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Health Department

NHS Management Executive
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Dear Colleague

HEALTH, SOCIAL WORK AND RELATED SERVICES FOR MENTALLY DISORDERED OFFENDERS IN SCOTLAND

Summary

1. With this letter we enclose copies of the Scottish Office policy governing health, social work and related services for mentally disordered offenders in Scotland which was launched by the Minister for Health and the Arts on 28 January 1999.

Background

2. The attachment to this letter was the subject of extensive consultations between 15 April and 31 August 1998 and now sets out the policy for the best organisation of care, services and support for mentally disordered offenders in Scotland.

3. The overall aim of the policy is to co-ordinate care and support for the benefit of the individual and to ensure public safety. The paper sets out steps that will involve multi agency and multi-disciplinary working to organise services which:

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

Addressees

For action:
General Managers, Health Boards
General Manager, State Hospitals Board for Scotland
Chief Executives, NHS Trusts
Directors of Social Work/Chief Social Work Officers
Directors of Housing/Chief Housing Officers

For information:
Chief Executives, Local Authorities
Chief Executive, COSLA
Chief Executive, Scottish Homes
General Manager, Common Services Agency
Executive Director, SCPMDE
Mental Welfare Commission for Scotland
General Manager, HEBS

Enquiries to:

Health
Mr P Harley

Tel: 0131 244 2426
Fax: 0131 244 2970

Social Work
Community Care: Dr D Bruce

Tel: 0131 244 5458
Fax: 0131 244 5315

Criminal Justice: Ms F Hird

Tel: 0131 244 5470
Fax: 0131 244 3548

Crown Office
Mrs C McDivitt

Tel: 0131 225 5806
Fax: 0131 226 6910

Scottish Prison Service
Mr J McNeill

Tel: 0131 244 8622
Fax: 0131 244 8691

Police
Miss A Ross

Tel: 0131 244 2149
Fax: 0131 244 2666

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NHS Management Executive
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Regent Road
Edinburgh EH1 3DG

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4. Agencies should be aware of 3 reviews which are in progress, or about to commence, and which may affect legislation and practice covering the detention, treatment and supervision of mentally disordered offenders. These are the review of the Mental Health (Scotland) Act 1984, under the chairmanship of the Right Hon Bruce Millan; the review of sentencing and treatment of serious violent and sexual offenders including those with personality disorders, under the chairmanship of the Hon Lord MacLean; and the Expert Panel on Sex Offending, under the chairmanship of the Hon Lady Cosgrove. The Millan and MacLean reviews are expected to report during the year 2000. The Expert Panel, which was announced in December 1997 to take forward key areas of 'A Commitment to Protect' (the 'Skinner Report'), will report annually to the Secretary of State on its past and planned work during its 3 year term.

Action

5. Health Boards, NHS Trusts, local authorities, the Scottish Prison Service, the Crown Office, the Police and other recipients are asked to ensure that this letter and attachment are distributed widely to all staff involved in the planning and delivering of services, care and accommodation for this care group (ie those who have committed an offence and also have a mental illness).

6. Each Agency is also requested to take the necessary steps to implement the recommendations within the attachment to this letter. Progress towards implementation will be monitored by The Scottish Office under established arrangements for these purposes. Where appropriate further guidance will issue in due course relevant to the action points identified in the attachment to this letter.

7. A copy of this letter and attachment are available on the internet (at www.scotland.gov.uk)

Yours sincerely

GEOFF SCAIFE
Chief Executive, NHS in Scotland

J HAMILL
Secretary, The Scottish Office Home Department

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Health Department

NHS Management Executive
St Andrew's House
Regent Road
Edinburgh EH1 3DG

HEALTH, SOCIAL WORK AND RELATED SERVICES FOR MENTALLY DISORDERED OFFENDERS IN SCOTLAND

The Scottish Office

1999

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PART I: REMIT AND GUIDING PRINCIPLES

1.1 This policy statement examines the provision of mental health and social work services for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work departments, the State Hospital and other psychiatric services in hospitals and in the community, and makes proposals for the organisation and development of these services throughout Scotland. This review does not in any respect change the role and responsibilities of Scottish Ministers in relation to State patients and is without prejudice to the work of the Millan Committee set up to review the provisions of the Mental Health (Scotland) Act 1984.

1.2 For the purposes of this paper 'mentally disordered offenders' covers those who are considered to suffer from a mental disorder as defined in the Mental Health (Scotland) Act 1984, whether or not they are, or may be, managed under its provisions and come to the attention of the criminal justice system. "Mental disorder" is used to cover those people with a mental illness or learning disability. The issues for people with a personality disorder, who do not commonly come under this heading, are also specifically considered. The term 'mentally disordered offender' covers wide variations in the state of mental health, in the severity of incidence in one individual over time and in the seriousness of actual or potential offending behaviour.

1.3 The overall objective is to promote the provision of a sufficient and effectively co-ordinated range of services (including health, criminal justice, social care, housing, education and employment and benefits advice) to meet the individual needs of mentally disordered offenders and the public interest. The public interest covers both the protection of the public and the most effective use of resources consistent with high standards of public safety.

1.4 In 1992 the Department of Health published the Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services (The Reed Report)(1) which related to England and Wales. This report has been widely accepted by clinicians and has become a part of the culture and working practice of forensic psychiatry in Scotland at a clinical level.

1.5 The Scottish Office policy on the delivery of these services is based on the same set of guiding principles and should be read with the Framework for Mental Health Services in Scotland (10). Mentally disordered offenders should be cared for:-

- with regard to quality of care and proper attention to the needs of individuals;
- as far as possible in the community rather than in institutional settings;

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- 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.

Services for mentally disordered offenders should include careful assessment and management of risk in appropriate facilities. Where possible general health and social care services for the mentally ill should be used for treatment and support. The offenders' rights as citizens should be respected. Care should be provided with attention to the specific and sometimes different needs of those in a minority by virtue of ethnic group, gender, creed or religion.

1.6 This review paper covers the services provided for 'adults', that is those aged 18 or over. The services may however on occasion be expected to deal with those aged from 16 to 18. The needs of children and adolescents are very specific and every effort should be made so that they are dealt with separately. It is acknowledged that young mentally disordered offenders are particularly vulnerable. The transfer of responsibility from teams concerned with children's and young persons' services to teams providing adult services should allow some flexibility. The appropriate age for transfer will vary from case to case and depend on the nature and complexity of the individual's condition.

Background

1.7 Service provision for mentally disordered offenders is a complex and difficult field. It covers many different agencies and professional groupings throughout the public, private and voluntary sectors. The boundaries between some of the service areas and the responsibility for co-ordination of services may be only partially or not sufficiently defined. There is a need to consider the effectiveness of the system as a whole and this paper attempts to do this by bringing forward a series of proposals for each of the individual service areas. At the same time it identifies the tasks to be addressed by health and social care service providers and those who require access to these services, including decision makers in the criminal justice system, eg procurators fiscal, the courts and the Parole Board. Given the interdependence of health boards, social work departments and voluntary agencies who are responsible for the bulk of service provision, there are many opportunities to create new working partnerships and to strengthen key areas, such as joint planning for the future of the services.

1.8 Although many mentally disordered offenders may be diagnosed as having more than one psychiatric condition, it is often the combination of medical and social factors which

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leads to their offending behaviour. The route to services for this group may be through social, criminal justice or health care agencies. The stated policy objectives should be effective joint responses for all, regardless of the severity of the presenting disorder, the seriousness of the offence, or the initial referral route.

1.9 Action will be taken forward by the relevant agencies which work together in this complex field. There are costs involved in providing the existing range of services and although additional costs may be associated with some of the key proposals there will be limited offsetting savings to be found elsewhere. The costs will have to be met within existing public expenditure totals.

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Co-ordination of Services and Public Safety

1.10 The co-ordination of services for mentally disordered offenders sets a special challenge. A large number of agencies is involved. From The Scottish Office point of view a range of financial and statutory relationships have to be accommodated within any overall plan. From the public point of view there is a need for reassurance that any dangerous behaviour by this group of offenders can be satisfactorily managed and contained at each level of service provision. Every stage of treatment should be preceded by a careful and detailed assessment of all the risks involved.

1.11 The mentally disordered offender is an individual who is entitled to treatment of his or her underlying condition and respect of their rights, as is any other individual. This is a matter which must take into account clinical and public protection issues. A variety of social and clinical facilities and treatments will be required within different settings and with varying levels of security so that the individual may be appropriately placed. Depending on the needs of the individual some of these facilities will be in hospital, some in prison and some in the community.

1.12 Providing the right services at the right time in the right place is particularly important for mentally disordered offenders. Thus, suitable psychiatric care or intervention may prevent or reduce offending behaviour. The right kind of secure hospital facilities will reduce pressure on the State Hospital. Good community support and related services will enable rehabilitation to take place in the community. The key to effective co-ordination is a clear overall framework with specific identification and acceptance of responsibilities. This paper sets out this framework.

The Framework

1.13 This paper examines the criminal justice process, the health and social care services and announces the policy for responding to the needs of the mentally disordered offender. A recurring issue in each section is that of sharing information between agencies. It is a basic principle that information about the health and welfare of a patient is confidential; that it must be safeguarded and that it should not be disclosed without the consent of the patient. Similar protections exist in relation to the information held by other agencies. There are, of course, circumstances where information can be disclosed without the patient's consent including where disclosure is in the public interest. For example where disclosure will prevent serious risk of harm to the individual or others and where it is necessary for the prevention, detection or prosecution of serious crime. The need for sharing or disclosure of information should be a consideration that is an integral part of clinical risk management.

1.14 While it is clearly important to safeguard patient information it is also essential that this should not act as a barrier to the provision of an integrated service. The decision to share

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information where it is in the interests of the patient and where appropriate safeguards are in place must be taken locally by a senior health professional or appropriate senior professional within other Agencies. Ideally this should be done with the agreement of the patient. The Scottish Office, Department of Health recognises that there needs to be a consistency of approach in this area however. It is therefore the intention to take forward work with other Departmental interests to identify the key principles and practical issues relating to the sharing of information and to develop guidelines and protocols are required and which can be adopted locally. These will be developed taking account of professional guidelines including those of the GMC and UKCC.

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PART II: THE CRIMINAL JUSTICE PROCESS

This section addresses those aspects of the criminal justice system which relate to mentally disordered offenders and, in particular, police procedures, procurator fiscal decision-making, court disposal and transfers to and from prison. The roles of health boards and local authorities are also considered along with the requirement for joint planning and working.

2: INVESTIGATORY PROCEDURES

Background

2.1 When a person appearing to suffer from a mental disorder comes to the attention of the police, whether or not criminal proceedings are involved, a medical opinion should be sought immediately, either from the person's own doctor if the incident occurs within the person's own home, a police surgeon or a hospital doctor. This examination may take place within the person's own home, at a "place of safety" (normally a hospital), or in exceptional circumstances within a police station for instance when there is a continuing risk of violence.

2.2 When such a person is found in a public place, and not necessarily suspected of having committed an offence, but who is in "immediate need of care and control" may be removed by the police (under Section 118 of the Mental Health (Scotland) Act 1984 (the 1984 Act)) to "a place of safety". The Act defines this as a hospital or residential home for persons suffering from a mental disorder or any other suitable place which is willing temporarily to receive the patient; but does not include a police station unless in an emergency when there is no alternative place available for receiving the patient. Wherever possible, local arrangements based on an inter-agency approach should ensure that a mentally disordered person receives appropriate support and care. If a police station has to be used, then a police surgeon or other doctor should be readily available. The consultation paper which issued in July 1997 on 'The roles and responsibilities of general practitioners and police in dealing with potentially violent mentally disordered persons in the community' explains this process in more detail (2).

2.3 Where persons who might be suffering from a mental disorder are taken to a police station, for example, due to the seriousness of the suspected offence, they are often seen first by a doctor contracted to the police, namely the police surgeon, to assess the medical condition of people who are in police custody. The role of these police surgeons is to make an assessment of the individual's fitness for detention by the police. The police surgeon should obtain any necessary medical background from the person's own GP, if possible, before reaching a decision on his or her fitness. If the person is considered to be fit for detention, the police would deal with the suspected offender under the terms of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act) as with any other suspected offender. If the mentally disordered person is considered to be unfit for detention, then they are considered

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for hospital placement under the relevant section of the 1984 Act. A report may still be submitted to the procurator fiscal for consideration of criminal proceedings. Some police surgeons may have little experience of dealing with mentally disordered people. In these cases assessment should be carried out preferably by an experienced psychiatrist who can then arrange appropriate mental health care, if necessary.

2.4 In some areas the operation of duty psychiatrist schemes, where experienced psychiatrists provide a prompt response to requests to examine people held in custody in police cells has demonstrated the value of the police being provided with an easily accessible psychiatric consultation service. In every case local arrangements between mental health services and the police should be in place.

2.5 The combined police, social work and health guidance "Interviewing People Who are Mentally Disordered: Appropriate Adults Scheme" (3) recommends that when the police interview an individual who is suspected of being mentally disordered, whether he or she is an accused, a witness or a victim, an "appropriate adult" should also be present. An appropriate adult should be someone who is completely independent of the police and, where possible, the interviewee and who has a sound understanding of and experience or training in dealing with mentally disordered persons or with the needs of a particular group. The guidance encourages the establishment of Appropriate Adult schemes throughout Scotland by June 1999, with police, social work and health interests locally nominating a lead agency.

Police Discretion

2.6 Where criminal behaviour is involved but only minor offences have been committed, the police may decide against charging and reporting the case to the procurator fiscal. In order to decide whether or not to report a case involving an alleged offender whose behaviour suggests that he or she may be suffering from a mental disorder, police need quick access to information and advice from health and social work services. Ideally local arrangements should provide for a single point of entry for referrals and for collaboration between health services (psychiatrists and community psychiatric nurses) and social welfare services (to include local authority criminal justice, community care and housing services as well as voluntary sector agencies). The police will particularly want to know whether the alleged offender is already under the care of the health or social services or whether to refer the person to one or both of these services before deciding whether charges should be brought. There should be hospital services available to accommodate mentally disordered offenders at short notice where they require containment for assessment or treatment in clinical facilities with an appropriate degree of security. This need may be independent of the severity of the alleged offence. Such individuals should not be left in custody while the process of law continues. In most cases a report will ensue and ultimately any decision to divert or remove the offender from the criminal justice process is a matter for the procurator fiscal, (see paragraph 5.18. While decisions about placement in the mental health system may need to

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take place urgently, decisions to drop charges should not. Discussion about this can take place with the psychiatric team involved in the patient's long term care. If a mentally disordered offender is considered to pose a severe risk to others, there should be careful consideration of the security requirements. Hasty decisions should be avoided.

Deciding about Prosecution

2.7 As with the provision of information and advice to the police, there needs to be good co-ordination between those responsible for providing information and advice to procurators fiscal. Local arrangements should provide a single point of entry for referrals as stated in the previous paragraph. (See also paragraph 5.18.)

2.8 Identifying those alleged offenders who may be suffering from a mental disorder is critical to this approach. Basic awareness training for police officers is already included in probationer, constable and detective training, and the Appropriate Adults guidance (3) recommends additional training in this area, covering how to identify mental disorder, basic techniques for dealing with mentally disordered individuals and appropriate forms of questioning. Police may also be able to make better use of information which is already available about repeat offenders previously identified as having a mental disorder and ensure that that is communicated to the procurator fiscal in the report. Procurators fiscal will also take account of such information and would welcome approaches by others with a knowledge of the accused and his circumstances.

2.9 As well as effective joint planning of the service to fiscals, each agency needs to be in a position to commit the necessary resources. Local arrangements for direct referral by the procurator fiscal for psychiatric assessment should be available. The correct identification of alleged offenders with mental disorder and the alerting of the procurator fiscal to the suspicion is a key trigger for accessing specialist services. It is also important for the police and the procurator fiscal to establish whether repeat offenders have been previously identified as suffering from a mental disorder, before deciding how best to proceed with cases.

The Health Board Role

2.10 Mentally disordered people who come into contact with the law should receive care and support from health or social work services. Health boards should ensure that this provision is covered by appropriate agencies. The service specification should ensure that mentally disordered individuals in police custody are examined by an experienced psychiatrist within 24 hours of the request being made. Health boards should ensure access to appropriate beds so that, if admission to hospital is appropriate this can be arranged quickly.

The Local Authority Role

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2.11 Local authorities contribute to services for mentally disordered offenders through their responsibility for planning and providing community care services in partnership with the NHS, through their responsibility for providing social work services in the criminal justice system and through their responsibility for housing services. They have statutory responsibility for providing mental health officers under the Mental Health (Scotland) Act 1984. In seeking to meet the needs of the mentally disordered offender, the role of criminal justice social work services is primarily concerned with providing information and advice for decision makers and with helping to access appropriate assessment, health and social care services. Their job is to complement the work of other local authority and health services in providing for those suffering from mental disorder who have offended. Housing services are a responsibility of the same unitary authority.

Joint Planning

2.12 Mentally disordered people have widely differing needs. Some require specialist services because of their offending behaviour but the majority can be looked after within the general mental illness or learning disability services. Multi-agency joint planning and resourcing of these services by health and social work agencies should be geared to meeting the needs of mentally disordered people who offend and, in particular, should provide, wherever possible, for their diversion from the criminal justice system at the earliest opportunity. Housing departments and other agencies will have an input where placement in the community is envisaged. Services for people with learning disabilities should be distinctively tailored to the health, education and social care needs of such persons.

2.13 A network of health and social care services, available to each police authority and procurator fiscal service, is required if the needs of mentally disordered people who come into conflict with the law are to be met and the right balance struck between meeting these needs and those of the public interest. Development of such networks should be an integral part of joint planning between the courts, police, criminal justice social work, community care and health services.

The Service Requirement

2.14 Health boards and social work departments should work together to develop services for mentally disordered people who come into contact with the criminal justice agencies through joint planning procedures which are already an integral part of the community care process. Health boards and local authorities should enter service level agreements with the criminal justice agencies to provide effective and flexible local arrangements for the initial assessment and treatment of people in their charge who appear to be mentally disordered. Procurators fiscal should be involved in discussions as to levels of service. These service agreements should cover:

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- the use of Section 118 of the 1984 Act ("removal to a place of safety");

- the availability to the criminal justice agencies of "duty psychiatrists" and "appropriate adult" services;

- the facilities and services that can be used for mentally disordered people diverted from the criminal justice system;

- the provision of specialised accommodation for mentally disordered accused persons who might otherwise have to be remanded unnecessarily in custody; and

- the specification should address the 3 levels of service to be provided:

    (1) emergencies within 24 hours;

    (2) urgent cases to be covered within one week; and

    (3) routine cases to be completed within 3 weeks.

- the specification should also cover the training needs of those who will be required to operate these services on a day-to-day basis.

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3: COURT PROCEEDINGS

The criminal courts require assistance in the following areas:

- *in assessing the fitness of an accused to plead;*
- *in assessing the state of mind of an accused person at the time of the offence;*
- *the disposal of a case where an Examination of the Facts (EOF) makes a finding that the person did the act or made the omission constituting the offence; and*
- *the disposal of a case if a person has been found guilty of an offence.*

This section addresses these requirements and identifies proposals for the improvement of the services available including multi-disciplinary assessment in the larger courts and the development of an emergency psychiatric service.

The Health Service Role

3.1 When the prosecution service suspects that an accused is mentally disordered, they will ask for a report from the local psychiatric service. Expert witness reports from psychiatrists and clinical psychologists may be provided for the prosecution, or defence. An assessment of mental disorder may be made at an early stage, with a recommendation for remand to hospital under the Criminal Procedure (Scotland) Act 1995, if the psychiatrist considers the person to be mentally disordered and detainable under mental health legislation. This allows for the gathering of more information and a further period of assessment before any final recommendation is made on disposal.

The Local Authority Role

3.2 Following conviction, or a finding at an Examination Of the Facts (EOF) that the person did the act or made the omission constituting the offence, the court may ask for a social enquiry report (SER) to be provided by criminal justice social work staff in accord with national standards, or a psychiatric report, or both. The court must obtain an SER in certain circumstances and may request one in any case.

3.3 The SER will include information and analysis of those aspects of the offender's circumstances and personality which may have a bearing on the person's offending behaviour. One aspect involves an initial assessment/screening of the offender's apparent state of mental health. If concerns are identified, the author of the social enquiry report can suggest that the court obtains a formal psychiatric report. Alternatively, the author may establish that the offender is currently receiving or has received treatment and may seek

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information and advice from the relevant medical services to include in the SER. The SER will also review disposal options appropriate to the assessment which has been made of the offender. The content of the SER is disclosed to the offender.

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Bail Decision-making

3.4 Mentally disordered people have the same rights as others to be considered for bail and they should not be deprived of this right. However, the police or court may be inhibited from releasing a suspect or granting bail, if a suspect is homeless, or because there is doubt whether the individual can understand an obligation to attend court if released. Social work departments can provide information and advice relevant to the decision by the court about whether to grant bail. Two bail information/supervision schemes have been established in Scotland (see paragraph 5.17) which check information about an alleged offender, access resources and, when requested by the court, offer a supervision service. Where no such scheme is in place, it is still possible through the arrangements for planning local authority criminal justice and community care services to provide for assessment, supervision and accommodation to be made available to the court in suitable cases. (See paragraph 5.20 also.)

Multi-disciplinary Assessment

3.5 Good practice suggests that the principle of multi-disciplinary assessment should apply so that the offender's health and social care needs can be fully investigated and comprehensive advice can be provided to the court to assist in decision making.

3.6 There are cases where symptoms of a mental disorder are not recognised until an individual appears in court or is remanded to prison. In such cases the psychiatric service provided for each health board's residents should therefore specify that the courts and procurators fiscal in their area require a promptly delivered psychiatric assessment service to assist the transfer of an accused person to hospital as and when required. Development of a service involving a duty psychiatrist with access to community or hospital resources would be the preferred means. The psychiatric service needs to be complemented by a multi-agency network of services including clinical psychology, nursing, social work and housing.

3.7 The commitment of staff and resources to multi-disciplinary assessment arrangements at the post conviction stage should be an integral part of the same joint planning among court, social work, criminal justice community care, and health as discussed earlier in relation to formal diversion (paragraphs 2.12, 2.13). Normally an offender, considered by the Court to be mentally disordered and who has committed an imprisonable offence has sentence deferred for an SER and/or psychiatric reports to be obtained. The Criminal Procedure (Scotland) Act 1995 governs the time periods that apply to these procedures. Assessments of this kind are best carried out in the community (whether in hospital or an out-patient clinic). It should not be necessary to remand the offender in custody for the sole purpose of enabling assessment.

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3.8 The court requires a properly co-ordinated multi-disciplinary assessment. To ensure a single entry system, arrangements for assessments of this kind should be the responsibility of the social work department (criminal justice social work services). The number of contributors to the assessment will depend on the circumstances of the case and on local court arrangements. Possible contributors should include psychiatry, social work community care or family services, clinical psychology, primary care and housing. Unless there are exceptional reasons, contact with the offender's family is an essential part of the assessment. Consideration, as known, of the issues relating to the victim, victim's family and the public are also an essential part of these assessments. The aim should be to develop, for the court, where appropriate, an individual service plan which identifies the potential range of services available to the offender in association with a suggested court disposal. If the court appearance results in custody, the plan should be sent to the prison by the Sheriff Clerk to inform work with the prisoner by prison-based medical and social work services.

3.9 To implement these proposals effectively, the authors of SERs need to have the skills and capacity to screen for mental health problems and to comment on the possible impact of a custodial sentence on someone with an identified mental health problem. This requires training which, subject to local agreement, should include other agencies involved to ensure all work from the same instruction base. See also paragraph 6.35.

3.10 A properly co-ordinated procedure for preparing multi-disciplinary assessment reports will be developed as a means of identifying the range of options available for mentally disordered offenders.

3.11 This approach requires more time for preparation of the reports and for consideration by the criminal justice agencies. Experience elsewhere has indicated that courts are prepared to provide longer adjournments (up to 8 weeks) to assist this procedure. The liaison required in preparing the reports will lead to increased collaboration in the provision of health and social care services for those who come before the courts.

3.12 Whatever local arrangements apply, supervised accommodation within the criminal justice network will not fully meet the needs of people with a range of mental disorders. Providing accommodation to ensure that accused persons who are mentally disturbed are not remanded unnecessarily in custody is largely a matter for community care service level agreements between health boards and local authority social work departments. Community arrangements will be inappropriate for the severely mentally disordered for whom local hospital care should be available. Local authorities and health boards should review the accommodation services provided for mentally disordered persons to ensure that they are not remanded unnecessarily in custody and that, wherever possible, they can be supported under existing community care arrangements.

Community-Based Disposals

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Deferred sentence

3.13 There are two main ways in which the court's powers to defer sentence may be used to deal with offenders with identified mental health problems. If the offender is receiving treatment, a deferred sentence provides a means for the court to allow the treatment to continue and to check its progress. A deferred sentence could also be used to motivate the offender to face up to the need for treatment. Voluntary support could be provided by the social work department or other social care agency to assist the individual in this respect.

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Edinburgh EH1 3DG

Supervision and treatment orders

3.14 The court can impose a supervision and treatment order on a person judged unfit to stand trial but who was found at an 'examination of the facts' to have done the act with which he was charged, or on a person who has been tried but acquitted on the ground of insanity at the time the act was committed. As the title of implies, this disposal involves both supervision and treatment in the community. It will be made only when the court considers it the most appropriate of the disposals available in these special circumstances, in respect of a person with a mental disorder who is considered able to live in the community with support and assistance from health and social care agencies. A joint circular of guidance has issued, (13).

Guardianship order

3.15 A guardianship order may be made by the court after consideration of an application by a Mental Health Officer made with the support of two doctors. As with supervision and treatment orders, the powers to enforce the order are limited and its use is best suited to mentally disordered offenders who may themselves require to be protected from abuse and who will adhere to the conditions laid down in the order. These may relate to arrangements for treatment/oversight and to where they should live. This order may be particularly suited to people with a learning disability.

Probation order with a condition of psychiatric treatment

3.16 The court may make a probation order of up to 3 years with a condition of psychiatric or psychological treatment of no longer than 12 months if it is assured that treatment is available either in an in-patient or an out-patient basis. The offender must give his/her informed consent. Orders of this kind require close co-operation between health and social work services. Primary responsibility for enforcing the order rests with the social work department (usually criminal justice social work services) but provision of individual care services remains with health/community care. The supervisory responsibility includes checking that the required treatment takes place and that a report is made to the court if, for whatever reason, it does not. Any recommendations to the court to make a probation order with a condition of psychiatric treatment should include an action plan setting out clearly the contribution of health, social work and any other social care agencies. This plan should be arrived at jointly and include the participation of offenders so that they can give their informed consent. The plan should set out clearly the commitment of the agencies involved. National standards for the supervision of probation orders require that progress is reviewed at regular intervals. These reviews should, wherever possible, involve the participation of all the agencies contributing to the action plan. A circular of guidance by the Home Department and the Department of Health is in preparation (1998).

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Hospital-based disposal options available to the Courts

3.17 For the purposes of this section references to "hospital orders" and "restriction orders" include references to orders that have the same effect as hospital orders and restriction orders. Before a person can be committed to hospital certain statutory conditions must be met, including that the grounds for admission to hospital set out in section 17(1) of the 1984 Act apply in relation to the person. The Mental Welfare Commission's protective duties (under the 1984 Act) towards people with mental disorder apply equally to mentally disordered offenders.

Remand for inquiry into physical or mental condition/Interim hospital orders

3.18 Under the Criminal Procedure (Scotland) Act 1995 courts have the power to remand an alleged offender in custody or on bail or commit him to hospital for up to 3 weeks at a time so that a medical examination and report may be made before deciding how to proceed. In certain circumstances the courts may impose an interim hospital order (maximum length 12 months) before proceeding to deal with the offender either by making a hospital order or in some other way (eg passing a sentence of imprisonment, with or without a hospital direction). The order is to allow sufficient time for a thorough assessment to be made of the person's mental condition where there would otherwise be difficulty in making such an assessment in the time available.

Hospital orders

3.19 Hospital orders can be made by the courts in the following circumstances:-

(i) where a person is convicted of offences punishable with imprisonment (other than offences for which the sentence is fixed by law);

(ii) where a person is acquitted on the ground of insanity at the time of the act or omission charged, either by a court or at an EOF; or

(iii) where an EOF makes a finding that the person did the act or made the omission constituting the offence.

Offences not punishable with imprisonment are excluded on the basis that it would be more appropriate to proceed under the 1984 Act in such cases. Hospital orders may be made only by the High Court or a sheriff court. These courts may not, in addition to making a hospital order, pass sentence of imprisonment or detention or impose a fine or make a probation order or a community service order. District courts have the power, in terms of the Criminal Procedures (Scotland) Act 1995, to remit a case to a sheriff court, if mental disorder is suspected.

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Restriction orders

3.20 Where a hospital order is made in respect of a patient the court may also make a restriction order. The test for making such an order is that the court must be of the opinion that it is necessary 'for the protection of the public from serious harm' to make the order 'having regard to the nature of the offence with which the person is charged, the antecedents of the person and the risk that as a result of his mental disorder he would commit offences if set at large'. The majority of prisoners transferred to hospital are also subject to a restriction direction. Any transfer of such patients within the hospital system to an area of lesser security requires the approval of the designated Scottish Minister.

Hospital directions

3.21 The courts may, when passing a sentence of imprisonment after conviction on indictment, direct that the offender be admitted and detained in hospital for continuing care. Once recovered he would transfer to prison if any balance of the prison sentence remained to be served. Otherwise, when the sentence expired he would be released direct from hospital into the community, unless he was still ill, in which case he may be subject to detention in hospital under civil procedures.

Leaflet for Victims of Mentally Disordered Offenders

3.22 A leaflet will be available from The Scottish Office for victims of mentally disordered offenders which includes factual information about the processes that apply to offenders who are ordered to be detained in mental illness hospitals under the Criminal Procedure (Scotland) Act 1995 and who are as a result subject to the Mental Health (Scotland) Act 1984.

4: SCOTTISH PRISON SERVICE

The Scottish Prison Service is committed to commissioning health services, including mental health services comparable within the constraints of imprisonment, to those available to other citizens.

Provision in Relation to Prisoners

4.1 In the light of the guiding principles outlined in paragraph 1.5 problems of mental illness among prisoners require a coherent response from the Scottish Prison Service, the health service and local authorities. This should take the form of a care management approach to the extent that the problems of individual prisoners warrant it and the constraints imposed by imprisonment allow. This could be facilitated by service level agreements between prison managers and health providers and between prison managers and the relevant

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social work departments. The aim should be the provision of a continuous, integrated throughcare package which maximises access to community based services at each stage: health, community care services and specialist voluntary sector services. So far as possible within the constraints of resources and of imprisonment, the Scottish Prison Service aims to provide or commission services for prisoners with mental health problems in line with best practice in the wider community. The number of registered mental nurses within Scottish prisons continues to rise, and they should be involved in the assessment of those suspected of suffering from a mental disorder.

The Nature and Scale of the Problem

4.2 The Prison Service will deal both with prisoners whose mental disorder may be appropriate for medical intervention and those whose disturbed behaviour is not the result of mental disorder as defined earlier. While the number of prisoners with psychotic illness who might be accepted for transfer to hospital is quite small, research suggests that the rate of psychological disturbance in Scottish prisons could be at least twice that in the general population and perhaps even higher among female prisoners. Experience suggests that prisoners are most at risk of developing, or suffering exacerbation of, mental health problems in the period immediately following reception, whether on remand or after sentencing. The loss of social acceptance, of material possessions, general medical conditions and separation from family, friends and other social supports can be expected to have a detrimental effect on mental health.

Identifying and Responding to the Problem

4.3 Those entering prison with a current mental illness problem pose particular difficulties. For others, a period in prison may expose an underlying condition, while some prisoners may develop a mental illness for the first time during custody. All such individuals need accurate diagnosis and appropriate health and social care. Local authorities will have an important contribution to make towards identifying and helping these vulnerable prisoners. For prisoners with mental illness, prison managers in preparing such agreements will consider what contribution might be made by relevant social work services available within the community, eg community care teams, mental health teams, hospital social work, specialist voluntary sector programmes, befriending schemes etc.

The Mental Health Needs of Prisoners

4.4 The following groups of prisoners, whether sentenced or on remand, may seek health service intervention for problems related to mental disorder, or be referred to medical staff by concerned staff:

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(1) Those who have a mental disorder which falls within the categories set out in section 1 of the 1984 Act. Prisoners in this group should transfer to hospital if they meet the statutory transfer criteria of the 1984 Act.

(2) Those who have a mental disorder but who do not meet the criteria for transfer to hospital.

(3) Those who ask for the help of the caring agencies within the prison system, although they may not specifically fall within categories (1) and (2) above.

Psychiatric Assessment and Treatment, including Transfer to Hospital

4.5 Mentally disordered prisoners need access to psychiatric care in prison and, if their condition merits it, admission to hospital services which offer an appropriate level of security. Prisoners who do not meet the criteria for hospital admission need to be treated in prison under a suitable regime agreed with the psychiatric services or on an "out-patient" basis. Specialist forensic psychiatric care should be provided to all prisons with links to local forensic and general psychiatric services. Just as many in the wider community will receive psychiatric care from a general practitioner, so many prisoners will receive psychiatric care from the medical officer (generally a visiting general practitioner). As some offenders will develop a mental disorder while in prison, The Prison Service must be able to identify those who need psychiatric care and, where appropriate, to arrange a transfer under the 1984 Act.

4.6 A person who develops a mental disorder while in prison on remand may not meet the statutory criteria for transfer to hospital under the 1984 Act. In such cases access to health and social work services in the community can be arranged if the court agrees. The proposed system for co-ordinating court reports (see paragraph 3.11) will enable the courts to make full use of alternatives to imprisonment. In order to ensure that those within the Scottish Prison Service responsible for looking after the needs of those who may be mentally unwell are able to do so, it is proposed that copies of the psychiatric court report accompanies the prisoner from court to prison. This should be the responsibility of the Sheriff Clerk. Reports should be marked "Confidential" and to be opened only by health care professionals within the prison. It is also essential that the prison medical officer is able to access essential information about a prisoner's psychiatric history. Links should therefore be formalised between prison medical officers and psychiatrists who previously have been responsible for a prisoner to ensure that relevant information is made available to the prison medical officer.

4.7 Prison managers should make suitable arrangements with health boards for the rapid assessment and transfer of prisoners suspected of suffering from a mental disorder. It is proposed that prison managers should arrange appropriate accommodation within the prison for psychiatric assessment and prison medical officers should ensure that full medical information on the prisoners being assessed is available to visiting psychiatrists.

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Return to prison

4.8 Prisoners transferred to hospital who recover from their mental disorder within the period of their sentence are required to return to prison. Similarly patients, to whom the new hospital direction applies, will, when hospital treatment is no longer needed, be required to transfer to prison to complete their sentences. Effective liaison should therefore exist between the responsible medical officer and The Prison Service. It is proposed that service commissioners should require treating responsible medical officers to submit regular progress reports on prisoner patients to the prison medical officer, visiting psychiatrist and The Scottish Office, Department of Health forensic psychiatric adviser. These reports should provide an early warning for both the visiting psychiatrist and the prison medical officer of any intention to return the patient to prison so that the necessary care and support can be allocated on the prisoner's return. At the point of return the responsible medical officer should provide the prison medical officer and visiting psychiatrist with an updated report. The majority of such prisoners will be subject to a restriction order and therefore cannot be returned to prison without the approval of the designated Scottish Minister. A warrant for this purpose should be requested from The Scottish Office.

Social Work Services

4.9 National standards require prison-based social workers to give a high priority to those prisoners identified as being vulnerable, including those at risk of self-injury or with other mental health problems. However, not all prisoners falling within categories (2) and (3) of paragraph 4.4 make use of social work services either from choice or because of the priority that can be afforded to the large number of prisoners received on remand or for short sentences.

4.10 Prison-based social workers must be alert to the possibility of mental health problems and possess the skills to identify and assess the needs of such prisoners, or have access to someone who can so advise. They need to be able to recognise those factors which have been identified as associated with increased vulnerability amongst prisoners, eg isolation, lack of contact with family and community supports, previous contact with psychiatric and community-based mental health services, previous self-harm, erratic behaviour etc. It should be standard practice for those preparing social enquiry reports to alert the social work unit in prison to any concerns they may have about the mental health needs of remand prisoners. This will allow prison-based social work staff to respond accordingly. They already have the obligation to alert prison management where they consider a prisoner may be at risk of self-harm. Equally, where prison social workers have concerns about the mental health of a remand prisoner, this information should be available to those preparing social enquiry reports. Information about mental health problems of prisoners, whether on remand or sentenced should be shared between prison social work staff, prison staff and health

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professionals on a need to know basis: arrangements will need to be in place to ensure that this happens.

4.11 Once community-based multi-disciplinary assessment procedures are established as proposed in section 3 (paragraph 3.11), these could be used to assess offenders remanded in custody who have mental health problems, to put together individual care plans and increase the disposal options available to the courts.

Aftercare on release

4.12 Local authority criminal justice social work staff have lead responsibility for pre-release planning and assistance with resettlement in the community for those prisoners who will be subject to statutory supervision on release. Where prisoners with mental health problems and those not subject to supervision on release seek assistance with resettlement in the community, decisions about whether the lead responsibility for an individual care plan should rest with health or community care social work staff will be determined by the severity and complexity of the prisoner's mental health problem. In either event, local authority and health personnel will require to work together to ensure that the health and social care needs are adequately met. Consultation with other agencies which might have a contribution to make towards the care plan is an essential part of joint work involving housing, education, employment, social security and specialist mental health organisations.

4.13 Where prisoners are released on statutory licence, including extended sentences, it is the responsibility of the supervising officer to ensure that the conditions of supervision are met, including any conditions which require medical or psychological treatment and that any such medical treatment is taking place. If it is not, whether through non-compliance by the supervised person or for some other reason, the supervising officer has to decide what action to take, wherever possible in consultation with the relevant health professional. Where the supervisor considers there is a risk of self-harm or harm to others as a consequence of failure to comply with any of the conditions, this should normally result in a report to the Parole and Miscarriages Review Division, of the The Scottish Office Home Department along with a recommendation on what action might be appropriate. In the case of supervised release orders the supervising social worker will report back to the court in every case where treatment is not being provided, irrespective of the degree of risk arising from the absence of such treatment.

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Serving prisoners

4.14 The Scottish Prison Service is aware of the benefits of developing multi-disciplinary supportive interventions for prisoners with mental health problems. This involves clinical psychologists, psychiatrists, mental health nurses, occupational therapists, social work, residential and education staff. The experience of the Barlinnie Mental Health Project ("Open Doors") suggests that this approach may offer a useful model for improving the quality of mental health services in penal establishments and may provide useful lessons for wider application - both in terms of preventing the inappropriate use of custody for remand prisoners and improving access to community-based services following sentence.

4.15 In terms of regime development, under the sentence management scheme the Scottish Prison Service is developing further opportunities for group work programmes and cognitive/behavioural learning. Assistance with social support networks in the community and the development of pre-release planning (as noted above, para 4.12) will also be important.

The Service Requirement

4.16 The Scottish Prison Service is developing service level agreements with local authority social work departments for the provision of all social work in prison, including that in respect of prisoners with mental health problems. Prison governors will enter service agreements with local health service providers for a forensic psychiatric service which will match the operational requirements of penal establishments. The service level agreements will cover the purchase of appropriate services from health and social work. These agreements will specify the identification and assessment of mental disorders, crisis intervention and continuing treatment on the basis of individual care plans, for those for whom transfer from hospital is either not possible or delayed, and effective programmes of aftercare. There should also be a specified requirement to have local NHS beds available for admission if required. The service specification should also require a response within 24 hours for emergencies, with urgent cases being dealt with within a week and routine cases within 4 weeks of referral.

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PART III: PROVISION OF HEALTH AND SOCIAL CARE SERVICES

This section describes the health and social care services for people defined as mentally disordered and who need assessment, treatment, rehabilitation and after care because they have come into conflict with the law. It includes an element of taking stock and illustrates both the complexities and interdependence of the various strands of service provision.

5: CURRENT HEALTH AND SOCIAL WORK SERVICES

HEALTH SERVICES

The General Practitioner

5.1 General Practitioners have an important role to play in early diagnosis and, by intervention and treatment of mentally disordered people, they may reduce the potential for anti-social behaviour and help to avoid offences against the law. GPs are also responsible for the general medical care of offenders who have been discharged from a long-stay mental hospital and consequently can support their rehabilitation programmes. Good practice guidance on the implementation of Care in the Community emphasises the need for effective inter-professional collaboration between the local psychiatric team, GPs and all members of the primary care team. The Care Programme Approach (4) in particular requires the key worker to keep the GP fully informed of adjustments and changes to individual programmes. Guidance to GPs and practice staff on the management of potentially violent patients is being prepared (1998). Effective communication between GPs and specialist forensic and general community mental health teams is essential at all times and especially when the care of the patient transfers from one team to another, ie from a young persons' team to a team caring for adults.

Local General and Forensic Psychiatric Services

5.2 The general psychiatric service, supported by forensic psychiatrists, provides most of the care for mentally disordered people including those who offend. This service is multi-disciplinary and involves doctors, nurses, clinical psychologists, occupational therapists and social workers at its core. It covers the assessment of mentally disordered offenders; the preparation of reports for the procurator fiscal and for the courts; the acceptance into local hospitals of people diverted from, or sentenced by the criminal justice system, and of State Hospital patients who no longer require such a high level of security; and the supervision of patients, including those subject to restriction orders who are in hospital or who are conditionally discharged into the community. A circular of guidance by the Scottish Office Home Department and the Department of Health will issue in 1999.

Out-Patient and Community Services

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5.3 Multidisciplinary teams and out-patient clinics provide support and follow-up for patients in the community. A proportion of these patients will be offenders. A wide range of input is possible, including continuing assessment by the psychiatric team, occupational therapy, psychological intervention and support for the patient and their family. The Care Programme Approach may be formally used to co-ordinate services.

In-Patient Care

5.4 The open door policy in psychiatric hospitals has a long history. However, not all psychiatric patients can be managed in this way. A number of groups have special needs in their psychiatric treatment. These include:

- the acutely disturbed who can cause disruption and discomfort to other patients, or may harm themselves seriously and who require short periods of intensive psychiatric care;

- forensic admissions for assessment and treatment remitted from courts and prisons to the State Hospital. They require a well-structured programme usually in conditions that provide some security.

- a group of patients with a serious, enduring mental illness with associated behavioural problems. Some of these patients may have had no contact with the criminal justice system.

Many of these patients have been managed locally throughout their illness while some may have spent a period of time at the State Hospital. The clinical teams make carefully considered and planned judgments for individuals undergoing rehabilitation to establish how and when patients are ready and able to assume greater responsibility for their own treatment and behaviour.

Intensive Psychiatric Care Units

5.5 Intensive Psychiatric Care Units (IPCUs) have not been generally regarded as secure but have been used jointly to provide intensive care for acutely disturbed patients and as forensic facilities for offender patients due to the lack of specific alternative accommodation. The units provide modest physical security, for example, lockable reinforced doors and windows, but largely depend for their security on higher than average staffing levels and a skilled nursing input. An IPCU may be a mixed or single sex unit and each nursing charge is usually not larger than 12 patients. They aim to provide adequate space and offer scope for meaningful day and evening activities for the patients. There is increasing tension between the needs of mentally disordered offenders accommodated in this way and those patients

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requiring acute and intensive care. Referrals and refusals of admission require close monitoring by the service manager responsible for the IPCU in order to ensure that the unit can rapidly accommodate those patients who cannot be managed in more open wards.

Forensic Psychiatric Services

5.6 Forensic psychiatry, which developed as a sub-speciality of psychiatry is the area for inter-action between psychiatry and the law in all its aspects. Forensic psychiatrists are concerned with the assessment, treatment, rehabilitation and after care of patients suffering from a mental disorder including those who offend or who are considered likely to offend. The service also covers some non-offending patients including those who are difficult to manage but whose behaviour is responsive to control and treatment. They provide a tertiary service and can give specialist advice to general psychiatrists and take over the treatment of some of the more difficult patients with behavioural problems.

Secure Provision

5.7 A small proportion of mentally disordered people present sufficient risk to themselves or others to need more secure care. Beyond the IPCUs there have been some attempts to provide low secure care for patients with enduring mental illness. However the only designated secure provision currently in Scotland is that of high security care at the State Hospital, Carstairs Junction. The State Hospital provides for persons who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities, as detailed in the 1984 Act. In Scotland some patients who may only require medium secure care are treated together with those who require high secure care at the State Hospital. (Security at the State Hospital is of a higher level than obtains in the medium secure hospitals in England and Wales and is equivalent to that of the Special Hospitals.)

The State Hospitals Board for Scotland

5.8 The State Hospital, is a high security hospital administered for Scottish Ministers as a Special Health Board. It serves as the Special Hospital for Scotland and for Northern Ireland and accommodates patients admitted under the Mental Health (Scotland) Act 1984 or Criminal Procedure (Scotland) Act 1995 and equivalent legislation in Northern Ireland. The State Hospital can accommodate up to 240 patients. Its ability to accept new referrals is dependent on Health Boards ensuring local facilities and support services are available for the transfer back of those patients who no longer require its special facilities.

SOCIAL CARE SERVICES

Local Authority Services

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5.9 The Social Work (Scotland) Act 1968 places a general duty on local authorities to provide for those with social welfare needs, including persons suffering from mental illness, in their areas. Further to this Section 8 of the 1984 Act requires local authorities to provide after care services for "any persons who are or have been suffering from mental disorder". The National Health Service and Community Care Act 1990 (the 1990 Act) gave local authorities the lead responsibility to develop community care plans and assess the individual needs of people for community-based social work services. The Act also introduced a specific grant for the development of mental illness services.

Mental Health Social Work

5.10 Social work authorities have a general duty of assessment and care management of vulnerable people including those who have mental health problems. Social workers play a number of roles in discharging this duty. They may be care managers in community care, criminal justice or children and family social work teams; they may be members of a multi-disciplinary community mental health teams; or they may be in out-of-hours teams or they may work in hospital settings.

5.11 Social work services are available in most general and psychiatric hospitals. Hospital social workers contribute as members of a multi-disciplinary team to patient assessment, treatment and rehabilitation, and work with families or carers. They also play a key part in mobilising community resources and in the rehabilitation process for patients who are being prepared for their return to the community. In addition hospital social workers prepare reports, prior to the removal of special restrictions applied to a patient under the 1995 Act, and may be appointed to act as the supervisor for restricted patients conditionally discharged from hospital.

5.12 A small number of social workers are based in the NHS primary health care service working in health centres dealing with social problems caused by mental illness or learning disability. In these locations they can also provide social care for people when they leave hospital.

Mental Health Officers

5.13 The social work departments of local authorities are required under the 1984 Act to employ Mental Health Officers (MHOs) who are experienced social workers with specific professional qualifications and who have completed an approved training programme. MHOs have a range of statutory duties and responsibilities including contributing to the social work department assessments of mentally disordered people; involvement of relatives in short term detention procedures; applications for long-term detention; consideration of guardianship; and after care.

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5.14 MHOs may be placed in any of the settings identified in paragraph 5.10. They must work closely with health professionals and can make an important contribution to work with mentally disordered offenders. MHOs are sometimes involved at an early stage with people suspected of having committed an offence, for example, in assessing people for possible detention under the 1984 Act or in the assessment of someone detained in a place of safety by the police.

5.15 Under the procedures of the 1984 Act, MHOs prepare social circumstance reports for the Responsible Medical Officer (RMO) for persons on a 28 day order to allow RMOs to make judgments about future disposal. They also prepare these reports for the Mental Welfare Commission for Scotland and provide information to the relatives of patients about their rights. They may be involved in the care of a number of mentally disordered offenders who have been placed under guardianship.

Social Work Services in the Criminal Justice System

5.16 Local authority social work departments are responsible for providing social work services in the criminal justice system under the Social Work (Scotland) Act 1968. Since 1991, the main services have been wholly funded by central government. National objectives and standards specify the detailed service requirements. Criminal justice social work services can contribute to the identification, management and treatment of mentally disordered offenders at the following stages of the criminal justice process.

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Bail Decision-Making

5.17 There are bail information and supervision schemes currently (1998) available in 2 Scottish courts (Edinburgh and Glasgow). The schemes obtain and check information which can assist the court to decide whether alleged offenders, including those with mental health problems, can be released on bail, with or without supervision.

Diversion from Prosecution

5.18 In some areas, criminal justice social work services have developed diversion schemes in collaboration with local procurators fiscal. A number of these schemes are being funded and evaluated as pilot initiatives. The aim is to divert cases from prosecution where there is sufficient evidence to prosecute but where, on the basis of information provided by the police, the criminal justice social work service, other social work services or health agencies, the procurator fiscal decides that prosecution is not in the public interest and that the alleged offender could benefit from an identified service which would assist him or her to deal with problems which may have led to criminal involvement. Most of these schemes defer prosecution pending the outcome of the diversion initiative. The service which the alleged offender receives may be provided by the social work department or other health and social care agencies. The criminal justice social work service takes the lead responsibility for dealing with referrals, although it does not itself necessarily carry out all aspects of the assessment or provide the full range of services which may be regarded as part of a diversion package. The police report to the procurator fiscal may identify mental health problems as a possible reason for the alleged offending. Such problems are unlikely to be sufficiently severe to warrant action under the relevant mental health legislation but may be amenable to help from both health and social care professionals, eg minor depressive illness, alcohol and other substance misuse, learning difficulties.

Reports for the Court

5.19 Social workers working for the criminal justice social work service prepare any social enquiry report required for the courts. These reports investigate the personal and social circumstances of the offender and examine his/her offending and possible reasons for it. (They are described more fully in paragraphs 3.2-3.11).

Court-based Services

5.20 Criminal justice social work services provide services to the courts. In the busier courts staff may be present in the court and be in a position to provide immediate assistance where necessary, eg checking information, contacting relatives, or alerting a hospital if the situation requires it. (See also paragraph 3.4.). In other courts a service may be accessed on request.

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Probation Orders

5.21 Criminal justice social work staff supervise offenders placed on probation by the court. Such orders range in length from 6 months to 3 years. The aim of the order is to prevent or reduce further offending by a combination of control and, where necessary, assistance to deal with problems associated with offending. Additional requirements may be included by the court to help meet these objectives. A significant number of those placed on probation may be experiencing or have experienced mental health problems and, depending on the severity of these problems, the probationer may have received, be receiving or require psychiatric treatment.

5.22 The court can make a probation order with a condition of psychiatric treatment. In these cases the probationer is required to submit to treatment for not longer than 12 months as a resident or non-resident patient. The court has to be satisfied on the evidence of a doctor that the mental condition requires and is susceptible to treatment and that treatment and supervision are available. In certain circumstances, the condition may be varied. The offender must consent to the proposals.

5.23 Criminal justice social work staff are normally responsible for supervising this type of order. They have a particular responsibility to ensure, as far as they can, that the offender attends for treatment and they must provide assistance, support and oversight. Orders of this kind require very close collaboration between the doctor responsible for medical treatment, the supervising social worker and the court. They are usually made where the court and the other professionals concerned consider that the offender does not require to be dealt with under the Mental Health (Scotland) Act 1984 but needs treatment and is unlikely to avail him/herself of it without a degree of oversight and ongoing support. The court may also consider that oversight and support of this kind reduces the risk of harm to others which the offender may constitute if dealt with in the community.

Social Work in Prison

5.24 Criminal justice social work staff based in prisons are required by national standards to give a high priority in their work with prisoners (whether on remand or following sentence) to those identified as being vulnerable, including those at risk of self-injury or with other mental health problems. They may work directly with these prisoners, assist prison staff to develop sentence plans and co-ordinate plans for discharge with the appropriate community-based health and social care agencies including, where appropriate, criminal justice social work services.

Post Prison Supervision

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5.25 Criminal justice social work staff supervise offenders who are released on parole or non-parole licence, extended sentence or supervised release order and also offer a voluntary service to offenders discharged from prison. In the case of offenders discharged on licence who have a continuing mental health problem, criminal justice social work staff should be involved in pre-release planning and where necessary negotiating access to appropriate community-based health and social work services.

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6: FUTURE HEALTH SERVICE PROVISION

The overall policy and guiding principles set out in Part I provide the framework for proposals on the future provision of health services for mentally disordered offenders. The section deals first with the national level and then examines the provision of locally-based services as a key factor in the strategy. This section should be read in conjunction with the provisions of the Framework for Mental Health Services in Scotland (9).

6.1 Application of the guiding principles necessarily leads to a patient-centred service which delivers care at the lowest appropriate level of security as close to the patient's home as their medical condition and personal circumstances allow. They also require that the service should develop on a sound local basis and should be readily accessible to patients from mainstream psychiatric hospitals if required.

6.2 Alongside the question of resource constraints, two factors need to be taken into account:

(a) the geography of Scotland is such that for some patients from widely dispersed rural communities the appropriate specialist treatment has to be provided at a distance from their homes; and

(b) for all mentally disordered offenders, treatment considerations must be viewed in tandem with the need to protect the public.

NATIONAL LEVEL - HIGH SECURITY CARE

The State Hospital

6.3 In considering the role of the State Hospital, successive Governments have chosen not to establish medium secure facilities in Scotland but have instead concentrated investment on facilities at the State Hospital which have provided suitable economies of scale. The State Hospital has become a centre of expertise in forensic psychiatry offering a comprehensive range of treatment facilities. The Government is satisfied that the case for a single high security establishment remains valid.

6.4 The concentration of services of any degree of security on one site does limit the range of treatment options for patients who need a decreasing level of security as they recover from the acute phase of their illness. Local forensic services have developed to a varying extent in different parts of Scotland from within existing budgets for mental health services.

6.5 The present arrangements also mean that:

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- the State Hospital regularly comes under pressure to take referrals for which there appears to be no alternative local provision; and

- when State Hospital patients are ready for transfer, there can be a reluctance on the part of some local services to accept them because of a perceived lack of appropriate local services, leading to lengthy delays in their transfer which may cause distress to patients who may have worked very hard at their own rehabilitation.

6.6 The State Hospital will continue to act as the national centre providing high security services for patients with mental disorders (including learning disabilities) who are likely seriously to threaten others on account of their dangerous, violent or criminal propensities, and whose condition is characterised by actions outside the normal range of aggressive or irresponsible behaviour and which can cause actual damage, injury or real distress to others.

The Demand For High Security Care

6.7 Applying the Glancy (5) and Butler (6) "norms" to the aggregate population of Scotland and Northern Ireland leads empirically to a requirement of some 200 beds at the State Hospital. More recently, evidence from the needs assessment carried out in England (1) indicates an overall level of demand of between 150 and 200 beds for Scotland and Northern Ireland. Other assessments are underway (1998).

6.8 A national needs assessment will be conducted involving representatives of all relevant agencies including the State Hospital, health boards and Trusts, the Scottish Prison Service, the criminal justice agencies and local authorities. As the State Hospital provides a high security care service for Northern Ireland, the Northern Ireland Office will also be involved to establish that country's continuing need.

6.9 Co-ordinated assessment is necessary to inform decisions on capital and other financial allocations. The NHS Management Executive will be responsible for co-ordinating and maintaining this assessment of the need for national high security services. However, pending the results of the proposed national needs assessment, and the full operation of a complementary local service, it is assumed that the State Hospital services should continue to aim to meet demand for around 200 patients.

6.10 Services to carers, prisons and other hospitals should be such that local forensic psychiatric opinion is sought as soon as it is considered that a referral to specialist care may be appropriate. The need for a State Hospital opinion or referral will be decided where appropriate. This allows knowledge of local facilities and services to be involved in the decision and has been shown to lead to improved patient care and continuity of care in the long term, and to prevent unnecessary admissions.

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Health Board Monitoring of their High Security Patients

6.11 The State Hospital Medical Sub-Committee regularly reviews each patient's case to confirm that their circumstances require their continued treatment at the State Hospital. Indications are that around 50 of the existing group of patients may not need such a high level of security if adequate alternative facilities and local support service networks were available in their home areas.

6.12 Health boards should become more closely involved in monitoring the progress of patients from their area accepted into the State Hospital from the Courts or the prisons or referred to the State Hospital from local hospitals and should develop suitable continuing and after care local services to allow these patients to return to their home area as soon as their condition warrants it.

6.13 By entering service agreements with health boards, the State Hospital will ensure that the boards retain interest in these patients while they are being treated in the State Hospital. The agreements will include a specification that no patient should remain in the State Hospital for more than 3 months after clinical agreement between the State Hospital and local services that the patient's needs no longer justify high security care. Health boards and local authorities will therefore include a matching requirement in their overall service specification.

6.14 The NHS Management Executive will monitor the effectiveness of these service agreements and take action with any health board where patient transfers out of the State Hospital appear unreasonably delayed.

LOCALLY-PROVIDED SERVICES

Local Forensic Psychiatric Services

6.15 In line with the Framework for Mental Health Services in Scotland (9) The Scottish Office believes that health boards should organise a range of in-patient facilities from general psychiatric to more specifically forensic, short and longer term and a range of community options with general psychiatric provision with more specialist forensic care in terms of both staffing and buildings. Each board's response will be appropriate to local needs and may involve for other responses to local health needs, joint arrangements with other boards. The concept of the "managed clinical network" (as described in the Acute Services Review Report (12)) is relevant; it implies a formal relationship between components of a service, based on standards of service, quality assurance and a seamless provision of care. Some NHS Trusts in Scotland are developing alternative lockable facilities, separate from their IPCU accommodation, designed to deal with patients who either need a decreasing level of

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security on their return from the State Hospital, or who need longer-term care and treatment but not in a unit where there is a high level of noise and disturbance. Experience in Scotland and elsewhere has shown that the security of patients is partly governed by the availability of well-trained and highly motivated staff and by access to facilities which engage patients in structured day time activities. The development of supporting local forensic psychiatric services should meet the demand in Scotland for suitable placements for returning State Hospital patients, and also provide, where appropriate, services to local courts, prisons and psychiatric services. It is proposed that health boards should investigate the need for a structured development of local facilities and services to provide for mentally disordered offenders from courts, prisons and returning from the State Hospital, who require assessment and treatment in conditions of lesser security than is provided at the State Hospital.

6.16 Small units suitably located throughout Scotland have the benefit of being locally-based and also integrated with local services including prisons. However, the more "medium secure" end of the spectrum of low to medium security requires a larger unit with its associated range of clinical staff and should be better able to provide the required range of services to patients by drawing upon a substantial pool of expertise and experience. In turn this would facilitate treatment at varying security levels and allow the specific needs of all patients within the group to be addressed. A larger staff grouping also helps to promote effective peer group review and clinical audit; it also generates more effective multi-disciplinary teamwork with resulting benefits for both patients and staff. An important feature of the management of care in such forensic psychiatric units will be the gradual calculated reintroduction of patients to taking responsibility for their own decisions. While this process will inevitably mean giving more choice and freedom to patients and some associated risk-taking by both patients and their therapists, it will be done against a higher basic level of security and staffing than is currently available locally.

6.17 The requirement to balance optimum unit size against the need for local services is recognised. In Scotland there needs to be a geographical distribution of these units to provide a reasonably accessible service involving close links with local services and bearing in mind also that different security requirements may apply in different areas. The staff-intensive treatment regimes required by the target group of patients indicate that units should be commissioned for multiples of around 12 patients. Good space standards and therapeutic facilities in such units are also essential to generate satisfactory performance. The staffing provision of all forensic psychiatric units should include occupational therapist, clinical psychologist and social work complements, the latter to assess the social care needs of patients and to play a key role in the co-ordination of plans for their resettlement in the community. The Scottish Office view is that 4 or 5 such units will be required, including in that number those already established in Perth and Aberdeen.

6.18 A small number of providers will deliver this forensic in-patient psychiatric service on an area or supra-board basis. The new facilities when available should reduce or remove

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the current requirement for forensic and other difficult patients having to mix with and live alongside more acutely ill and disturbed individuals and create a more stable and secure environment for patients, staff and the public. They will only be successful in conjunction with a range of local forensic general and community services as described. Such local general forensic and community services will be required to support the local position in all health board areas, and not only those in which the new units are established. (See paragraphs 6.30-6.34, and 7.16.) The NHS locally should determine appropriate staffing levels in the light of local needs. The Royal College of Psychiatrists recommends that in-patient forensic units of this type should have a consultant to patient ratio of 1 to 12-15 patients. The National Health Service Management Executive will ensure that proposals for area or supra-board forensic psychiatric units are developed by the health boards to be served by them along with a full range of local forensic services.

6.19 The contribution of experienced staff will be crucial to the development of these new facilities and should be utilised wherever possible. Supra-board forensic psychiatric units should be associated with existing forensic mental health services, bearing in mind the locality of prisons, especially remand prisons. The availability of this type of unit will improve the treatment options available to certain non-offender patients, for example, violent or difficult to place patients, whose needs are different from those of the more acutely ill patients normally considered appropriate for an IPCU. Local and supra-Board forensic services are tertiary services and should be accessed only via the responsible consultant forensic psychiatrist. Services should include in-patient facilities for medium and long-stay care, in conditions similar to those specified for IPCUs or dedicated learning disability units, for patients returning from the State Hospital, remanded and transferred from court and transferred from prison plus some general psychiatric patients requiring similar care. The local forensic psychiatric services should be resourced to provide high standards of multi-disciplinary in-patient and out-patient follow up care; to enable off-site assessment of patients and to facilitate liaison with the general psychiatric services. The consultant forensic psychiatrist in each case will ultimately be responsible for the admission decisions on individual patients.

People With Personality Disorders

6.20 The management and care of persons with a personality disorder can present particular problems alongside the care of other mentally disordered patients. People with a personality or psychopathic disorder are not a homogeneous group for whom established social, penal or medical treatment techniques have proved successful. People with personality disorder who offend are usually dealt with by the criminal justice system. Disposal, whether to prison or hospital or in any other way, will depend on the circumstances of the individual case.

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6.21 Where there is doubt about diagnosis of a patient convicted of a serious offence, an interim hospital order, under the Criminal Procedure (Scotland) Act 1995, may be made to allow for further assessment or treatment for a period of up to 12 months. A recommendation may then be made for a hospital order if a treatable mental illness is considered to be present. Increased use of the interim hospital order procedure will give scope for psychiatric reports to be compiled which contain, for the benefit of the court, specific recommendations on the appropriateness of a hospital disposal. For those offenders who are convicted and sentenced on indictment but who are also mentally disordered, a hospital direction is now available so that when it is considered by the responsible medical officer the patient no longer needs to be detained in hospital for treatment, the patient may be transferred to prison.

6.22 Consideration of the disposal and wider management of personality disordered offenders will be taken forward separately by the Committee set up under Lord Maclean to examine the sentencing and treatment of, serious sexual and violent offenders, including those with personality disorders.

Operation of Intensive Psychiatric Care Units

6.23 Experience within the National Health Service in Scotland has demonstrated that the IPCU model works well for the client group for which it was designed ie short term acutely disturbed patients with behavioural problems directly related to psychiatric disturbance. Mainland health boards should continue to ensure appropriate local IPCU provision for the acutely mentally ill. There should be local needs assessment to determine the size of the service - a 12 bedded unit (or multiples of 12 or less) with generous space provision and levels of nurse staffing is the recommended IPCU model for acutely mentally ill patients.

General and Community Psychiatric Services

6.24 The needs of the mentally disordered offender should be met on clinical grounds bearing in mind the protection of the public. It will often be appropriate for general psychiatry services to be involved either right from the start or after a period in forensic care. The forensic services need to work in tandem with general psychiatry services, in a parallel and interlinking way. This will ensure that the mentally disordered offender is cared for by the right person in the right place and also that there is no inappropriate blockage of the forensic service. Service planning arrangements should bear in mind that general psychiatry services and community support will continue to be required to meet the needs of some of these patients.

6.25 The principles of good mental health care, including access to care in the community, should apply to mentally disordered offenders cared for by the general and forensic psychiatric services. At some suitable point in their treatment, many of these patients will either return to the community or, if they are forensic patients, be transferred back to the care

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of the general psychiatric service or other specialists, although a small number may need to remain under long term forensic care. Health boards should specify the close liaison required between the general and forensic psychiatric services and the State Hospital to allow patients to be integrated into the provision of out-patient and outreach services.

6.26 A number of patients in local hospitals and the State Hospital recover sufficiently to leave hospital. These patients are offered a placement under their home area's community care arrangements as close to their home as appropriate in the individual circumstances of each case. It is the joint responsibility of the patient's health board and local authority social work department to commission this form of care and to ensure that sufficient specialist residential provision is available to accommodate those ready to leave local hospitals. A key issue to be addressed in making this provision is that of public safety. Well-resourced after-care teams will be required for intensive follow-up of patients previously assessed to be high risk in the community.

Community Psychiatric Nurses

6.27 The management and support of many patients in the community has been shown to improve with the support of community psychiatric nurses or community learning disability nurses and wherever possible plans should be made to incorporate their contribution into the care of mentally disordered offenders. These nurses may assist in training police officers to identify and interview mentally disordered people; they may visit offenders in their home, be involved directly in group therapy sessions and may also take part in assessment visits to offenders in prison and courts. These nurses may also become key workers for some mentally disordered offenders.

The General Practitioner

6.28 The general practitioner may reduce the likelihood of delinquent or offending behaviour by the early identification, intervention and treatment of an underlying mental disorder. GPs also play a vital role in maintaining the rehabilitation of offenders released from prison or discharged from hospital and consequently they should have ready access to appropriate advice. The role of the general practitioner in relation to the multidisciplinary psychiatric team may be very specific to the needs of the patient, for instance, in focusing primarily on the patient's general health requirements. In this regard, health boards should specify the level of inter-professional collaboration necessary to meet the needs of GPs and primary care teams. Advice should be readily available to GPs on the management of potentially violent patients.

Health Board Responsibilities For Service Development

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6.29 Just as the need to maintain an effective national facility at the State Hospital is recognised, there is also a need for health boards to develop a database recording the appropriate services for people with a mental disorder whose normal place of residence is within their catchment area, and taking into account those in prisons and elsewhere in NHS care. There will also be occasions where a Board must accept responsibility for a non-resident patient, for example, because the onset of the problem behaviour took place in their area or because the caring relative is resident there.

6.30 Plans for treating mentally disordered offenders should be prepared in the context of the Framework for Mental Health Services in Scotland (9). Where a health board's plan is judged unsuitable, the National Health Service Management Executive will require that board to submit within 6 months of being requested to do so, their proposals for the care of people suffering from a mental disorder and who have offended or are considered likely to offend. These proposals will also cover some non-offenders detained in the State Hospital, IPCU or dedicated disability unit, and those patients who have had to remain in intensive care units longer than 3 months. Patients who are unmanageable in local wards because of aggressive, disorderly, irresponsible or anti-social behaviour beyond the ordinary level of resources and skills of the mental health service and who can be expected to be a hazard or danger to themselves or others, should also be included.

6.31 The detailed specification for this local service will cover integrated multi-disciplinary assessment, treatment, rehabilitation and after-care service for mentally disordered offenders, and those non-offender patients with similar needs. It will ensure that patients have the same liberty, rights, autonomy and choice as any other member of the community within the constraints of the law and their potential danger towards others or themselves.

6.32 The broad principles on which local services will be based are as follows:

(1) all arrangements should seek at all times to reduce the risk of offending behaviour consequent upon mental disorder and thereby to afford protection to the public;

(2) service provision and delivery should be designed to meet the individual needs of patients, and patients who are clinically judged to require the high security of the State Hospital should continue to be located there;

(3) the service should be delivered flexibly and comprehensively to respond to the individual needs of patients, and should be specialised in order to attain the level of expertise required to implement individual treatment programmes effectively, providing out-patient, day-patient and community care where appropriate in addition to in-patient treatment;

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(4) multi-disciplinary working methods should be adopted to ensure the most effective management, assessment and treatment of patients and support to other agencies;

(5) as continuity and consistency of care and treatment are essential, as far as possible the same team of local professionals should be responsible for the service to an individual throughout their care as an in-patient and subsequently in the community;

(6) close liaison should be maintained with the State Hospital on the care required to facilitate the earliest appropriate return of patients from each Board's catchment area.

(7) close liaison should also be maintained with prison services to ensure prisoners with mental illnesses requiring in-patient care are transferred to hospital.

6.33 Within an agreed framework, health boards and Trusts should work towards a number of specific objectives:

- at local level a specialist service which works in tandem with the general mental health service and works closely with the criminal justice system; and management of the system so that the needs of patients and the requirement to protect the public are given equal consideration;

- suitably secure local and area forensic psychiatry accommodation for patients who have severe and enduring forms of mental illness associated with difficult and dangerous behaviour and for offender patients who require specialist services;

- specialist forensic community services for those who require such services, and onward referral to other agencies for those who do not;

- the earliest return of appropriate patients from the State Hospital to local services and the transfer of mentally disordered offenders in prison to hospital facilities where this is required;

- regular evaluation and review of service delivery in the context of changing needs and developments.

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6.34 The psychiatric service planned by health boards should also require the development of a comprehensive service involving good working relationships with the State Hospital.

From a managerial and clinical point of view there is a need to ensure:

- that no patient is admitted to the State Hospital without prior assessment by, or discussion with, and agreement of the local forensic psychiatric team;
- that local clinicians and managers are involved in monitoring the progress of patients in the State Hospital;
- that periodic multi-disciplinary case conferences are instituted for each patient;
- that reports for the State Hospital on patients eligible for outward transfer are produced in good time;
- that the assessment of patients in the State Hospital should be carried out within 3 weeks of the request to the local psychiatric team and transfers, if agreed clinically, should be accomplished within 3 months;
- that trial leave provisions should be made in appropriate cases; and
- that a range of facilities are made available as appropriate to patients on transfer from the State Hospital, including general and forensic facilities, in hospital and the community.

The health boards' specification of these objectives should be in measurable terms. Performance indicators and outcome measures should be incorporated into the commissioning, provision and delivery of the service.

Staff Training

6.35 Clearly specified training levels agreed between health board and NHS Trusts enable staff to feel more confident in managing their duties and responsibilities. It can also lead to a reduction in day to day incidents and in the need for crisis measures, including the isolation of patients. In terms of training, teaching and research, collaboration between the State Hospital and local forensic services provides broad development of expertise, for example, through mutual exchange of consultant sessions. Professionally accredited nurse training schemes and exchange visits should be designed and developed by a joint working group involving senior staff from forensic psychiatric nursing in the local services, the State Hospital and university institutions.

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7: FUTURE SOCIAL CARE PROVISION

This section deals with the interlocking role of community-based social care services for mentally disordered offenders that complement the health service proposals set out in the preceding section. The emphasis is on joint working between Health Boards and social work authorities to plan and develop their services throughout Scotland.

The Framework of Community Care

7.1 Under the Government's policy on community care, mental health services are increasingly provided by multi-disciplinary community teams or by other specialised community services. Primary care services also link with the care provided by local authority community care services, which in turn are supported by a range of partners including housing, education and voluntary and independent sector organisations. Most mentally disordered people who have, or are alleged to have, offended are not in hospital but are in the care of health professionals and social work staff in the community.

7.2 Care has to be taken to recognise the distinctive statutory supervision and accountability procedures of criminal justice social work services where the offender is subject to a court order or is on licence from the Parole Board. However, it is for health and community care services to make and fund the provision which would normally be made to a non-offending person with similar mental health needs, for the duration of the supervision, and thereafter. The assessment of the extent of this provision should be carried out by health and community care staff working closely with criminal justice social workers. It follows that there is a need for comprehensive, well-integrated community services which operate in a variety of settings, with sufficient flexibility to respond to individual needs, whether or not the offender is under any form of statutory supervision.

7.3 The Government has taken several initiatives to develop services for mentally disordered people. For example, the Care Programme Approach was introduced in the 1992 Departmental circular "Community Care: Guidance on Care Programmes for people with a mental illness including dementia" (4). A further circular on the Care Programme Approach was issued in 1996. A Mental Illness Specific Grant was also introduced in 1991 to assist local authorities in the provision of social care and has been used to fund projects for this care group. These developments complement local authorities' general duties under Section 8 of the 1984 Act to provide after care services for any persons who are or have been suffering from mental disorders, and Section 55 of the NHS and Community Care Act 1990 to provide assessment and care management of vulnerable people including those with mental disorder. The Framework for Mental Health Services in Scotland (9) is also relevant.

7.4 Health boards and social work authorities will therefore already be including mentally disordered offenders in their local assessment and care management procedures. The available services and possible development proposals should be identified in a section in

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their community care plans devoted to this client group and in annual and strategic plans for 100% funded criminal justice social work services. Monitoring of these plans by The Scottish Office will seek to ensure that proper account is being taken of the need to develop these services.

7.5 NHS staff play an important role in contributing to community-based assessments and in the development of programmes of community care. Community care planning teams in developing their joint links between social work departments, housing agencies and health boards should ensure that local psychiatric and psychological services have an opportunity to contribute to the planning process. These links will also assist in the development of a joint approach to assessment and service delivery. Planning for social work services in the criminal justice system should be aligned as far as practicable with planning for community care services to ensure that appropriate access to social care services is available.

7.6 While housing bodies will not be responsible for the provision or management of most accommodation for mentally disordered offenders, they may require to provide or secure the provision of mainstream housing in some cases and manage such housing. Health boards and social work department community care services should collaborate in advance with housing departments and agencies for this purpose.

Public Safety

7.7 According to the guiding principles in paragraph 1.5, mentally disordered offenders should be held at no greater (and no less) security than is necessary. This also applies to the programme of community care for those who do not need to be in hospital. In particular this approach requires:

(a) effective systems to identify and manage individual and changing needs and risks; and

(b) a range of accommodation and other appropriate support, eg day care, home care, respite care, employment training and advocacy/befriending.

7.8 It is essential that the care and treatment of mentally disordered offenders in the community meet the requirements of the criminal justice system and of public safety. This will result in constraints on individual care plans. Some mentally disordered offenders, for example patients on restriction orders on conditional discharge and former prisoners on statutory supervision or licence, are subject to special supervision and will require specific follow-up monitoring. However, their health and social needs are likely to be similar to those of non-offenders with mental disorders and consequently, they need access to a similar range of services. Health and social work services for mentally disordered offenders should be planned and developed parallel to and linked with the general community-based mental

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health service with special attention to supervision and monitoring where this is needed for public safety reasons.

7.9 Each case must be jointly assessed with criminal justice and community care interests closely involved to determine an outcome which meets the following aims:

(a) safeguards public safety;

(b) delivers any statutory requirements (such as probation, etc);

(c) meets the needs of the offender in a way that is likely to reduce offending behaviour.

In the majority of cases there are no special forensic needs arising from the offending behaviour. Decisions about the provision of local services must therefore take account of the need to cater for mentally disordered offenders, and for ensuring that they gain access to them. All mentally disordered offenders, especially those who require services that take account of their "special needs", should be provided with a properly co-ordinated programme of specialised care, treatment or supervision and effective multi-disciplinary pre-release planning undertaken before discharge from hospital or release from custody. In all cases service provision is tailored to meet individual needs while ensuring that public protection is a key consideration.

7.10 Criminal justice social work has a statutory responsibility to supervise orders made by the courts and by the Parole Board on offenders, who may suffer from mental disorder, in accord with national standards on throughcare. Depending on the assessment of needs and risks and the agencies involved, day-to-day case management may be undertaken by a community care specialist, but the criminal justice social worker must retain oversight of the order and responsibility for enforcing it. In effect, the supervision requirement may be seen as a means of securing satisfactory local co-ordination of service plans between criminal justice, health and social care agencies. The main contribution of the criminal justice social worker may be in managing the interface with the criminal justice system and ensuring that any licence conditions are met.

Individual Care Plans

7.11 The Care Programme Approach (4) specifies arrangements for ensuring that people in the community who have severe and enduring mental illness and complex health and social service needs are provided with individual care plans which set out the support and care they will receive. All severely mentally ill people whether in the community or in hospital prior to discharge should be assessed for the Care Programme Approach (4). This applies to patients in all hospitals including the State Hospital.

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7.12 Given the need to focus the Care Programme Approach on people with severe and enduring mental illness and complex needs, including some who also have learning disabilities, the approach should not be applied to all mentally disordered offenders. Those who do not meet these criteria would, however, benefit from care management. The principles of a co-ordinated approach and an identified key worker as set out in the guidance on the Care Programme Approach (4) for people with severe and enduring mental illness should also be applied to people with a learning disability who, on discharge into the community, are considered to be at risk of breakdown or re-offending while living in the community. Essentially the approach provides continuity between hospital and community support services. Consideration should always be given in the assessment to whether the patient will require support and supervision by a social worker with specialist mental health training. In all cases where the Care Programme Approach (4) is being followed, consideration should be given to the allocated social worker being a mental health officer.

7.13 Unless detained, a person may discharge himself or herself from the Care Programme at any time. It is therefore important that the key worker named in the Programme should take all reasonable steps to make contact with the person whatever the circumstances, so that the health and community care authorities are fulfilling their requirements to monitor and if necessary act on the person's behaviour. It is also essential that GPs are kept informed of progress and of any decision on the part of an individual patient to withdraw from the programme.

A Local Model

7.14 Local government re-organisation provided opportunities for building fresh links between the new councils and health boards. Services for mentally disordered offenders require multi-agency working as recommended in the Framework for Mental Health Services in Scotland (9). The health board could act as the base for a local forum to consider the needs of this group. This would provide a source of co-ordinated expertise and guidance for local developments; it would also be able to identify service needs and gaps in provision. The local forum should include nominees from the health board, social work, criminal justice and community care services and housing departments; appropriate voluntary organisations should also be included as well as the police, procurators fiscal and the courts. The forum should communicate directly with both general and forensic psychiatric services in the health board area and also with the services provided for people with learning disabilities. Modernising Community Care – An Action Plan (11) sets out ways in which agencies can work on an integrated basis to secure better results for those who use community care services.

7.15 A senior group should be established to focus on agreeing shared objectives and on setting agreed strategic targets and priorities at a local level; these officers should where

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possible have the authority to commit their own agencies to action on services for mentally disordered offenders and to resource contributions. Further an operational group should be set up in each area with a mandate to deliver the committed action, to devise practical arrangements for securing collaborative assessments and to develop both service provision and monitoring requirements.

7.16 Some smaller health board areas will not be able to support a viable multi-agency approach to the provision of the more specialised services for mentally disordered offenders. When this is the case, a joint approach with social and health care agencies in adjacent health board areas should be pursued. A minimum scale for such a grouping might relate to a population base of around 600,000. It is of course only a guideline figure and other factors including geography, demographic distribution and the location of prisons will be relevant to the establishment of this type of liaison group.

7.17 As with other examples of community care, the local financing and commissioning implications of joint service provision will play an important part in developing local collaborative effort. Contracting-out and other arrangements must operate in the interests of enhanced patient care and add value to the contributions of individual agencies. A model for these joint arrangements is set out in the paper "Community Care: Joint Purchasing etc for Inter-Agency Working, MEL (1992) 55" (10). Similar working arrangements should be applied for services for mentally disordered offenders.

7.18 Attendance at meetings of the operational group may vary according to the task being undertaken. However, well-defined and agreed arrangements for ensuring that specialised professional contributions will be sought as part of the co-ordinated approach to service provision are essential to the success of this proposed local model.

Day Services

7.19 Access to structured day activities is central to the successful habilitation or rehabilitation of many mentally disordered offenders. These individuals have difficulty in obtaining employment and the day services should enable retraining to take place alongside any continuing rehabilitation or educational initiatives which were begun in hospital. Multi-agency centres, providing "drop in" and timetabled access to psychiatric, general medical, nursing, and social work support, will be particularly valuable. As voluntary bodies will contribute significantly to these day services, both through their own provision and through support to statutory services, their representatives should be involved at the earliest possible stage in the planning process. The Social Work Services Inspectorate has reported on day services for people with mental illness (7). This includes much valuable information on good practice.

Advice and Referral

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7.20 While the pattern of services is for local assessment and determination, some level of demand for advice and referral can be anticipated on a "round the clock" basis. This means that in all areas there should be 24 hour access to advice and help.

7.21 It follows that what is needed is an effective local emergency out-of-hours network operated by someone with a list of duty contacts or a standing arrangement. The development of such a service and how it might be organised and financed is clearly a matter for local consideration. Suitable referral points can now be introduced with the aid of modern telecommunications systems and a managed rotation of on-call staff who are trained to deal with these enquiries.

Involvement of Families and Carers

7.22 Another of the guiding principles in good comprehensive service provision is that mentally disordered offenders should be cared for as near as possible to their own homes or families if they have them. Continuing care for offenders following their discharge from hospital or prison can be provided in their own homes if this is in the interests of the individual patient and their carers. This is of course subject to considerations of public safety and victim concerns.

7.23 Consequently there is an important role for patients, their families and other informal carers in the organisation and planning of these services. The Patient's Charter requires that this should include, where possible, involvement in:

(a) care and treatment decisions;

(b) the running of particular services or facilities;

(c) service planning.

7.24 It follows that patients should become involved in planning their care as should families and carers whenever this is consistent with the patients' wishes. When a care plan depends on a major contribution from family or other carers, this should be agreed with them in advance. Families and carers will often need to be supported in order to cope with particular stresses and with the practical effects of a family member being subject to a hospital order eg, involving possible lengthy travel to visit the State Hospital. Support for families in the early stages of psychological distress can help to prevent deterioration in personal relationships and reduce the pressures on the offender. Special attention may need to be given to the welfare of any children in the family. In terms of the Children (Scotland) Act 1995, such children will be regarded as children affected by the disability of a family

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member. As such they will, at the request of their parent or guardian, be entitled to an assessment of their needs in their own right by the local authority.

Voluntary Agencies

7.25 Voluntary agencies are involved in the care of mentally disordered offenders through their activities in the general field of mental health. This ranges from individual support involving advocacy on behalf of patients through to the provision of accommodation by negotiation with housing providers. Community care planning arrangements offer the basis for involvement of social work authorities and health boards along with the voluntary organisations in their area and the opportunity to create links between voluntary bodies, social work authorities and the local psychiatric services. Volunteers can act as appropriate adults in cases where police are questioning persons suspected of having committed an offence or who may have been the victim of an offence and who are thought by the police to be mentally disordered.

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8: SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

This section is about the services provided for people with a learning disability who offend. It illustrates the need for a variety of services to be provided by health, social services and the criminal justice system, after an individual assessment of the offender has been carried out. The majority of these services should be community-based, but there is a need for some semi-secure and secure facilities. Similar services may also be necessary for people who are at risk of losing their residential or daytime placement through behaviour which causes physical harm to others, and will be covered separately under the learning disability review (1998-99).

Introduction

8.1 For the purposes of this document people with learning disability are those who, by reason of their developmental intellectual impairment, need additional specialist services to lead a normal life or as normal a life as possible. The range of competence is very wide. Many have difficulties in addition to their learning disability that present them, their families and service providers with further challenges.

8.2 People with a learning disability may need assistance in coping with police interviews and court procedures. Following the Departmental Circular 2/1990, updated by the joint Police, SWSG and Health guidance (Interviewing People who are Mentally Disordered: "Appropriate Adult" Schemes) (3), "appropriate adult" schemes have been established in Scotland to facilitate police interviews with mentally disordered adults. People with a learning disability can be particularly vulnerable in prison. The criminal justice system should be aware of their special needs. Diversion schemes should be available for use when appropriate. It is, however, helpful for some people with a learning disability to see the consequences of their behaviour in a similar way to other citizens.

Current services for offenders with a learning disability

8.4 Some people with learning disability who offend are treated in hospital or in the community under the Mental Health (Scotland) Act 1984. A guardianship order may be used on the grounds of learning disability (mental handicap is the term used in the Act). Hospital treatment may be appropriate if the person suffers from mental impairment (or a severe impairment) of intelligence and social functioning associated with abnormally aggressive or seriously irresponsible conduct.

8.5 The health service provides facilities for specialised assessment and treatment of offenders. Assessment is carried out by appropriate professionals (eg nurses, psychiatrists, clinical psychologists and speech therapists) and may take place in the community, in hospital or in prison. Subsequent treatment may be provided in the community by multidisciplinary community teams, at a day hospital, in local in-patient facilities (many of

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which are in large learning disability hospitals) or within the secure facilities of the State Hospital.

8.6 Social work services have the lead responsibility for care in the community, both as providers of criminal justice services and as planners of social work services. The point at which social services may become involved with someone with a learning disability who may have offended will vary dependent on individual circumstances. Some will have been diverted whilst others may have been admonished. In other instances, people with learning disabilities may not always be recognised as needing additional assessment/support. When Social Enquiry Reports are requested prior to disposal, criminal justice services are involved. They may decide to consult with both social work colleagues in learning disability teams and with health professionals. (Paragraphs 3.2-3.17 and 5.9-5.25 also apply to people with learning disabilities.)

Future services

8.7 The Scottish Office view is that there should be a joint assessment of learning disability need by health boards and local authorities. Service providers should cater for the majority of offenders with a learning disability who require a comprehensive range of health, education and social work services to meet their needs. Serious offenders with learning disabilities should be separated from others where possible.

8.8 A range of services will be necessary including:

- support from social work services, criminal justice social workers, primary health care teams, specialist learning disability teams and voluntary organisations;
- community accommodation with resident staff who may receive support from the agencies described above;
- potentially lockable well-staffed NHS accommodation for the purposes of assessment and treatment which should be in the form of small units;
- secure accommodation for the very small number of people who require such provision.

There should be linked access between the dedicated secure settings and less secure forms of accommodation in the community. There also should be adequate and properly planned aftercare including access to the necessary range of rehabilitation and training facilities and opportunities. Community care assessment as part of the discharge planning process should be included in the aftercare arrangements.

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The respective roles of agencies

8.9 There should be liaison between all the relevant agencies: criminal justice services, National Health Service, police, prison and social work services and appropriate multi-agency agreements should be made.

8.10 Health boards and local authorities should ensure that an individual care plan is prepared for each person receiving a service, which takes a risk assessment into consideration. Services should be provided in the least restrictive environment consistent with public safety. An appropriate adult service should be established, with a register of identified individuals who should receive regular training. Independent advocates should be available for the service users.

8.11 Carers' needs should also be taken into account. The Carers (Recognition and Services) Act 1995 is concerned with carers who are either providing or intending to provide substantial amounts of care on a regular basis. A carer meeting these requirements is entitled, on request, to an assessment of their own needs. Adequate day and respite care services should be provided.

8.12 There should be evidence of training strategies for all staff involved with the service. Monitoring systems should be in place to ensure that appropriate treatment/care plans are in place and are reviewed regularly.

The role of service providers

8.13 Appropriate services should be provided for offenders with a learning disability through multi-agency liaison and an assessment of the local need. There should be a range of treatment facilities (eg community, residential and specialised semi-secure or secure, which may be local or national). There should be a recognition that while the majority of offenders with a learning disability will need relatively short-term support, there is a small group who have severe enduring difficulties and will require long-term supervision.

Care for learning disabled offenders in the community

8.14 At a local level there should be comprehensive community plans and individual treatment packages, ensuring that care and supervision are provided in the least restrictive environment. A framework should be established to ensure multi-agency involvement and information sharing systems. Health service staff should be involved in all relevant points in assessment and treatment.

8.15 As indicated in paragraphs 8.10 and 8.11, appropriate adult schemes should be in place, advocacy services should be available and the needs of the carers should be

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considered. There should be a support service for victims with a learning disability. Procedures for dealing with abuse should be in place. Suitable accommodation should be available in the community, with opportunities for work, leisure and educational placements. Training should be available for staff of all agencies working within the offenders service. Monitoring systems should be established.

Semi-secure accommodation

8.16 This should be provided in small units dedicated to the needs of this client group. There should be facilities for comprehensive assessment and treatment, with close links to community resources. These units may also be used in the rehabilitation of people from secure units.

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Secure accommodation

8.17 Although only a small number of learning disabled offenders will require such a facility, their stay may be prolonged and it is important that there is multi-professional input and treatment plans which are regularly reviewed. The environment should be congenial and adequate educational and recreational activities should be provided. It is likely that such units will be regional or national and it is important that links with the area of origin be maintained.

Aftercare

8.18 Services should be available for learning disabled offenders following discharge from prison or specialised semi-secure or secure facilities to offer support and reduce risk of re-offending.

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PART IV: THE WAY FORWARD

9: PROPOSALS

The specific proposals linked to each of the preceding sections of this report are drawn together in sequence in this part under the associated section headings and sub-headings. The form and content of each proposal is as stated earlier.

PART II: CRIMINAL JUSTICE PROCESS

2. POLICE PROCEDURES

The Service Requirement

Paragraph 2.14 Health boards and local authorities should enter service level agreements with the criminal justice agencies to provide effective and flexible local arrangements for the initial assessment and treatment of people in their charge who appear to be mentally disordered. Procurators fiscal should be involved in discussions as to levels of service. These service agreements should cover:

- the use of Section 118 of the 1984 Act ("removal to a place of safety");

- the availability to the criminal justice agencies of "duty psychiatrists" and "appropriate adult" services;

- the facilities and services that can be used for mentally disordered people diverted from the criminal justice system;

- the provision of specialised accommodation for mentally disordered accused persons who might otherwise have to be remanded unnecessarily in custody; and

- the specification should address the 3 levels of service to be provided:

    (1) emergencies within 24 hours;

    (2) urgent cases to be covered within one week; and

    (3) routine cases to be completed within 3 weeks.

- the specification should also cover the training needs of those who will be required to operate these services on a day-to-day basis.

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3. COURT PROCEEDINGS

Multi-disciplinary Assessment

Paragraph 3.6 The psychiatric service provided for each health board's residents should specify that the courts and procurators fiscal in their area require a promptly delivered psychiatric assessment service to assist the transfer of an accused person to hospital as and when required. Development of a service involving a duty psychiatrist with access to community and hospital resources would be the preferred means. The psychiatrist needs multidisciplinary support from social work, psychology, nursing and housing. The psychiatric service needs to be complemented by a multi-agency network of services.

Paragraph 3.10 A properly co-ordinated procedure for preparing multi-disciplinary assessment reports should be developed in the larger courts as a means of identifying the range of options available for mentally disordered offenders.

Bail Decision-making

Paragraph 3.12 Local authorities and health boards should review the accommodation services provided for mentally disordered persons to ensure that they are not remanded unnecessarily in custody, and that, wherever possible, they can be supported under existing community care arrangements.

4. SCOTTISH PRISON SERVICE

Psychiatric Assessment and Transfer to Hospital

Paragraph 4.7 Prison managers should arrange appropriate accommodation within the prison for psychiatric assessment and prison medical officers should ensure that full medical information on the prisoners being assessed is available to visiting psychiatrists.

Return to Prison

Paragraph 4.8 Service commissioners should require treating responsible medical officers to submit regular progress reports on prisoner patients to the forensic psychiatrist of the Prison and the Scottish Office Department of Health's forensic psychiatric adviser. These reports should provide an early warning for both the Trust and the prison service of any intention to return the patient to prison so that the necessary care and support can be allocated on the prisoner's return. At the point of return the responsible medical officer should provide the prison and the visiting psychiatrist with an updated report.

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The Service Requirement

Paragraph 4.16 The Scottish Prison Service is developing service level agreements with local authority social work departments for the provision of all social work in prison, including that in respect of prisoners with mental health problems. Prison governors will enter service agreements with local health service providers for a psychiatric service which will match the operational requirements of penal establishments. The service level agreements will cover the purchase of appropriate services from health and social work. These agreements will specify the identification and assessment of mental disorders, crisis intervention and continuing treatment on the basis of individual care plans, for those for whom transfer from hospital is either not possible or delayed, and effective programmes of after-care. The service specification should also require a same-day service for emergencies, with urgent cases being dealt with within a week and routine cases within 4 weeks of referral.

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PART III: PROVISION OF HEALTH AND SOCIAL CARE SERVICES

6. FUTURE HEALTH SERVICE PROVISION

The State Hospital

Paragraph 6.6 The State Hospital will continue to act as the national centre providing high security services for patients with mental disorders (including learning disabilities) who are likely seriously to threaten others on account of their dangerous, violent or criminal propensities, and whose condition is characterised by actions outside the normal range of aggressive and irresponsible behaviour which can cause actual damage, injury or real distress to themselves or others.

The Demand for High Security Care

Paragraph 6.8 A national needs assessment will be conducted. This will involve representatives of all relevant agencies including the State Hospital, health boards and Trusts, the Scottish Prison Service, the criminal justice agencies and local authorities. As the State Hospital provides a high security care service for Northern Ireland, the Northern Ireland Office will also be involved to establish that country's continuing need.

Health Board Monitoring of their High Security Patients

Paragraph 6.12 Health boards should become more closely involved in monitoring the progress of patients from their area accepted into the State Hospital from the courts or the prisons or referred to the State Hospital from local hospitals and in developing suitable

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continuing and after care local services to allow these patients to return to their home area as soon as their condition warrants it.

Local Forensic Psychiatric Units

Paragraph 6.15 Health boards should investigate the need for a structured development of local facilities and services to provide for mentally disordered offenders from courts, prisons and returning from the State Hospital, who require treatment in conditions of lesser security than is provided at the State Hospital.

Paragraph 6.18 The National Health Service Management Executive will lead in ensuring proposals for area or supra-board local forensic psychiatry units are developed by the health boards to be served by them.

Paragraph 6.19 The services should include in-patient facilities for medium and long-stay care, in conditions similar to those specified for IPCUs or dedicated learning disability units, for patients returning from the State Hospital, remanded and transferred from court and transferred from prison plus some general psychiatric patients requiring similar care. The local forensic psychiatry unit should be resourced to provide high standards of in-patient and out-patient follow up care; to enable off-site assessment of patients and to facilitate liaison with the general psychiatric services.

Operation of Intensive Psychiatric Care Units

Paragraph 6.23 Mainland health boards should continue to ensure appropriate local IPCU provision for the acutely mentally ill. There should be local needs assessment to determine the size of the service - a 12 bedded unit (or multiples of 12 or less) with generous space provision and levels of nurse staffing is the recommended IPCU model for acutely mentally ill patients.

The General Psychiatric Service

Paragraph 6.24 Service planning arrangements should bear in mind that general psychiatric services and community support will continue to be required to meet the needs of some of these patients.

Community Services

Paragraph 6.25 Health boards should specify the close liaison required between the general and forensic psychiatric services and the State Hospital to allow patients to be integrated into the provision of out-patient and outreach services.

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The General Practitioner

Paragraph 6.28 Health boards should specify the level of inter-professional collaboration necessary to meet the needs of GPs and primary care teams. Advice should be readily available to GPs on the management of potentially violent patients.

Health Board Responsibilities for Service Development

Paragraph 6.30 Plans for treating mentally disordered offenders should be prepared in the context of the Framework for Mental Health Services in Scotland (9). Where a health board's plan is judged unsuitable, the National Health Service Management Executive will require that board to submit within 6 months of being requested to do so, their proposals for the care of people suffering from a mental disorder and who have offended or are considered likely to offend. These proposals will also cover some non-offenders detained in the State Hospital, IPCU or dedicated learning disability unit, and those patients who have had to remain in intensive care units longer than 3 months. Patients who are unmanageable in local wards because of aggressive, disorderly, irresponsible or anti-social behaviour beyond the ordinary level of resources and skills of the mental health service and who can be expected to be a hazard or danger to themselves or others, should also be included.

Paragraph 6.33 Within an agreed framework, health boards and Trusts should work towards a number of specific objectives:

- at local level a specialist service which works in tandem with the general mental health service and works closely with the criminal justice system; and management of the system so that the needs of patients and the requirement to protect the public are given equal consideration;

- suitably secure local and area forensic psychiatry accommodation for patients who have severe and enduring forms of mental illness associated with difficult and dangerous behaviour and for offender patients who require specialist services;

- specialist forensic community services for those who require such services and onward referral to other agencies for those who do not;

- the earliest return of appropriate patients from the State Hospital to local services and the transfer of mentally disordered offenders in prison to hospital facilities where this is required;

- regular evaluation and review of service delivery in the context of changing needs and developments.

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Staff Training

Paragraph 6.35 Professionally accredited nurse training schemes and exchange visits should be designed and developed by a joint working group involving senior staff from forensic psychiatric nursing in the local services, the State Hospital and university institutions.

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7. FUTURE SOCIAL CARE PROVISION

Public Safety

Paragraph 7.8 Health and social work services for mentally disordered offenders should be planned and developed parallel to and linked with the general community-based mental health service with special attention to supervision and monitoring where this is needed for public safety reasons.

A Local Model

Paragraph 7.15 A senior group should be established to focus on agreeing shared objectives and on setting agreed strategic targets and priorities at a local level; these officers should, where possible, have the authority to commit their own agencies to action on services for mentally disordered offenders and to resource contributions. Further an operational group should be set up in each area with a mandate to deliver the committed action, to devise practical arrangements for securing collaborative assessments and to develop both service provision and monitoring requirements.

8. SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

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