



**Forensic
Network**

**Guidance on Patient Referral to or
Within Scottish High and Medium
Secure Services**

2025

Contents

1. Introduction	2
2. Definitions of Risk	3
3. Defining High & Medium Security	4
4. High & Medium Secure General Admission Criteria	6
4.1 Liability to Detention	6
4.2 Patients with a Primary Diagnosis of Personality Disorder	6
4.3 Patients with a diagnosis of Intellectual Disability	7
4.4 Older aged patients	7
4.5 Patients under the age of 18	7
4.6 Patients with identified additional care needs	8
4.7 Exclusion Criteria	9
4.8 Medium Security Additional Admission Criteria	9
5. Admission Pathways	10
5.1 Admission from Prison or Court	10
5.2 Transfers between Levels of Forensic Mental Health Secure Care	10
5.3 Exceptional Circumstance Admissions	13
6. Conflict Resolution Process	13
7. References	14
List of appendices	16
Appendix 1: Legislative and Policy Framework	17
Appendix 2: Matrix of Security	21

1. Introduction

This revised guidance, derived from a clinical consensus across the Medium and High Secure Estate in Scotland and informed by a review of the international literature should be used to support clinical judgement in individual cases and appropriate liaison between colleagues. It is designed to address referrals for all patients irrespective of diagnosis or sex, although some considerations are addressed for particular groups.

There are patients who will be exceptions to this guidance. In addition, there will be patients who are considered borderline as to which level of security is most appropriate. In progressing the care of such patients, discussion between services is fundamental to ensure appropriate care is delivered.

This guidance is intended to offer a supporting framework to assist clinical teams when making decisions about the appropriate level of security required. The core factor in considering which level of security is required should always be the individual needs and risks presented by the patient. This guidance aims to provide clarity in relating the nature of risk to the level of security required. The guidance may be used by clinicians not normally working in a forensic setting or in settings such as a mental health tribunal or court, to more easily communicate and determine the appropriate level of security.

1.1 The Scottish High and Medium Secure Estate

High Security

Scotland has a single high secure unit, The State Hospital. This unit has male mental illness and intellectual disability beds. Provision for female patients is also made at the State Hospital.

Medium Security

There are three regional medium secure units in Scotland, one national medium secure intellectual disability service and one national medium secure adolescent service:

- **The Orchard Clinic** serves the East of Scotland and has medium secure mental illness provision for males and females.
- **The Rowanbank Clinic** has male and female mental illness beds, both rehabilitation and acute. The female mental illness beds are funded by NHS Greater Glasgow and Clyde whereas the male beds are from the West of Scotland. The rehabilitation beds admit patients from both the acute ward and step down patients from high security. Rowanbank Clinic also hosts the National Medium Secure Intellectual Disability Unit with male and female intellectual disability beds.
- **The Rohallion Clinic** serves the North of Scotland. This unit has male mental illness patients and does not admit female patients.
- **National Secure Adolescent Inpatient Service (Foxgrove)** is expected to open in 2025. The service will provide medium secure care for both male and female patients aged 12-17, who have a major mental illness and/or intellectual disability.

2. Definitions of Risk

At the core of decisions around which level of security a patient should be referred to is the individual risk the patient is assessed as presenting. Secure services aim to protect the public as part of risk management strategies, while also delivering clear benefits to the patient. These benefits include supporting recovery and rehabilitation alongside upholding human rights, particularly the rights to liberty, autonomy, family life, and community access.

Care and treatment should be delivered in a setting that imposes the minimum restriction on the freedom of the patient that is necessary to safely manage the patient's risk. This initial decision relies on analysis of the available information to construct an individualised assessment of risk, risk management plan and outline formulation.

In Scotland, the Risk Management Authority (RMA) (2018) Standards and Guidelines: *Risk Assessment Report Writing* recommends that risk assessments adopt a formulation-based approach. The RMA advises that opinions on the level of risk include:

- The likelihood of risk of serious harm to others
- The factors which make the risk of serious harm more or less likely to occur
- The nature of characteristics underpinning that risk
- The degree of amenability of these characteristics to change (with intervention, and across time)
- The manageability of risk: a) currently b) following exposure to interventions c) while subject to statutory supervision in the community and d) in the longer-term

It is expected that any patient at the time of assessment presents an imminent risk of serious harm should they abscond will require referral to high security. Patients who present a serious but less imminent risk of harm to others may be safely managed in medium security however, this is dependent on individual need and circumstances. Ultimately any clinical decision around risk should be based on an individualised assessment of risk, risk management plan and outline formulation.

3. Defining High & Medium Security

The core document in defining high and medium secure units in Scotland is the Forensic Network Report [*Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland*](#) (2004). This document produced a matrix of security outlining the physical and procedural differences between low, medium and high secure care in the NHS Scottish Secure Estate as it existed at that time. The document provides brief definitions of security levels and a detailed analysis of specific components of environmental and physical security.

The definition of **high security** is *'High Security arrangements should be capable of preventing even the most determined absconder. High secure services should only be provided in secure hospitals with a full range of therapeutic and recreational facilities within the perimeter fence, acknowledging the severe limitations on the use of outside services and facilities.'*

The definition of **medium security** focuses on new admissions from Court and not on Prison transfers or those moving from high security, *'Medium security is the level of security necessary for patients who represent a serious but less immediate danger to others. Patients will often have been dealt with by the Crown Courts and present a serious risk to others combined with the potential to abscond. Security should therefore be sufficient to deter all but the most determined. A good range of therapeutic and recreational facilities should be available within the perimeter fence to meet the needs of patients who are not ready for off-site parole but with the emphasis on graduated use of ordinary community facilities in rehabilitation whenever possible.'* (It is noted that the reference to Crown Courts is not applicable to Scotland and for this jurisdiction should be read as meaning patients prosecuted under solemn procedure.)

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

Kennedy (2002) detailed the components of security: physical, relational, procedural and specialist management arrangements. Kennedy produced a table (table 1) examining violence at presentation as a guide for security need at the time of admission (which should be considered with the other factors listed in table 2). That work emphasised that these factors assist in the assessment and require to be considered as part of the whole picture of need. In reviewing this guidance, a review of the literature was carried out and there was not a more recent version of these criteria which is why they have been retained to allow clinicians to consider these factors.

Table 1: Violence as a guide for security level (Kennedy, 2002)

Graveness of Violence	Behaviour
High (grade 1)	<ul style="list-style-type: none"> - Homicide - Stabbing penetrates body cavity - Fractures skull - Strangulation - Serial penetrative sexual assaults - Kidnap, torture, poisoning
Medium (grade 2)	<ul style="list-style-type: none"> - Use of weapons to injure - Arson - Causes concussion or fractures long bones - Sexual assaults - Stalking with threats to kill
Low (grade 3)	<ul style="list-style-type: none"> - Repetitive assaults causing bruising - Self-harm or attempted suicide that cannot be prevented by two-to-one nursing in open conditions

Table 2: Consideration of violence and other factors for admission to different secure levels (Kennedy, 2002) *Grades in table refer to those defined in Table 1 above*

Admission Guidelines	Low Secure	Medium Secure	High Secure
Violence	<ul style="list-style-type: none"> - Grade 3 - Public order/nuisance offending 	<ul style="list-style-type: none"> - Grade 2 	<ul style="list-style-type: none"> - Grade 1
Immediacy	<ul style="list-style-type: none"> - Acute illness or crisis likely to resolve in 3-6 months 	<ul style="list-style-type: none"> - Relapses abrupt - Unpredictable 	<ul style="list-style-type: none"> - Unpredictable - Inaccessible to staff
Specialist forensic need	<ul style="list-style-type: none"> - Recall or crisis of former medium/ high-security patient - Current mental state associated with violence 	<ul style="list-style-type: none"> - Arson - Jealousy - Resentful stalking - Exceeds low secure capacity 	<ul style="list-style-type: none"> - Sadistic - Paraphilias associated with violence - Exceeds medium security
Absconding	<ul style="list-style-type: none"> - Impulsive absconding 	<ul style="list-style-type: none"> - Pre-sentence serious charge - Other obvious motivation to abscond 	<ul style="list-style-type: none"> - Can coordinate outside help - Past absconding from medium or high security
Public confidence issues	<ul style="list-style-type: none"> - Short-term family sensitivities 	<ul style="list-style-type: none"> - Predictable potential victims - Local notoriety 	<ul style="list-style-type: none"> - National notoriety

In assessing the appropriate level of security across Scotland these factors should be used to guide discussion. These factors should **NOT** be considered an inflexible set of criteria for each level of security, but instead as offering a supporting framework to assist clinical teams in their decision making. The primary consideration when determining the appropriate level of security should be based on an individualised assessment of risk, risk management plan and outline formulation.

It should be emphasised that criteria referring to the offence do not apply to transfers from higher to lower levels of security (i.e. a patient who may have committed a serious offence may be transferred to high security and following treatment their risk will have reduced significantly to allow safe transfer to the medium secure estate). In such circumstances, it would be inappropriate for the offence at the time of admission to dictate current security level placements.

All decisions should be consistent with the legislative and policy framework set out in Appendix 1.

4. High & Medium Secure General Admission Criteria

This section sets out general admission criteria for forensic services, whilst section five outlines admission pathways for different groups such as those being referred from prison or court, and those transferring between levels of the forensic mental health secure estate.

4.1 Liability to Detention

It is expected that all admissions to high or medium security will be detained under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or the relevant sections of the Criminal Procedure (Scotland) Act 1995 as amended by the 2003 Act.

Patients have the right to appeal against being detained in conditions of excessive security, whether in high or medium secure settings. When an application for such an appeal is submitted, the current service should notify the receiving service as early as possible to allow for the sharing of any relevant views.

4.2 Patients with a Primary Diagnosis of Personality Disorder

This guidance makes no change to the position in Scotland that patients with a primary diagnosis of personality disorder are ordinarily better managed in other services. To be clear those patients with personality disorder with other mental disorders as a primary diagnosis are not excluded from forensic services on this basis.

The background to this position is the Forensic Network [*Report of the Working Group on Services for People with Personality Disorder*](#) (2005a) which concluded that patients with a primary diagnosis of personality disorder are unlikely to have the significant impairment of decision-making capacity to render them liable to civil detention. The Maclean Committee (Scottish Executive, 2000) also recommended patients with a primary diagnosis of anti-social, dis-social, or psychopathic personality disorder are not admitted to the mental health system and that the Criminal Justice Services should be the primary agency responsible for the assessment and containment of risk.

4.3 Patients with a diagnosis of Intellectual Disability

Patients with a confirmed diagnosis of intellectual disability (ID) should ordinarily be managed within the intellectual disability secure estate, including intellectual disability patients who have a comorbid mental illness.

Specialist forensic ID service provision is consistent with the principles of Section 1 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This should ensure that the specific specialist nursing, psychological rehabilitation and rehabilitation is available. It should be noted that some NHS Boards have forensic intellectual disability services. Foxgrove will be able to admit under 18's with mild to moderate ID. Any elective transfer between the intellectual disability and mental illness estate should involve discussion between referring and receiving multi-disciplinary teams.

When making decisions in this area, the level of risk posed by the patient should guide the determination of the appropriate level of security. In cases where there is potential conflict regarding the need for specialist ID provision, consideration should be given to which service can best meet the patient's needs; guided by the principles outlined in the [Independent Review of Learning Disability and Autism within the Mental Health Act](#) and the [Coming Home Report](#).

4.4 Older aged patients

In Scotland, there is no distinct Secure Estate for older adult patients. Serious violence resulting in prosecution is rare in the elderly, albeit inpatient violence is frequently encountered in old age psychiatry units. Offenders who would ordinarily be managed by older adult services can be admitted on a case-by-case basis; there is no upper-age limit to this general admission criteria. The principle factor in considering which level of security is required should always be the individualised assessment of risk, risk management plan and outline formulation.

4.5 Patients under the age of 18

Section two of the Mental Health (Care and Treatment) (Scotland) Act 2003 requires any functions in relation to a child (under 18) should be discharged in a way that best secure the welfare of the child and supported the creation of age-specific services for those under 18. In 2013, the Mental Welfare Commission published Guidance on the [Admission of Young People to Adult Mental Health Wards](#) (Mental Welfare Commission, 2013).

Foxgrove will provide a national medium secure service for young people, aged 12 - 17. Although this service is a designated medium secure unit, benchmarking exercises with services in England have suggested that Foxgrove should be able to care for the majority of young people with high secure needs, if specific risk management plans are developed. There are no high secure adolescent services within the UK.

In exceptional circumstances, admission of an under 18 to an adult forensic mental health service may need to be considered, including until Foxgrove is open. Such admissions should be discussed with the clinical team at Foxgrove who are already able to provide advice. Admission to an adult service may be required if specific risk issues or child protection considerations arise that suggest admission to Foxgrove is contraindicated. Any under 18 requiring admission to an adult ward should be assessed and admitted based on risk on a case-by-case basis. If a child is admitted to an adult ward and cannot be admitted to Foxgrove,

options for cross-border transfer to an appropriate adolescent forensic mental health service in England should be explored.

Individuals aged 16 or under should not be admitted to an adult forensic mental health service. Admission of those aged 16 - 18 should be exceptional and must involve careful liaison with clinicians at Foxgrove to ensure that the young person's needs are appropriately assessed by adolescent services while they are receiving forensic care. In any case where a patient under the age of 18 is admitted to an adult service, a review should be conducted and appropriate learning shared.

Young people referred to Foxgrove aged 17 ½ or older should be jointly assessed by Foxgrove clinicians and the adult forensic service that is assumed will likely best meet their needs, if they were to require transfer to adult inpatient services at age 18. If a joint assessment is not practical, as a minimum standard, Foxgrove clinicians should liaise via case discussion with adult forensic services and a decision to admit jointly agreed. Written notification will be made to the appropriate adult medium secure unit on admission of any patient aged 17 ½ or older to support transition planning if required.

4.5.1 Admission of Patient under 18 to the State Hospital

The admission of a patient under 18 to the High Secure Estate requires particular scrutiny. Any recommendation concerning the possible admission must first be considered and approved by the Child Referral Management Group, whose role is to ensure that all reasonable alternatives have been considered. Referral to the State Hospital should only be considered following an assessment by Foxgrove clinicians. Foxgrove, when operational, will generally offer admission to patients under 18 years old who meet high secure criteria, however, admission to the high secure estate may need to be considered in specific circumstances. For example, if it is thought the risks cannot be managed within Foxgrove, there is an escalation in risk during an admission to Foxgrove that requires a higher level of security and/or if issues arise around association with other patients.

Similarly, any admission should be the subject of a review and appropriate learning shared with the Forensic Network Operational Group (formerly Inter Regional Group) to allow national oversight and monitoring of the estate.

A copy of the admission process to the State Hospital can be found within [The State Hospitals Board for Scotland – Referrals Policy and Procedures](#) (The State Hospitals Board for Scotland, 2025).

4.6 Patients with identified additional care needs

Within the secure mental health estate, many individuals with specific needs receive the care they require. However, there are some patients whose needs may not be optimally met within existing services. Clinical teams must carefully consider whether any additional needs warrant care in a different environment, one that can offer enhanced care options, while ensuring equality of treatment and care for mentally disordered offenders (MDOs).

4.7 Exclusion Criteria

The following criteria generally indicates that a patient is **not suitable** for admission to high or medium secure forensic mental health services:

- i. The patient exhibits disruptive or antisocial behaviour in the community or local adult mental health inpatient services but are unlikely to inflict serious physical or psychological harm to others.
- ii. The patient requires close observation to prevent self-injury or suicide, unless this is associated with significant risk of harm towards others.
- iii. The patient requires long-term care, but for whom low secure services would be adequate.
- iv. Patients under the age of 16 who meet referral criteria will generally be admitted to Foxgrove. In exceptional circumstances, individuals aged 16 - 18 may be considered for admission to adult high or medium secure services, following appropriate assessment and negotiation.
- v. The patient may benefit from the structure, supportive environment, or specialist treatments available in secure care, but does not meet the risk threshold necessary for admission to high or medium secure services.

4.8 Medium Security Additional Admission Criteria

4.8.1 Foreseeability of Regular Escorted Community Access

Patients considered for transfer to the medium secure estate are those for whom there is no serious or imminent risk to the public in the event of absconding, beyond the initial period of stabilisation following transfer. A key criterion for admission to medium security is the foreseeable potential for regular, escorted access to the community.

Where regular access to escorted suspension of detention in the community is not foreseeable, typically due to risk-related concerns, transferring a patient from high to medium secure services may result in a reduced quality of life. This is particularly relevant given the extensive facilities available within the secure perimeter of high-security settings, which support access to structured activities and the wider secure campus. The same may also apply to patients with complex clinical needs combined with elaborate risk management plans, who require to be on high levels of observation for long periods of time and require exceptional relational and procedural security which cannot be sustainably delivered in an estate geared towards a shorter length of stay, without compromising quality of life.

There are a small number of patients whose risk can only be safely contained by a lengthy admission to Hospital.

5. Admission Pathways

5.1 Admission from Prison or Court

Placement in the appropriate level of security is an issue for clinical judgement based on an individualised assessment of risk (considering relevant evidence-based factors associated with violence risk), risk management plan and outline formulation. There are no specific factors such as particular offences that ‘automatically’ confer a specific level of security rather having considered an individual’s particular risk the level of security required to meet that is decided.

5.2 Transfers between Levels of Forensic Mental Health Secure Care

5.2.1 Patients Transferred from High Secure Care to the Medium Secure Care

Patients should be referred when the clinical team responsible for the patient consider it is appropriate to request a view from a medium (or low secure) service to consider which level of security the patient could now be managed in. Referrals should be supported by recently updated documentation including the Enhanced Care Programme Approach (eCPA) document, end-of-treatment psychology reports, and Structure Professional Judgement (SPJ) risk assessments which incorporate formulation and scenario planning in line with RMA guidelines. The risk assessment should clearly identify the critical risk factors along with the necessary interventions, monitoring, supervision and victim safety plans required to manage and contain the identified risks. It should also include scenario planning and a traffic light document (or similar) relevant to a medium secure setting. An accompanying opinion from the Responsible Medical Officer (RMO) should outline the patient’s progress within high secure conditions, including any ‘testing out’ undertaken within the unit or in the community.

Given the complex nature of some cases, it is important that there is early involvement of the local authority and NHS Board responsible for the patient, preferably continuous involvement, following initial admission using the eCPA as a vehicle. This should allow for the early identification of a Link Clinician and aid planning in the event that an Out of Area placement is necessary. Involvement of the regional medium secure unit may also be required. This will be of particular importance where patients are transferred prisoners or are subject to an Order for Lifelong Restriction (OLR) where there are additional complexities.

The criteria for transfer from high secure care to a medium secure care as outlined in Kennedy (2002) is summarised below:

Table 4: Criteria for transfer from high to medium secure care (Kennedy, 2002)

Move	High to Medium Secure
Stability	- Two years of stability - Relapses may be abrupt
Insight	- Accepts legal obligations to take treatment as a minimum
Rapport	- Tolerates daily intrusions and constrictions of hospital life - Participates in treatment and occupational programmes
Leave	- None necessary - Visits prior to trial leave are usual

Whilst the Kennedy (2002) criteria outlines that two years stability would be necessary prior to moving from high to medium secure care, it was felt that this may be an unduly restrictive rule. The process of transfer can be commenced after a year's stability on medication with the presumption that there will be a further period of testing during the pre-transfer discussions. There is no requirement that symptoms be in remission, although the presence of symptoms directly relevant to risk would be a concern and therefore transfer may not be appropriate.

The following guidance on additional clinical aspects may support the transfer from a High to Medium Secure environment:

- i. No recent sudden relapse with implications for risk management while on prophylactic treatment
- ii. Patient has sufficient insight that they accept the need to take treatment
- iii. Tolerates daily intrusion and restrictions of hospital life
- iv. Participates in treatment and occupational programmes dependent on mental state. It is acknowledged that some patients' motivation may be impaired by serious mental disorder and they need not necessarily remain in high secure care
- v. Be "tested out" within high security. This normally means that the patient will have full grounds access and meaningful episodes of suspension of detention relevant to the individual's risk formulation.
- vi. There should be no recent episode of significant undermining of procedural security within high security
- vii. Has not posed a risk to patients or staff within a high secure environment and there are no grounds for believing that the risk could not be contained in lesser security
- viii. It is recognised that lower secure psychiatric services may not have as readily available access to offender behaviour work aimed at reducing potentially high-risk behaviours such as fire setting, sexual assaults or stalking. However, there would still be the requirement that the patient would need to be of a sufficient degree of risk to justify detention in that security level. Treatment needs on their own should not be sufficient to require a patient to remain in high secure or medium secure care. The absence of a particular treatment being available in a receiving unit must be weighed in the clinical consideration. The core factor in considering which level of security is required should always be the individual needs and risks presented by the patient.
- ix. The patient should be in receipt of a stable medication regime i.e. transfer should not normally proceed when recent changes in medication that are important to a patient's risk management plan have taken place

5.2.2 Patient Transfer from Lower Secure Care

The transfer of this group of patients will require careful liaison between referrer and the receiving service and may be subject to regional protocols. The following points should be seen as guidance and there are likely to be many exceptions:

- i. In normal circumstances transfer to conditions of higher security should be predicated in an increased risk to others rather than to self. The risk to self should normally be manageable in lower secure services with optimal use of medication and increased observation. However, there will be a small number of exceptional patients who will require the procedural security available within a higher secure environment to prevent serious self-injury.
- ii. Patients should not normally be transferred to a higher level of security to access specialist treatments which are not available within their current environment. Regional services will require to develop networks of specialists to support the treatment of both offence-related and non-offence related treatments throughout the spectrum of care.
- iii. Within a low secure environment an increase in risk of violence, sexually inappropriate behaviours or fire-raising may target other patients, staff or visitors. The degree of behavioural disturbance may be less than those contained within the Kennedy guidelines (2002) given that the behaviour will have persisted in a controlled environment in Hospital, while under observation and on treatment.
- iv. In normal circumstances, the patient's risk will not have been contained despite optimised multidisciplinary interventions (medication, psychology, structured activity and increased observations). The timeframe for the above will be discussed between the referring and receiving teams.
- v. Where aggression or sexually inappropriate behaviour is unpredictable, this may prompt referral to a higher level of security.

5.3 Exceptional Circumstance Admissions

There may be circumstances where it may be necessary to consider the admission of patients to the State Hospital. This process is set out in [The State Hospitals Board for Scotland – Referrals Policy and Procedures](#) (The State Hospitals Board for Scotland, 2025).

6. Conflict Resolution Process

The Forensic Network developed a process for resolving clinical conflicts between forensic mental health services in 2005. This became Scottish Government Policy in HDL (2006) 48, Annex C. The process aims to assist services in Scotland to find a suitable resolution to disputes within a reasonable timeframe. Any clinical disputes around admissions to appropriate levels of security can be addressed through this process. A full outline of the process can be found in the [Forensic Network Conflict Resolution Process](#).

A similar Conflict Resolution process has been developed for the Forensic Child and Adolescent Mental Health Services (CAMHS) Network. While it closely mirrors the process used within the adult Forensic Network, it incorporates some key differences. Notably, at least one of the clinicians involved in preparing an expert report should be a Consultant Forensic Child and Adolescent Psychiatrist. Given the limited number of such experts in Scotland, an agreement has been established with the English Medium Secure Adolescent Network, allowing their clinicians to be approached for support when necessary. This process, if enacted, would be supported by the Forensic Network.

7. References

- British Psychological Society (2015). *Guidance on the assessment and diagnosis of intellectual disabilities in adulthood*. Leicester: The British Psychological Society. Available at: <https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20on%20the%20Assessment%20and%20Diagnosis%20of%20ID%20in%20Adulthood.pdf>
- Forensic Network (2004). *Definition of Security Levels in Psychiatric Inpatient Facilities in Scotland*. Carstairs: Forensic Mental Health Service Managed Care Network. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/LevelsofSecurityReport.pdf>
- Forensic Network (2005a). *Report of the Working Group on Services for People with Personality Disorder*. Carstairs: Forensic Mental Health Service Managed Care Network. Available at: <http://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/Personality-disorder.pdf>
- Forensic Network (2005b). *Resolving Clinical Conflict between Forensic Mental Health Services in Scotland*. Carstairs: Forensic Mental Health Service Managed Care Network. Available at: <http://www.forensicnetwork.scot.nhs.uk/publications/forensic-network-reports/>
- Forensic Network (2005c). *Forensic Mental Health Services & Scottish Prison Service: Security Liaison*. Carstairs: Forensic Mental Health Service Managed Care Network. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/Security-LiaisonReport.pdf>
- Forensic Network (2008). *Leading Change in Forensic Services: A Multi-disciplinary and Multi-agency Approach to Improve Care Pathways for Forensic Service Users in Scotland*. Carstairs: Forensic Mental Health Service Managed Care Network. Available at: <http://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/Leading-change.doc>
- Home Office & Department of Health and Social Security (1975). *Report of the Committee on Mentally Abnormal Offenders (Butler Report)*. London: HMSO.
- Kennedy, H.G. (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, 8, pp.433–443. <https://doi.org/10.1192/apt.8.6.433>
- Mental Welfare Commission for Scotland (2013). *Good Practice Guide: Young People in Adult Mental Health Wards*. Edinburgh: Mental Welfare Commission for Scotland. Available at: https://www.mwscot.org.uk/media/126377/mental_welfare_commission_guidance_on_the_admission_of_young_people_to_adult_mental_health_wards_review2_.pdf
- Millan Committee (2001). *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984*. Edinburgh: Scottish Government. Available at: https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

Rampton Hospital & Forensic Network (2014). *High Secure Mental Health Services for Women in Scotland: Protocol for Referral, Cross-Border Transfer and Post-Transfer Arrangements*. Nottingham: Nottinghamshire Healthcare NHS Foundation Trust. Available at: <https://www.forensicnetwork.scot.nhs.uk/wp-content/uploads/2016/10/High-Secure-WomenReferral-Protocol.doc>

Risk Management Authority (2018). *Standards and Guidelines: Risk Assessment Report Writing*. Paisley: Risk Management Authority. Available at: <https://www.rma.scot/wp-content/uploads/2018/10/STANDARDS-AND-GUIDELINES-FOR-RISK-ASSESSMENT-REPORTWRITING.pdf>

Scottish Executive (2000). *Report of the Committee on Serious Violent and Sexual Offenders*. Edinburgh: Scottish Executive. Available at: https://content.iriss.org.uk/throughcare/files/pdf/longterm/lt4_risk2.pdf
Scottish Executive Health Department (2006). *Forensic Mental Health Services [NHS HDL (2006) 48]*. Edinburgh: Scottish Executive Health Department. Available at: https://www.sehd.scot.nhs.uk/mels/HDL2006_48.pdf

Scottish Government (2021). *Independent Review into the Delivery of Forensic Mental Health Services (Barron Report)*. Edinburgh: Scottish Government. Available at: <https://www.gov.scot/publications/independent-review-delivery-forensic-mental-health-services-final-report>

Scottish Government (2022). *Scottish Mental Health Law Review: Final Report (John Scott QC)*. Edinburgh: Scottish Government. Available at: <https://www.gov.scot/publications/scottish-mental-health-law-review-final-report>

Scottish Office (1999). *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland [MEL (1999) 5]*. Edinburgh: Scottish Office. Available at: https://www.sehd.scot.nhs.uk/mels/1999_05.pdf

Scottish Parliament (1984). *Mental Health (Scotland) Act 1984*. Available at: <https://www.legislation.gov.uk/ukpga/1984/36/contents>

Scottish Parliament (1995). *Criminal Procedure (Scotland) Act 1995*. Available at: <https://www.legislation.gov.uk/ukpga/1995/46/contents>

Scottish Parliament (2003). *Mental Health (Care and Treatment) (Scotland) Act 2003*. Available at: <https://www.legislation.gov.uk/asp/2003/13/contents>

The State Hospitals Board for Scotland (2025). *Referrals Policy and Procedure*. Carstairs: The State Hospitals Board for Scotland. Available at: <https://www.tsh.scot.nhs.uk/wp-content/uploads/2022/11/TSH-CP14-Referrals-Policy-and-Procedure-Feb-25.pdf>

United Kingdom (1998). *Human Rights Act 1998*. London: The Stationery Office. Available at: <https://www.legislation.gov.uk/ukpga/1998/42/contents>

List of appendices

1. Legislative and Policy Framework
2. Matrix of Security

Appendix 1: Legislative and Policy Framework

From legislative and policy there emerge several basic principles for providing secure care: that security level and care should always be to the patients benefit; that the patient should be as close to home as possible; that the service is of benefit to promote recovery; and that patients have the right to appeal the security level. The following legislation and policies were considered to be of key importance in detailing the background to admission guidance.

Health, Social Work and Related Services for Mentally Disordered offenders in Scotland NHS MEL 5 (1999)

Admitting people to the Secure Estate must in accordance with the principles of [MEL 5 \(1999\)](#), which states that mentally disordered offenders should be cared for:

- With regard to quality of care and proper attention to the needs of the individual
- Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others
- As near possible to their own homes or families, if they have them
- Within services which maximise rehabilitation and their chances of sustaining an independent life

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

The [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#) has a set of guiding principles which should be considered whenever discharging a function by virtue of it. These principles are:

- The present and past wishes and feelings of the patient which are relevant to the discharge of the function;
- the views of the patient, their carer, guardian or welfare attorney;
- the importance of the patient participating as fully as possible;
- the range of options available;
- the importance of providing maximum benefit;
- the patient is not treated in a way that is less favourable than the way in which a person who is not a patient might be treated in a comparable situation;
- Non-discrimination i.e. the patients should not be treated less favourably regardless of background and characteristics;

After having regard to those principles the Act states that *“the person shall discharge the function in the manner that appears to the person to be the manner that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances.”*

The Act has no generic description of the purpose of the State Hospital or the Medium Secure estate, but in several parts the “State Hospital” is referred to:

- Section 126(6) in respect of appeals to the Tribunal against transfer to the State Hospital, the Tribunal must be satisfied that: the patient requires to be detained in hospital under conditions of special security; and
- That those conditions of special security can be provided only in a State Hospital.

- Patients will continue to have a right of appeal against transfer to the State Hospital, to be exercised within 12 weeks of transfer. From 2006, patients have had a right of appeal against detention in excessive levels of security (section 264 for The State Hospital (high security) and 268 for other hospitals).

The Forensic Mental Health Services Managed Care Network Definition of Security Levels in Psychiatric Inpatient facilities in Scotland

The Forensic Network commissioned the [Definition of Security Levels in Psychiatric Inpatient Facilities](#) report, which was endorsed by the Network Board in 2004, following wide consultation. The report defines the purpose of security as,

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

The report identifies the physical and environmental characteristics that are designed to reduce risk at high security (The State Hospital) as compared to lower security.

The Human Rights Act 1998

The Forensic Mental Health secure estate is legally required to operate at all times and in all respects within the framework of the European Commission of Human Rights. In particular, admission can only be justified if patients are assessed by expert medical opinion as meeting the criteria for detention and this decision has been reviewed by due process of law.

The qualified rights to liberty, and to private and family life, apply to all patients in the secure estate. The providers of secure services have to ensure that any limitation in these qualified rights can be justified on the basis of risk, by balancing the conflicting rights of other patients, staff and the general public.

The [Human Rights Act 1998](#) places an obligation on all Secure Hospitals to provide patients with both the factual and legal reasons for admission. Referring authorities must therefore ensure that the hospital has possession of all of the factual circumstances in order that the patient can be fully advised, including in writing, of the reasons for any subsequent admission. The patient is thus able effectively to exercise an appeal. Arrangements will be made to ensure prompt patient access to advocacy services.

Millan Principles (2001)

The Millan Committee conducted a comprehensive review of the 1984 Act and established ten principles in the paper [New Directions – Report on the Review of the Mental Health \(Scotland\) Act 1984](#). Some of this guidance can clearly be considered to apply equally to both high and medium security. These ten principles are:

1. *Non-discrimination* - People with substance misuse problems should, wherever possible, retain the same rights and entitlements as those with other health needs.
2. *Equality* - All interventions will be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion, or national, ethnic or social origin.
3. *Respect for diversity* - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group, and social, cultural and religious background.
4. *Reciprocity* - Where society imposes an obligation on an individual to comply with a programme of treatment or care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.
5. *Informal care* - Wherever possible, care, treatment and support should be provided to people with substance misuse problems without the use of compulsory powers.
6. *Participation* - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully. Information should be provided in a way which makes it most likely to be understood.
7. *Respect for carers* - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
8. *Least restrictive alternative* - Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
9. *Benefit* - Any intervention should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
10. *Child welfare* - The welfare of a children affected by substance misuse should be paramount in any interventions imposed on the child under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Independent Review into the Delivery of Forensic Mental Health Services

The [Independent Review into the Delivery of Forensic Mental Health Services](#), often referred to as the 'Barron Report', was published in February 2021. At the time of writing the recommendations are in the process of implementation. These recommendations may change aspects of the delivery of forensic mental health care in Scotland, particularly with regard to the governance of services. The emphasis of the report is very much on a human rights based approach and the principles of legislation which are discussed above.

Scottish Mental Health Law Review

The [Scottish Mental Health Law Review \(SMHLR\)](#) was published in September 2022 and at the time of writing is being considered further by Scottish Government. In its proposals a 'Human Rights Enablement' (HRE) approach is recommended. Whilst no firm proposals are yet available as to how this would operate in the forensic area the review of this guidance was cognisant of the recommendations and approach suggested. Further reviews of this guidance may be required as proposals develop.

Appendix 2: Matrix of Security

The Matrix of Security – An Excerpt of the Definition of Levels of Security Report (2004)

ENVIRONMENTAL SECURITY					
Delineator	Low			Medium	High
	Open ward	IPCU/locked rehab	Locked forensic unit/ward		
DESIGN AND CONSTRUCTION					
Perimeter (e.g. fence)	Standard hospital specifications		No secure perimeter, but secure outside area. Secure external windows	No secure perimeter, but secure outside area. Secure external windows. Deterrent perimeter fence with motion sensors	5.2m secure fence, additional motion detection perimeter
Control of access to the site	Standard hospital specifications	Double locked doors		Electronic airlock	Airport level security
Building design to deter escape	Standard hospital specifications - not specifically designed to deter escape	Specifically designed to deter escape		Robust construction able to deter and delay determined escape	Robust construction able to withstand determined escape with tools
Window / door security	Standard hospital specifications	Window restrictors / reinforced windows	Doors opening outward (interview room and bedroom), window restrictors / reinforced windows	Keypad entry, internal doors reinforced. Communicating doors alarmed if kept open. Two way opening (interview room and bedroom) doors, reinforced windows with anti-smuggling grid on external windows.	Prison service approved locks, airlock systems some break-proof windows, some use of electronic control of doors. No external windows
Furniture design	Standard hospital furniture			Heavy and robust	
EQUIPMENT					

X-ray / metal detector / ion detector	None routinely used	Hand held metal detector		X-ray machine, arch and handheld metal detector, ion detector, sniffer dogs from partner organisations if required
Personal alarm systems	Standard personal alarms	location specific	location specific - response team alerted by pager	location specific security alerted and tannoy to hospital campus and response team
Physical restraints	None used			handcuffs for exceptional leave
Campus observation (CCTV)	Limited to specific locations		Complete external, point of access, air locks, kept 2 weeks	complete campus and perimeter, kept 3 weeks
Availability of additional secure area for behaviourally disturbed patients	None	Normal bedrooms used	Individual additional secure area available with bedroom and living area	A range of individual secure areas with bedroom and living space

PROCEDURAL SECURITY					
Delineator	Low			Medium	High
	Open ward	IPCU/locked rehab	Locked forensic unit/ward		
COMMUNICATIONS					
Patients phone calls	No restriction except in “exceptional circumstances”			Can be monitored or stopped	
Patients letters/mail	Can be monitored in a limited way – Section 117 MH(S) A 1984			All post X rayed. Can be monitored - Section 117 MH(S) A 1984 - with additional statutory powers	

Patients electronic mail / access to the internet	Not supervised if available	Supervised access on site unsupervised off site	No access
Staff communications	Unrestricted received mail		Received mail is x-rayed
ITEMS – RESTRICTED (or prohibited)			
Searching patients	As warranted by individual risk assessment	On admission including possessions and as warranted by individual risk assessment - random searches following LOA	On admission, following LOA, regular personal – and regular room searches.
Searching visitors, official visitors, staff	None routine		None routine – but secure lockers available for bags (not allowed in patient areas)
			Searched if metal detectors are set off and random entrance and egress searches. Bags searched if suspicious item seen in x-ray imaging.
Drug access/screening	Screening dependant on clinical need	Urinary drug screening on basis of clinical need and on admission & random screening	
Alcohol access/screening	Access to alcohol on leave approved by MDT. Alcometer available		No access to alcohol permitted
Access to pornographic materials and/or materials portraying violence	MDT discretion, individual patients		Routine screening and controlled access
ITEMS – Daily living equipment			
Cutlery	supervised meals	Restricted metal cutlery - counted after use, supervised meals	
OT equipment (e.g. kitchen)	MDT approval		Graduated access following individual risk assessment and MDT approval
Fire setting materials (e.g. cigarette lighters)	Dependant on individual risk assessment	Controlled/limited access, no fire setting material with patients	

ITEMS - Access to money, valuables and belongings				
Access to belongings	At MDT discretion		Limited number of items and limited access	
Access to money/valuables	Dependant on individual assessment of capacity	Dependant on individual assessment of capacity. May be restricted	Dependant on individual assessment of capacity. May also be restricted on LOA to reduce absconsion risk	Dependant on individual assessment of capacity. Money and valuables are also restricted on site and on LOA for security reasons

PROCEDURAL SECURITY					
Delineator	Low			Medium	High
	Open ward	IPCU/locked rehab	Locked forensic unit/ward		
PEOPLE- Visitors					
Visitor ID and approval	Not generally required		Identification required. Prior approval by MDT, Unit policy. Visitors must agree code of conduct	Identification required then special ID provided and checked on exit. Prior approval by MDT. Visitors must agree code of conduct	
PEOPLE- Child Visitors					
Child visiting policy	Nursing staff discretion	approved by MDT		Social work assessment required, approval via MDT	
Visiting arrangements procedure	Specified visiting areas (other restrictions dependant on risk present at time)		Special family visiting room away from clinical area	Special family visiting suite away from clinical area	
PEOPLE - Internal movement between clinical areas in a psychiatric facility					

Patients	May be escorted		Escorted within Unit – no access to administrative areas	Grounds access for some patients - monitored by CCTV, some escorted, prohibited areas in the campus
Visitors / official visitors	May be escorted	Escorted		Escorted - bussed to location of visit
Staff	None		Not limited, but electronically recorded	Electronically recorded and restricted access to some areas

PROCEDURAL SECURITY

Delineator	Low			Medium	High
	Open ward	IPCU/locked rehab	Locked forensic unit/ward		
PEOPLE- Patient absence from the hospital					
Routine pass (e.g. “testing out”)	Standard hospital policy		Unit policies including individual risk assessment		Usually a minimum of two escorting staff
Exceptional LOA (e.g. court, hospital)	Standard hospital policy		Unit policies including individual risk assessment.	Unit policies including individual risk assessment. Local police informed.	Handcuff meeting, police liaison, more escorting staff
Prevention and management of absconsion	Standard hospital policy		Unit policies – description card (ID) completed every time a patients leaves clinic and returns, key information and risk assessment given to police in case of absconsion		Individual risk assessment for each LOA, usual to have 2 or more staff escorting. Individual risk assessment of grounds access. Range of multi-agency contingency plans, network of sirens

Prevention and management of escape	Standard hospital policy			Unit policy. Key information and risk assessment given to police	Contingency planning, liaison with police, siren
Policies	General hospital policies	General hospital policy. Some unit policies	General hospital policy. Some forensic unit policies	Detailed forensic unit policies	High secure forensic hospital policies
Contingency planning	Limited contingency planning		Multi-agency planning for evacuation, escape and absconsion		Range of multi-agency contingencies for hostage, riot, escape, barricade, rooftop