DRAFT FOR CONSULTATION
20 June – 19 August 2005

Forensic Mental Health Services and Scottish Prison Service

Security Liaison

CONTENTS

1. Introduction

This report is the result of a working group (Recommendation 5.2 Working Group) commissioned by the Forensic Mental Health Services Managed Care Network Advisory Board. Recommendation 5.2 relates to a recommendation of the Definitions of Security Levels in Psychiatric Inpatient Facilities in Scotland report which was formally endorsed by the Advisory Board, following a wide consultation, on 3 September 2004.

Recommendation 5.2 stated;
"One important source of admission 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."

This working group is one of a series commissioned by the Network Advisory Board whose reports will inform Scottish Executive policy and guidance in terms of the planning and provision of Forensic Mental Health Services in Scotland.

2. Membership

Membership of the group was;

Doug Irwin, Security Director, The State Hospital (Chair)
Ian Dewar, Consultant Psychiatrist, The State Hospital
Roisin Hall, Head of Psychology, Scottish Prison Service
Heather Keir, Head of Health, HMP Cornton Vale
Bill McKinlay, Governor, HMP Barlinnie
Tony Simpson, Assistant Director of Prisons, Scottish Prison Service
Vivienne Gration, Forensic Network Project Manager (Admin Support)

3. Acknowledgements

The group would like to acknowledge the work of Kenny McGeachie, Mental Health Services Co-ordinator with Scottish Prison Service particularly in his drafting of the protocol for transfers from Forensic Mental Health Services back to SPS custody.

The group would also like to thank Dr Andrew Fraser, Head of Health with Scottish Prison Service for his joining the wider reference group in place of Roisin Hall.

The group would like to formally thank Scottish Prison Service for hosting the meetings at Carlton House.

4. Terms of Reference

The remit of the group was;

To address recommendation 5.2 as laid out in the Definitions of Levels of Security Working Group report of July 2004.

The terms of reference for the group were:

- Consider how to ensure that there is closer liaison and awareness in both Forensic Services and Scottish Prison Services of security assessments.
- Consider how security intelligence can be shared between Forensic Services and the Scottish Prison Service.
- Match referrals from prison to levels of security (e.g. Prisoners needing low or medium security should not be referred to The State Hospital).
- Compare Scottish Prison Service security assessments to the matrix.

5. Working Arrangements

The group had an initial meeting on 9 November 2004 to receive a presentation from the Chair regarding the Forensic Network, and to discuss the Terms of Reference. At this initial meeting it was agreed that a subgroup would be formed, with the wider group acting as a reference group to be consulted at reporting stage and that Doug Irwin, Ian Dewar, Tony Simpson and Vivienne Gration would form the sub group to work through operational details and draft the report.

Four further meetings were held and a draft report circulated to the wider reference group on 13 May 2005. During this period Roisin Hall was appointed to the Risk Management Authority. Andrew Fraser, Head of Health, SPS was asked to comment in her place. Heather Keir was unable to attend the first meeting and agreed to form part of the wider reference group. Comments from the wider reference group were considered and added.

6. Method

The subgroup compared operational knowledge of the SPS, State Hospital and the wider NHS within the context of the terms of reference. The subgroup quickly established that Forensic Mental Health Services and the SPS can appear similar at times, to the extent of using the same terminology, but the appearance disguised fundamentally different organisations with differing core business and history. In addition terms used commonly in both organisations and apparently similar could relate to totally different models and approaches. This is explored further at Item 4.

7. Deliberations

Item 1
"Consider how to ensure that there is closer liaison and awareness in both forensic services and SPS of security assessments."

We agreed to add 'and information' to this recommendation, as we felt this would be beneficial. We agreed areas for consideration would be around the transfer of individuals between organisations, but also general awareness of each organisations approach.

Item 2
"Consider how security intelligence can be shared between Forensic services and SPS."

We agreed that security information

- Could potentially pass in either direction at the time of referral or transfer between organisations if specific to an individual.
- Be passed outwith that arrangement should either organisation become aware of specific items of particular relevance and sufficient magnitude. Information received in a hospital relating to a prison should be passed to the local police contact who will arrange for this to be passed to the relevant prison through Force Intelligence structures. Information received in a prison relating to a hospital will be passed by the prison intelligence unit to their local police contact who arrange for this to be passed to the hospital through Force Intelligence structures
- Be passed more generally if non specific.

Item 3
"Match referrals from Prisons and levels of security (e.g. prisoners needing low or medium security should not be referred to the State Hospital)."

We recognised that The State Hospital is often the default referral and that, as services develop, referring practice will change. The referring practice of individual services will be assisted if useful guidance on the use of the matrix can be produced. We also noted that the initial referral would be made from a visiting NHS psychiatrist working within the SPS, and that this allowed early consideration of intelligence information necessary for the purpose of deciding the appropriate level of security for referral and for the clinician receiving the referral.

Item 4
"*Compare SPS security assessments to the matrix."*

Initial discussions demonstrated that some fundamental issues affected this recommendation, all around use of language and core purpose. The Scottish Prison Service exists for a very different purpose to Forensic Mental Health Services; however sometimes they can look and sound the same, using similar terminology to mean different things.

The key aims of the SPS are

- To keep in custody those committed by the courts;
- To maintain good order in each prison
- To care for prisoners with humanity;
- to provide prisoners with a range of opportunities to exercise personal responsibility and to prepare for release and;
- To play a full role in the integration of offender management services

Forensic Mental Health Services will have individual mission statements or key aims. Despite that, all will reflect "Health, Social Work and related services for Mentally Disordered Offenders in Scotland"(NHS MEL (1999) 5, Scottish Office 1999) which in turn reflects the "Reed" Principles (*Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Chairman Dr Reed) Department Of Health, Home Office (1992)) 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

These two sets of aims clearly demonstrate the different approaches. Both organisations have similar aims in terms of care and security, but have traditionally placed perhaps different emphasis on particular elements.

The most commonly used terminology to discuss differing security approaches to individuals are high, medium and low. These again have differing meanings to the two organisations. In health, high, medium and low refer to levels of risk and of security provided by units, with the underpinning assumption that as a patient is assessed as moving from high to low risk, they should move from a high security unit to a low security unit.

The Scottish Prison Service (SPS) estate is not divided into high, medium and low levels of security; those establishments providing higher levels of security may also have prisoners there because of the length of their sentence rather than assessed risk. High, medium and low are applied as supervision levels to an individual prisoner within the establishment.

The SPS supervision levels, the Levels of Security matrix and the work of Kennedy (Kennedy H.G. (2002) Therapeutic uses of security: mapping forensic mental health services by stratifying risk**.** *Advances in Psychiatric Treatment*, **8**, 433-443) can be mapped across as at appendix one. This is potentially useful for services to compare approaches and also to highlight areas of difference when using apparently common language.

8. Recommendations

The Group concluded that the following items of work would be required to deliver the Terms of Reference;-

1) Protocol for referral and transfer from SPS to Forensic Mental Health Services.

The group agreed that a protocol should be produced under which the SPS visiting psychiatrist, SPS intelligence staff and Health Centre staff could discuss and agree the referral route and relevant intelligence information to be shared as part of the referral.
The protocol is in full at appendix two.

2) Protocol for return to SPS from Forensic Mental Health Services.

Returns to the SPS should take place under Care Programme Approach (CPA) arrangements; this protocol provides reminders about key areas of information of use to the SPS. The diversity of CPA policies across different parts of the Forensic Mental Health system means a detailed protocol is impractical
Any reception to an SPS establishment is assessed under the prisoner supervision system and allocated a supervision level within 48 hours of reception. This decision will be informed by the CPA meeting and relevant intelligence. The protocol is in full at appendix three.

3) Document mapping SPS and Forensic Mental Health Services organisations and key individuals with contact details.

The group agreed that there were areas of both services where referrals and transfers were so frequent that key personnel in both organisations would be very familiar with each other. Conversely some elements of the system would deal with transfers less frequently. In addition, very few would be familiar with all elements of the system, so this information would be useful to professionals across the services.

4) Arrangements for sharing intelligence about individuals or organisations out with referral and transfer.

The group felt that it was likely that, as individuals transferred back and forth between organisations; useful security information may be disclosed. This may be about organisations or individuals. Although such information may not be common place, a mechanism could easily be created that would allow information to be exchanged with appropriate safeguards between a Responsible Medical Officer and SPS intelligence.

5) A Forensic Mental Health Services Security Operations group linking with the SPS Operations Managers Group.

The SPS has an Operations Managers Group which, as part of its remit, considers security intelligence and information. It shares such information on current drug use, drug smuggling methods, creation of weapons or escape tools and similar information. The State Hospital has previously been part of this group. We recommend that a Forensic Mental Health Services Security group be established and that the State Hospital representative to the SPS Operations Managers Group could chair such a regular meeting.

This would ensure a useful flow of information about security threats and issues between both organisations.

6) Booklet produced and available for all dealing with interface between Health & SPS

The production of protocols and other information does not in itself ensure useful dissemination and communication. We suggest that a booklet is produced and circulated to key points of the network and services dealing with Mentally Disordered Offenders. We suggest that the booklet includes;

- References to key strategy documents and statements
- Service map of people and organisations
- Protocol for referral and transfer from SPS to Forensic Mental Health Services
- Protocol for return to SPS from Forensic Mental Health Services
- Arrangements for intelligence sharing about individuals or organisations outwith referral and transfer arrangements
- Document mapping Forensic Network "levels of security" Matrix and other Health information against SPS supervision levels
- Information regarding Forensic Mental Health Services Security Group

Any such information could also be provided by and intra or internet link.

7) Recommendation for regular Information Sharing Group to be established.

This group should combine Forensic Mental Health Services and SPS Network Board representatives and operational staff from both organisations. The group would have a governance remit and a meeting frequency of six monthly is suggested with an agenda including

- Changes of model of risk or security
- Significant Service Developments
- Critical incidents and reviews
- Quality of Information
- Any relevant or appropriate research and audit
- Delays, misunderstandings and problems
- Key Personnel changes
- Review of MDO Guide booklet

9. Conclusion

The group formed a view at an early stage that we should suggest using existing mechanisms whenever possible, and that any level of complication would be difficult to implement and sustain over a complex system. We feel these recommendations meet these targets as well as the requirements of the remit.

10 Bibliography

Kennedy H.G. (2002) Therapeutic uses of security: mapping forensic mental health services by stratifying risk**.** *Advances in Psychiatric Treatment*, **8**, 433-443

Department Of Health, Home Office (1992) *Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Chairman Dr Reed)

Scottish Executive Health Department (1999) *Health and Social work related services for mentally disordered offenders in Scotland.* MEL (1999)5

Appendix One

General Descriptor	SPS Supervision Definitions		SPS Supervision Flowchart		Kennedy – Table 1 & 3	Kennedy – Table 2	Security Matrix – Forensic Network	
							Physical	Procedural
High	All Activities and movements require to be authorised, supervised and monitored by prison staff	All have implications for sentence planning: appropriate establishment, location within establishment, planning of offending behaviour programmes, work placements, timescale of transfer to open conditions and security measures if out with establishment	Any of 1 – 4 + "yes" requires HIGH supervision. Any of 5 – 10 + "yes" requires MEDIUM supervision. None of 1 – 10 = "Yes" requires LOW supervision	1. Within 12/12 of sentence of 4 years or over for a serious assault (Placement in long term prison)	Homicide, stabbing penetrates body cavity, Fracture Skull, strangulation, serial assaults	<u>Immediacy</u> – unpredictable=, inaccessible to staff	Range of physical factors including differences in construction of perimeter, type of access control, guild standard, alarm, detection and observation systems and other technology and equipment	Range of procedural factors including differences in Pt access to communications, degrees of restriction or prohibition of items, control of patients visitors and movement, degree of access to community facilities and likely incidents and contingencies
				2. Previous history of serious violent offending within past 3 years	↓	<u>Specialist Forensic Need</u> – sadistic paraphilias associated with violence		
				3. Means and willingness to escape, now or a history of behaviour in last 2 years	Move from HIGH to MEDIUM Security: <u>Stability</u> – 2 years, possibility of abrupt relapse <u>Insight</u> – accepts legal obligation to take prescribed medicine <u>Rapport</u> – Tolerates daily intuitions and constriction <u>Leave</u> - none	<u>Absconding</u> – can co-ordinate outside help, prev h/o absconding from M or H security		
				4. Means and willingness to organises serious indiscipline eg drug dealing		<u>Public Confidence Issues</u> – national notoriety		
					↓			
Medium	Activities and movement are subject to locally specified limited supervision and restrictions			5. Previous involvement in violence or fear including behaviours in last year (in prison)	Use of weapons to injure, arson, concussion or long bone fracture, sexual assault, stalking with threats to kill	<u>Immediacy</u> – relapses abrupt and unpredictable		
				6. Current substance abuse	↓	<u>Specialist Forensic Need</u> – arson, jealousy, resentful stalking		
				7. Significant psychological/ psychiatric history in last year	Move from MEDIUM to LOW Security <u>Stability</u> – 1 yr, possibility of abrupt relapse <u>Insight</u> – accepts legal obligation to take prescribed medication, is supported by friends and family. <u>Rapport</u> – openness and trust with MDT, limited exploration of current mental state <u>Leave</u> – Regular escorted in grounds, occasional escorted community	<u>Absconding</u> – pre-sentence serious change other obvious motive		
				8. Serious outstanding charge		<u>Public confidence issues</u> – predictable, potential victims, local notoriety		
				9. Impulsive behaviour in past year				
				10. Likelihood of vulnerability in present location				
Low	Activities and movements specified locally are subject to minimum supervision and restrictions.*				↓	<u>Immediacy</u> – Acute illness or crisis liable to resolve in 3 – 12 months <u>Specialist Forensic Need</u> – Current mental state associated with violence, recall of prev H or M pt <u>Absconding</u> – impulsive absconding <u>Public confidence</u> – short term family issues		
					Repetitive assaults causing bruisising, self harm or attempts suicide that cannot be managed in open conditions			

*(and could include license conditions and unsupervised activities in the community).

Appendix Two

PROCEDURE – PRISONER BEING REFERRED FROM SPS TO FORENSIC MENTAL HEALTH SERVICES UNDER THE TERMS OF THE MENTAL HEALTH ACT

1. If a prisoner is identified as likely to require transfer under the Mental Health Act, the SPS Healthcare Manager will arrange for the visiting consultant psychiatrist to see the prisoner and convene a case conference for the same day/session, giving 3 working days notice if possible.

2. The following will be involved and will arrive prepared with relevant information

    - Visiting Consultant Psychiatrist
    - Healthcare Manager – prisoners medical history
    - Residential Unit Manager – prisoners sentence management details
    - Intelligence Analyst/Security Manager – prisoners security and intelligence records

3. The case conference will consider all necessary aspects of the prisoners/patients situation including known security concerns. The Intelligence Analyst will pass on all relevant information (or the gist of such information, if the detail is prejudicial to third parties or security). The visiting consultant psychiatrist will decide on the most appropriate referral, based on the feedback received from case conference members.

4. A record of the case conference, including risks (prepared in a manner that can be fully disclosed to the prisoner/patient) will be prepared by the Healthcare Manager and will form part of the referral, and ultimately, documentation accompanying the prisoner/patient.

Appendix Three

PROCEDURE - A PERSON BEING REFERRED FROM FORENSIC MENTAL HEALTH SERVICES BACK INTO SPS CUSTODY

1. The decision that a patient is deemed suitable for transfer will be supported and informed by multi-professional assessment by the Forensic Mental Health Service. Ideally, this assessment should include the ongoing involvement of SPS healthcare services. When a patient is identified as likely to transfer to prison, the Forensic Mental Health Service will convene a case conference giving 3 working days notice if possible.

2. The following will be involved and will arrive prepared with relevant information.

   - Responsible Medical Officer
   - Forensic Mental Health keyworker, case manager or CPA coordinator
   - SPS Residential Unit Manager
   - SPS Healthcare Manager, Clinical Manager or Mental Health Nurse

3. The case conference will consider all necessary aspects of the patient's situation including known security concerns. The RMO will pass on risk assessment, risk management, treatment and care plans and other information (or the gist of such information, if the detail is prejudicial to security or third parties). This will be supported and informed by the Forensic Mental Health keyworker, case manager or CPA coordinator.

4. The SPS Residential Unit Manager will, based on feedback received from case conference members, decide on the most appropriate location and care regime for the patient and discuss a suitable transfer date. This decision will be supported and informed by the Healthcare Manager, Clinical Manager or Mental Health Nurse.

5. A record of the case conference, including risks (prepared in a manner which can be fully disclosed to the patient) will be prepared by the Forensic Mental Health keyworker, case manager or CPA coordinator and will form part of the documentation accompanying the patient.