# Definition of security levels in psychiatric inpatient facilities in Scotland

# Contents

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We were very grateful to Mick Collins, Research Nurse and Chris Ashwell, Security Liaison Nurse from Rampton Hospital for sharing their work on the Security Needs Assessment Profile and for making the journey to speak to the group on the 7th of May. The group were impressed by their research and approach and their visit sparked a lot of useful discussion and debate.

The group acknowledges the contribution made by Ed Finlayson, Head of Social Work, The State Hospital, South Lanarkshire Council. Ed joined us for our last meeting and advised the group from a Social Work and community services perspective.

We thank Dave Jago, Head of Publications at The Royal College of Psychiatrists for giving us permission to reproduce tables from Harry Kennedy's paper "Therapeutic uses of security: mapping forensic mental health services by stratifying risk" *(Advances in Psychiatric Treatment*, **8**, 433-443)

We would also like to thank our colleagues, both those who contributed to informal consultation about elements of security, and those who offered their support and advice over the past six months.

**Terms of reference**

Following the Forensic Mental Health Services Managed Care Network meeting in Stirling on Tuesday 16 September 2003, Andreana Adamson, Chief Executive of the Network, set up this expert group to address the question of defining levels of security in psychiatric inpatient settings. The primary purpose of the group's work was to contribute to a strategic national planning document on the development of forensic psychiatric services in Scotland.

The group was additionally tasked to consider:

- relevant literature regarding levels of security;
- whether protocols would be required regarding transfers between different levels of security;
- the implications of defining levels of security on the current provision of forensic psychiatric services; and
- what developments might be required in the future, including the future role of the State Hospital.

The expert group was multi-professional, with representatives from nursing, security, the prison service, the Scottish Executive, psychiatry, social work and psychology. After the group's first meeting the group decided to extend membership to Dr Mark Davidson and Mr Doug Irwin; Dr John McGinley stepped down from the group.

**Summary of the work of the group**

The group first met on 3rd December 2003 in Stirling and subsequently met in full on 3 occasions including a final meeting on 7th May 2004. Additionally, the chairman and the group facilitators met regularly at the State Hospital and the entire group was regularly updated and asked for comment between meetings via e-mail. We have informally consulted colleagues widely about the approach we have taken and obtained details about security measures in a number of settings.

A body of background information was prepared by the group facilitators and distributed to the group; a full bibliography is at the end of this report. In addition, Innes Walsh gave a presentation to group on the topic of needs assessment of mentally disordered offenders. The chairman interviewed Professor Pamela Taylor, who chairs the Royal College of Psychiatry working party on security levels. The SNAP project team from Rampton Hospital presented their research on levels of security to the group in Stirling on 7 May.

The group considered elements of security which had a possibility of illustrating differences between levels of security. These were drawn from a brainstorming session, with the addition of items from the literature. The group then cross-tabulated the variables against levels of security and in so doing created a matrix which helps to define inpatient security in Scotland.

The final report was submitted to the Forensic Network on 28th May 2004. The Chairman gave oral presentations on the work of the group at Network board meetings on 5th March and 4th June 2004. It is planned to present this report at a special meeting organised by the Network on 21st June 2004 at Stirling.

The report was written in the knowledge that regulations are being prepared in respect of sections 281-286 of the Mental Health (Care and Treatment) (Scotland) Act 2003 in relation to communication and security. The new Act necessitates the development of statutory regulations on communications and security and these require to be soundly based and justifiable. It is foreseeable that as the regulations are developed that standards and practices will change and that therefore the current matrix of security is also likely to change. It should also be noted that while the group has delivered on its remit and the following report and recommendations relate are addressed predominantly to NHS facilities and the State Hospital in particular, the terms have equal application to all psychiatric public and private inpatient care.

*CHAPTER ONE*

## Introduction to the report

1.1 On 28th January 1999 the Minister for Health in Scotland launched the Policy Document "Health, Social Work and related services for Mentally Disordered Offenders in Scotland"(NHS MEL (1999) 5, Scottish Office 1999) (The MDO Policy). The policy statement examined the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work department, the State Hospital, other psychiatric services in hospital, and in the community. There were also proposals for the organisation and further development of these services throughout Scotland. The MDO policy has subsequently been adopted by the devolved administration and continues to be Scottish Executive policy.

1.2 The Department of Health published the Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services in 1994 (the Reed Report, Department of Health 1994). The Scottish MDO Policy document explicitly adopted the same set of guiding principles identified by Reed, that 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 institutional settings
- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others
- in such a way as to maximise rehabilitation and their chances of sustaining an independent life
- as near as possible to their own homes or families if they have them.

1.3 The MDO Policy, which was complementary to the Framework for Mental Health Services in Scotland ((NHS MEL (1997) 62, Scottish Office 1997), tasked Health Boards with organisation of range of inpatient facilities from the general psychiatric to more specifically forensic, short and longer term and a range of community options. The policy also highlighted the concept of the "managed clinical network" as described by the Acute Services Review report (The Scottish Office, HMSO, 1998). This highlighted the need for a formal relationship between components of a service based on standards of service, quality assurance and seamless provision of care.

1.4 A review of progress of the implementation of the MDO Policy was commissioned from the Scottish Development Centre for Mental Health. . The Scottish Executive Department of Health in 2001 (NHS, HDL, (2001) 9) published a Care Pathway Document, which was an outcome of the Scottish Development Centre report and local agency received a digest report on progress in their area. The guidance which accompanied the care pathway document advocated the establishment of local forensic care forums, which should consider and advise locally on how best to advance implementation of the MDO Policy; the agencies are invited to report to the Scottish Executive annually.

1.5 In the autumn of 2001 a review group was set up to consider the governance and accountability of the State Hospital's Board for Scotland. A consultation paper resulted from that review: "The Right Place, The Right Time" (Scottish Executive 2001b). Following consultation, the Forensic Mental Health Services Managed Care Network was created in 2003. The Network now has the task of overseeing the development of services for mentally disordered offenders across Scotland. It will provide a strategic overview and direction for the planning and development of

specialist services. It will develop protocols to support the transfer of patients between different levels of service and accommodation and has a potential role in dispute resolution.

1.6 At an early point it became clear that a definition of the different levels of security in psychiatric care was required to allow strategic planning to take place. Although this is the primary reason why this group was established, new legislation in Scotland gave it added importance.

1.7 In January 2001 the review of the Mental Health (Scotland) Act 1984, chaired by the Right Honourable Bruce Millan, reported to the Scottish Parliament (Scottish Executive 2001c). The Millan Committee devoted a chapter to high risk patients and recommended that patients should have a right of appeal to be transferred from the State Hospital or a medium secure facility to conditions of lower security. That proposal was adopted in the Mental Health (Care and Treatment) (Scotland) Act 2003, Part 17, Chapter 3 (s*ee Appendix I*) and is due to be implemented by May 2006.

The group was therefore mindful that a definition of different levels of security would be required by Mental Health Tribunals and others to help decide questions of appropriate security level.

1.8 At an early stage the group decided not to extend its remit to include consideration of security within community placements. An important theme emerging within the literature in England and Wales is the role of community mental health teams in relation to mentally disordered offenders (Holloway 2002) and in particular the relationship between generic and forensic community services (Buchanan 2002).

It is appreciated that for various groups of patients the conditions of lesser security may well be made available through the provision of suitable community services. For example there is strong evidence that the needs of many women and also many patients with a diagnosis of learning disability or other intellectual impairment can best be met by commissioning services that provide close supervision in the community rather than conditions of security in a hospital environment. Such services are likely to reflect the importance of relational security, and appropriately trained and skilled staff from a variety of backgrounds.

The group acknowledge that these aspects of service provision may be addressed in the current work of the other specialist groups currently reporting on the needs of women and those with a learning disability. **Further to this, we recommend to the Network that forensic community services, including the use of security, would be an important topic for a future working group**

1.9 One important source of admissions to forensic services is from the Scottish Prison Service, and closer liaison and awareness in both services of each others security assessments is desirable. In addition, security intelligence should be available to admitting clinical teams so that a safe level of security can be identified**. We recommend further work be done comparing security assessment in prison and the Matrix.**

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*CHAPTER TWO*

# Literature review

## 2.1 A Historical perspective

2.1.1 Security has always been a feature of psychiatric care. Since the idealistic laws of Plato (translation by Saunders TJ 1970) there has been identified a responsibility on those caring for the mentally disordered to prevent them from harming others. If carers failed in this duty then they were liable to pay compensation. There is evidence that this principle was realised in Roman Law (Modestinus). It was not until the 'great confinement' of the mentally ill (Foucault, 1987) that security measures would become more systematised.

2.1.2 Mechanical restraint was the mainstay of security in the 'mad-houses' of the nineteenth century (Porter), although at an early point the Tuke family at the Retreat near York popularised the alternative of moral therapy. Even there, mechanical restraint was used as a last resort and security was identified as a feature of safe care:

> 'In the construction of [asylums], cure and comfort ought to be as much considered as security, and I have no hesitation in declaring that a system which, by limiting the power of the attendant, obliges him not to neglect his duty, and makes his interest to obtain the good opinion of those under his care, provides more effectively for the safety of the keeper, as well as for the patient, than all the apparatus of chains, darkness and anodynes'. (Tuke 1813)

What marks out Tuke's approach was the identification that security was not merely physical but also relational. The quality of the professional relationship between patient and carer promotes safety.

2.1.3 Parliamentary Inquiries at the beginning of the nineteenth century into abuses in the 'madhouses' of the day spurred a movement to reform psychiatric care in the United Kingdom. This culminated in the County Asylums Act 1845 and the creation of regulatory mechanisms to inspect and control psychiatric care. John Connolly (1856) was a leader of the anti-restraint movement and, as an alternative, seclusion was popularised.

2.1.4 Asylum sites whose grounds are now conveniently converted to retail and residential use were then on the fringe of conurbation. Marked by high walls and isolation, the key of the attendant became symbolic of a custodial period of psychiatric care. The moral therapy of Tuke could not be replicated in such industrially scaled institutions, which by 1930 locked away some 250,000 patients in the United Kingdom (Jones, 1993).

2.1.5 The Victorian asylum may have had impressive physical security but just as controlling were sets of rules and regulations distinct to the institution. Institutionalisation was coined as a diagnosis in itself to describe the long term behaviour changes brought about by such care. Erving Goffman (1961) described the practices in an American Asylum many of which would be rejected today as inhumane. However such practices served a function; in an age before there was any effective treatment for mental illness, institutionalisation helped maintain a safe internal environment (Crichton, 1995).

2.1.6 In the rules and regulations of the Victorian asylum there was embodied another aspect of security; procedural. The institutional rules could not simply be done away

with, they required sublimation. The Ashworth Inquiry (Department of Health, Blom-Cooper 1992) identified numerous institutional practices which no longer had a place in modern mental health care, such as the routine seclusion of new admissions. Such practices were done away with but their function was not fully understood and alternatives not provided. This was the context of the security failures investigated by Fallon a decade later.

2.1.7 Perhaps the greatest legacy of the Fallon Inquiry is the introduction of safe child visiting procedures throughout secure care in the United Kingdom. The most controversial bequest comes not from Fallon, but the report Fallon suggested should be commissioned: Tilt (2000). The Tilt report, which dealt with security in the three English Special Hospitals, is not applied in Scotland. The Tilt report has been widely criticised for being overly rigid, particularly in its approach to physical security (e.g. Exworthy and Gunn 2003).

**2.1.8 The Group concluded that, there is always a danger imposing security on a patient population who do not consent or may not be capable of consent and who may have other vulnerabilities. A historical perspective reveals that the balance between freedom and restriction is not easy to strike. Security has always been a necessary part of psychiatric care and this section reveals the roots of environmental, procedural and relational security. Before any practice is dismissed as being overly restrictive its function first needs to be understood and if necessary a better alternative introduced.**

## 2.2 The Model of Security which comprises Environmental, Procedural and relational security

2.2.1 It is widely accepted that the level of security appropriate for an individual patient should match the risk posed; to self, other patients, visitors, staff and the general public (from the Reed 1994 principles). There was little need to carefully define what different levels of security meant when, in the United Kingdom, the choice of secure care was between a special hospital and a local psychiatric service. Following the Butler Report (Home Office and Department of Health and Social Services 1975) there was the development in England and Wales of medium secure units. Scotland opened its first medium secure unit, The Orchard Clinic, at the end of 2000 and similar units are proposed elsewhere in Scotland.

2.2.2 Faulk in 1986 was an early writer on the different aspects of security in a psychiatric hospital setting. He divided security into three aspects: physical security; high staff to patient ratios; and therapeutic policy. This was further interpreted in the Reed Report (1994): security was divided into physical or environmental aspects, procedural aspects and relational aspects. This division has general acceptance and was adopted by Tilt in 2000 when reviewing the high security hospitals in England. Within a psychiatric setting, writers have identified that security is not an end in itself, rather it creates a safe environment for other therapeutic work to take place. Indeed, without the creation of a safe environment it is difficult for therapeutic activity to occur.

2.2.3 The Tilt Report was produced in response to Recommendation of the Report of the Committee of Enquiry into the Personality Disorder Unit, Ashworth Special Hospital (The Fallon Enquiry). In the event, the terms of reference for the review went beyond the Fallon Enquiry recommendation in that they encompassed both physical and relational security at all three high security hospitals in England. The Tilt Report reinforced an approach to security which comprises environmental, relational and procedural aspects. Some authors add a fourth component, specialist management

arrangement (e.g. Kinsley 1998), which consists of a number of aspects of clinical governance. These aspects of security, such as lines of reporting and policy compliance, are generally considered under the umbrella term of procedural security.

2.2.4 **The group concluded that that the model of security, which consists of environmental, procedural and relational aspects, has utility. Further we recommend the following principle is adopted**:

***The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community.***

2.3 Research about security level and need

2.3.1 Within the British context, there have been various investigations into the appropriate security level for psychiatric inpatients; the patient characteristics for particular levels of security and conversely what security need is appropriate for particular patient groups. Research is made more difficult when there is a wide range in the provision of security characteristics within particular levels; e.g. environmental security at English medium secure units. There is a further complication in that services are in a state of change and development. Much of the published literature illustrates the inappropriate placement of patients, usually in excessive security. Those studies which illustrate excessive security in Special Hospitals are summarised in table 1.

Table 1 British studies examining excessive security in Special Hospitals

| Authors | Sample | Number of Patients assessed | Security level assessors | Proportion assessed as not requiring special security |
|---|---|---|---|---|
| Taylor *et al* 1991 | Total English Special Hospital population on census day | 1708 | RMO | 37% |
| Maden *et al* 1993 | 20% sample of English Special Hospital population admitted over 1 year | 296 | 1) Research Team<br>2) Clinical Team | 1) 63%<br>2) 50% |
| Shaw *et al*1994 | All patients from NW Region (England) in Special Hospital | 119 | 1) RMO<br>2) Independent Panel | 1) 45%<br>2)67% |
| Murray *et al*1994 | Special Hospital patients from NW Thames RHA on a census day 1992 | 107 | Panel including research team member | 64% |
| Bartlett *et al* 1996 | Special Hospital patients from SW Thames July1992 | 92 | RMO | 47% |
| Bartlett *et al* 1996 | Special Hospital patients from SW Thames June 1993 | 87 | RMO | 40% |
| Thomson *et al* 1997 | State Hospital Survey. All resident patients from 25.8.1992 –13.8 1993 | 241 | RMO | 53.3%<br>(no expressed view on security need in a further 9.3%) |
| Pierzchniak *et al* 1999 | All North London HA patients in maximum security, mid 1990s | 79 | 1) Panel designed to replicate real clinical decision making, n=79<br>2) RMO n=50 | 1)25%<br>2)52% |

2.3.2 It is clear from table 1 that there is consensus that a large proportion of patients detained in high security do not require that level of security. Early studies appeared to show that the consultants in charge of cases (RMOs – Responsible Medical Officers) were more conservative than external assessors in judging security needs. It has been suggested that this was because of a lack of awareness regarding what security other facilities could offer (e.g. Shaw 2002). The reverse finding was found by Pierzchniak *et al* 1999, who suggested that the panel used in their study more accurately represented real clinical decision making because of its particular composition. Bartlett *et al* 1996 note a discrepancy between RMOs response to a postal questionnaire and the actual pattern of referral to medium secure and other services.

2.3.3 A mistake in interpreting these studies would be to assume the High Secure Hospital population had a static composition throughout the period. As Medium secure services expanded following the Reed Report (1994) the first cohort of patients who were admitted to such new provision were the most clinically appropriate. That in turn may have had an influence on how the new units developed; a specialisation in treating those with psychotic illness and offending who responded to treatment and could be safely moved on to units of lower security. The remaining patients inappropriately placed in excessive security would have other characteristics impeding their progression; e.g. personality disorder, organic disorder and multiple diagnoses. A growing theme in the literature was difficulties in provision for those requiring long term secure accomodation (Reed 1997); most medium secure units were not designed for this patient population.

2.3.4 A key study examining access to Medium Secure Units in England and Wales was published recently in three papers: Melzer *et al* 2004a, 2004b and Grounds *et al* 2004. Melzer 2004a found that the main determinants of admission to medium security, in 418 patients to 34 medium secure units, during the first six months of 1999, were: features of acute schizophrenia; non-compliance with treatment; a history of sexually inappropriate behaviour; and self harm as a reason for referral. A grave index offence and recent or numerous custodial sentences were also important. It was concluded that the match between security need and admission was poor; one fifth of those assessed to require medium security were not admitted; just under a quarter of those admitted needed low locked or a low open setting.

2.3.5 Grounds *et al* (2004) described a qualitative study of admission decision making which revealed a complex interaction of factors. The study revealed a range of contextual factors which influenced decision making; the need for senior clinicians to act as gate-keepers and ensure throughput of patients; and the importance of a collaborative shared vision amongst the multidisciplinary team regarding which sort of admissions were appropriate. Security need was not a factor to the fore and clinicians resisted pressures which would conflict with their perception of the primary therapeutic purpose of their service.

2.3.6 In the third part of the study the clinical and security needs of patients referred to Medium secure units, but who were not admitted or who were placed on a waiting list was examined (Melzer *et al* 2004). The study concluded there was a substantial mismatch between the need for medium security and available places. A third of those identified as requiring medium security did so on a long term basis but few patients with such needs were admitted. Conversely 42% of those admitted did not require medium security. In those cases local services were unable to cope and patients appeared to primarily require containment because of acute psychosis. This observation was also identified by Coid & Kahtan and may indicate a shortage of provision in low secure locked units (Intensive Psychiatric Care Units) together with

clinical needs being identified as those the medium secure unit were designed to manage. There was also identified a lack of appropriate psychological treatments within medium security; 40% of those identified as requiring cognitive behaviour therapy could not have their need met.

2.3.7 The section below identifies that one possible determinant for the need of high or medium security is the gravity of the index offence. However a number of studies examining the patient characteristic in medium security reveal that patients with grave offences are frequently directly admitted (e.g. Murray 1994, James *et al* 1998, Coid *et al* 2001). It would also be a mistake to assume that patients in England seamlessly travel down levels of security until final discharge to community care. Murray (1996) found that half of a sample of 555 patient in medium security were discharged straight into the community.

2.3.8 Medium and high security psychiatric services are currently commissioned in England by Regional Specialist Commissioning Groups (Vaughan & Done 2000). Cohen & Eastman 2000, Marshall *et al* 1985, Shaw *et al* 2001 and Shaw 2002 attempt to clarify the assessment of need which in turn should help the development of admission criteria to secure care. Coid and Kahtan (2000) developed a four level scale to describe security need, but that framework can best be used retrospectively to calculate burden on a service rather than plan for the future.

**2.3.9 There is consensus that many patients are held in excessive security in consideration of the level of risk posed to themselves or others and in view of their assessed care needs. Security need is not necessarily the main factor influencing admission to medium security in England; there are also particular deficiencies in the provision of long term medium and low locked provision together with appropriate psychological treatments. Forensic needs assessment frameworks are in development.**

## 2.4 Mapping Secure Psychiatric care

2.4.1 Kennedy (2002) adopts the environmental, procedural and relational model of security and compares key differences between high secure, medium secure, low secure, open ward and forensic community services. Kennedy suggests a model for mapping psychiatric services and concludes:

> ‘ mental health services maintain a safe and effective process of treatment and rehabilitation through the stratification of patients according to the risks they present. Awareness of the therapeutic importance of environmental, relational and procedural security is valuable in drafting safe treatment plans for patients and in the organisation and management of all mental health services. Relational security is by far the most important element in the maintenance of the therapeutic progress of patients. . . .
>
> The definitions of levels of security here are simplified guidelines only, but have been of benefit in planning and organising a catchment area service and in choosing appropriate placements for patients when they had to be out of area. The definitions and categories are also of some assistance in organising the operational policies for secure and other mental health units and broad services, particularly in relation to the resources required for risk management. The guidelines for transfer of patients from one level of security to another should also be taken to be flexible and for implementation only by experienced clinicians who can make an assessment of the individual patient. However it is increasingly necessary to be able to communicate the form and content of such assessments as the basis of a clinical opinion . . .’

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

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

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

2.4.5 Kennedy further comments:

> "For mapping purposes, any mental health service can be described as a system made up of sub-systems. Forensic services are, therefore, always a sub-system of the mental health service for a given region. Table [1] sets out a matrix which stratifies units (sub-systems) according to security, length of stay and population served. This attempts to describe a whole system by including open and community units at local and regional levels. . . Every system, and every sub-system within it, can be mapped according to its structure, processes and outcomes."

2.4.6 Kennedy also considers the behavioural patterns which may guide which security level is appropriate for different patients, particularly drawing on the research of Pierzchniak *et al* 1999: Tables 2 and 3.

Table 2 (Reproduced from Kennedy 2002)

**Violence at presentation as a guide to security needed at the time of admission (N.B. this should never be taken in isolation from the other factors listed in table[3])**

| *Graveness of violence* | *Behaviour* |
|---|---|
| High<br>(Grade 1) | Homicide<br>Stabbing penetrates body cavity<br>Fractures skull<br>Strangulation<br>Serial penetrative sexual assaults |
| Medium<br>(Grade 2) | Use of weapons to injure<br>Arson<br>Causes concussion or fractures long bones<br>Sexual assaults<br>Stalking with threats to kill |
| Low<br>(grade 3) | Self-harm or attempted suicide that cannot be prevented by two-to-one nursing in open conditions<br>Repetitive assaults causing bruising |

Table 3 Dangerousness as a guide to security needed on admission (from Kennedy 2002 )

| **Dangerousness as a guide to security needed on admission(specialist forensic need is not necessarily correlated with dangerousness)** | | | | | |
|---|---|---|---|---|---|
| *Admission Guidelines* | *Forensic Community Services* | *Open wards and 24 hour nursed care* | *Low Secure* | *Medium Secure* | *High Secure* |
| *Violence* | No recent violence | Self-harm Lesser degrees of violence | Grade 3 Public Order/ Nuisance offending | Grade 2 | Grade 1 |
| *Immediacy* | Does not need daily monitoring | Confides in staff | Acute illness or crisis likely to resolve in 3-6 months | Relapses abrupt Unpredictable | Unpredictable Inaccessible to staff |
| *Specialist forensic Need* | Self-medicated Admissions to medium or high secure units Reintegrating with local services | Cannot co-operate with voluntary treatment Compliant when formally detained | Recall or crisis of former medium-/ high-security patient Current mental state associated with violence | Arson Jealousy Resentful stalking Exceeds low secure capacity | Sadistic Paraphilias associated with violence Exceeds medium security |
| *Absconding* | Will not break off contact | If absconded, would not present an immediate danger | Impulsive absconding | Pre-sentence serious charge Other obvious motive to abscond | Can co-ordinate outside help. Past absconding from medium or high security |
| *Public Confidence Issues* | No local victim sensitivities No high –risk Relationships | No local notoriety | Short term family sensitivities | Predictable Potential victims Local notoriety | National notoriety |

2.4.7 Kennedy stresses that the material in tables 2 and 3 are simply guidelines and cannot be a substitute for clinical and multidisciplinary experience. The criteria identified were derived from a panel rating process for 176 patients in high and medium security (Pierzchniak et al 1999). Grade of past violence, immediacy and absconding all have a close relationship to the risk an individual poses; decisions made on the basis of risk are in keeping with the principles identified in the MDO policy and proposed legislation.

2.4.8 Forensic need does not necessarily neatly fit with the principle of least restriction. Higher security psychiatric units are likely to have a wider range of specialist therapeutic interventions for offending, particularly psychological interventions. Units of lesser security still require to be sufficiently familiar and experienced in such interventions to provide follow-up or relapse prevention work. It would be difficult to justify transfer to a unit of higher security if the only reason to do so was the provision of a specialist therapeutic intervention. Lack of a particular intervention might well increase risk, but if that intervention could be provided safely in a unit of lesser security, then that is preferable.

2.4.9 The issue of public confidence is particularly problematic. Again it would be hard to justify detention in higher security solely based on notoriety. Realistically media interest is an important factor in planning the care of high profile patients. In some cases media interest is a sufficient destabilising factor to cause increased risk. It may be necessary to move patients in such cases but the better option would be consideration of a move to the same level of security rather than high. Media exposure also may increase risk to the patient from others and to any escorting or visiting staff when in the community.

2.4.10 There is variation across the levels of security regarding gender mix. The State hospital has separate male and female accommodation but allows some association of male and female patients. The Orchard Clinic has mixed wards with the possibility of female only areas. Also victim issues are of great importance and the proximity of potential and past victims may directly have a bearing on risk.

2.4.11 A lack of continuity of care may also increase risk. As in England, many patients from the Orchard clinic, who are followed up by the specialist forensic community team, are discharged directly in to the community. Towards the end of such an admission, detention in medium security is unlikely to be justifiable should a patient appeal under new legislation. However transfer to a new clinical team may be undesirable. Mechanism will need to be developed to provide both appropriate level of security and continuity of care.

2.4.12 Kennedy also identifies the criteria to help guide decision-making about reducing security level. At the Inquiry into the death of Georgina Robinson (Blom-Cooper 1995), Dr Udwin described the desirable characteristics of ‘supervisability’ for discharged restricted patients. Kennedy sums up the desirable characteristics for a forensic patient to move to discharge as stability, predicability and toleration of a degree of control and intrusion by clinicians. Table 4 is taken from Kennedy 2002 and tabulates the features often looked for when considering a diminution of security. These items are not dissimilar to some of the guidance found in the memorandum of procedures for restricted patients (Scottish Executive 2002).

Table 4 Signs of Diminished need for security (from Kennedy 2002)

| Move | High to medium security | Medium to low security | To community or open placement |
|---|---|---|---|
| Stability | Two years' stability<br>Relapses may be abrupt, over days | One year's stability<br>Relapses may be abrupt over days | Relapses occur over weeks and are predictable |
| Insight | Accepts legal obligations to take treatment as a minimum | Accepts treatment and legal obligations<br>Is encouraged to do so by closest friends or family | Realistic appraisal of risk of relapse<br>Practical approach to relapse prevention<br>Family and friends, if involved are aware and supportive |
| Rapport | Tolerates daily intrusions and constrictions of hospital life<br>Participates in treatment and occupational programmes | Capable of openness and trust with members of multidisciplinary team<br>Capable of limited exploration of current mental state as related to risk | Open and trusting with all members of multi-disciplinary team<br>Capable of communicating matters relevant to risk<br>Tolerates intrusion and restricted autonomy of treatment plan<br>Not excessively dependent on others |
| Leave | None necessary<br>Visits prior to trial leave are usual | Can use escorted leave in hospital grounds most of the time and community leave sometimes | Capable of using unescorted leave in the community for over 6 months |

**2.4.12 We conclude that there may be many complex considerations which currently influence decisions about the appropriate security level for a patient. Bearing in mind legislative changes, the legally justifiable determinant of level of security is best estimation of level of risk posed by an individual to themselves or others. Issues of patient mix, availability of appropriate therapeutic services, public confidence and continuity of care may be important secondary considerations, but would not in isolation justify a level of security in excess of that estimated to satisfactorily safely contain the risk posed.**

## 2.5 The Security Needs Assessment Profile (SNAP)

2.5.1 Collins, Davies and Ashwell from Rampton Hospital in England have been developing a structured framework to aid decision making regarding the appropriate level of security for a psychiatric inpatient (Collins & Davies 2001, Collins *et al* 2003). They identified 22 security items (table 4) split between the three domains of physical, procedural and relational skills.

2.5.2 The 22 criteria were developed from detailed analysis of security practice in high and medium secure services and through extensive consultation with clinicians and security staff, these were then developed into the detailed descriptor of the item. Each criterion was then further developed into a graduated ordinal scale with each point on the scale representing a level of need. These were broadly correspondent with high, medium, low and open which are the generally accepted levels of security in England.

2.5.3 After revisions as a result of extended consultation, the instrument was used in needs assessment. Statistical principal component analysis revealed some underlying components within the first draft, and an analysis of scoring patterns against ideal placements for patients revealed some stratification across different perceived global security needs. Collins et al (2001) recognised that that the ordinal references may not have been totally accurate and embarked upon their current study of English forensic units to ground the descriptors in clinical reality

2.5.4 The most recent version of the SNAP is presented in appendix 2. For each item there is a general descriptor and 4 criteria intended to match levels of need: 3 = high, 2 = medium, 1 = low locked, 0 = open. To further illustrate each item there is a case vignette with a suggested level of security to meet the need highlighted in the vignette.

2.5.5 The criteria describe the desirable characteristics at each level of need. Those criteria for high and medium security include prescriptive guidelines from Department of Health in England and Wales which set certain security standards, although Collins et al have found variation in application of the guidelines in medium secure units. For a population of patients with a past history of serious violence it is the physical and procedural items that most helpfully discriminate between the initial levels of security. All such patients will require a high degree of relational skills no matter the setting or how far they have progressed to care in the community. Item 21, Response to nursing interventions and treatment programmes, is the only item where the emphasis is placed on the patient and the therapeutic relationship, rather than the healthcare provider. It is perhaps the most important item when considering a step down in security. Again all levels of security would aim at fostering patient concordance and co-operation.

2.5.6 Although the SNAP can be scored for research purposes, scoring would be misleading in the clinical context. It has not been demonstrated that each item is equally important. If different items were of different importance then the score on each would require weighting to produce an accurate overall score. Also an individual patient may only score highly on a few discrete items but nevertheless require a high level of security because those few items make it unsafe for that individual to be managed elsewhere. In a similar approach to the HCR 20, the SNAP is intended to structure the discussion of clinical teams, give a common framework between different clinical teams to discuss difficult cases and overall improve decision-making. There will remain a temptation to add up the scores of patients and this must be recognised as a misleading clinical activity.

2.5.7 The SNAP continues to be developed and further piloting is planned. It has been supported by the English National Forensic Mental Health Research and Development Programme. For the reasons described below, the SNAP cannot be transplanted into a Scottish context. In particular it was not designed with a statutory appeal against level of security in mind. Although it represents the factors currently clinically important in England in decision making, these Tribunals may not consider all legally important factors in Scotland.

2.5.8 **We recommend the SNAP is a focus of further research in the Scottish context. Together with the approach suggested in chapter 4 (using the matrix of security), research in Scotland could develop a comprehensive, research-based instrument to aid clinical decision-making.**

**We recommend the Forensic Mental Health Services Managed Care Network consider advocating the use of research and development funds to put out to tender proposals to undertake such research.**

Table 4 The SNAP topics of security

**Domain I Physical security**

1. Perimeter
2. Internal
3. Entry
4. Facilities

**Domain II Procedural security items**

5. Patient supervision
6. Environment
7. Searching
8. Access to potential weapons and fire setting materials
9. Internal movement
10. Leave
11. External communications
12. Visitors
13. Visiting Children
14. Media Exposure
15. Access to illicit substances
16. Access to alcohol
17. Access to Pornographic materials
18. Access to information technology equipment

**Domain III Relational Skills items**

19 Management of violence and aggression
20 Relational skills
21Response to nursing interventions and treatment programme
22 Security intelligence

## 2.6 The need for a Scottish perspective

2.6.1 Within the English context, levels of security have been reviewed. The Tilt report, along with the associated Department of Health directions, set prescriptive standards in the security of the English Special hospitals. The Royal College of Psychiatrists currently has a working party chaired by Professor Pamela Taylor exploring the definition of security from the perspective of the UK and Ireland. It is important in Scotland, however, for there to be a distinct approach to this issue whilst drawing on appropriate work done in England and elsewhere. There are several ways in which the provision and services in Scotland are different to those in England:

a) Forensic psychiatric services in Scotland do not have the same proportion of patients with primary anti-social personality disorders. This comprises some 25% of the Special Hospital population but only 6 % of the State Hospital population (Thomson *et al* 1997). (For a detailed discussion on the different approach to antisocial personality disorder in Scotland see Darjee & Crichton 2003)

b) The provision of medium secure psychiatric facilities is in its infancy in Scotland.

c) Unlike England, Scotland retained its local low secure locked facilities, which in many areas had a mixed intensive care function and low secure forensic function. Some of these units then developed some degree of enhancement with their level of security and became more specifically forensic (e.g. the Blair Unit, Aberdeen). There remains some scope for comparison with England in that similar services to these have been developed in some areas: Cripps *et al* 1995 and Cohen & Eastman 2000.

d) Scotland has its own distinct legal system. Following devolution there is a widening gap between the jurisdictions in Criminal and Mental Health Law. For example, in Scotland there are no Dangerous and Severe Personality Disorder proposals, but a Risk Management Authority is to be established in 2004 and a sentence of Order of Lifelong Restriction put in place.

## 2.7 Assessing the success of security

2.7.1 In reviewing the literature it is clear that security in a hospital setting is not an end in itself; rather it facilitates safe treatment and rehabilitation. Conlon *et al* (1995) suggested that security and the therapeutic environment had to be balanced and that greater security was counter-therapeutic. However, security is not counter to wider therapeutic goals but integral to the therapeutic process. Before any treatment can take place the environment must be reasonably safe. Security is one aspect of overall clinical management. Its success cannot simply be gauged by outcome measures that relate purely to security outcomes, e.g. number of absconsions, but to outcomes which also take into account wider therapeutic objectives. A unit can achieve a perfect absconsion record by never testing out any patient; but this would be a failure in providing appropriate wider treatment. Lack of security has in the past been most clearly identified following tragedy (Reid 1978). There is a need to identify and develop outcome measures which both help to audit security measures, but also do not lose sight of the function of security within a hospital setting.

2.7.2 The Memorandum of Procedures on Restricted patients requires RMOs to report any serious incident involving a restricted patient to the Scottish Executive and Mental Welfare Commission for Scotland (Scottish Executive 2002). The definition of serious incident would include any major breach of security. However, there is no collation of this information distributed to RMOs or MDTs working in secure settings. The Mental Health and Well Being Support Group for the Scottish Executive (NHS HDL(2000)16) published guidelines on risk management and how to conduct critical incident reviews following security breaches but again there has been no collation or central repository of incident reviews in secure settings.

2.7.3 In England there has been a radical change in the way adverse incidents in the NHS are investigated following Sir Liam Donaldson's *An Organisation with a Memory*. This marked a deliberate shift away from a 'blame culture' to one which encouraged openness and learning from mistakes. As a result of *An Organisation with a Memory*, the National Patient Safety Agency was formed who are developing systems of adverse incident review based on Root Cause Analysis (see www.npsa.org.uk). In addition, the Mental Health Act Commission has categorised security incidents in relation to severity in order to clarify reporting and investigation expectations.

**2.7.4 We conclude that more can be done to learn from security breaches and audits of security standards. This is an area which merits further research and can usefully consider developments in England.**

## 2.8 Defining security levels

2.8.1 It is notable that the literature has avoided any succinct definition of security levels. In the past the different levels of security were often simply defined by comparison to neighbouring security levels. Security in different settings has arisen through time and by a combination of common sense, comparison to prisons, official guidelines, comparing practices and learning from security breaches. The group was unconvinced that a short definition would be useful in the decision making process regarding individual patients. There may be a place for such a definition in planning, however, and one of the best brief definitions was suggested through personal correspondence with Mick Collins, and is by the Forensic Services Specialist Commissioning Team, North Nottinghamshire Health Authority. Their suggested definitions can be found in table 5. This brief definition is focused on new admissions via court and not on prison transfers or those moving down the levels of security. The definition in does, in summary, outline some of the key differences between the levels of security, but for a definition to be useful in planning and clinical decision making, greater detail is required.

Table 5 A brief definition of security levels

**High Security** is the level of security necessary only for those patients who pose a grave and immediate danger to others if at large. Security arrangements should be capable of preventing even the most determined absconder. High secure services should only be provided in secure hospitals with a full range of therapeutic and recreational facilities within the perimeter fence, acknowledging the severe limitations on the use of outside services and facilities.

**Medium Security** is the level of security necessary for patients who represent a serious but less immediate danger to others. Patients will often have been dealt with in the Crown Courts and present a serious risk to others combined with the potential to abscond. Security should therefore be sufficient to deter all but the most determined. A good range of therapeutic and recreational facilities should be available within the perimeter fence to meet the needs of patients who are not ready for off-site parole, but with the emphasis on graduated use of ordinary community facilities in rehabilitation whenever possible.

**Low Security** is the level of security deemed necessary for patients who present a less serious physical danger to others, often dealt with in the Magistrates Courts and identified by court assessment/diversion schemes. Security measures are intended to impede rather than completely prevent absconsions, with greater reliance on staffing arrangements and less reliance on physical security measures

*CHAPTER THREE*

## Defining levels of security in Scotland

3.1 The approach the group has taken to define different levels of security closely follows the approach taken by Kennedy (2002) and the SNAP project. We have identified key criteria, which discriminate between current levels of security currently present in Scotland. Table 7, The Matrix of Security, lists those key characteristics that vary, cross-tabulated with different levels of security. The group, through discussion and informal consultation, has selected the characteristics because they help discriminate between levels of security. The security matrix does not and is not designed to describe the entirety of a psychiatric service. We found that it was in environmental security and procedural security that differences occurred.

3.2 There is a danger in interpreting this work as minimising the importance of relational security. Relational security is of absolute key importance but the components of relational security are desirable across the range of levels of security and therefore are not good discriminators. Staff to patient ratios tend to be higher in all locked psychiatric settings, but all services aspire to provide sufficient staff number for their population of patients. A full complement of multidisciplinary staff skilled in a wide range of therapeutic interventions is an aspiration shared by all and is not in itself a feature of higher security. Confusion arises because in higher security there tends to be a good range multiprofessional staff and therapeutic interventions.

3.3 The approach here therefore is more descriptive than prescriptive at high security and medium security. As there is currently only one example of each of these levels in Scotland, the characteristics closely reflect the current status quo at the State Hospital and the Orchard Clinic. Towards the lower levels of security there is more variation between facilities across Scotland. Where there is variation in practice we have chosen to adopt what we consider to be a good enough standard for the various discriminating criteria. However, many facilities will exceed that standard.

3.4 It is foreseeable as services develop that standards and practices will change therefore this current matrix of security is also likely to change as services develop. Of greater importance than the content is the approach. **If this approach is found to be useful then updated versions of the Matrix can be developed to reflect changing standards**.

3.5 **The purpose of the matrix of security is to provide a common framework of what is provided at different levels of security and the function of each element, in order for meaningful service planning to take place and the development of protocols for the transfer of patients between levels of security.**

**3.6 The Matrix of Security is not intended to be or designed to be an authoritative legal document.**

3.7 **The Group agreed that although the function of a psychiatric in-patient unit might vary, the key characteristics of different levels of security remain the same.** Functionally psychiatric units may vary by diagnosis, gender, age and length of stay. For example, the key characteristics of security in mental illness should be the same for learning disability or acquired head injury; or those in a short to medium term facility should be the same as a medium to long term facility.

3.8 **The group identified the following different levels of security in Scotland**.

1. **High security**, The State Hospital, Carstairs.
2. **Medium security**, e.g. The Orchard Clinic, Royal Edinburgh Hospital and other planned medium secure units.
3. **Intermediate forensic rehabilitation**, e.g. The Blair Unit, Aberdeen, The Forensic Unit, Leverndale Hospital in the Forensic Unit, Murray Royal Hospital
4. **Low secure locked/ Intensive Psychiatric Care Units** (IPCU) e.g. IPCU, Royal Edinburgh Hospital, IPCU, Falkirk and District Royal Infirmary.
5. **Low secure open units** i.e. general adult admission wards.

**3.9 The Matrix of Security**

3.9.1 The matrix of security is useful in describing different levels of security in terms of elements that differ between services. It is important to realise, however, that the matrix does not lead to one comprehensive definition of each level of security, as not every element has a gradation that matches "low, medium, high". Rather it highlights the differences that exist between the levels and may be used to give a framework to clinical decisions around levels of security for patients.

3.9.2 In trying to define the differences between levels of security, there has been some obvious simplification. For instance, any particular service has a dynamic patient mix to take account of when determining the ability to cope with, or deliver effective care to, an individual patient. Also, the matrix taken alone may underplay the interdependent relationship between features of environmental and physical security; physical aspects of the environment may be rendered useless by inappropriate procedure.

3.9.3 The elements identified by the group as delineating factors have been grouped into themes by considering the rationale for the particular aspect of security, and these are summarised in table 6. In addition, these have then been related to the patient features and presenting problems which would indicate a need for higher security. We have avoided categorisation across levels because there is a tendency to categorise through comparison with another level (medium is higher than low but lower than high) or describing lower secure care needs through absence of higher secure care features and presenting problems.

Table 6 Summary of themes and items in the matrix of security

| Environmental Security | |
|---|---|
| Design and construction | |
| | Perimeter |
| | Control of access to the site |
| | Building design to deter escape |
| | Window/door security |
| | Furniture design |
| Equipment | |
| | X-ray/ metal detector/ion detector |
| | Personal Alarms |
| | Physical Restraints |
| | Campus Observation (CCTV) |
| | Availability of additional secure area for behaviourally disturbed patients |
| Procedural Security | |
| Control of COMMUNICATIONS | |
| | Patients phone calls |
| | Patients letters/mail |
| | Patients electronic mail / access to the internet |
| | Staff communications |
| Control of ITEMS | |
| Restricted (or prohibited) See note on prohibited items list | |
| | Searching patients |
| | Searching visitors, official visitors, staff |
| | Drug access/screening |
| | Alcohol access/screening |
| | Access to pornographic materials and/or materials portraying violence |
| Equipment for Daily living | |
| | Cutlery |
| | OT equipment (e.g. kitchen) |
| | Fire setting materials (e.g. cigarette lighters) |
| Money and Valuables and belongings | |
| | Access to belongings |
| | Access to money/valuables |
| | |
| Control of PERSONS | |
| Visitors | |
| | Visitor ID and approval |
| Child Visitors | |
| | Child visiting policy |
| | Visiting arrangements procedure |
| Internal Movement | |
| | Patients |
| | Visitors / official visitors |
| | Staff |
| | Provision of recreations/therapies |
| Patient Absence | |
| | Routine pass (e.g. “testing out”) |
| | Exceptional LOA (e.g. court, hospital) |
| | Prevention and management of absconsion |
| | Prevention and management of escape |
| Policies, procedures and contingencies | |
| | Policies |
| | Contingency planning |

3.9.5 Environmental Security

The delineating factors of environmental security demonstrated in the matrix can be separated into elements that describe:

- The physical design and construction of the hospital, unit or ward.
- equipment that is available to the service to control the environment, and react quickly to violent incidents

3.9.5.1 Design and construction

Physical characteristics of the buildings and perimeter are increasingly designed to deter or prevent more sophisticated or sustained attempts to overcome them. Conversely there may be higher grade building features in lower secure services where there is more dependence on the fabric of the building to provide environmental security, due to the absence of a separate perimeter with additional features, such as that provided in high security.

Patient secure care need

The items within the design and construction theme are primarily to reduce the likelihood of escape. Therefore, features and presenting problems of patients who would be appropriately placed in higher security would indicate that they have the ability and motivation for escape (planning capability, a lack of engagement with care and treatment and "confederates" or friends and family who are able to assist in an escape attempt) and may pose an immediate and serious danger to public.

3.9.5.2 Equipment

Environmental security also includes the equipment that is available to the service to control the environment, and react quickly to violent incidents. These include alarm systems, CCTV, detection equipment and additional secure areas for patients.

Patient secure care need

The items listed in the equipment theme are used to control the environment, and react quickly to violent incidents. Therefore patients for whom higher security provision is appropriate may show low predictability or a history of acting in concert. They are likely to engage in serious, skilled and sustained attempts overcome multiple layers of security and these require a co-ordinated response from the organisation. This may include internal acts such as rooftop protests, barricades and hostage-taking.

3.9.6 Procedural Security

The delineating factors of procedural security identified by the may be categorised as:

- control of communications;
- control of items such as potential weapons, pornographic or violent media and intoxicating substances;
- control of persons, access, egress, movement within the facility and LOA for patients

There is overlap between these themes, for example, a postal package that contains a dangerous item may be controlled by communication policy, and control of visitors includes searching which is carried out in order to limit, or eliminate, items from the environment.

3.9.6.1 Control of Communications

Communications (telephone, email or letter) can be reasonably restricted by the service when there is concern about the protection of the receiving party when a patient is sending communications. Alternatively, the receipt of communications that can be reasonably suspected to be of a criminal nature may be curbed in High Secure environments. Note: Sections 281-286 of the Mental Health (Care and Treatment) (Scotland) (Act) 2003 relate to communication and security. **It is foreseeable that as the regulations are developed that standards and practices will change**

Patient secure care need

Patients requiring care in a higher secure setting would be assessed as being likely to use communication systems to: arrange escape, arrange harmful substances or other criminal activity; deliver threats of harm to others; and subvert the safety and security of the facility. In addition there may be significant victim and child protection issues.

3.9.6.2 Control of items

There are items that are controlled in order to limit or eliminate them from the environment.

Patient secure care need

For patients with higher secure care needs it is likely that they would pursue drugs, weapons, escape tools or inappropriate sexual/violent materials. These patients, or their friends and family, are likely to attempt to bring restricted or prohibited items into the facility, either by their own volition or because of manipulation by others, and the outcome if used may be severe.

Access to equipment for daily living that may be used as a weapon or escape tool (for instance fire setting materials, cutlery and kitchen equipment and tools) is controlled across the levels of security.

Patient secure care need

Patients for whom higher security provision is appropriate are likely to show an ability to plan or conceal items to use as a weapon or escape tool and creatively adapt or use everyday items for violence, escape or severe disruption . Therefore access is restricted and a higher level of supervision required as the patients exhibit impulsive serious violence with weapons and unpredictability.

3.9.6.3 Prohibited items

The group was aware that all units had items which were either restricted or banned altogether. Prohibited item lists appeared to have been generated by a combination of common sense and adverse incident. Some items were obviously prohibited across the board such as illicit drugs and weapons. For other items there was a trend towards controlled access and permitting free access towards the lower end of security. There remained wide variation. For example football colours are not permitted in one unit but are permitted in medium and special security. **We concluded there was a need to further research which items could be reasonably prohibited in which settings and then issue guidelines to ensure a consistent and equitable approach across the range of psychiatric settings in Scotland.**

3.9.6.4 Control of Persons

Access and egress is increasingly restrictive through increasing levels of security. Medium and high security are likely to have a single controlled entry with identification checks and escort arrangements within the facility. Patient movement is likely to be subject to high levels of control and supervision either inside the unit or outside on leave.

Patient secure care need

For patients presenting with higher secure care need there are differing reasons why a high level of control of persons may be required. For instance, control of visitor access, egress and movement on site would be in response to a high likelihood of assisting in accessing illicit items, or escape. Conversely, there may be a significant risk to visitors, particularly child visitors and control measures are required for their protection. The control of patient movement would tend to be in response to an assessment of significant likelihood and determination of violence, escape, absconsion, rooftop protests, barricades and hostage-taking.

3.9.13 Policy, procedure and contingencies

Delineators in procedural security also include an expression of the special nature of the particular operational policies and procedures of the facility and the level to which detailed and multi-agency contingency planning is necessary.

Table 7 The Matrix of Security (cont.)

| ENVIRONMENTAL SECURITY | | | | | |
|---|---|---|---|---|---|
| **Delineator** | **LOW** | | | **Medium** | **High** |
| | **Open ward** | **IPCU/locked rehab** | **Locked forensic unit/ward** | | |
| **DESIGN AND CONSTRUCTION** | | | | | |
| Perimeter (e.g. fence) | Standard hospital specifications | | No secure perimeter, but secure outside area. Secure external windows | No secure perimeter, but secure outside area. Secure external windows. Deterrent perimeter fence with motion sensors | 5.2m secure fence, additional motion detection perimeter |
| Control of access to the site | Standard hospital specifications | double locked doors | | electronic airlock | Airport level security |
| Building design to deter escape | Standard hospital specifications - not specifically designed to deter escape | Specifically designed to deter escape | | robust construction able to deter and delay determined escape | robust construction able to withstand determined escape with tools |
| Window / door security | Standard hospital specifications | Window restrictors / reinforced windows | Doors opening outward (interview room and bedroom), window restrictors / reinforced windows | Keypad entry, internal doors reinforced. Communicating doors alarmed if kept open. Two way opening (interview room and bedroom) doors, reinforced windows with anti-smuggling grid on external windows. | Prison service approved locks, airlock systems some break-proof windows, some use of electronic control of doors. No external windows |
| Furniture design | standard hospital furniture | | | Heavy and robust | |
| **EQUIPMENT** | | | | | |
| X-ray / metal detector / ion detector | None routinely used | Hand held metal detector | | | xray machine, arch and handheld metal detector, ion detector, sniffer dogs from partner organisations if required |
| Personal alarm systems | Standard personal alarms | location specific | | location specific - response team alerted by pager | location specific security alerted and tannoy to hospital campus and response team |
| Physical restraints | None used | | | | handcuffs for exceptional leave |
| Campus observation (CCTV) | Limited to specific locations | | | Complete external, point of access, air locks, kept 2 weeks | complete campus and perimeter, kept 3 weeks |
| Availability of additional secure area for behaviourally disturbed patients | None | normal bedrooms used | | Individual additional secure area available with bedroom and living area | A range of individual secure areas with bedroom and living space |

Table 7 The Matrix of Security (cont.)

| PROCEDURAL SECURITY | | | | | |
|---|---|---|---|---|---|
| **Delineator** | **LOW** | | | **Medium** | **High** |
| | **Open ward** | **IPCU/locked rehab** | **Locked forensic unit/ward** | | |
| **COMMUNICATIONS** | | | | | |
| Patients phone calls | No restriction except in "exceptional circumstances" | | | Can be monitored or stopped | |
| Patients letters/mail | Can be monitored in a limited way – Section 117 MH(S) A 1984 | | | | All post X rayed. Can be monitored - Section 117 MH(S) A 1984 - with additional statutory powers |
| Patients electronic mail / access to the internet | Not supervised if available | | Supervised access on site unsupervised off site | | no access |
| Staff communications | unrestricted received mail | | | | received mail is x-rayed |
| **ITEMS – RESTRICTED (or prohibited)** | | | | | |
| Searching patients | As warranted by individual risk assessment | On admission including possessions and as warranted by individual risk assessment - random searches following LOA | | On admission, following LOA, regular personal – and regular room searches. | |
| Searching visitors, official visitors, staff | none routine | | | None routine – but secure lockers available for bags (not allowed in patient areas) | Searched if metal detectors are set off and random entrance and egress searches. Bags searched if suspicious item seen in x-ray imaging. |
| Drug access/screening | Screening dependant on clinical need | Urinary drug screening on basis of clinical need and on admission & random screening | | | |
| Alcohol access/screening | Access to alcohol on leave approved by MDT. Alcometer available | | | | No access to alcohol permitted |
| Access to pornographic materials and/or materials portraying violence | MDT discretion, individual patients | | | Routine screening and controlled access | |
| **ITEMS – Daily living equipment** | | | | | |
| Cutlery | supervised meals | Restricted metal cutlery - counted after use, supervised meals | | | |
| OT equipment (e.g. kitchen) | MDT approval | | | graduated access following individual risk assessment and MDT approval | |
| Fire setting materials (e.g. cigarette lighters) | Dependant on individual risk assessment | Controlled/ limited access, no fire setting material with patients | | | |
| **ITEMS - Access to money, valuables and belongings** | | | | | |
| Access to belongings | At MDT discretion | | | Limited number of items and limited access | |
| Access to money/valuables | Dependant on individual assessment of capacity | Dependant on individual assessment of capacity. May be restricted | | Dependant on individual assessment of capacity. May also be restricted on LOA to reduce absconsion risk | Dependant on individual assessment of capacity. Money and valuables are also restricted on site and on LOA for security reasons |

Table 7 The Matrix of Security (cont.)

| PROCEDURAL SECURITY | | | | | |
|---|---|---|---|---|---|
| **Delineator** | **LOW** | | | **Medium** | **High** |
| | **Open ward** | **IPCU/locked rehab** | **Locked forensic unit/ward** | | |
| **PEOPLE- visitors** | | | | | |
| Visitor ID and approval | Not generally required | | | Identification required. Prior approval by MDT, Unit policy. Visitors must agree code of conduct | Identification required then special ID provided and checked on exit. Prior approval by MDT. Visitors must agree code of conduct |
| **PEOPLE- Child Visitors** | | | | | |
| Child visiting policy | Nursing staff discretion | approved by MDT | | Social work assessment required, approval via MDT | |
| Visiting arrangements procedure | Specified visiting areas (other restrictions dependant on risk present at time) | | | Special family visiting room away from clinical area | Special family visiting suite away from clinical area |
| **PEOPLE- Internal Movement between clinical areas in a psychiatric facility** | | | | | |
| Patients | may be escorted | | | Escorted within Unit – no access to administrative areas | Grounds access for some patients - monitored by CCTV, some escorted, prohibited areas in the campus |
| Visitors / official visitors | may be escorted | Escorted | | | Escorted - bussed to location of visit |
| Staff | None | | | Not limited, but electronically recorded | electronically recorded and restricted access to some areas |
| Provision of recreations/therapies | Range – with majority off ward | | | On Unit wide range of secure activities. Range off-site available | On campus range of secure activities |

Table 7 The Matrix of Security (cont.)

| PROCEDURAL SECURITY | | | | | |
|---|---|---|---|---|---|
| **Delineator** | **LOW** | | | **Medium** | **High** |
| | **Open ward** | **IPCU/locked rehab** | **Locked forensic unit/ward** | | |
| **PEOPLE- Patient absence from the hospital** | | | | | |
| Routine pass (e.g. "testing out") | Standard hospital policy | | Unit policies including individual risk assessment | | Usually a minimum of two escorting staff |
| Exceptional LOA (e.g. court, hospital) | Standard hospital policy | | Unit policies including individual risk assessment. | Unit policies including individual risk assessment. Local police informed. | handcuff meeting, police liaison, more escorting staff |
| Prevention and management of absconsion | Standard hospital policy | | | Unit policies – description card (ID) completed every time a patients leaves clinic and returns, key information and risk assessment given to police in case of absconsion | Individual risk assessment for each LOA, usual to have 2 or more staff escorting. Individual risk assessment of grounds access. Range of multi-agency contingency plans, network of sirens |
| Prevention and management of escape | Standard hospital policy | | | Unit policy. Key information and risk assessment given to police | Contingency planning, liaison with police, siren |
| **Miscellaneous** | | | | | |
| Policies | General hospital policies | General hospital policy. Some unit policies | General hospital policy. Some forensic unit policies | Detailed forensic unit policies | High secure forensic hospital policies |
| Contingency planning | limited contingency planning | | Multi-agency planning for evacuation, escape and absconsion | | range of multi-agency contingencies for hostage, riot, escape, barricade, rooftop |

*CHAPTER FOUR*

## Using the Matrix of Security

### 4.1 Further development of the Matrix

4.1.1 We have developed the matrix which we commend as a useful starting point, however it would be premature to use the matrix to make policy decisions with regard to disputes about the suitable level of security for individual patients

4.1.2 The matrix of security is not a static framework but one, if it is to be useful, which is subject to change. The group expects that following wider consultation there will be changes to the descriminating characteristics and their descriptions. There then is required a period of piloting. We recommend that the matrix be used by clinical teams to identify the appropriate level of security at each patient's annual review. This could eventually become part of a structured needs assessment. Rather than rigidly go through a checklist we suggest that the relevant items of the matrix be highlighted in the discussion and documentation. It might also be useful to use the matrix in a similar fashion when referrals to and from the State Hospital are discussed. The intention is that the Matrix will focus discussion on those key differences in security that makes the State Hospital necessary for the safe treatment of an individual patient.

4.1.3 Throughout our approach we have drawn a distinction between security need and other treatment needs. Patients are detained in excessive security for two reasons: unavailability of a space at an appropriately lower level of security and unavailability of the right treatment in what lower secure provision is available. The experience of England is not simply that there is a lack of medium secure beds but a lack of the right type of medium secure beds. In addition to identifying which patients at the State Hospital do not require special security it is necessary to identify treatment needs. It is poor management to transfer a patient who does not require special security to a unit which cannot provide appropriate treatment. Perhaps one of the reasons longer term patients have difficulty in moving on from Special to medium security in England is the poor provision of psychological services to devise treatment plans for long term challenging behaviour. Also the provision of psychodynamic support for staff groups dealing with difficult staff patient dynamics is undeveloped in Scotland.

**4.1.4** If in the course of a year's pilot the matrix can be improved and every patient at the State Hospital can have a detailed examination of his or her security and treatment needs then the Network will have valuable additional information for service planning**. We recommend that the State Hospital, in conjunction with network partners organise a pilot of the Matrix for annual reviews, admission and discharge discussions.**

4.1.5 **We conclude that the matrix as we have presented it here is not a substitute for evidence based development through a research project. We have highlighted areas for further research and we support the development of the Forensic School as an appropriate model to address these.**

*CHAPTER FIVE*

## Summary of conclusions and recommendations

5.1 The group acknowledge that these aspects of service provision may be addressed in the current work of the other specialist groups currently reporting on the needs of women and those with a learning disability. Further to this, we recommend to the Network that forensic community services, including the use of security, would be an important topic for a future working group.
(paragraph 1.8)

5.2 One important source of admissions to forensic services is from the Scottish Prison Service, and closer liaison and awareness in both services of each others security assessments is desirable. In addition, security intelligence should be available to admitting clinical teams so that a safe level of security can be identified. We recommend further work be done comparing security assessment in prison and the Matrix.
(paragraph 1.9)

5.3 The Group concluded that, there is always a danger imposing security on a patient population who do not consent or may not be capable of consent and who may have other vulnerabilities. A historical perspective reveals that the balance between freedom and restriction is not easy to strike. Security has always been a necessary part of psychiatric care and this section reveals the roots of environmental, procedural and relational security. Before any practice is dismissed as being overly restrictive its function first needs to be understood and if necessary a better alternative introduced.
(paragraph 2.1.8)

5.4 The group concluded that that the model of security, which consists of environmental, procedural and relational aspects, has utility. Further we recommend the following principle is adopted:

*The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community*
(paragraph 2.2.4)

5.5 There is consensus that many patients are held in excessive security in consideration of the level of risk posed to themselves or others and in view of their assessed care needs. Security need is not necessarily the main factor influencing admission to medium security in England; there are also particular deficiencies in the provision of long term medium and low locked provision together with appropriate psychological treatments. Forensic needs assessment frameworks are in development.
(paragraph 2.3.9)

5.6 We conclude that there may be many complex considerations which currently influence decisions about the appropriate security level for a patient. Bearing in mind legislative changes, the legally justifiable determinant of level of security is best estimation of level of risk posed by an individual to themselves or others. Issues of patient mix, availability of appropriate therapeutic services, public confidence and continuity of care may be important secondary considerations, but would not in isolation justify a level of security in excess of that estimated to satisfactorily safely contain the risk posed.
(paragraph 2.4.12)

5.7 We recommend the Security Needs Assessment Profile is a focus of further research in the Scottish context. Together with the approach suggested in chapter 4 (using the matrix of security), research in Scotland could develop a comprehensive, research-based instrument to aid clinical decision-making. We recommend the Forensic Mental Health Services Managed Care Network consider advocating the use of research and development funds to put out to tender proposals to undertake such research.
(paragraph 2.5.8)

5.8 We conclude that more can be done to learn from security breaches and audits of security standards. This is an area which merits further research and can usefully consider developments in England
(paragraph 2.7.4)

5.9 It is foreseeable as services develop that standards and practices will change therefore this current matrix of security is also likely to change as services develop. Of greater importance than the content is the approach. If this approach is found to be useful then updated versions of the Matrix can be developed to reflect changing standards.
(paragraph 3.4)

5.10 The Group agreed purpose of the matrix of security is to provide a common framework of what is provided at different levels of security and the function of each element, in order for meaningful service planning to take place and the development of protocols for the transfer of patients between levels of security.
(paragraph 3.5

5.11 The Group agreed that the Matrix of Security is not intended to be or designed to be an authoritative legal document.
(paragraph 3.6)

5.12 The Group agreed that although the function of a psychiatric in-patient unit might vary, the key characteristics of different levels of security remain the same. Functionally psychiatric units may vary by diagnosis, gender, age and length of stay. For example, the key characteristics of security in mental illness should be the same for learning disability or acquired head injury; or those in a short to medium term facility should be the same as a medium to long term facility.
(paragraph 3.7)

5.13 We concluded there was a need to further research which items could be reasonably prohibited in which settings and then issue guidelines to ensure a consistent and equitable approach across the range of psychiatric settings in Scotland.
(paragraph 3.9.6.3)

5.14 If in the course of a year's pilot the matrix can be improved and every patient at the State Hospital can have a detailed examination of his or her security and treatment needs then the Network will have valuable additional information for service planning. We recommend that the State Hospital, in conjunction with network partners, organise a pilot of the Matrix for annual reviews, admission and discharge discussions.
. (paragraph 4.1.4)

5.15 We conclude that the matrix as we have presented it here is not a substitute for evidence based development through a research project. We have highlighted areas for further research and we support the development of the Forensic School as an appropriate model to address these.
(paragraph 4.1.5)

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