FORENSIC MENTAL HEALTH SERVICES MANAGED CARE NETWORK

REPORT OF THE SERVICES FOR WOMEN WORKING GROUP

Dr Willie Black
Consultant Forensic Psychiatrist
State Hospital

Mrs Angela Robertson
Clinical Effectiveness Manager
State Hospital

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1. EXECUTIVE SUMMARY OF MAJOR RECOMMENDATIONS

OVERALL

1. **Dedicated multidisciplinary teams responsible for providing Forensic Psychiatry Services for Women should be established within local Forensic Services across Scotland. As a minimum there should be at least one such service within each of the 4 regional groupings. These should provide, direct secure and open inpatient care as well as community care. They should also be a source of support and expert advice to other local services. All of Scotland should be covered by such a service.**

2. **The core patient group should be adult women with complex mental health needs who present a risk to others. These services should not exclude patients on the grounds of personality disorder.**

3. **Adolescent Forensic Psychiatry services should also be developed within Scotland.**

4. **Provision should be made within Learning Disability services for the small number of learning disabled women who have forensic needs.**

SPECIAL SECURE SERVICES

5. **Until Secure Services for Women are available Scotland-wide, the Women's Service at the State Hospital should continue as a high quality service. It should not, in the meantime be run down. Where service improvements are required (for instance development of the rehabilitation service and standard of accommodation) these should be made. Only once there is clearly no need for the service, should it be closed.**

6. **A disputes resolution system should be established between The State Hospital and local services.**

OTHER SECURE SERVICES

7. **Secure beds for women should be available across Scotland, with each of the four regional groupings containing at least one unit. These units should be seen as part of the Forensic Psychiatry Services for women rather than the whole of them.**

8. **Secure beds should be provided in small, self-contained units of no more than 10 beds which will generally best located within the existing or planned secure units.**

9. **The living accommodation for women in these secure units should be separate from that for any male patients. Some sharing of therapeutic and social facilities between male and female patients may be appropriate.**

10. **Clinical services in the secure units should be directed and largely provided by the Forensic Psychiatry Service For Women Team.**

11. **Staff working on these units should be individuals who have elected to work with women and who have been selected for their training and experience in so doing.**

12. **A full range of treatment, occupational, educational and recreational activities must be provided.**

13. **Provision must be made for the handful of very disturbed challenging individuals who are likely to need hospital (or equivalent) care with a high level of relational security over several years. Highly individualised bespoke packages of care are the best option in these cases.**

NON-SECURE INPATIENT SERVICES

14. **The forensic psychiatry service for women team in any area must ensure good working relationships with local colleagues. In particular there should be clear protocols regarding issues such as access to secure or IPCU beds, continuing responsibility for female forensic patients in non-secure beds and hand-over between services.**

15. **A local disputes resolution procedure should be in place.**

COMMUNITY SERVICES

16. **No single model of community working is prescribed. The balance between forensic psychiatry service for women teams providing direct community care and providing consultation to other services, will inevitably vary. Most important is agreement and clarity with other services as to the roles they perform in any particular case.**

17. **Multidisciplinary and multiple agency working is particularly important at the community stage with the need for constant shared risk assessment and risk management plans.**

18. **A care programme approach is likely to be appropriate for any female forensic patient moving to the community.**

CRIMINAL JUSTICE SYSTEM

19. **There should be in place arrangements to allow speedy assessment of mentally disordered women taken into custody or appearing before the courts. Clear lines of liaison should exist between the forensic psychiatry service for women team and those providing the first line of assessment. Women should not be remanded in custody purely for reports.**

20. **Alternatives to imprisonment for women should be developed.**

21. **There should be clearer liaison between women's prison services and local services.**

GENERAL

22. **Links should be formed and strengthened between forensic psychiatry services for women and non statutory sector organisations with an interest in women's mental health.**

23. **All women under the care of forensic psychiatry services should have access to individual advocacy. Consideration should be given to how their collective interests can be best independently represented.**

24. **The promotion of physical health should be a priority, particularly within inpatient services. Good quality general medical input should be available and a well woman clinic staffed by a female medical practitioner should be provided.**

25. **There should be a clear risk assessment and risk management procedures within the team and clear protocols for communicating this with other agencies.**

26. **There should be clear child protection procedures for any service, inpatient or outpatient, and appropriate child visiting arrangements for any inpatient service.**

2. INTRODUCTION

Although a majority of general mental health service users are women they account for only a small minority of patients within secure or forensic psychiatric care. Currently only 6% of The State Hospital inpatient population are female. The figures for lower levels of security are not available for Scotland but approximately 16% of the medium secure population in England and in Wales are women.

This is a particular problem as in addition to other gender issues women forensic patients present differently in terms of their mental disorder, social and offending profiles.(Smith et al 1991, Bland et al 1999, Thompson et al 2001,). In particular:

> Women are more likely to be civilly detained rather than detained as a result of criminal proceeding and are more likely to have been transferred from other hospitals than from the criminal justice system..
>
> Women are less likely to have committed a violent offence but more likely to have committed an offence of fire setting.
>
> Although many male forensic patients come from deprived abusive backgrounds this history even more marked for female forensic patients.
>
> Borderline personality traits with histories of deliberate self harm and other impulsive self-damaging behaviour is more common.

The consequence of these differences and the small numbers of women are that their needs are not always well met by forensic services which have to cater for the overwhelming

majority who are male. At worst there can be no provision whatsoever made for women. More often women find themselves outnumbered and vulnerable in a threatening environment with facilities that may not meet their needs, is unduly restrictive and geographically disruptive of family and other community relationships.

Politically this has not been a prominent issue in Scotland, although the 1998 review "Women Offenders - A Safer Way" commented on the lack of mental health services for women offenders.

The issue has received rather more attention in England and Wales. The pressure group Women in Special Hospitals has over some decades raised the profile of women in secure care. The paper "Secure Futures for Women: Making a Difference" (Department of Health 2000)surveyed in detail the experiences and views of women users of secure services, their families and those providing care and treatment. A series of Department of Health publications on the theme of mainstreaming women's mental health have considered, along with more general mental health provision, the needs of women in secure and forensic services (Department of Health, 2000,; Department of Health, 2002; Department of Health 2003) .

The Forensic Mental Health Services Managed Care Network Advisory Board commissioned the current paper. They did so against a background of increasing awareness of unevenness of provision across Scotland, the rising profile of patients placed inappropriately in conditions of Special Security and legislative change obliging service providers to provide appropriate services.

Our given remit was:

- Propose options on best configuration of services for women
- Address any requirements for high security
- Size the population of Scotland
- How will these services fit into the overall national plan
- Provide costed plans where possible

The working group comprised of a wide range of professionals working in the field across Scotland representing all major disciplines and all geographical areas. Full details are given in Appendix 1.

The working group comprised the main personnel involved in the current organisation and delivery of forensic psychiatry services to women in Scotland. We therefore considered ourselves well placed to gather evidence about current provision and to identify gaps therein. We had neither the time nor resources to perform a formal needs assessment. Indeed when it comes to forensic psychiatry any such procedure might be considered of dubious validity. There is no objective measure of “forensic need” or agreement as to who might be a “forensic patient”.

We considered good practice guidance about service delivery and what evidence there is about treatment methods. Much of the literature and guidance in this field is inevitably value based rather than evidence based in the strict scientific sense. A number of specific commentaries on particular topics were commissioned from outwith the working group.

We made no direct attempt to consult service users at this time mainly due to time considerations. However much of the work referred to early above has canvassed users views extensively. Collective experience suggests that the issues raised in England do indeed apply in Scotland.

In the course of preparing this report some very detailed submissions have been made on a number of topics by individual members of the working group. Where it has been impossible to do these full justice in the main body of the text they have been reproduced in full as appendices.

Acknowledgements

Thanks are due to the members of the Working Group who made time at short notice to attend lengthy meetings leaving them far from home on Friday afternoons. Additional information was provided to us by Ian MacKenzie, Lanarkshire, Stephen Wilkie, Renfrewshire, & Dr Bill Dickson Fife. Louise Adam of the State Hospital Patients Advocacy Service provided a paper on Advocacy (reproduced as an Appendix). Vivienne Gration provided invaluable administrative and logistical support. Particular thanks are due to Karen Shaw and the other medical secretaries who coped ably and good-naturedly with the considerable extra workload.

3. OVERVIEW OF CURRENT SERVICE PROVISION

3.1 NATIONAL OVERVIEW

Estimated numbers of in-patients, out-patients/community & prison

Service	Current in-patients	Community	Total
Greater Glasgow	*Data not currently available*	*Data not currently available*	-
North and East of Scotland			
Fife	0	0	0
Grampian	1	0	1
Highland	0 (*assumed)*	0 (*assumed)*	0
Orkney	0 (*assumed)*	0 (*assumed)*	0
Shetland	0 (*assumed)*	0 (*assumed)*	0
Western Isles	0 (*assumed)*	0 (*assumed)*	0
East of Scotland			
Borders	0 (*assumed)*	0 (*assumed)*	0
Forth Valley	2	7	9
Lothian	8 *(including 1 OAT from Tayside)*	1 *(+3 planned from in-patients)*	9
Tayside	2	3	5
West of Scotland			
Argyll & Clyde	1	3	4
Ayrshire & Arran	2	3	5
Dumfries and Galloway	0 (*assumed)*	0 (*assumed)*	0
Lanarkshire	0	8	8
Other			
State Hospital	15	*Not applicable*	15
Cornton Vale	*Not applicable*	*Not applicable*	-
Numbers known to services	**31**	**25**	**56**

Please note this is not a definitive needs assessment – it simple aims to give an indication of the number of women currently under the care of forensic services across Scotland.

Overview of Service Provision

The main point that emerges from the figures and descriptions of services across Scotland is the lack of any dedicated forensic services for women across much of Scotland. Only in Glasgow, Perth and the State Hospital are there psychiatric and other practitioners with specific responsibility for female patients. The only exclusively female inpatient forensic unit is Alexandra ward within the State Hospital.

Estimating the total number of "female forensic patients" is very difficult given a lack of agreement about what a forensic patient is or should be. The above table details the number of inpatients and outpatients under the care of forensic psychiatrists. Obviously there may be

other patients currently under the care of general psychiatrists who would have similar characteristics. However, it appears that the number of female forensic patients is small with no particular concentration in any part of the country other than the State Hospital.

Information collected by Claire Lamza for her MSc thesis *"Using Research to Identify Women's Characteristics in the High Security Setting"* looking at a 10 year cohort of admissions to the State Hospital confirmed that admissions came from all across Scotland with no obvious patterns: other than that the largest health boards account for the greatest. Those health boards with the smallest catchment populations obviously have the smallest number of women who have been forensic patients.

Some of the common issues emerging from the descriptions and discussions were:

1. Difficulty in finding in-patient places for female forensic patients.

2. Particular difficulty of finding secure beds for anyone not suitable for conditions of special security.

3. The need to manage deliberate self-harm and the sequelae of childhood sexual abuse.

4. The lack of resources to meet these treatment needs.

5. The difficulties of managing men and women in the same environment: the women's needs are not met and they are seen as disruptive of the overall service.

6. The importance of and the lack of suitable supported community placements.

3.2 SERVICE SUMMARIES

GREATER GLASGOW

Inpatients
This information is not currently available.

Admission criteria
As the Women's team has only recently been established admission criteria are not yet available.

Outpatients/community
This information is not currently available.

Diagnostic mix
The information is not currently available.

Service provision
Glasgow has provided Forensic Mental Health Services to female mentally disordered offenders for over 20 years. In the past this has consisted of:
1) Psychiatry, Clinical Psychology and Community Forensic Psychiatric Nurse Services at various times to Cornton Vale Prison and to the courts
2) Long standing links with the State Hospital

3) Multidisciplinary, assessment, treatment, consultancy advice and training services to help social work and criminal justice system agencies working with female mentally disorder defendants

General psychiatry and rehabilitation services have continued with in-patient care of female mentally disordered offenders. This has been variable according to the context and facilities of each sector, and has changed as the move to community psychiatry has progressed. In particular as the male forensic wards were developed and separated from IPCUs, these wards are being rationalised and changed in function.

In recent years a virtual women's team has been drawn together within the Forensic Mental Health Directorate and this is now being formalised. From April 2004 this team will comprise a part-time commitment of a consultant forensic psychiatrist, consultant clinical forensic psychologist, occupational therapist, community nurse, and social worker. Two part-time secondments from in-patient nursing teams are expected in due course. The women's team will hold weekly assessment and follow-up clinics.

Consultative work
This team will build on the city-wide contacts and joint working already in place and will formalise many of these. It will continue to work in tandem with inpatient general psychiatry services with female mentally disordered offenders, providing specialist assessment, treatment, advice and consultation as appropriate.

Local issues
No local issues have been identified.

Future directions
The Women's team will link with other inpatient services providing tertiary care to this group of women and plan towards the opening of the new unit in Stobhill Hospital in coming years. It is intended that this unit will have a low secure women-only ward with a dedicated team. The ward will have a minimum of two and a maximum of 6 beds according to demand. There is also provision for up to two women to be accommodated in the IPCU in the medium secure area, separately from male patients.

NORTH AND EAST OF SCOTLAND

FIFE

Inpatients
There are no women inpatients currently. Typically, between 2 and 4 would come into the IPCU in the course of a year. It is estimated that there may be 12-15 women who could be described as forensic coming into contact with services across Fife in a year, but there are no figures available.

Admission criteria
There are no specific admission criteria but typically the women would be difficult to manage, may have offended or the courts have asked for an assessment, or they are returning from the State Hospital or Orchard Clinic.

Community
As there is no Forensic Service there are no figures available.

Diagnostic mix
The women's diagnoses can include borderline traits in their personality, psychosis, schizo-affective disorders and, occasionally, depressive illnesses.

Service provision
There is no Forensic Service but the consultant psychiatrist for the sole IPCU in Fife at Stratheden Hospital deals with forensic patients, as do other general psychiatrists.

Consultancy
None, as there is no Forensic Service.

Local issues
- The Intensive Psychiatric Care Unit (IPCU) accommodation is mixed sex although the women would have separate rooms and toilets

Future directions
- Fife is working with the North of Scotland regional group to develop forensic services.

GRAMPIAN

Inpatients (data correct at May 2004)
One woman is currently in the care of the service. Prior to this recent admission, there have been 7 admissions since 2000. Of these 7 women admitted, 3 were from Cornton Vale, 3 were from the courts and one came from a local women's service.

Admission criteria
There are no strict admission criteria but the women would require to be detained under the Mental Health (Scotland) Act 1984 (MHSA) or Criminal Procedures (Scotland) Act 1995 (CPA), or be convicted and require further assessment within a low secure setting.

Community
The only other input available can be as an out-patient and from the Forensic Outreach Team, which is available Monday to Friday 9 – 5. No women are being cared for in the community at present.

Diagnostic mix
The women are predominantly dual diagnosis, usually with affective disorders and borderline personality disorders. There have been some women with purely depressive illnesses.

Service provision
The Forensic Service in Grampian includes an Acute Forensic Ward, IPCU, a Forensic Hostel and an Outreach Team. There is not a dedicated team with responsibility for women's forensic services.

There are 2 designated female forensic beds within the mixed gender low secure IPCU in the Blair Unit. Patients are managed by a Forensic Multi-disciplinary team comprising a consultant psychiatrist (1 wte), input from a specialist registrar (SPR) and a senior house

officer (SHO), 17 nurses and a social worker (1 wte). Patients are assessed by the life skills team (includes occupational therapists and nurses), and an education worker, and input is dependent on need. Patient can be referred to a psychologist as required. Team treatment models are not specifically geared toward this special group but there is individual access to the service as appropriate, i.e. psychology, life skills team, social work etc.

Consultancy
Psychiatry and psychology provide input to the prisons, and forensic psychiatric consultancy to the general service at Royal Cornhill Hospital.

Local issues
- The non-specific environment for the women
- A lack of specialist knowledge, skills and experience
- A general lack of gender specific staffing except for normal guidelines
- There is no provision on this site for learning difficulties

Future directions
- There are no specific developments planned for women but the North of Scotland regional group is considering their needs in the on-going development of services.

HIGHLAND

Inpatients (data correct at April 2004)
Currently, there are no in-patients although recently there was a case of one women whom the service had great difficulty in managing in the unit and who still causes management difficulties that are being dealt with.

Community
There are no women at present who it is considered would benefit from a women's unit although one women, now very well who remains subject to a restriction order, may have benefited from a women's service rather than the State Hospital to which she was admitted a number of year ago.

Diagnostic mix
The one woman in contact with the service has a diagnosis of paranoid schizophrenia set against a backdrop of alcohol and drug dependence which is believed to be related to her chaotic state whilst unwell.

Admission criteria
There are no formal admission criteria for women.

Service provision
There is no designated forensic service for women or men in Highland although patients have access to the same facilities as general patients. In terms of outpatient/community service provision it is difficult to address this question directly apart from commenting that there is no dedicated service for female offenders. Dr A G Hay, the consultant psychiatrist who provided the information on Highland Region for this report, advised that he did not currently have any female offenders on his caseload.

Local issues

- The lack of forensic services for males and females and the need to both improve the in-patient facilities and look towards a more comprehensive outreach service.
- As with adult male offenders the region essentially provides a service as complete as possible given the relatively small size of the catchment area and the geographically dispersed nature of the population. As such any numbers will be small. Notwithstanding, there is still a need to provide these women with a service. There is a cohort of patients who do not require the maximum security of the State Hospital but who cannot be managed, or are managed with great difficulty within the service, which in effect does not even have a low secure forensic unit. Forensic patients are dealt with within the settings of the IPCU or a lockable rehab facility. In relation to any proposed female offenders unit it is suggested that the numbers in Highland are very small, ranging from between zero and one although it is very difficult to say with any degree of accuracy as such a facility has not been an option previously.

Future directions

There is a need to network with other regions in relation to the provision of medium and high security.

ORKNEY

There are no mental health beds in Orkney and there is no consultant psychiatrist. Any patients would be referred to services in Grampian. There is no Forensic Service.

SHETLAND

There are no mental health beds in Shetland. There is one consultant psychiatrist. Any patients would be referred to services in Grampian. There is no Forensic Service.

WESTERN ISLES

There are 6 general mental health beds in the Western Isles in an acute psychiatric unit. There are two consultant psychiatrists, one of whom specialises in older people and learning disability. Any patients would be referred to services in Highland. There is no Forensic Service.

EAST OF SCOTLAND

BORDERS

There is no forensic service or IPCU in the Borders. Patients requiring this level of care are transferred to Lothian. The Orchard Clinic provides medium secure care.

FORTH VALLEY

Inpatients (data correct at January 2004)

There are currently 2 in-patients. The patient mix is often forensic, and includes drug-resistant schizophrenia and borderline personality disorder.

Admission criteria
There are no formal inpatient admission criteria for forensic female in-patients other than that they require either acute or medium to long stay low secure care secondary to their mental illness and associated behaviour. Normally, over 18 and under 65. Admissions are considered on an individual basis, with no absolute exclusions.

Community
There are 7 women in the care of the forensic community mental health team.

Diagnostic mix
The women cared for by the service in Forth Valley presenting with 'forensic' difficulties have a high incidence of major mental illness, personality disorder, substance misuse, history of violence to self and others, disengagement form services, non-compliance with medication, self-harming behaviour, childhood sexual abuse, absconding form care, history of IPCU care, lack of social support and histories of contact with psychological therapies departments. They are commonly diagnosed with schizophrenia/other psychosis, mood disorders and borderline personality disorder. Other diagnoses include Personality Disorder (other) and a small number with Learning Difficulties.

Patients are detained half and half MHSA and CPSA with one conditional discharge.

Service Provision
There are no specialist in-patient forensic services. Women requiring in-patient care are managed in a 12 bedded mixed sex IPCU in Falkirk, in acute admission wards or in medium/long stay low secure and open care. The majority of more dangerous forensic females are contained in the 24 bedded low secure medium/long stay ward, Trystpark, Bellsdyke Hospital. There are currently 6 female beds in this unit but they are not designated as "forensic". Trystpark continues to provide medium/long stay slow rehab for female mentally disordered offenders and, occasionally, women with borderline personality disorders.

Forensic mentally disordered females are dealt within the community by all specialities of psychiatry but the more dangerous ones have the option of being managed by the Forensic Community Mental Health Team. The Forensic Community Mental Health Team has a good record of managing severely mentally disordered offenders in the community with input from forensic psychiatry, forensic CPNs, an MHO, CJSW and Forensic Psychology.

The staff in the team have been fully trained in cognitive behavioural skills for high risk recidivists, HCR 20, and some in PCLR. There is a full risk assessment and management system in place and all patients are managed via CPA.

There is also a Court Liaison Scheme to 3 courts run Monday-Friday to avoid inappropriate remand in custody of women mentally disordered offenders who meet the criteria for detention in terms of the Mental Health (Scotland) Act.

Consultative work
Dr Morrison and Dr Prinsloo work as the Visiting Psychiatrists to the Remand Unit at HMP Cornton Vale. The prison is populated by a large number of women from deprived backgrounds who have a history of physical, emotional and sexual abuse, self-harm,

substance misuse and related offending. They have often attracted a diagnosis of borderline personality disorder.

Local issues

- There is no specialist secure environment for female mentally disordered offenders or women with severe borderline personality disorder
- At present, although the women are in separate units within the ward, there is the potential for sex offenders and sexually abused females under one roof and this is felt to be unacceptable.
- As with other areas in Scotland, difficult patients with borderline personality disorder often find their psychological and behavioural disturbances criminalised. In situational crisis, they may have threatened to jump off a bridge and, in the absence of a therapeutic 'safe' alternative; they are remanded on breach of the peace charges. There is no specific service for borderline personality disorder in Forth Valley, although general adult, forensic, CJSW, psychology and CBT services all have patients with this problem. There is a generally accepted significant gap in service for this group.
- There are insufficient CBT Therapists, especially in in-patient services where small numbers of more severe cases cause management problems
- There are staff training gaps in existing general out-patient services, day services and in-patients, particularly around risk assessment/ management and CBT
- It would be useful to have DBT available for women with borderline personality disorder in both in-patient and out-patient services. Funding for training has recently been agreed.
- Old age psychiatry highlighted aggressive patients with dementia but they were not normally classified as female MDO
- Increasing need for in-patient forensic rehabilitation skills and resources plus occupational therapy and forensic psychology to support this risk assessment, graded community reintegration/testing and risk management planning.

Future directions

In the reprovisioning of medium/long stay care Trystpark is planned to become all male and a 5 bedded low secure/securable female ward is going to be created in one of the other wards on the site. This is not specifically a forensic resource and it is likely the patient mix will be similar to that already described.

Funding has recently been agreed for training of staff in DBT.

LOTHIAN

Inpatients (data correct at May 2004)

There are currently 8 inpatients in the Orchard Clinic, 1 in the acute ward and 3 and 4 in the two rehab wards. This is fairly representative of the volume of female patients generally. 2 of these 8 patients are out of area treatments (1 Tayside, 1 Argyll & Clyde). In total, there are 50 beds in the Orchard Clinic but none are specifically gender identified.

Admission criteria
Patient requiring admission to Redwood (admission ward, Orchard Clinic) will have most or all of the following characteristics:

- Normally over 18 years and under 65 year
- Untried, not as yet sentenced, or convicted Mentally Disordered Offenders liable to detention under the Mental Health (Scotland) Act 1984 or Criminal Procedures (Scotland) Act 1995
- Require assessment or treatment of a mental illness
- Should not have an established principal diagnosis of learning disability, traumatic brain injury or personality disorder
- Present a risk to self or others arising from mental illness such that medium secure is appropriate and is the least restrictive treatment setting
- Are to be detained in the first instance under Section 52 of the Criminal Procedures (Scotland) Act 1995
- Likely to require treatment for a period not in excess of two years
- Exceptionally, non-offender patients who satisfy other criteria

Admission criteria for Hawthorn and Cedar, the rehab wards are also available.

Community
There is one patient in the community at present although plans for 3 more women to move into a shared house with staff support provided by Barony Housing are at an advanced stage.

Diagnostic mix
The women are most commonly schizophrenic, although there is one with a bi-polar illness and one with a depressive illness. The service does not admit women with a single diagnosis of borderline personality disorder unless, exceptionally, they are acutely depressed or suicidal. However, two have a dual diagnosis of schizophrenia and borderline personality disorder (which their management problems tend to be related to). Some have a dual diagnosis with a borderline IQ which is a complicating factor. All patients are detained, half MHSA and half CPSA.

The women have complex care needs with a history of sexual abuse and need psychological input. The therapies available include cognitive behavioural therapy, dialectical behavioural therapy, cognitive analytical therapy, and psychodynamic therapy.

Service provision
In term of other services in Lothian, the IPCU at the Royal Edinburgh does have some women but does not take mentally disordered offenders and the IPCU at St John's. Livingstone has also recently stopped taking mentally disordered offenders. Therefore, the Orchard Clinic provides the only inpatient care in conditions of security. There are around 3 female admissions to the Orchard Clinic a year. Some patients will stay for a short time and return to general psychiatry or Cornton Vale. The acute wards wills take people for assessment if there is no security needs have been identified but this happens rarely (less than once a year). The catchment area is Lothian for all admissions to low secure forensic care and extends to include Borders, Fife and Forth Valley for all medium secure admissions. These patients will normally return to their own area for rehabilitation. The service takes out of area treatments (OATs) on a case by case basis (one at present).

There is not a dedicated team with responsibility for women's forensic services. However, the Orchard Clinic has 4 Multi-disciplinary Teams sectorised by geographical location rather than gender or diagnosis. All 4 RMOs currently have women patients. Overall, the teams comprise consultant psychiatrists (3.2 wte), psychologists (1.9 wte), occupational therapists (4 wte OTs, 5 rehab/technical instructors/helpers), social workers (4 wte), nursing staff (94 wte), pharmacy (0.5 wte), and physiotherapist (2 sessions). The occupational therapy service also occasionally buys in Art and Music Therapy and Adult Education.

Services in the community are provided by the Orchard Clinic psychiatrists, social workers and 3 forensic community psychiatric nurses (2 new posts since spring 2004).

Consultative work
The service provided risk assessments and advice to other services in Lothian. Occasionally, reports will be done on women from the area detained in Cornton Vale Prison. However, good support is available from Dr Morrison in Forth Valley and Dr Black of the State Hospital who provide sessions to Cornton Vale.

Summary of local issues
- In-patient turnover can be slow with particular difficulties in moving on patients with borderline personality disorder or low IQ.
- The acute ward is not really suitable for women. Currently, there is only one women being cared for with a group of men which can be isolating and there can be difficulties given the patient mix.
- There may be a central directive to have single sex accommodation. This would be contrary to the decision taken at set-up to have the facility to allow the women to be separate to manage potential rivalries.
- The service does not admit women with a single diagnosis of borderline personality disorder. There is no clear service to meet the needs of these women.
- There is a shortage of provision for women (and men) with Learning Disabilities. These patients do not mix well with patients with mental illnesses and should not share the same accommodation. Smaller dedicated units would be preferred.
- There is an absence of a service for women with a single diagnosis of borderline personality disorder. Housing with appropriate staff support in the community may be an option.

Future directions
- Although the Barony Housing project is in its embryonic stages, if it goes well the service hopes to work again with other such initiatives; small projects providing peer support with lots of staff input.
- There are initial proposals for the development of community work including community teams.
- A Forensic Hostel (not female only) would be an important step but there are no firm plans.

TAYSIDE

Inpatients
There are currently 2 inpatients in the care of the service.

Admission criteria
Women between 16 and 65 diagnosed with a severe and enduring mental disorder, who have committed offences; particularly offences that would put others at risk.

Outpatients
There are 3 outpatients and one displaced patient in the Orchard Clinic.

All of above patients are long-term patients with severe and enduring illness and history of offences against the person.

Diagnostic mix
They are a heterogeneous group, usually detained under the MHSA who are characterised by complex histories of chronic psychiatric problems. There is an increased incidence of previous institutional care sexual abuse when compared with the male groups. The problems presented by this group are of increased assaultiveness on fellow patients and staff whilst the index offences are frequently less serious than those of male patients.

Service provision
There are currently 2 beds on the Murray Royal side. One bed is in the Moredun A general adult psychiatry ward. This is ward staffed by general psychiatry nursing staff which is currently locked. occupational therapy provision is within the realms of general adult psychiatry. There is no specialised psychological input. There is social work provision from the forensic psychiatry social worker. This is a high turnover general adult psychiatry ward; there is no secure women only outside space and no current focused activities provided for the forensic patient outwith an educational project which was recently set up by forensic psychiatry. The second bed is in a shared side room in Elcho Rehabilitation Ward. The ward is unlocked and it is staffed with general adult psychiatry nursing staff. Patient activities are provided by the general adult psychiatry services.

In terms of dedicated services for women, there is one consultant psychiatrist employed on a part-time basis who offers services to 2 male in-patient wards and the day patient services. There is a specialist registrar and a senior house officer, neither of whom are based in wards where the female beds are.

An elective diversion scheme exists which is open to male and female patients. In general, this allows patients who have committed relatively minor offences to be brought to the attention of general adult psychiatry.

Consultative work
Given the difficulty of offering in-patient services there is a certain amount of consultative work carried out by Dr Richard. Her opinion is sought by general adult psychiatry consultants who are having difficulties in managing female mentally disordered offenders or clinical disturbed women. The general adult psychiatry staff are often quite burned out by the experience of trying to manage these patients in a setting of high turnover acute wards and it is difficult to meet the needs of the teams.

Summary of local issues
- Currently patients are managed in high turnover adult general psychiatry wards. This is a disturbing setting for managing such patients with disadvantages for the female mentally disordered patients and for those from general adult psychiatry. Other patients using the

facility may be depressed, timid, etc and therefore vulnerable. Attention to risk is less of a priority for the patients normally cared for in this unit.

- Nursing staff working in this area are trained to deal with general adult psychiatry patients, but have no experience of forensic psychiatric nursing.
- The nursing team are more likely to have to depend on other sources of nurses i.e. bank staff, agency nursing, disrupting the continuity of care for the patient
- The beds are in wards staffed with general adult psychiatry nursing staff.
- Female patients form a minority amongst receiving care in medium hand high security setting and are greatly outnumbered by male patients and there has been an increasing awareness of the specific needs of this group in relation to the complexity and difficulty in caring for them.
- In the current service, physical environment issues that affect staff ability to ensure the safety and appropriate supervision of patients have been highlighted, with reports of serious self-harm incidents occurring.
- There is not currently an identified staff team that has been specifically trained to care for this patient group and there is a lack input from other key agencies and professions, such as psychology.
- Female patients are dispersed across the hospital site and this causes difficulty in establishing and carrying out an identified model of care. A different social worker is available to attend to the needs of the patient in this area who has minimal psychiatric contact and no experience of forensic psychiatry.
- There is no specialised occupational therapy input.
- There is no specialised psychology input in either site.
- The in-patient provision in the form of the acute general adult psychiatry ward (Moredun A) has four different day areas within the ward, many side rooms, and two bathroom facilities. It is difficult to maintain observation of the patient without keeping them on special or constant observation. This can be intrusive for the patient and can provoke increased aggression and irritability.
- There is no secure garden facility where patients can have safely have access to fresh air without the risk of absconsion.

Future directions
The proposal for an interim arrangement is to adapt another area of the hospital in order to deliver an in – patient service including 6 beds, one of which can be used a rehab bedsit unit. In addition to the above an area should be set aside as a "crisis suite" including all facilities to ensure intensive management where this is warranted.

WEST OF SCOTLAND

ARGYLL & CLYDE

Inpatients (data correct at May 2005)
The service has 1 inpatient currently.

Admission criteria
None available. The route of referral includes generic Community Mental Health Teams, prisons and social work colleagues. Community team patients are referred through generic Consultant Psychiatrists. Generic Consultant Psychiatrists within Argyll & Clyde have the opportunity to refer Forensic patients to the Forensic Community Mental Health Team. It

would therefore be likely that serious mentally disordered female offenders would be known to this service.

Community
The are 3 patients in the care of the service.

Diagnostic mix
The women tend to have diagnoses of schizophrenia, bipolar disorder or borderline personality disorder. Alcohol and illicit drug misuse further complicate most patients' presentation.

Service provision
Argyll & Clyde Health Board area provide Forensic Mental Health Services to both male and female patients. This is determined by offending behaviour and mental health presentation. Access to services is not gender related.

Forensic female in- patients would primarily be cared for within Arran IPCU at Dykebar Hospital and Succoth IPCU at Argyll & Bute Hospital. Arran IPCU is an 8 bedded mixed sex ward, which provides care to both forensic and generic patients. There are currently four females within Arran of which two present with Forensic issues. Succoth IPCU is also an 8 bedded mixed sex ward, which provides care to both generic and forensic patients. There are currently two females within Succoth of which one has a forensic history.

Argyll & Clyde has a dedicated forensic community mental health team who provide a tertiary care service to mentally disordered offenders residing in the area. There is not a dedicated team with responsibility for women's forensic services. However, the FCMHT was established in early 2003 and continues to develop in terms of female patient numbers. The team currently provide care packages to both male and female patients in the Community. All patients are incorporated into the care programme approach.

The FCMHT comprises a consultant forensic psychiatrist (1 wte), a nursing team leader (1 wte), forensic community mental health nurses (5 wte), a social worker – North of Clyde (1 wte) and medical secretaries (2 wte). There are some vacancies currently consultant forensic psychologist (1 wte) and social workers (2.5 wte).

Consultative work
A&C currently provide two sessions per week to HMP Greenock (the only prison establishment within A&C Health Board area). Other penal establishments such as HMP Cornton Vale can also refer individuals to the FCMHT if they are returning to the A&C Health Board area.

Local issues
- There is no specialist secure facilities for mentally disordered female offenders within the A&C Health Board area
- There are no IPCU single sex beds at present (this may mean vulnerable female patients being exposed to predatory males)

Future directions
Argyll & Clyde Health Board area are committed to expanding their Forensic Services both in the community setting and inpatient services. This can be seen through the development of

the Forensic Community Mental Health Team and the West of Scotland Medium secure unit being established at the Dykebar hospital site in Paisley.

AYRSHIRE & ARRAN

Inpatients
The service has 2 inpatients currently.

Admission criteria
There are no strict admission criteria but, in the main, the women who enter the IPCU are either detained under the Mental Health Act or the Criminal Procedures Act. Whilst the main criteria for admission would include assessment in relation to mental disorder, the service has also taken women who have a borderline personality disorder.

Community
There are 3 patients in the care of the service and one patient is in Cornton Vale.

Diagnostic mix
The women's diagnoses include dual diagnosis, schizophrenia and borderline personality.

Service provision
There is not a dedicated team with responsibility for women's Forensic Services. There are no specific inpatient services for women, albeit those who return from the State Hospital would go either to the IPCU or the intensive continuing care unit at Ailsa Hospital (ICCU). Individuals who come from prison or court go to the IPCU, which has 7 beds. Both the IPCU and ICCU cater for male and female patients.

Services in the community include Forensic Mental Health Services made up of one team leader, one consultant forensic psychiatrist (new post due to be advertised), three charge nurses, one staff nurse, one personal secretary. At present the service is negotiating funding for a part-time clinical forensic psychologist.

Women are given the same support as men which includes:

- Transfer and resettlement of State Hospital transfers
- Court liaison services
- Caseload and support from the forensic team
- Joint work and assessment with criminal justice teams

Local issues

- There are no specific services for women
- Forensic services provide through-care to HMP Kilmarnock. There were attempts to do something similar at Cornton Vale but due to small numbers, travel, and costs the service was withdrawn

Future directions

- Five year plan to re-develop ICCU to smaller units which will include a forensic rehab focus

- The service recommends that some national through-care services for women in Cornton Vale with all health boards contributing to provide through-care of this client group should be considered

DUMFRIES & GALLOWAY

There is no forensic service in Dumfries & Galloway or local IPCU, and patients requiring this level of care are transferred to Hartwood in Lanarkshire. There are 6 General Adult Consultant Psychiatry posts. One of the psychiatrists, Dr David Hall, has a special interest in Forensic Psychiatry.

LANARKSHIRE

Inpatients (Data correct at May 2004)
There are no women currently in the forensic assessment unit in NHS Lanarkshire.

Admission criteria
There are no specific referral criteria for women. Patients aged 16-64 years (under 18s may be considered if they have left secondary school education, and after consultation with the Adolescent Services - over 65s may be considered after consultation with Older Adult Services) with a combination of characteristics from the following groups: -

a) Suffering from severe and/or enduring mental health problems

b) Serious aggressive or irresponsible conduct and/or inappropriate sexual behaviour

c) Those likely to present an ongoing major risk to the safety of others because they are either:
   - A mentally disordered offender in custody or involved in Court proceedings
   - In or imminently to be discharged from the State Hospital
   - Are currently detained under the Criminal Procedure Act/Mental Health Act

d) Patients likely to benefit from specialist mental health treatment and rehabilitation because of an acute and/or ongoing severe mental health problems will be offered assessment

Community
There are currently only eight women receiving outpatient follow-up by the Forensic Service. This is from a range of professional including consultant forensic psychiatrists, FCPNs and a chartered clinical psychologist.

Diagnostic mix
There is not a dedicated team with responsibility for women's forensic services. The women cared for by the Forensic Service in NHS Lanarkshire present with a range of complex difficulties and major mental health problems. This includes major mental illness, personality disorder, substance misuse, history of violence to self and others, self-harming behaviour, and childhood sexual abuse. They can be diagnosed as having schizophrenia and other psychoses, mood disorders and borderline personality disorder. It is important to point out that the Forensic Service in NHS Lanarkshire does not accept patients with a primary diagnosis of personality disorder with no other associated mental health difficulties.

Service provision
There is no specialist in-patient forensic facility for women. If there is a need for admission then they will be cared for in a 15 bedded mixed sex IPCU/forensic assessment unit at Hartwoodhill Hospital. This is a low secure facility and the only one of its kind in Lanarkshire. There is, occasionally, the need for a crisis admission and this may take place on open wards in general psychiatric beds throughout Lanarkshire.

Follow-up in the community will be by the most appropriate member of the Forensic Service and this includes consultant forensic psychiatrists (1.5 wte), chartered clinical psychologist (1 wte), forensic team leader (1 wte), senior charge nurses (2 wte) and senior occupational therapist (1 wte). There are on occasions the need for joint assessment and follow-up and, again, this is decided by the team to meet the needs of each individual client.

The Forensic Service also provides advice to the criminal justice services and generic mental health services on difficult to manage cases. There is no specific female service in Lanarkshire and there are currently no plans to develop such a service. The Forensic Service offers assessment of clients at Cornton Vale on an individual basis.

Local issues
- There is no specialised secure environment in Lanarkshire for women. The only facility available is a mixed sex low secure forensic unit. This has the potential to be problematic if women are admitted who have a history of being sexually abused and who may be cared for in an environment with patients who may have a history of sexual abuse of others.
- The Forensic Service do not accept patients with the primary diagnosis of personality disorder and to my knowledge there is no specific services for this particular client group in Lanarkshire. There is only one chartered clinical psychologist working with the Forensic Service, although the service is currently attempting to recruit a CBT Therapist to offer input on a sessional basis.
- The consultant forensic psychiatrists do not provide regular sessions to Cornton Vale although they will assess clients from Lanarkshire on an individual basis if requested.

Future directions
The re-provision of low secure services is currently being discussed with key personnel in NHS Lanarkshire. There is no specific timetable for this but it will take cognisance of the forensic medium secure unit being built at Dykebar Hospital and will be in conjunction with development of rehabilitation services in Lanarkshire.

THE STATE HOSPITAL

Inpatients (Data correct at March 2004)
Total population varies 12-20 currently 15, typically 30% turnover pa.

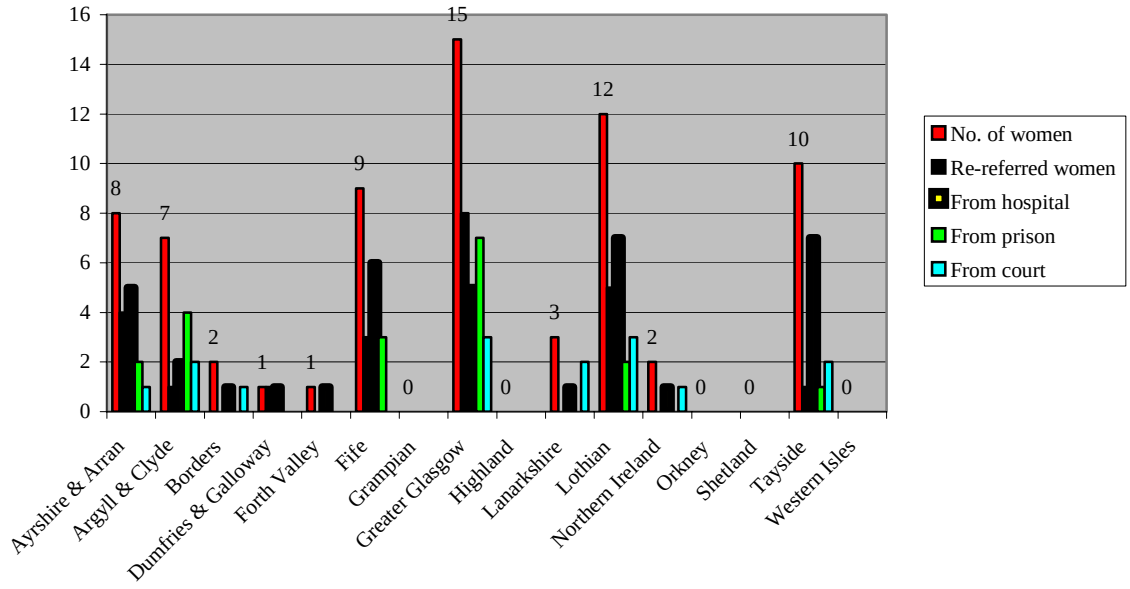
Admission criteria (from Admission Policy 2004)
When a referral is made to the State Hospital there are three main issues which need to be considered:

1. The presence or absence of a recognisable mental disorder
2. Liability to detention under the Mental Health (Scotland) Act 1994
3. Risk to others encompassing need for special security

As a general principle it is consideration of risk of violence to others that distinguishes a person who requires admission to the Hospital from one who can be cared for at lower levels of security.

Figure 1 illustrates the Health Board of origin for women in the State Hospital. More than half (53%) the women are referred from other hospitals, 27% from prison and 21% from the courts.

Figure 1: Health Board Area responsible for Women in the State Hospital 1993-2003



Community

There is no substantive community outreach service but there can be occasional involvement in aftercare.

Diagnostic mix

In terms of diagnosis the women are clinically diverse, not very forensic with a diverse set of needs. 33% have a 10 year association with TSH, only 13% continuous. The average stay is 18 months. Between 1991 and 2001, 70 women were transferred out and 29% were at home by 2002.

Service provision

The service is provided across two ward. Alexandra Ward has a 3 bedded Admission/High Dependency Area and 15 bedded Continuing Care. Earn Ward has a 3 bedded rehabilitation flat.

There is good day space in Alexandra ward. There is a well-established Multi-disciplinary Team comprising; consultant psychiatrist (0.5 wte), SHO (0.5 wte), nursing (all grades) (40 wte), occupational therapy (1wte), psychologist (0.5wte), social worker (0.5 wte). The nursing team are all volunteers

In terms of therapies there is special provision for dialectical behaviour therapy, CBT for psychosis and substance abuse therapy.

Consultative work
Dr Black provided a consultation service covering Scotland & N Ireland and takes referrals for admission, clinical advice and medicolegal opinions. He provides 2 Consultant Sessions at HMP Corntonvale.

Summary of local issues
- The patients' rooms are irredeemably cell like.
- The rehab service is provided by a different nursing team.
- The needs of 93% male majority inevitably prevail.
- Women only sessions work & recreation are very limited.
- Nursing ratios are poor compared with the average IPCU despite similar levels of disturbance.
- It is a very heterogeneous patient group.
- None of the patients need a high level of environmental security. Many would benefit from higher levels of staffing.
- The geographical isolation causes problems for families.

Future directions
Discussions are underway to improve the accommodation as part of a capital works programme at the hospital which it is hoped will improve the environment as well as facilitating the integration of the rehab service. This will lead to the development of separate nursing teams for each of 3 functional units. There must be a focus on the development of specific work & recreation opportunities for women.

However, in the longer term the appropriateness of detaining women in conditions of special security must be reconsidered as other services develop.

SCOTTISH PRISON SERVICE

The only exclusively female prison in Scotland is HMP Cornton Vale, Stirling. It currently houses some 240 women, a mixture of remanded and convicted and young offender and adult prisoners. Due to overcrowding at Cornton Vale, a 40 bedded unit for convicted female prisoners recently opened in HMP Greenock. There are also very small female units in the predominately male prisons in Dumfries, Aberdeen and Inverness.

HMP Cornton Vale
The prison achieved undeserved notoriety in the late 1990s following a spate of 7 suicides during a 2-½ year period. This led to the commissioning of the 1998 report *Women Offenders – a Safer Way*. This highlighted the fact that many vulnerable young women, with a history of abuse and deprivation, were been remanded or sentenced to Cornton Vale following relatively minor offending. It made recommendations to identify alternatives. Some of which are in place, but the daily female population in Scottish prisons, and Cornton Vale in particular, has continued to rise steadily since 1998.

Service provision
There has always been relatively high mental health input at HMP Cornton Vale. This has been augmented since 1998. At present there are 7 Registered Mental Nurses employed

within the prison, an addictions worker and a Clinical Psychologist, who in addition to consultation work with other disciplines, sees a number of patients for individual, mainly cognitive behavioural work.

Psychiatric input is provided by a Consultant from the State Hospital who does 2 sessions (conducts a clinic for convicted prisoners) and by a 2 Consultants from Forth Valley who contribute a session each and see remanded prisoners. For the remand service (which is largely concentrated in Ross House) there is a well developed mental health team and mental health meeting which allows discussion between the mental health disciplines and also custodial staff. Efforts to establish such a system for convicted prisoners have been less successful mainly because of the difficulties of involving custodial staff from a number of blocks in the one meeting. A positive side of this difficulty is that more time is available for individual consultations. Data was not available for the number of prisoners at any one time in contact with psychiatrists or other mental health professionals, however in 2003 there were 475 consultations for convicted prisoners and 226 for remand prisoners.

Diagnostic mix

Most of the prisoners could be best regarded as suffering from anxiety depression disorders or chronic post traumatic stress disorders against a background of multiple social stressors, generally complicated by substance abuse. Most have a history of deliberate self-harm, usually occasional, sometimes habitual and frequent. A smaller number are psychotic. Although many of these women are successfully treated within prison, a number require transfer to hospital because of the severity of their symptoms, the risk involved in their management in prison, refusal to take medication (which cannot be legally enforced in prison), and failure to respond to treatment in prison. In 2003, 9 prisoners were transferred to other hospitals. Four of these were convicted prisoners transferred under Section 71. Five were remand prisoners transferred under Section 70; of these remand prisoners 2 were transferred to the State Hospital. All other prisoners were transferred to less secure provision.

Local issues

- There is a high turnover of prisoners, with many having only brief spells in prison. Imprisonment therefore interrupts any normal care arrangements and it is difficult for prison staff to liaise adequately with local services.
- Social continuity for these unfortunate women have is often broken by imprisonment. Many leave with no idea of where they will be living. They will be allocated a temporary address by the local homelessness service at some point in the day of their liberation. This makes liaison with any future General Practitioners or sector psychiatrists virtually impossible. The best that can be done is often the “To whom it may concern” letter to be given to the patient.
- Occasionally difficulties arise with those patients identified as requiring transfer to hospital. Usually these difficulties relate to the absence of available inpatient beds in the home area. Sometimes they arise because of disputes as to clinical need, particularly those patients diagnosed as suffering from borderline personality disorder by local services but appearing psychotic in prison. These transfer difficulties are particularly pronounced for non-secure services. For the State Hospital there is little problem in the continuity provided by having a close medical link and also no lack of female beds.
- There is a general recognition that follow up continuity of care is inadequate and that greater use should be made of the care programme approach. Staffing levels and the fact that we are dealing with several hundred sector teams hinder this at present.

- A number of women seem to be being remanded to Cornton Vale purely for the purpose of obtaining a psychiatric report from the visiting psychiatrist. This is a futile and undesirable practice. It has obvious disadvantages for the women. Also those providing reports are unlikely to have easy access to quality information about the women or local service availability. Any recommendations they make as to disposal have to be implemented by others and are therefore of limited value to the courts involved.

Future directions

The main themes in the mental health strategy for HMP Cornton Vale are the improvement of general liaison with outside services and also formal involvement in care programming with other services.

4 PROPOSED SERVICE PROVISION – GENERAL OVERVIEW

4.1 Guiding Principles

Section 1 of the *Mental Health (Care & Treatment) Act 2003* sets out statutory principles to which those discharging functions under the act must have regard. Chapter 3 of the act also introduces a right of appeal against detention in conditions of excessive security.

The following Principles incorporate these new legal requirements, the venerable but still applicable Guiding Principles of the Reed Report, (Department of Health & Home Office, 1992) subsequently accepted in Scotland (Scottish Office, 1999)and also recommendations of *Women's Mental Health: Into the Mainstream (*Department of Health, 2002). They also attempt to address human rights legislation particularly in respect of principles of non-discrimination, right to liberty and the right to private and family life.

Forensic Mental Health Services for women should provide care:

- That takes into account the needs of patients as women and as individuals.
- That is gender sensitive (not merely gender blind) and, irrespective of cost, provides care of equal standard to that available to male patients.
- That takes into account the wishes of the patient and their carers, named person and any guardian or welfare attorney.
- That allows and facilitates the fullest possible participation of patients.
- That provides maximum benefit to the patients with the aim of the fullest possible independence.
- That considers all the options available.
- That imposes no unjustifiable disadvantage on a patient. Specifically -
    - Care should be provided in the least restrictive safe environment.
    - And as close to the patients' home or family & friends as possible.

While these principles emphasise the rights of individual patients they also acknowledge that some patients present risks to themselves and others, who have a right to be kept safe. The challenge at both a service design and individual care level is to balance the need for public protection with this individual rights.

4.2 Scope of a Forensic Psychiatry Service for Women.

There is no general agreement about what patients are best managed in forensic rather than other psychiatric services. We are wary of offering an overly prescriptive definition: Where resources are scarce there is a risk that service inclusion criteria can become over-rigid, service-focused, exclusion criteria.

However we felt it useful to give some broad indication of the likely characteristics of the women likely to be within the remit of a forensic service.

- They will suffer from complex and long-term mental health problems (such as mental illness complicated by personality disorder and substance abuse).

- They will present a risk to others. Many of these women will have come into conflict with the criminal justice system. Not all however, will have been prosecuted even in cases of quite serious violence. This is particularly the case where the violence has been perpetrated within hospital. These patients may still have the same needs and present the same risks as those who have been prosecuted.

- Many of these patients will present a considerable risk to themselves and this may account for much of the challenge they present to services. However, ordinarily it would not be necessary or appropriate to treat someone who is purely a risk to themselves within a forensic service.

- The extent to which patients suffering from Personality Disorder should be the business of Forensic Psychiatry services is always a matter for debate. The situation is complicated for women by the substantial number of patients diagnosed as suffering from Borderline Personality Disorder whom many would argue are better regarded as suffering from mental illness. We felt that a diagnosis of personality disorder should not automatically exclude anyone from any part of a forensic service. We recognised that particularly when it came to detention in hospital very careful consideration of the risks and benefits of any intervention will be required in each individual case.

We concluded that separate provision should be made for 2 groups of women who occasionally are currently referred to and admitted to forensic services, but whose management within forensic services is generally unsatisfactorily.

- Girls under the age of 18 should not, except in the most exceptional circumstances, be placed within general forensic services.

- There are a small number of learning disabled women currently within forensic services. These women are best placed in a dedicated Forensic Learning Disability service or within General Learning Disability services.

Separate provision for each group should be made. The number of such patients from both groups (known anyway to Forensic Services) is so small, both Scotland wide, and particularly in any one area, that highly-individualised bespoke packages of care may be the most economical as well as the most therapeutic option. In the case of adolescent girls there should be clear protocols established governing the transition to adult services.

4.3 Organisation of a Forensic Psychiatry Service for Women

A comprehensive Forensic Psychiatry Service for Women should provide care that meets all their treatment needs while keeping the patients and others safe without unduly restricting their liberty. It should be flexible enough to respond to changing needs, particularly changing security needs, and to allow and facilitate progression to maximum independence.
Access to secure beds is required. So too is easy progression to non-secure inpatient facilities or community services.
The service should be gender sensitive and staffed by a multidisciplinary team experienced and trained in working with this women forensic patients.

Most of all it should be available: at present the provision of such services is piecemeal with some variation across Scotland with most areas having no dedicated service for women and there being a general dearth of manpower and other resources.

We therefore suggest that within each of the four regional grouping currently developing their forensic services in Scotland there should be established a dedicated team with specific responsibility for Forensic Psychiatry Services for Women. This should be multi-disciplinary and, as a minimum, should include a Consultant Forensic Psychiatrist, nursing, clinical psychology, occupational therapy and social work staff. It should have full administrative back-up. The remit of these teams should be overall responsibility for the services within the areas covered by each of the regional consortia.

As well as providing direct care of patients within secure units within the region, they would be involved in providing other inpatient care and community care either directly or in consultation with other local services. Such services should cover all of Scotland. Depending on local circumstances, it might be appropriate to have more than one team providing Forensic Psychiatry Services for Women in any one regional grouping.

Recommendation 1:
Dedicated multidisciplinary teams responsible for providing Forensic Psychiatry Services for Women should be established within local Forensic Services across Scotland. As a minimum there should be at least one such service within each of the 4 Regional Groupings. These should provide, direct secure and open inpatient care as well as community care. They should also be a source of support and expert advice to other local services. All of Scotland should be covered by such a service.

Recommendation 2:
The core patient group should be adult women with complex mental health needs who present a risk to others. These services should not exclude patients on the grounds of personality disorder.

Recommendation 3:
Adolescent Forensic Psychiatry services should be developed within Scotland.

Recommendation 4:
Provision should be made within Learning Disability services for the small number of learning disabled women who have forensic needs.

4.4 The Security Needs of Female Forensic Patients

We were aware that another working group is working on definitions of security. We felt it appropriate, however, to make some comments on the particular security needs of female forensic patients.

Firstly, female patients have less need for physical security in the form of escape proof perimeters or geographical isolation.: By and large female forensic patients have lesser histories of particular violence towards the general public and are rarely escape risks.

However they have a greater need for relational and procedural security. This may take the form of specific therapeutic intervention from a variety of disciplines as well as high levels of nursing support and supervision.

The risks that female forensic patients present tend to be more quickly variable than in male forensic patients (who typically present graver but less immediate, and less acutely variable risks). The ability to adjust relatively quickly relational and also procedural security factors (such as access to hospital grounds or the community) is therefore important.

4.5 Special Secure Provision

Much valuable work is done with women patients at The State Hospital. Given the lack of alternative provision it currently may well be the best of a very limited range of options available for the women detained there. However none of the female patients currently in the State Hospital require or benefit from the high perimeter security. Their treatment, and relational and procedural security needs, could in theory (but realistically, not currently in practice) be met in physically less secure settings.

The development of a comprehensive network of forensic psychiatry services for women across Scotland should logically render the Women's Service at the State Hospital unnecessary. The implementation of Chapter 3 of the Act in May 2006 may, if it is applied in the spirit of the Millan report, accelerate this process.

Rarely, female patients might require a greater level of security than might be available normally within other secure services. These could be dealt with by exceptional arrangements, either within these other secure services or in the most exceptional cases utilising the high secure services still available within England. In the experience and opinion of the working group such cases might arise no more than every three or four years.

Realistically there will be a continuing need for the service provided by the State Hospital for some years to come while local services are developed.

Recommendation 5:
Until alternative Secure Services for Women are available Scotland-wide, the Women's Service at the State Hospital should continue as a high quality service. It should not, in the meantime be run down. Where service improvements are required (for instance development of the rehabilitation service and standard of accommodation) these should be made. Only if and once there is clearly no need for the service, should it be closed.

From time to time clinical disputes arise as to whether a patient requires admission to the State Hospital or is fit to move back to local services. Anecdotal evidence suggests these debates may be more common for female patients. At present there is no non-judicial mechanism for resolving these and the *status quo* usually prevails – with potential disadvantage or risk to the patient or others.

Recommendation 6:
A disputes resolution system should be established between The State Hospital and local services

4.6 Other Secure Provision

We decided to avoid making distinctions between medium and low secure care. The fact is that most secure units, other than special secure hospitals, allow for the level of security to be tailored on an almost individual basis: some patients in medium security might be subject to much greater restriction than would prevail in special security while other enjoy a high level of freedom.

The exact number of secure places needed for women will vary from time to time within each area. At currently apparent levels of need, four units (one in each of the regions Greater Glasgow, South-East Scotland, West Scotland, and North Scotland) of *no more than* ten beds each are likely to be adequate.

Ten beds is as large as any women's secure unit should be. In practice fewer beds may be required in any given area at any one time. A local needs assessment taking account of women placed out of area would give an indication of the required unit size. We were impressed by the proposal for the planned Stobhill Unit that allows, through flexible design of the building, the size of the women's unit to be easily varied and thus lessen the bed redundancy.

It is important to reiterate that these proposed secure units should not be regarded as the whole of or even the main part of the Forensic Psychiatry Services for Women – merely a vital component.

Recommendation 7:
Secure beds for women should be available across Scotland, with each of the four regional groupings containing at least one unit. These units should be seen as part of the Forensic Psychiatry Services for Women rather than the whole of them.

The units are unlikely to be large enough to be practically viable on their own or to offer an adequate range of therapeutic and occupational and similar facilities to patients, and so will generally be best provided within other existing or planned secure units.

Merely designating, either in advance or an ad hoc basis, generic beds as being for female forensic patients, is not satisfactory and certainly does not allow female patients to live separately from men or to receive a gender sensitive service. Some sharing of facilities with forensic services for men will be economically necessary and may well be beneficial. Careful consideration however needs to be given to how these shared resources are used so to take into account the needs and wishes of individual female patients and to offer a choice.

Recommendation 8:
Secure beds should be provided in small, self-contained units of no more than 10 beds which will generally best located within the existing or planned secure units.

Recommendation 9:
The living accommodation for women in these secure units should be separate from that for any male patients. Some sharing of therapeutic and social facilities between male and female patients may be appropriate.

Staffing Secure Units
This group of patient is a challenging one with, as has been highlighted, different needs from other forensic patients. Working with them involves stresses and risks different from those typically presented by male forensic patients and requires specific skills.

Recommendation 10:
Clinical services in the secure units should be directed and largely provided by the Forensic Psychiatry Services for Women Team.

All staff working on the units should be people who have elected to work with this staff group and who have been selected for their training and experience in doing so. In order to provide a gender sensitive service, care should be taken to avoid a preponderance of male staff and restraint and other policies on the unit should show due sensitivity to the likely past experiences of these patients.

Recommendation 11:
Staff working on these units should be individuals who have elected to work with women and who have been selected for their training and experience in so doing.

Treatment
A full range of treatment modalities must be available in each unit. Treatment should be of the best quality and, to the extent that this is available and applicable, be based on evidence based practice and accepted guidelines.

Recommendation 12:
A full range of treatment, occupational, educational and recreational activities must be provided.

4.7 Long-term Secure Provision

We have not chosen to define the secure units in terms of how long a patient might require in-patient treatment. The arbitrary, but widely used 18 to 24 month limit used by many secure units will be more than enough for most patients. Others might need somewhat longer and should not be denied care because of that.

There are however a small number of women who are likely to need hospital treatment over many years. These include women with severe treatment resistant psychotic illnesses associated with disturbed behaviour and a few with severe personality disorder usually associated with mental illness, who have been institutionalised and continue to present a major challenge. Both groups require high levels of relational security rather than physical security. They are few in number (four women currently in The State Hospital would meet the description, as might a similar number elsewhere), and apart from their need for a high level of care over a long period of time, they are otherwise disparate group, originating from all over Scotland.

Because of all these factors we do not advocate any single solution, but suggest that the most appropriate approach would be the development of very highly tailored, bespoke packages of care for each individual assembled by health and social services staff working in collaboration with the voluntary sector and pooling their expertise and also funding.

Recommendation 13:
Provision should be made for the handful of very disturbed challenging individuals who are likely to need hospital (or equivalent) care with a high level of relational security over several years. Highly individualised bespoke packages of care are the best option in these cases.

4.8 Other Inpatient Services & Links with General Psychiatry

At times women previously under the care of forensic teams will require admission to hospital but will not require conditions of security. This might be as a progression from a period of treatment in a secure unit or during periods of crisis, whilst otherwise being cared for in the community. Anecdotally it would seem that there are at times difficulties in finding general inpatient places for women identified as "forensic". How widespread or common this is, is difficult to tell but it is clear that, in some cases at least, such demarcation disputes can result in patients receiving less than ideal care with unnecessary admissions to the State Hospital or even prison..

It is not essential that the Forensic Psychiatry Services for Women Team have direct access to non-secure beds or that they always retain direct responsibility for all patients admitted to non-secure beds. What is important is that patients get admitted to the appropriate place at the appropriate time and that any organisational barriers to this are minimised.

There should be good relationships between forensic and general psychiatrists. These should be reinforced by clear protocols governing issues such as access to non-secure IPCU beds, continuing responsibility for female forensic patients in non-secure beds. Clear agreement about hand-over of patients from one service to another should be in place to maximise continuity.

Recommendation 14:
The forensic psychiatry service for women team in any area must ensure good working relationships with local colleagues. In particular there should be clear protocols regarding issues such as access to secure or IPCU beds, continuing responsibility for female forensic patients in non-secure beds and hand-over between services.

We noted that one of the sources of tension between general and forensic services was a general lack of resources, both in terms of specialist staff and also inpatient places. Addressing these deficiencies only within the forensic services might not be expected to lessen these tensions. Forensic services should not be developed at the expense of general, acute or rehabilitation services. Forensic services are only part of a matrix of psychiatric care

Some of the measures that might improve relationships between general and forensic teams are discussed in Appendix 4.

Sometimes goodwill and clarity will not be enough to ensure agreement and there should be effective local dispute resolution procedures.

Recommendation 15:
A local disputes resolution procedure should be in place.

4.9 Community Services

The extent to which forensic services continue to provide input to their patients once they move on to the community varies considerably across Scotland. We do not recommend any particular model of working. Considering the area covered by each of the regional groupings, geographical factors will often be decisive. The majority of women will eventully become the responsibility of general psychiatry community mental health teams. A smaller number will be managed longer term by forensic services: either directly by the women's team or by a local forensic service.

The most important thing is that there is agreement and clarity among community services about who does what in any particular case. Again there should be clear protocol for transferring cases. In some circumstances, shared care between different teams will be appropriate. The forensic psychiatry services for women team should be available to provide consultation or direct therapeutic input to any general or forensic psychiatry service requiring it.

Recommendation 16:
No single model of community working is prescribed. The balance between forensic psychiatry service for women teams providing direct community care and providing consultation to other services, will inevitably vary. Most important is agreement and clarity with other services as to the roles they perform in any particular case.

The point has been well made that although forensic patients may be defined by the risk that they present and thus may be placed in conditions of obvious security, this risk inevitably increases whenever a patient moves down to a lower level of security with the greatest risk increase coming with the move to the community.

Thus the need for very close inter-agency and disciplinary working is greatest at this point. There is a need for continuous shared risk assessment and shared risk management plans. Any patient considered to have presented such a risk as to warrant the input of a forensic team is likely to present a continuing risk, best managed by means of an augmented care programme approach.

Recommendation 17:
Multi-disciplinary and multi-agency working is particularly important at the community stage with the need for constant shared risk assessment and risk management plans.

Recommendation 18:
A care programme approach is likely to be appropriate for any female forensic patient moving to the community.

4.9 Court & Prison Liaison

Often women with mental disorder find themselves in police custody or before the courts. Although it would not be feasible for all such women to be assessed by members of the women's team, there should be clear protocols in place to allow their rapid involvement. Historically different approaches to court liaison and diversion have evolved across Scotland. We felt this diversity was not necessarily a bad thing, so long as the practitioners providing the court & police liaison have ready access to the women's team. Also the team must be in a position to respond quickly to any request.

We were concerned that since the publication of "Women Offenders – A Safer Way" the number of women being sent to prison inappropriately has actually risen. Some courts at least continue to remand women to prison in order to procure psychiatric reports. This is risky, inappropriate and generally ineffective. It should be avoided.

Recommendation 19:
There should be in place arrangements to allow speedy assessment of mentally disordered women taken into custody or appearing before the courts. Clear lines of liaison should exist between the forensic psychiatry service for women team and those providing the first line of assessment. Women should not be remanded in custody purely for reports.

The level of mental health input at HMP Cornton Vale in particular is quite good. There are few difficulties in identification of mental disorder or in providing outpatient treatment. The two areas where difficulties mainly arise are in transferring out prisoners who require hospital treatment, and in liaising with services all over Scotland.

Imprisonment disrupts people's lives, including interrupting the continuity of any care they may have been receiving. Prisoners may become homeless because of their imprisonment and are frequently released uncertain of where they will be housed. This makes advance planning extremely difficult. The problem is particularly acute for those coming into prison on short-term remands or very short sentences. The best way of avoiding this is the avoidance of imprisonment, except when necessary. Alternatives must be available- for instance supported bail hostels- but often are not. The plea has been made before (Scottish Office 1998; Scottish Office 1999) but is worth repeating.

Recommendation 20:
Alternatives to imprisonment for women should be developed.

Links, already in place in some cases, should be developed with local services with HMP Cornton Vale and any other prison that may come to house women. This should be the responsibility of the Forensic Psychiatry Services for Women Team. Not all women transferred from prison will necessarily go to forensic services, and forensic services will not be involved in the follow up of all women with mental disorder leaving prison. However, clear lines of liaison and protocols for transfer and aftercare should be set up and monitored.

Recommendation 21:
There should be clearer liaison between women's prison services and local psychiatric services.

5. PROPOSED SERVICE PROVISION – SPECIFIC ISSUES

Having set out the broad strategy and major recommendations for developing Scotland-wide services for women, I will now consider in some depth a number of specific aspects of this. This should not be seen as an exhaustive list.but merely an attempt to highlight some of the main issues involved in this field of work

5.1 Psycho-social Interventions

Effective treatment for anyone with serious mental disorder invariably involves multi-modal, multi-disciplinary and multi-agency work. Given the complexity and risks involved this is even more important in forensic practice

Particular issues to be addressed with women forensic patients include:

1. Deliberate self-harm
2. Other impulse control difficulties often associated with a lack of coping resources.
3. Effects of childhood abuse and neglect.

There needs to be available a wide and flexible range of intervention. Some specific therapies seem to have specific value in this group of women - for example, dialectical behaviour therapy, developed for those with borderline personality disorder has been used successfully in the State Hospital for women exhibiting the same behaviours, but against a context of severe mental illness. However the menu of treatments should not be fixed.

We would see a Clinical Psychologist as an essential member of any Psychiatry Services for Women Team However skills for the provision of psychosocial interventions exist within all disciplines and should be developed and used to the maximum.

It should be possible for women at all levels of security or living within the community to access the psychosocial help that they require without having to move to a more restrictive level of care.

Mark Ramm considers this area in greater detail in Appendix 5.

5.2 Nursing issues

Within any mental health care team, nursing staff are by far the largest group. Historically the nursing role in forensic psychiatry has had a heavy emphasis on supervision and containment. Whilst the importance and therapeutic worth of this aspect of care should not be under estimated, the nursing role is much wider. In appendix 5 Clare Lamza expands on the role and required skills of nurses working with female forensic patients. General recommendations of the working group are that:

1. Within secure units for women, *at least* one member of nursing staff on duty for each inpatient is required to allow safe observation and supervision and other therapeutic engagement to co-exist.
2. Nursing staff working in such unit should be individuals who have chosen to work there and with this particular client group, and should have been selected for their experience and training in this work.
3. The majority of the staff on duty at any one time should be female.

4. There should be an emphasis on therapeutic working, often in collaboration with other disciplines.

5.3 Social Work Issues
In appendix 6 Mairi Brackenridge expands on the social work issues. She highlights the key role of the social worker identifying and meeting the needs of the women in relation to their links to their families and communities.

Also highlighted is the use of Care Programme Approach, augmented where necessary.

5.4 Occupational Therapy Issues.

David Greer in appendix 7 gives a detailed treatment of this aspect of the service. The main points and recommendations are that we agree it is vital that good occupational therapy provision is available, particularly across the transition points from hospital to community.

5.5 Non-Statutory Sector Role
The voluntary or non statutory sector is becoming increasingly important in the support and care of people with mental health problems, particularly in the community. It provides practical support, particularly in areas such as housing, occupation and training, support with activities of daily living, specific therapeutic input and support for patients and their families. It can be a powerful source of advocacy. The sector is probably under utilised, particularly in respect of forensic services.

The input is likely to be particularly useful for those women whose needs are poorly met by existing services and who need something designed specifically for them. We had a number of anecdotal accounts of this working very well in practice, although it is an approach that because of funding or organisational issues seems to be quite difficult to use on a more general basis.

Recommendation 22:
Links should be formed and strengthened between forensic psychiatry services for women and non statutory sector organisations with an interest in women's mental health.

5.6 Advocacy

Appendix 8 by Louise Adams is a paper on the subject of advocacy in general, and advocacy for women in particular.

One of the very significant differences between the provision of forensic psychiatric services for women in Scotland compared to England is the absence of any specific advocacy group for women in secure care. In England, Women in Special Hospitals (WISH) have been a powerful voice for women in secure care (not just special hospitals) over many years and have ensured a high profile for this group.

That WISH, or an equivalent, have not flourished in Scotland is probably because of the very small numbers of women in secure care in Scotland, and also, paradoxically, the fact that the women in secure care in Scotland are a rather more disabled, less articulate group than historically have been found in Special Hospitals.

We support the need for advocacy for woman forensic patients both at an individual level and at a collective level. At present the latter very much falls to those of us providing the service. This is a good thing as far as it goes, but would be better added to and informed by other independent voices.

Recommendation 23:
All women under the care of forensic psychiatry services should have access to individual advocacy. Consideration should be given to how their collective interests can be bet independently represented.

5.7 Physical Health Needs

Psychiatric morbidity is associated with an excess of physical morbidity and mortality. Some of this is related to disease factors, some of it is iatrogenic. Often the two factors interact as in the case of diabetes mellitus and schizophrenia. Lifestyle factors are often important, and for patients in secure care may be aggravated by for instance limited opportunities for exercise or provision of a less than optimally nutritious diet.

Within any inpatient setting there should be a culture of both health promotion (for instance providing education about healthy lifestyle) and health facilitation (providing the culture and facilities to put this into practice).

In addition to these, general needs, women have specific health needs. There should be regular well woman clinics staffed by at least one female medical practitioner.

Recommendation 24:
The promotion of physical health should be a priority, particularly within inpatient services. Good quality general medical input should be available and a well woman clinic staffed by a female medical practitioner should be provided.

5.8 Risk Assessment and Management

Explicitly, or more often implicitly, this is part of virtually everything we do as forensic (or indeed any other soft of health care) practitioners.

There is some competition between models of risk assessment with actuarial and clinical approaches competing. For women valid actuarial data is largely missing

We fully endorsed the notion of clinical risk management as a dynamic process which should be kept under constant review and should be founded on structured clinical assessment of information from a variety of sources. It should be seen as the responsibility of all concerned in an individual's care.

The most important function of risk assessment is to produce a risk management plan which should be an integral and dynamic part of any individual's care or treatment plan. It should be shared across the team and with anyone else with a need to know.

It is important that all those working with the patient have a good knowledge of past risk, the factors involved in these and an understanding of the likely relapse signature.

Recommendation 25:
There should be a clear risk assessment and risk management procedures within the team and clear protocols for communicating this with other agencies.

5.9 Family and Other Relationship Issues

The maintenance of pre-existing family and other important relationships must be an important part of the care of any woman in forensic care. Hospitalisation, particularly if at some distance from the patient's home, may attenuate family relationships which might already have been damaged because of an individual's prior behaviour. All should be done to maintain, and where necessary improve an individual's relationships with their family or friends whilst in care. It is important to work with families as fully and openly as possible (bearing in mind the wishes of the individual patient).

There are particular issues for women with children. Particularly in cases where there is reason to regard the woman as a risk to her children, very careful risk management will be required as will close working with social workers working with family. The welfare of the child is always paramount. There should be clear child protection and child visiting policies. For inpatient units visiting arrangements should be pleasant and homely and configured in such a way as to ensure that any child visiting her mother does not have to come in contact with other patients.

Recommendation 26:
There should be clear child protection procedures for any service, inpatient or outpatient, and appropriate child visiting arrangements for any inpatient service.

As regards intimate relationships, obviously women coming under the care of forensic services have the same needs and rights to form relationships as others. Many however will have had a history of suffering abuse in past relationships and will be vulnerable to further abuse or exploitation. Clearly also any partner met in a forensic setting is likely to present some risks of their own.

The management of such relationships calls for very careful and sensitive assessment. Sometimes it will be necessary in the interests of one or both partners to impose some limits. These should always be proportionate and set on a case by case and flexible basis rather than being determined by the rules of the institution.

5.10 Workforce and Training Issues

There is a general shortage of trained forensic practitioners with particular problems in nursing, psychology and occupational therapy. This may well impede the development of forensic psychiatry services generally across Scotland. There is clearly a need to train more staff in all of these disciplines.

It is apparent, again particularly in the named disciplines that retention of staff is an issue and thought should be given as to how career in this area of work can be improved.

As specifically regards forensic practitioners working with female patients, there should be available in-service training in gender issues and their implications for working with female patients.

5.11 Performance Management

Clearly the generic clinical governance standards of patient focus and safe and effective clinical care apply as much to this field of work as any other. Specific standards, for instance for the management of schizophrenia, will apply to any patient with that diagnosis and may be more widely applicable. There is however a relative lack of hard evidence about what is good, effective treatment in this group and also no general agreement as to what are valid outcome measures or key performance indicators.

One area that can be measured is the accessibility of these services. Time from referral to assessment or time spent on waiting lists can give some indication of this.

When dealing with very small numbers of patients any quantitative data, must be interpreted cautiously. It should however be collected by each of the services. There should be some prior agreement between the services as to what an appropriate dataset might be.

Much useful information might be gathered from qualitative data looking at patients and their families' experiences of services in treatment.

5.12 Network Development

We would expect the Forensic Mental Health Services Managed Care Network Advisory Board to drive and monitor the development of these services.

There would be clear advantages for practitioners in all disciplines working within each forensic psychiatry services for women team to have access to a regular forum, meeting on a regular basis. The model of the Forensic Club would be a useful one. Some interchange with similar proposed networks working with women in secure services in England would also be useful.

5.13 Financial Issues

Part of our remit was to cost any proposals made. It soon became apparent that even if we had had the time to do this, we lacked the information (and possibly the expertise). It is clear however that providing good quality services to what is in forensic psychiatry services, a small minority group, is inevitably expensive. The per capita costs are always likely to be higher than the per capita costs for male patients for any given level of service.

Although the overall cost of these proposed changes and service provision are likely to be greater than the current situation, there will be some savings. These proposals should make it easier for women to move from secure care to low care and then into the community.

The location of the secure facilities within facilities which either exist or are planned should also lessen the capital financial impact of these proposals. There will also be revenue efficiencies in the ability to share some management and administrative costs, as well as other common services.

From our discussions it was clear that obtaining funding for individual packages of care is an inconsistent and rather opaque process. Disputes about area of residence & responsibility can dominate discussions. Clearer national & local frameworks for making sure that "money follows the patient" are required.

6. CONCLUSION

We have presented a survey of current forensic psychiatry provision for women across Scotland and have set out the broad outline of a network of services which would cover the whole of Scotland providing expert advice and direct inpatient and outpatient care on, as far as is practical, a local basis. We have made a number of specific recommendations as to how such a service might be organised, the essential elements of such a service and how it might relate to other services.

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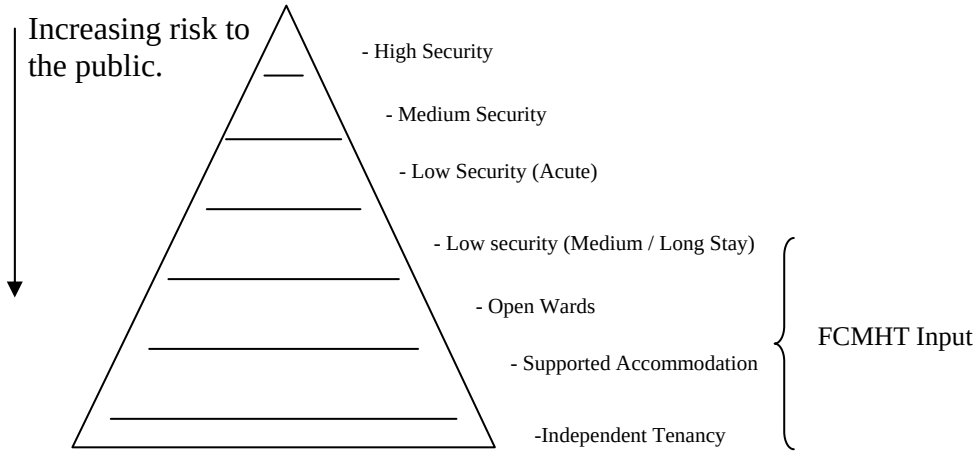
APPENDICES

Appendix 1:
Membership of Services for Women Working Group

Chair: Dr Willie Black	Consultant Forensic Psychiatrist	The State Hospital
Facilitator: Angela Robertson	Clinical Effectiveness Manager	The State Hospital
Mairi Brackenridge	Head of Criminal Justice Social Work	South Lanarkshire
Anne Carpenter	Consultant Psychologist	Douglas Inch Clinic, Greater Glasgow Primary Care Trust
Dr Fiona Clunie	Consultant General Adult Psychiatrist	Royal Edinburgh Hospital
Paul Gilius	Team Leader – Community Forensic Mental Health Services	Ayrshire & Arran Primary Care Trust
Alistair Grant	Clinical Services Co-ordinator	The Blair Unit, Royal Cornhill Hospital, Aberdeen
David Greer	Senior Occupational Therapist	The State Hospital
Heather Keir	Head of Health	HMP Cornton Vale
Claire Lamza	Clinical Nurse Specialist	The State Hospital
Dr Anne Macdonald	Consultant Forensic Psychiatrist	Douglas Inch Clinic, Greater Glasgow Primary Care Trust
Dr Rhona Morrison	Consultant Forensic Psychiatrist	Forth Valley Primary Care Trust
Dr Mark Ramm	Head of Clinical Psychology	The Orchard Clinic, Lothian Primary Care Trust
Dr Karen Richard	Consultant Forensic Psychiatrist	Tayside Primary Care Trust
Dr Andy Wells	Consultant Forensic Psychiatrist	The Orchard Clinic, Lothian Primary Care Trust

Appendix 2:
A Forensic Community Mental Health Team for Female Mentally Disordered Offenders.



A Forensic CMHT is an integral part of mental health services, for the vast majority of mentally disordered offenders in the community who represent a risk to themselves and/or others because of the severity of their mental illness and associated offending behaviour. It must be supported by access to a full range of specialist services with increasing levels of staffing and relational security. The definition for patients managed by this type of service should include those patients who have complex needs similar to female MDOs but who have not yet offended ie potential for dangerous or violent offending secondary to mental illness but have not yet acted on it. The service should aim to prevent serious offending and not simply manage risk after the event e.g. delusions or hallucinations to kill a named victim present.

Definition of Patient Group

"People suffering or appearing to suffer from a major mental illness whose behaviour brings them into the Criminal Justice System and are a cause for concern either because of the seriousness of the offence or their potential dangerousness. The service will also offer input to those with severe mental disorder who pose a risk to the safety of others but may not necessarily be offenders. Mental disorder, as outlined in the Act, means mental illness (including personality disorder) or mental handicap however caused or manifest". Patients often have complex needs and a dual diagnosis.

Females with severe borderline personality disorder often feature in this group due to the lack of alternative, appropriate psychological services. Their self-harming behaviour is often dealt with via criminal justice services"

The risks managed by this type of service are greater than at any other tier of the service from which the patient may have cascaded down because the external controls are reduced. There is no physical security and an increased risk of disengagement, risk of non-compliance with medication, access to drugs, alcohol, weapons and potential victims. Monitoring of mental state is also less frequent.

Team membership (component disciplines)

- Forensic psychiatrist
- Forensic CPN (Small case load -10)
- Social work (MHO, CJSW)
- Clinical forensic psychologist
- Pharmacy advice
- Occupational therapy
- Cognitive and behavioural therapist (access)
- Administrative support

Service delivery

- Court liaison scheme (Mon – Fri) (FCPN led service with medical backup).
- Access to acute low secure inpatient beds (emergency and medium to long stay).
- Established links with medium and high security hospital (managed care network, CPA)
- Augmented CPA (multidisciplinary / multi-agency care co-ordination which includes risk management plan update).
- Access to supported accommodation (joint funding / staffing?).
- (Social and mental health needs require to be addressed).
- Staff with behavioural management skills preferable (CBT skills).
- Forensic outpatient clinics in locally accessible clinics with security alarms.
- Formal liaison with police, social work, CJSW to encourage joint working.
- Staff training regarding risk assessment / management planning.
- Develop an agreed system eg based on HCR – 20, SVR-20, PCL-R or more equivalent structured clinical judgement tools for female MDOs (if available).
- Proactive support and monitoring of small caseload to encourage patient's acquisition of coping strategies for stress, crisis resolution, problem solving and early intervention if illness relapse or alteration in risk status.
- Cognitive and behavioural skills for high risk recidivists (staff training) (individual and group therapy).
- Specific therapies / interventions / assessments by team e.g. anger management, sex offender work, CBT etc (forensic psychology input may be useful).
- Ensure ready access to interpreting services for deaf and non English speaking patients
- Utilise specialist services e.g. CADS, clinic for deaf, EMDR etc.
- Access to psychotherapy or psychotherapy supervision particularly to address sexual abuse related issues (Staff experience in work with CSA victims to be encouraged) and team dynamics.
- Staff training re suicide risk assessment and management strategies for deliberate self harm.
- Regular team meetings / staff supervision / case reviews to encourage peer support and foster communication to manage risk appropriately.
- Detailed system of documentation which is readily transferable between services if patients move, in order that important risk management information is not lost.
- FCMHT perform role of advising on carrying out risk assessment /risk management planning for colleagues in other specialities.
- Specialist court report advice for courts pre and post conviction.
- Service should be needs led and flexible rather than driven by strict protocols and criteria for inclusion / exclusion.

- Risk assessment should include full case note review of all records (including medical, social work, police), case note summary, preparation of risk summary, risk management meeting, HCR 20 or equivalent and development of risk management plan (regularly updated).
- Mental health awareness training and risk assessment / management training is essential for all agencies interfacing with the service to ensure appropriate referrals.
- Numbers of patients are typically small so the female service should be part of a fully functioning FCMHT servicing both sexes.
- Access to jointly staffed social crisis and bail hostel for females (joint staffing)
- Nurses with CBT training.
- Use of baseline forensic needs assessment e.g. CANFOR (?shared health / social work)
- Ensure social routinely assesses needs for advice or support re: benefits, housing, childcare (to decrease services and allow access to treatment
- Needs assessment re social support (e.g. independent living support services)
- Develop crisis intervention plan and document telephone contact numbers for patient / carers
- OT inputs re skills acquisition, structured day time activity
- Reduced weekend service to ensure crisis cover for known patients on caseload
- Random urine testing / blood testing to monitor illicit drug abuse and medication compliance
- FCPN in-reach to IP areas to establish rapport pre transfer to FCMHT care or maintain links with FCMHT patients temporarily in inpatient care during relapse of illness
- Develop liaison staff for local prison, medium and high security
- Court diversion scheme
- Develop integrated care pathway for patient movement between services to ensure smooth transition / no loss of risk management related information
- Develop carer needs assessment (social work led)

Issues particularly relevant to female MDO services

- Childhood sexual abuse related issues
- PTSD related symptoms
- Deliberate self harm
- Child care / bonding / access
- Poor problem solving / coping strategies
- Rapid fluctuations in mental state and associated risk
- Borderline personality disorder
- Substance misuse

Borderline personality disorder

It is important to discourage "Criminalisation" of psychological and behavioural problems associated with borderline personality disorder due to lack of appropriate community resources for this group. **Specific "non forensic" services require to be developed for BPD***

Summary FCMHT

- Multidisciplinary team (Forensic psychiatry, nursing, SW, psychology, OT)
- Small case loads

- Proactive follow up
- Augmented CPA (includes risk plan)
- Risk assessment / management system
- OP clinics in locality
- Active staff training programme re management of violence, CBT skills, risk assessment, anger management etc
- Training role for partner agencies
- Develop forensic needs assessment for patients (and carers)
- Links with CADS
- Crisis intervention plan
- Court Diversion scheme
- Access to specialist bail hostel for females (joint staffing)
- Access to social crisis centre (joint staffing)
- Forensic CPN led court liaison scheme (Mon – Fri)
- In reach to referral sites
- Access to IP beds (acute and long stay)
- Access to supported accommodation
- Provide advice to local services and courts
- "Flexible needs led" service
- Clear documentation system re risk management plan
- Specific skills in assessment and management of DSH, PTSD, CSA
- Reduced weekend service (to cover crisis in patients on caseload)

Dr Rhona Morrison
Consultant Forensic Psychiatrist
Forth Valley Primary Care Trust

Appendix 3:
Needs for Secure Inpatient Provision

Admission Criteria
Women aged 18 – 65 suffering from major mental illness often with dual diagnosis including learning disability, personality disorder (in particular borderline personality disorder), substance misuse and eating disorder.

Offending Behaviour
The patients may be subject to criminal proceedings or may have exhibited offending behaviour without being prosecuted. In general terms these are people who would cause harm to others as a consequence of poor control of their symptomatology.

Needs of this population are in general terms; admitted for somewhat longer lengths of stay and the in-patient provision has to be seen within a long-term view of management of chronic disease.

A number of these people will also require shorter assessment for the purpose of preparation of reports for the court or for general adult psychiatry.

Size of inpatient unit
Recommended that it should be no bigger than 10 beds and that it may have to provide multiple functions because of the relatively small numbers of patients falling into this category. The functions that would take place would include:

Assessment
Treatment
Rehabilitation
Close Supervision and Zonal Observation
Crisis Suite Provision

Architecture
The accommodation should be able to provide medium and low security so that services can be tailored to individual needs of patients at different stages in the patients' journey.

It should be co-located with other Forensic Services to allow for staff development and training and to minimise burnout. It should optimise also internal supports.

In the development the clinician should work closely with the architects to ensure optimal design to meet the needs of this group.

Particular considerations

Internal
Zonal Observation
Crisis Suite for intensive nursing care
Sub-division to allow variation of security
Single rooms with integral sanitation, distant control of plumbing
Appropriate staff accommodation

Ample activity areas adaptable for education, arts and crafts, social skills training
Visiting areas allowing for child and family visiting
Rehab considerations

External
Site should be close to other parts of Forensic Services for dealing with unstable incidents, staff support.
Low risk of contact with inappropriate groups.
Not close to main thoroughfare.
Ample outside garden space to allow for patients to have access to fresh air and activity in the fresh air.

Security
Bedrooms should be en-suite which should be lockable with external control of plumbing. Doors should open in either direction and have viewing panels.

Staffing
Appropriate multi-disciplinary input including psychiatrists, nursing staff, activity workers, social workers, occupational therapists, psychologists, educational workers, secretarial, administrative and records staff. Staff should have appropriate time to allow for training and professional development.

Management systems should be geared to prevent inter-disciplinary dispute and to optimise inter-disciplinary support and co-operative working including appropriate integrated shift patterns, particularly with a view to activity staff so that patients do not become bored, with subsequent increase in self-harm and bickering.

Activity
An appropriate and fulfilling day is integral to the good management of this patient group, in particular education and physical exercise and possible use of supported employment would improve self esteem in this group.

Community infrastructure
Part of treatment is the initial testing in the community and there should be ease of access to appropriate accommodation for this group. In addition they should have access to appropriate day facilities and ongoing community support.

It should also be borne in mind that when assessing appropriate numbers of accommodation for this group the possibility of re-admission should be borne in mind.

Dr Karen Richard
Consultant Forensic Psychiatrist
Tayside Primary Care Trust

Appendix 4:
Links with General Adult Psychiatry

Problems:

1. Patients and services both heterogeneous groups.

2. Forensic and general adult services may have different models of care.

3. Acute admission wards have an acute focus with high turnover and can find it difficult to contain disturbed behaviour. Longer term issues may not be addressed.

4. Need adequate numbers of rehab and continuing care beds.

5. Lack of crisis or relapse prevention beds.

6. When and how should female forensic patients be handed over to general services?

7. Resources. When a patient is assessed as no longer needing high/medium/low security this may not guide general services on the resources or amount of staff input the patient needs.

8. Risk assessment – confidence of general services doing an assessment, training issues.

What may help general adult psychiatry services in managing female forensic patients

1. Comprehensive, multidisciplinary handover once a patient is stable or if in the community the placement is working (CPA or equivalent).

2. Risk assessment with actions to be taken and relapse signature.

3. Adequate rehab and continuing care beds.

4. Adequate community placements (including highly supported accommodation) for female forensic patients.

5. Consultancy and support from forensic services. Good working relationship.

6. Chronic disease model of care, assertive approach, focus on important issues.

Dr Fiona Clunie
Consultant Psychiatrist
Royal Edinburgh Hospital

Appendix 5:
Psychological and social interventions including individual psychotherapy

Most services and treatments for forensic patients are focussed on the predominantly male population. However, the needs of female forensic patients would often seem to be different. Women patients have significantly different profiles in terms of their social and offending behaviour and in their history and expression of mental health problems. This means that services and treatments for women will also need to be different and will sometimes require specialist expertise. Unfortunately there has been a lack of development of forensic interventions from a female perspective.

Female forensic patients are a heterogeneous group with complex needs and therefore require varied and comprehensive services. They generally have chronic psychiatric and social histories with a high incidence of sexual abuse and institutional care. While their index offences and forensic histories are often less serious than those of male patients they may be frequently among the more difficult patients to manage. This is because their behaviour can be chaotic and challenging often including self-harm and/or problematic anger and aggression towards fellow patients and staff. High quality assessment is essential for being able to identify needs and matching these needs to specific treatments.

It is clear that interventions need to be provided to address both clinical needs and offending behaviour. These interventions must also be provided at various appropriate levels.

1. Safe validating environment.
2. Interventions incorporated within on-going clinical care
3. Psycho-educational and protocol-directed treatments
4. Formulation driven psychotherapy
5. Systemic and Dynamic Interventions

These varied interventions are characterised by their degree of systematisation, complexity and depth of therapeutic approach. Increased depth is associated with greater individual tailoring to client needs. Those patients with engagement problems, personality difficulties, or problematic behaviour which is deeply entrenched within dysfunctional styles of coping or low self esteem issues will often require more complex psychotherapy interventions. Correspondingly, greater specialisation in techniques and in clinical supervision is required with more complex levels of intervention. This obviously has resource implications, particularly in the clinical time and the level of training required by therapists.

Summary of psychological interventions

1. Safe validating environment

Whether female patients are in hospital, prison or the community, they require a safe and validating environment as a vital backdrop for recovery and change. This positive therapeutic Milieu requires:

- Frontline staff who have experience of working with women
- An emphasis on working with female patients' families
- Close multidisciplinary working to manage care and risk issues effectively

2. Interventions incorporated within on-going clinical care

Some interventions will involve the whole care team in delivering a planned treatment to a particular patient. This may include aspects of a DBT programme or a specific behavioural programme to address self-harm etc. Because such interventions need to be carefully co-ordinated and evaluated they are often more suited to inpatient environments.

3. Psycho-educational and protocol based interventions

These interventions can be delivered in a multitude of forms. They usually involve individual therapy or group therapy, but can involve couple therapy or family therapy. This level of intervention is usually more time limited, more structured, and although interactive, it is more unidirectional in information flow than formulation driven psychotherapy. It involves less disclosure and is therefore less threatening for the patient. It is more homogenous and less individually tailored. This type of intervention is best suited for those individuals who are prepared to consider change, but is also appropriate for those who lack information or good coping-skills or who are sceptical but willing to participate. While resistance to treatment and denial are acknowledged, these interventions do not give these barriers explicit focus, instead the programme strategy and group process are designed to address them. Such psycho-educational and protocol based interventions could include stress management interventions, drug and alcohol interventions, psychological treatments for offending, coping with mental illness groups etc. However, many of these interventions have currently been written with male patients in mind and they may need to be specifically re-designed for women.

4. Formulation based psychotherapy

These interventions can involve individual therapy; group therapy; couple therapy; or family therapy. Clinical intervention methodologies may include:

Cognitive Behaviour Therapy (CBT)
Cognitive Analytic Therapy (CAT)
Interpersonal Therapy (IPT)
Emotion Focussed Therapy (EFT)
Narrative Therapy (NR)
Eye Movement Desensitisation Reprocessing (EMDR)
Dialectical Behaviour Therapy (DBT)
Dynamic psychotherapy (DP)

Such interventions are required in relation to four broad areas:

a) "<u>General psychopathology</u>":

Anxiety disorders
Depression
Self-esteem
Grief and loss
Substance abuse
Self-harming behaviours
PTSD/Trauma
Anger
Shame etc.

It should be noted that women's experience and expression of these difficulties is often different to that of men.

b) Mental Disorder:

Mental Illness
-including drug resistant psychosis
Personality Disorder
-including Borderline personality disorder
Dissociation
(Low intellectual ability)

c) Offending Behaviour

Female offending profiles are generally different from men. Psychological offence focussed therapies therefore need to be delivered which are orientated specifically to women (e.g. violence, arson). Often women can find it particularly difficult to acknowledge themselves as perpetrators or sexual abusers. They may find their situation particularly difficult to manage if they have harmed or abused their own child.

d) Issues requiring to be addressed from a specifically female perspective:

"Well woman" issues e.g. breast cancer
Victimisation issues (Victim-work) Power issues
Social and parenting skills
Life skills
Forced or elective terminations in the past
Weight gain due to medication
Adoption issues
Daughters of alcoholics/ substance users
Sexual and physical abuse survivors
Sexuality- lesbian/ bisexual issues
Eating disorders
Sexual dysfunction

Women may need to address a number of issues that are unlikely to affect men in the same way in our culture. Additional factors may also be more pertinent for them as a result of sexual abuse or intimidation in their past. Examples of such issues are 'being perceived as attractive or unattractive', 'guilt about their sexual activities' or 'shame about not fulfilling a wife of mother role'. They may feel particularly distressed if the result of them being hospitalised or imprisoned if this means that they are parted from children. This can lead to worries about the care of their children. Equally if illness or detention has prevented them from having a family, this can lead to feelings of loss in relation to fulfilling an anticipated mothering or nurturing role. Sensitivity and understanding in relation to such issues is crucial in the provision of treatment. The provision of appropriate child friendly family visiting areas and therapy facilities may be particularly important in this process.

4. Systemic and Dynamic Interventions

Often systemic and dynamic work with the whole family, staff teams or systems can be extremely useful. With families it can help to cultivate positive relationships and support

networks and with staff groups it can enhance understanding and prevent problems like staff "splitting". Often the overall intervention needs to pay special attention to involvement of children and family.

5. Therapist Gender

In the area of therapy there is a need for therapists and care staff who have wide experience of working with women. Usually the gender of a specific therapist should be a consideration in providing therapy to a female patient. For example, it may be that a woman who has been abused by men in her past would find it difficult or traumatic to work with a male therapist. However, each case should be assessed on its own merits during the course of a patients treatment since male therapists and positive male figures in the therapeutic environment can be important in facilitating a corrective therapeutic experience.

6. Evaluation of Psychological Interventions

It is clear that women in forensic mental health services present a somewhat different profile from men. This means that normative-data needs to be obtained and appropriate assessment instruments developed which are specific to the female gender and their environment. This is particularly true in the area of risk assessment where it seems risk factors that apply to men may not apply in the same way to women. The literature suggests that a variety of psychological interventions can be extremely effective in helping female patients to deal with distress and to address offending behaviour. Without adequate research into these areas, however, it will not be possible to fully develop and evaluate psychological and individual psychotherapies that fully meet the needs of female patients.

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Mark C. Ramm
Head of Clinical Psychology
The Orchard Clinic Forensic Psychiatry Unit
The Royal Edinburgh Hospital
Morningside
Edinburgh
EH10 EHF

Tel: 0131 537 5854
Fax: 0131 537 5857
e-mail mark.ramm@Lpct.scot.nhs.uk

Appendix 6:
Essential Elements of Nursing Interventions

There are several areas where Registered Nurses come into contact with women who have 'forensic' problems. The nursing skills that promote effective and helpful relationships with this group of women can be divided into four levels.

The first level does not require specific forensic knowledge but core skills essential to nursing in any field.
The second level requires more specific knowledge of forensic issues.
The third level would require a knowledge of forensic and women's issues.
The fourth level relates to the advanced practitioner, working with women in forensic services .

The first level where there may be contact with female 'forensic' patients is in the following settings:

- Accident and Emergency Departments
- Acute admission wards in local psychiatric hospitals
- Community care
- Nurse lawyers
- Police stations

For the majority of nurses in these settings, they will have no specialist forensic knowledge. Therefore, having core skills, as described by Peternelji-Taylor (2000), are essential. Often these skills can make a positive difference when providing effective care and management of the woman with 'forensic' problems within this setting

- Respect and dignity for another human being no matter how horrific the crime
- Role modelling by teaching prosocial values
- Excellent listening and assessment skills
- Being flexible and able to adapt therapy to the individual
- Believing people can change
- Self-awareness of one's own abilities
- Confidence in one's own abilities
- Enriched understanding of subcultures
- Excellent report-writing skills
- Being able to recognize one's limitations
- Ability to motivate change
- Assertiveness
- Non-judgemental attitude
- Maturity
- Life experiences

Nursing care in a forensic service requires a particular knowledge base, in addition to the skills that are required and used in the settings listed above.

For other services such as:
Intensive Psychiatric Care Units based in local psychiatric hospitals

Court Diversion nurses
Medium Secure Psychiatric unit
High Security Psychiatric hospital

Nurses are usually at the second level, and even then, may have different levels of knowledge and skills. These centre on risk management, offending behaviour and the specific sections of the Mental Health Act (Dale et al, 2001). The following are core skills, characteristics and competencies of the forensic mental health nurse (Watson in Kettles et al, 2002).

- Fire searching, escorting, visitor control
- Risk assessment and management
- Assessment and Management of dangerousness
- Prevention and management of Aggression
- Observation, communication
- Management of hostage and other security breaches

The third level would relate to nurses who have gender awareness and sensitivity when working with women in a forensic setting, in addition to their other skills listed above. Understanding and knowledge relating to the following are required:

- Why gender matters in secure settings
- Women's pathways into forensic/secure services
- The impact of women's life experiences on their mental health
- Staff roles in forensic settings
- Counselling
- Planning and participating in groups
- Planning and participating in programmes
- Research skills
- Therapies and treatments, including CBT and Psychosocial interventions

And finally, the fourth level relates to the nurses who have advanced training and have developed specialist skills working with women who access forensic services. These nurses:

- Design and develop 'specialist' nursing interventions for women
- Undertake research into the needs of women
- Disseminate and publish on research
- Liaise with external service providers on services for women with forensic problems
- Provide follow-up care for women once discharged from a forensic/secure service
- Work within the multi-professional arena
- Develop service wide standards and practices
- Have knowledge specifically relating to gender-sensitive practices and care

It is vital to recognize that whatever the levels of knowledge or expertise nurses have, the fundamental skills that are taught in every nurse's training, that relate to building a caring, therapeutic alliance will be helpful for women who use forensic services.

Claire Lamza
Clinical Nurse Specialist
State Hospital

Appendix 7
Forensic Services for Women: Social Work Issues

Social Work should be part of the multi-disciplinary team bringing a contribution that identifies the needs of the woman in relation to their links to both their family and the community. Social Workers would have a role to play in the risk assessment and management process contributing information both on their individual needs, their offending and knowledge of the social support network available to them. Experienced social work staff also have the skills to provide a case management role both providing individual interventions to the woman and in coordinating the input of other professionals.

Social work staff should be an integral part of the team. The model of service that currently exists in hospital and prison settings where staff are co-located alongside other professionals but employed by a local authority is a good one. Through this staff can be seen as part of the team but have access through their employing body to the expertise of other individuals that can make a contribution, and to ongoing professional development.

For women returning to the community links need to be developed with appropriate community based services. Both the CPA process and the criminal justice through care developments provide models for this. This would identify a worker as the key link for return to the community who would play an increasing role towards the point of discharge. The social work unit could provide a communication link.

Preferably the social work staff should have some years experience. Staff with experience of working in mental health would be essential but it would add value if they also had a criminal justice or child care background. Although our knowledge of what works with women offenders is still limited nevertheless a number of developments including the time out facility in Glasgow will begin to add to our knowledge base of what is an effective service.

Social work services will have a key role to play where a woman has family ties and responsibilities and particularly where she continues to be in contact with her children. However part of the social work role will also be to contribute to the development of Child protection and child visiting policies. These need to take account of the paramountcy of the welfare of the child, the needs of the women who still have contact with their children and the needs of those women who have no longer contact with their children and the impact other children visiting have on them.

Close contact with the relevant children and family workers will be essential as the work being undertaken by the service, and/or events taking place in the community, will have an impact on ongoing family relationships.

Many women using the service will have had experience of abusive personal relationships. Throughout Scotland as part of the general partnership working through community planning, local areas are developing strategies and services that meet the needs of women who have experienced abuse. The needs of women with mental health and other needs are not well understood. However local developments need to develop responses that are sensitive to such women and the Service could have a critical role in this. This would also be important where women are returning to local areas and require a network of services to provide support.

Social work through its links to other key services in the local area could also provide support to long term rehabilitation plans by establishing formal links with relevant services that can contribute to appropriate community based packages of support including housing, benefits substance misuse, employment and training.

Finally women requiring Forensic Services are likely to experience stigma as a consequence of society's general ignorance or lack of understanding of mental health and its impact on behaviour. Through local planning links we need to ensure that we develop better understanding of the issues, ensuring that women who return to the community are safe from prejudice and harassment.

Mairi Brackenridge
Head of Criminal Justice Social Work
South Lanarkshire

Appendix 8
Occupational Therapy Issues

General Principles

- All patients should have access to occupational therapy services.
- The ability to engage in a range of meaningful and purposeful occupations is an important aspect of maintaining and regulating an individual's mental health.
- The focus of the occupational therapists' interventions is the engagement of patients in the doing of everyday activities in order to promote health and reduce or mange risk and offending behaviour.

Staffing

- Female forensic patients present significant clinical and behavioural challenges to professionals. Their needs are best met by experienced senior occupational therapists.
- Patient to staff ratios are dependant upon need. However, it would not be envisaged that it should exceed 1:5 if effective intervention is to take place.
- There are significant recruitment and retention issues within occupational therapy; these problems are particularly severe in forensic services consideration would need to be given as to how these problems can be ameliorated.
- For reasons of practicality, clinical effectiveness and safety, interventions frequently require the involvement of more than one therapist. This combined with the need for professional support and development, leads to the recommendation that occupational therapy positions are not set up in isolation. If due to small patient numbers it is necessary to do so then consideration should be given to the professional support requirements of the appointee.

Intervention

- The doing of occupational therapy is often subtle as it uses everyday activities as its therapeutic media.
- It may be appropriate for the delivery of specified intervention to be done by unqualified or more junior staff, however this should be under the direction of experienced senior occupational therapy staff.
- The Model of Human Occupation (MOHO), a conceptual model of practice, is frequently used within forensic settings and provides a comprehensive frame of reference to guide practice. Its use is recommended within this challenging population.

Delivery of Care

- The nature of occupational therapy is that interventions occur in the most appropriate, natural environment. Interventions may take place in the patients' residential setting, in off ward activity areas or the wider community. The aim of intervention is to involve patients in real life situations.
- Interventions will frequently involve liaison and joint work with family and other service providers.
- Frequently, interventions occur at a series of transition points, when a patient is preparing to move from one environment to the next. Throughout this process patients move through three stages of functioning: exploration, competence and achievement. The purpose of occupational therapy is to assist the patient in this journey.

David Greer , Senior Occupational Therapist
The State Hospital

Appendix 9:
Contribution to the Women's Services Group from the Patients' Advocacy Service

It came as a great surprise, while researching this contribution to discover that there is relatively little literature relating specifically to women and advocacy, least of all women in secure psychiatric care and advocacy. Given what I have found, I will attempt to run through the variety of advocacy models that are around in general and then look at provision that is available specifically for women in other parts of the country. I will then present some points for discussion around what could be done to improve the situation at the State Hospital.

This paper has been prepared relatively quickly and does not do justice to the depth of issues that it has brought up.

Models of advocacy
The following is taken from "Independent Advocacy - A Guide for Commissioners"[1]and the Advocacy 2000 "Principles and Standards."

Advocacy has two main themes:
- Safeguarding individuals who are in situations where they are vulnerable
- Speaking up for and with people who are not being heard, helping them to express their own views and make their own decisions

Collective Advocacy
People in similar situations come together – with or without external support-to make common cause, draw strength from each other and get their collective voices heard.

Self-advocacy: This is often considered to be a model of advocacy in itself, such as with the organisation "People First", where people are supported (most often by peers) to speak up for themselves. Self-advocacy should be a goal towards which most advocates are supporting the people they are working with.

In the "Principles and Standards"[2] document collective/self-advocacy is:

- An identified group of individuals
- Is made up only of users, likely users, or past users of care or support services which are provided by, or on behalf of, local authorities or health boards
- Advocates, as a significant part of its activity, points of view which the group has collectively identified to be put forward
- Itself decides, and is free to decide, without any significant influence from anyone who is not part of the group, how to act; and
- Has only practical or legal restrictions on its action that could not be removed.

[1] The Scottish Executive January 2001
[2] Principles and Standards Advocacy 2000: January 2002

Independent Professional Advocacy
An agency with expert knowledge of the legal, health or welfare system uses this expertise to represent the person's interests and to assist the person to get their point across more effectively. The service may be provided by independent paid professional staff or by volunteers with relevant training and/or experience.[3]

Citizen Advocacy
An ordinary unpaid citizen gets to meet a person who is in a vulnerable situation. Seeks to understand their views and concerns, does what he/she can for as long as it takes (for life if necessary) to ensure they are treated well and to help them get what they need and want.[4]

As can be seen from these descriptions the Patients' Advocacy Service (PAS) adopts the "Independent Professional Advocacy" model, in conjunction with the use of volunteers. To the best of my knowledge, this is the model adopted in all the secure hospitals, although volunteers are not used in the three "specials" in England. This is a debate for another time, although Di Barnes in her paper "Independent Specialist Mental Health Advocacy Services" acknowledges that volunteers may "add value"[5]

PAS provide a generic non-gender specific model. The advocacy practice at present tends towards an issue-based, reactive service, although strong developments are being made to introduce "drop-in" advocacy sessions for patients on wards, which is an attempt to draw in those who may be less likely to put themselves forward for an advocate. At present PAS is heavily reliant on ward staff and other professionals to refer the most disempowered patients. This situation may be improved across the hospital if advocacy were invited to meet all patients on arrival (with the patients agreement), thus making the crucial initial contact which could lead to an ongoing advocacy relationship throughout the patient's journey in the hospital. This would ensure advocacy support at the stage where patients may feel most vulnerable. It would also contribute to a move away from the association that is frequently made between advocacy and complaint-making, rather than identifying the advocate as someone independent who can support patients to feel more empowered in decisions that are being made about their care and treatment.

Advocacy for women:
This is not an issue that has been raised specifically at The State Hospital until now. It is expected that PAS advocates who work on the women's ward will use the advocacy skills they have developed to work skilfully and empathically with all patients in the hospital, treating them as individuals. However, based on my reading for this, there is a suggestion that this may not be enough to be sufficiently sensitive to women's particular needs. Given the strong body of work that exists to suggest the vast majority of women in the secure hospital system do not require this level of security, if indeed, any do, this can only emphasise the vulnerability of an already isolated group of people. It appears that abuse of all kinds was a very sad reality for women in some other secure hospitals in the past with services at Ashworth described as being "militaristic", "male-dominated" with women saying they felt "almost constantly emotionally abused and at times physically abused…they feel

[3] The Scottish Executive January 2001

[4] The Scottish Executive January 2001

[5] Independent Mental Health Advocacy Services: Di Barnes August 2002

chronically frightened and overwhelmingly powerless" as well as this, the regime was found to be "infantilizing, demeaning and anti-therapeutic"[6]

The best, and possibly only, example of a gender specific advocacy model was Women in Secure Hospitals (WISH). WISH was commissioned to work in Ashworth's women's service, while it was still open and now has branches in a number of regional secure units in England. It is WISH's view that:

"[They] would not argue that an advocacy team comprised of both women and men workers cannot deliver a gender-sensitive service to women. However, we believe that to do this it must be informed by an understanding that delivering advocacy to women requires a discrete, stand-alone service and not one that is bolted onto a generic gender neutral provision. Only in this way can advocacy for women be protected from the pressures recognised by the Reed Committee (1993) which stated that: 'In male-dominated environments, women's needs…are liable to be over-looked'."[7]

Following discussions with a member of staff at WISH, I tried to get a flavour of what was unique about their style of advocacy work. Unfortunately, I think there may be very high sensitivity around discussing services too freely, due to the market forces that are in play among advocacy services in England. What I did gather, from them and those who have worked in close proximity to them was that the "relational" "process-based" advocacy approach they have is essentially based on spending a great deal of time with the women in the services they work in. This meets the needs that are generally recognised in literature about women in mental health services such as "Into the Mainstream" where it is clear that women value, above all being listened to, with the follow-ups taking the form that women are comfortable with, and feel in control of. Time is often spent at social events to gather collective issues, which are conveyed to the hospital, rather than solely on individual's behalf. There is also a strong case put forward for those working with women to be women with high degree of understanding about the underlying factors that contribute to mental ill-health in women, such as disrupted care and abuse of all sorts, to name but two. "The essence of our work was its emphasis upon building open, equitable and non-judgemental relationships with women who engaged with us. The essence of our work was its emphasis upon building open, equitable and non-judgemental relationships with women, with a focus on process, rather than on issues and outcomes."[8]

Louise Adams
Advocacy Coordinator
The State Hospital Advocacy Service

[6] Blom-Cooper, L (1992)[in Powell, J.L. "women in British Special Hospitals: A sociological Approach 2001
[7] Namdarkhan, L. "A gender-specific advocacy model, or 'I found my voice and I love it' " (In Working Therapeutically with Women: Jessica Kingsley Publishers 2004)
[8] Namdarkhan, L. As above