet provision.

The use of cupboard or storage spaces for "odd items of plant" is to be discouraged.

Minimum corridor widths should take into consideration the need for space for staff to manoeuvre patients during potentially violent episodes.

6.5.4 Scale of Wards

Individual wards should contain accommodation for a maximum of 15 patients.

Further Reading

Available Design Guidance

Lighting and colour for hospital design.
Drake, Littlefair, Loe and Camgöc - BRE/South Bank University - NHS Estates

Partitions HTM 56
Department of Health & The Welsh Office - London: The Stationery Office
* For guidance on sound requirements only*

Acoustics Design Considerations HTM 2045
NHS Estates: London: HMSO

In-patient Accommodation: Options for Choice HBN 04
NHS Estates: London: The Stationery Office
Sections 9.1 - 9.14 inclusive only noting working areas around a bed - not room sizes
Note: En-suite bathroom option C is not suitable.

Creating Excellent Buildings A Guide for Clients Cabe

National Care Standards Independent Hospitals Scottish Executive
Standard 13
Standard 15
Standard 23

Definition of Security Levels in Psychiatric In-patient Facilities in Scotland
Background Reading for Design Team

National Care Standards, Care Homes for Older People
Scottish Executive
Standard 4-18
Standard 4-20
Standard 4-21
Standard 4-24

CHAPTER SEVEN

Conclusions and Recommendations.

7.1 From the content of chapter 4 it is clear there are a plethora of possible standards which could aptly apply to Scottish forensic psychiatry. Largely left out from that review are wider standards and guidance documents which apply to psychiatry, medicine and social care more broadly but still require to be followed in forensic mental healthcare. Chapter 5 remedies a gap in the standards specific to forensic psychiatry by converting the matrix of security into a standards framework and begins to address guidance regarding assessment of risk to others. The Risk Management Authority (RMA) in due course give guidance on its remit and this is likely to have a small direct effect on risk assessment in forensic healthcare settings but a much larger indirect influence. The guidance on risk is likely to require updating following recommendations from the RMA.

We recommend the secure care standards, including the section on social work standards for medium secure settings (4.10) and the section on risk assessment and management (4.14), and the model building design are endorsed by the Forensic Network.

7.2 Reflecting on the influence of standards it is clear that simply stating how a service should perform does not necessarily translate into that standard of performance at the coal face. There require to be systems in place to drive quality improvement and, as reflected by the product range offered by NHS QIS, the Care Commission and other bodies, this can be done in a variety of ways.

Recent standards relating to schizophrenia and adult admissions by QIS have included guidance on what measures can be taken to check that the standard has been met. That is also the model for the Occupational Therapy standards and is adapted to the proposed secure care standards. To be effective such standards require to be part of a system of working for them to have enduring influence.

One method is periodic review, such as that carried out by QIS in relation to the schizophrenia standards. With this method there is a risk that special efforts will be made around the time of inspection and that improvements in service are not fully knitted in to the operation or a system of local review and improvement.

7.4 A more integrated approach is the adoption of standards into the performance indicators (PIs) of a unit with systems in place to routinely gather the necessary data. There must be room for flexibility to adapt certain standards but as a starting point:

We recommend that the QIS standards for schizophrenia (which apply) and the secure care standards are adopted to inform the performance indicators for in-patient forensic units in addition to other standards from the literature summarised here and elsewhere.

7.5 This requires a system to collect the relevant data routinely and results should be reviewed at least quarterly by the senior managers of the unit and integrated into audit. Results could appear in an annual report and be

part of the regular review process carried out by the Mental Welfare Commission. For Consultant Psychiatrists, such data would usefully fulfil some of the requirements for reappraisal and revalidation.

7.6 For NHS organisations, senior managers of operational units should feedback information to their Clinical Governance Committee. Certain local PIs could be recommended for adoption as Key Performance Indicators (KPIs) for forensic mental health and thus included in the Performance Assessment Framework and Accountability Review. This would strengthen the importance of quality in forensic mental healthcare at a Health Board level. The Scottish Executive may also consider if they would like to set certain KPIs. Mental Health Division at the Scottish Executive already monitors, for example, restricted patient absconds, but do not do this in comparison to non-restricted patient absconds or the rate of successful suspension of detention. If the Executive were to set certain forensic healthcare KPIs it would be important for them not to simply focus on security but also the wider advancement of MDO policy.

7.7 The disadvantage of 'top down' standards is lack of flexibility and local ownership. QIS also promotes as driver of quality improvement the development of Integrated Care Pathways (ICP). By their nature these are locally created, informed by the wider standards context. Key to their operation are systems of local review along with analysis and early remedying of divergence. ICPs are already in operation in the State Hospital and Orchard Clinic and monitor both health and social care performance. Where operational, there is overlap with the Care Programme Approach and the requirements of the schizophrenia standards. Data from ICPs could provide much of the necessary data for the purpose of monitoring PIs.

We recommend that forensic units develop multidisciplinary Integrated Care Pathways for each stage of the patients clinical journey: pre-admission assessment, admission, continuing care and discharge. A wide variety of standards might influence what is included but the schizophrenia standards, secure care standards and existing practices regarding Care Programming should be influential.

7.8 QIS offer, as one of their products, aid in the construction of ICP and accreditation of best practice.

We recommend that Integrated Care Pathways in forensic settings are submitted to NHS QIS for accreditation.

7.9 Although standards for risk assessment are likely to be influenced in the future by the Risk Management Authority it would appear likely that certain historical data will continue to form an important part of risk assessment. There is currently lack of co-ordination in the gathering of this information leading to costly repetitive exercises in information gathering without necessarily any reduction in error. Judgements about whether past behaviours have occurred or not should be made on the balance of probabilities in keeping with the Maclean proposals.

We recommend that on admission to forensic mental healthcare comprehensive historical risk information is documented which would satisfy, but not be limited to, the information required for the historical factors of the relevant risk assessment tool being used by the organisation (at a minimum the historical information required for the Psychopathy Checklist revised and HCR20 etc.) and allow for a detailed formulation and characterisation of risk. That document would follow the patient through different settings and could be updated if new historical information comes to light rather than recreated. The Historical Risk Document should not simply have scores but document the necessary information which may then be scored for the purpose of risk assessment.

7.10 In this particular area there is a strong argument for standardisation of the Historical Risk Document and the Forensic Network could propose a proforma and guidelines to be adopted.

We recommend that the Forensic Network considers promoting a standard Historical Risk Document

7.11 There is also the opportunity to learn from good practice across Scotland and benchmarking both for PIs and ICPs. The Forensic Network has a role in disseminating best practice and monitoring the performance of forensic mental healthcare.

We recommend that the data from Performance Indicators and Integrated Care Pathways is forwarded to the Forensic Network who will disseminate best practice and collate data for the purpose of benchmarking.

7.12 By its very nature Forensic mental healthcare is prone to the occurrence of adverse outcomes. As the leading forensic psychiatrist Dr Adrian Grounds (1995) commented, 'there is only meaningful outcome in forensic psychiatry – silence – the absence of disaster, but disaster cannot always be avoided'. As inevitably there are perioperative deaths even for routine surgical procedures, there will be patients who fail when tested out, or who will go on to seriously reoffend. The task then for services is to review the clinical care given and identify lessons to be learnt. Currently there is a system of Critical Incident Review but no system to collate or disseminate findings.

We recommend that Critical Incident Reviews from forensic services are copied to the Forensic Network Board, who will collate findings and disseminate advice on improving clinical practice, including advice on the adoption of new or revised Performance Indicators.

7.13 The model of Critical Incident Review most commonly used in forensic settings is that described in *Risk Management Report* (Mental Health Reference Group 2000) which was endorsed by HDL (2000) 16. If the Scottish Executive request a CIR following an adverse event involving a restricted patient it is this guidance which is referred to. In the English context the methodology being piloted for HSG(94)27 homicide reviews and other similar inquiries is Root Cause Analysis and a substantial

programme of training and appraisal of this methodology is underway. Both the MWC and QIS have a role in investigating adverse incidents and are currently liaising with each other to identify which agency should lead in different circumstance.

We recommend that the Forensic Network Board monitors the implementation of Root Cause Analysis in England and the outcome of discussions between QIS and MWC. It is likely the CIR policy will require updating and the Forensic Network should keep under review the need for a working group to consider this area.

7.14 We have had difficulty in eliciting the views of users

We recommend the Scottish executive issues guidance on the circumstances when user consultation requires consideration by research ethics committees

7.15 We have identified a need to review the needs of victims.

We recommend the Forensic Network commissions an expert working group to consider the needs of victims; those people harmed by the offending behaviour of people with mental health problems.