THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)

FORENSIC SERVICES

October 2006

THE BAMFORD REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY
(NORTHERN IRELAND)

FORENSIC SERVICES

CONTENTS

		Page
Foreword		v
Executive Summary		vii
PART ONE - INTRODUCTION		
Chapter 1	The Needs of Service Users, Carers and Service Providers	1
Chapter 2	Principles, Values and Standards	3
PART TWO – COMPONENTS OF FORENSIC SERVICES		
Chapter 3	Police Stations	9
Chapter 4	Bail	19
Chapter 5	Court	21
Chapter 6	Prisons	27
Chapter 7	Probation	45
Chapter 8	Secure Inpatient Services	51
Chapter 9	Community Forensic Services	67
Chapter 10	Forensic Learning Disability Services	77
Chapter 11	Specific Issues	87
	• The Assessment and Management of Risk	87
	• Personality Disorder	93
	• Autistic Spectrum Disorder	100
	• Services for Women	103
	• Forensic Psychotherapy	106
PART THREE – IMPLEMENTING CHANGE		
Chapter 12	Implementing Change	109
Recommendations		125
Appendix		143
Membership		145
Glossary		146
Bibliography		147

FOREWORD

The Bamford Review of Mental Health and Learning Disability consists of a number of interlinked reviews under one overarching title and encompasses policy, services and legislation.

The Review Steering Committee presides over the work of 10 major Expert Working Committees, 4 of which commenced their work by April 2003 and the remaining 6 by November 2003.

In consultation with Government we have agreed to produce our reports separately in a phased manner.

This report represents the first major review of Forensic Mental Health and Learning Disability Services in Northern Ireland. Although there have been some welcome improvements in services in recent years, current services in Northern Ireland fall very substantially below those available in other parts of the United Kingdom. In producing this report Fred Browne and his committee have integrated evidence and experience from a very broad range of stakeholders. I am grateful for all their hard work.

All of our committees have adopted an evidence-based approach, drawing on existing relevant information and research and, where necessary, commissioning research. Exemplars of best practice from local, national and international sources are informing our reports.

We have maintained a clear vision for Mental Health and Learning Disability services in Northern Ireland. Widespread consultation with stakeholders has endorsed our vision and the strategic direction of the Review. A feature of the Review process is the contribution of service users and carers across both Mental Health and Learning Disability; their insights, advice and guidance continue to be invaluable.

As Chairman of the Review I wish to thank all who have contributed to the preparation of this report.

Roy McClelland (Professor)
Chairman

October 2006

Executive Summary

This report makes detailed recommendations on the development of Forensic Mental Health and Learning Disability Services in Northern Ireland. The report is interlinked with the other reports of the Bamford Review of Mental Health and Learning Disability (Northern Ireland). It shares the values and principles that are common to the whole Review and it takes account of the needs of all the interested parties, including forensic service users and their carers, service commissioners, providers and the wider public. At its heart the report is concerned with the development of services for mentally disordered offenders and others with similar needs. Most of the recommendations stem from 2 underlying themes:

1. **People who are subject to the Criminal Justice System (such as prisoners, people who are on probation, on bail or attending court or police stations) have high levels of mental disorder. Currently the services to meet the needs of these people are inadequate. These members of our society should not be deprived of assessment, treatment or care for their mental disorders because they are subject to the Criminal Justice System. Rather they should have access to services that are equivalent to those available to the rest of our society. Where people are subject to the Criminal Justice System, services should be provided in co-operation with the Criminal Justice Agencies.**

2. **The majority of people in our society who suffer from mental disorder pose no increased risk of causing harm to others. However, some people suffer from mental disorder that is associated with significant risks of causing serious harm to others. It is in the interests of these individuals and the wider society that they are provided with evidence-based treatment and care that helps minimise the risks. The Health and Personal Services (HPSS) should provide services to identify and assess people suffering from such disorders, whether they are currently in hospital, in prison, in police stations or in the community and the HPSS should provide these individuals with appropriate treatment, care and safeguards. Where such individuals are subject to the Criminal Justice System a joint co-operative approach is required between the HPSS and the Criminal Justice Agencies.**

This report examines these and related issues in detail and makes a series of recommendations. Implementation of these recommendations will lead to important changes in peoples' lives, including the following:

- People who suffer from mental disorder and who are subject to the Criminal Justice System or whose disorder poses significant risks of serious harm to others will have their needs identified more effectively and they will be provided with timely access to assessment, support, treatment and care, for example:

  - Prisoners suffering from major mental illness will no longer have to wait in prison for lengthy periods of up to several years before they can be transferred to hospital to receive the treatment they require;

  - It will become possible for unsentenced prisoners and other individuals to be admitted to a high security hospital facility for detailed assessment so that properly informed decisions can be made about further placement, treatment and care;

- Service users will receive appropriate psychotherapeutic treatments;

- Mentally disordered people in police stations will have access to a range of mental health and learning disability services;

- People who have so far not received adequate services, such as those suffering from personality disorder and other developmental disorders, will have access to assessment and evidence-based treatments;

- People will no longer receive treatment in conditions of security and restriction which is greater than their condition and circumstances require.

• Service users will find that services are of high quality and that service providers work effectively together to assess and meet their needs, for example:

  - Services will be based on agreed values, principles and purposes and will be developed through joint planning between the relevant parties, including service users and carers;

  - Services will be evidence-based and developed to meet assessed needs;

  - Services will establish appropriate arrangements for information sharing, joint working, continuing improvement and mental health promotion.

• Carers will experience services that are developed and delivered to take account of their needs, for example carers of mentally disordered prisoners will receive appropriate information and support.

• The public will be better informed about mental disorder and the relationships between mental disorder and risk. They will be assured that services work together effectively to identify and minimise the risks associated with mental disorder and also that services are efficient and provide value for money.

• Staff will be recruited in accordance with workforce plans that meet the needs of services. Staff will be appropriately trained and supported.

In order to achieve these outcomes the Review makes the following recommendations:

A Regional Forensic Network

A Regional Forensic Network should be established to co-ordinate the planning and delivery of forensic services at regional and local levels.

Police Stations

The Review Implementation Team should lead the co-ordination of planning and developing mental health and learning disability services to police stations in liaison with the Regional Forensic Network.

Courts

Service commissioners should commission a full range of statutory and independent mental health and learning disability services to meet the needs of mentally disordered people attending courts.

In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity according to the schedule proposed in Chapter 12, a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

Prisons

The project overseeing the transfer of lead responsibility for prison healthcare to the NHS must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published before April 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs.

The Review supports the recommendations made by Professor McClelland and colleagues (2005)[13] in relation to the assessment, treatment and care of prisoners on committal to prison.

A multi-agency consortium should be formed to promote the development of psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by Department of Health, Social Services and Public Safety (DHSSPS) with input from criminal justice agencies and the relevant health sector bodies.

Probation

Probation Board for Northern Ireland (PBNI), the Regional Forensic Network and the Implementation Team should agree joint arrangements to assess and monitor the needs and should provide services for individuals, their carers, their representatives, service providers and the wider community.

Secure Inpatient Services

The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. The Department of Health, Social Services and Public Safety (DHSSPS) must take the lead in urgently finding solutions to the current obstacles to treatment and care in conditions of high security.

The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users. In particular the DHSSPS must plan and develop long stay medium secure services and step-down low secure and community services.

Community Forensic Services

The 5 Community Forensic Teams that are currently partly staffed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity and supported by appropriate facilities in the community. Community forensic services should be further developed to meet assessed need.

Forensic Learning Disability Services

Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security and in the community. A regional inpatient and community forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

The DHSSPS must urgently address the current obstacles to service users with learning disability receiving inpatient care, including the lack of step-down services at low security and in the community.

Risk Assessment and Management

The DHSSPS, Northern Ireland Office and relevant others should produce a comprehensive interagency and community response to help offenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder.

Personality Disorder

The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community. Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed. Services should be evidence-based or, where there is inadequate evidence, they should be established in a way which gathers and contributes to the evidence.

Offending by Adults with Asperger's Syndrome or High Functioning Autism (AS/HFA)

The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suffering from AS/HFA.

Services for Women

Service commissioners and providers must ensure that services are gender sensitive. The DHSSPS should consider whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

Forensic Psychotherapy

The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches. All clinical staff working in forensic services must be provided

with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

Regional Guidance and Procedures

The DHSSPS should establish reviews including:

- assessment of fitness for interview, fitness to attend court and related matters;
- the appropriate adult scheme; and
- the Discharge Guidance.

Quality Assurance

Standards and mechanisms for assuring the quality of mental health and learning disability services must be developed by the relevant regional body with responsibility for quality assurance, service commissioners, providers and by the Regional Forensic Network.

Mental Health Promotion

Service commissioners, providers, the Regional Forensic Network and the regional body with responsibility for mental health promotion should identify opportunities for mental health promotion within the Criminal Justice System and forensic mental health and learning disability services and ensure that appropriate services are provided and their impact evaluated.

The DHSSPS should lead the establishment of a Regional Prison Mental Health Promotion Group to address mental health promotion and suicide prevention.

Research and Assessment of Need

Research should be commissioned to assess and monitor the needs for forensic services of people in the Criminal Justice System, in inpatient settings and in the community. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high, medium and low security and in community facilities. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder and other developmental disorders. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

The joint DHSSPS/Northern Ireland Prison Service (NIPS) project to transfer responsibility for prison healthcare to the National Health Service (NHS) must ensure that a detailed assessment of the needs of mentally NHS disordered prisoners and their carers is carried out. An assessment should also be commissioned to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements.

The NIPS should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community, including lower security placements for mentally disordered women.

Research should also be commissioned to evaluate the methodology of assessing people in police stations and prisons with a view to ensuring the accurate identification of specified forms of mental disorder and need.

Information Systems

The DHSSPS should ensure that development of Information Systems within the HPSS takes full account of the need to provide health and social care for people subject to the Criminal Justice System. Where appropriate, health and social services systems should link with Criminal Justice Systems in support of joint working.

Learning and Development

The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders in the Criminal Justice System and in health and social services.

Training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development, closely integrating training with clinical practice.

Recruitment and Retention

The DHSSPS must ensure that development and maintenance of forensic services is supported by robust workforce planning.

Funding

Current services are under-developed. Funding is required for the development of mental health and learning disability inpatient services at high security, long stay medium security and low security. There are also needs to provide accommodation and day facilities in the community, mental health and learning disability community teams, services for mental health and learning disability services to the prisons, and to support people in police stations, in courts and in contact with probation. Funding is also required to develop comprehensive personality disorder services and psychotherapy services.

Conclusion

The Review believes that all of these recommendations and the others detailed in this report are necessary and realistic and that the objectives are achievable over the next 15 years through a planned and co-ordinated approach that involves all the relevant parties working together to meet the needs. An implementation plan is included to assist with the sequencing and prioritisation of the recommendations.

Finally it must be acknowledged that the development and provision of services for mentally disordered offenders and others with similar needs is a highly emotive topic. Perhaps the greatest challenge that we all face is to recognise our capacity for prejudice, discrimination and rejection of these disadvantaged individuals, to acknowledge their legitimate needs and to make the necessary and sustained commitments to action, as described in this report.

CHAPTER 1

THE NEEDS OF SERVICE USERS, CARERS AND SERVICE PROVIDERS

1.1 People in need of forensic services are some of the most marginalised, stigmatised, vulnerable and poorly understood individuals in Northern Ireland and the services to meet their needs are some of the least developed. This report reviews mental health and learning disability services for mentally disordered offenders and others with similar needs in Northern Ireland. The report makes recommendations for action in relation to specialist Forensic Services and also the range of other mental health and learning disability services. This report should be read in conjunction with the other reports from this Review. McCall[1] has also completed a literature review and needs assessment of forensic services in Northern Ireland.

1.2 While forensic service users have features in common, each person must be respected as a unique individual. Many have experienced multiple disadvantages during childhood such as frequent family separations, physical, psychological and emotional abuse and neglect, lack of close, confiding and supportive relationships, inconsistent parenting and alienation from school and community. As a consequence, many have personality difficulties such as chronic low self esteem, lack of empathy for others, difficulties in relationships with authority and poor impulse control. Many have resorted to abuse of alcohol and other substances which appear to offer temporary relief from mental distress, but which contribute further to disturbance of mood and behaviour and to social alienation. Abuse of substances may precipitate the onset of mental illness or aggravate established illness. Those who develop mental illness may be further distressed by severe disturbances of thought, perception and mood. Major illnesses often impair the capacity to appreciate the illness and the need for treatment. Offending behaviour may occur as a consequence of a chaotic and disintegrated phase in the life of the individual. The combination of some or all of these elements often leads to offending behaviour and societal reactions that include fear, rejection and discrimination.

1.3 The needs of forensic service users are not just narrowly confined to the amelioration of symptoms of mental disorder. Services responding to therapeutic and care needs must address the wide range of problems specific to each individual with the aim of helping him or her integrate into society. Where the individual has behaved in a violent or dangerous manner this must include careful assessment of risk.

1.4 The needs of carers must also be addressed. Carers may have experienced difficulties understanding the nature of the service user's problems and providing appropriate support. They may have been traumatised or become alienated. Carers of forensic service users require assessment of their own needs and provision of the necessary information and support.

1.5 Staff who work with forensic service users and carers must have the understanding and ability to deal with the wide range of problems that present. They must possess the abilities

to work in partnership with users, carers and many others and to view situations from many different perspectives. Work of this nature generally evokes a wide range of emotions and staff require training and support to help them respond appropriately. Staff providing forensic services encounter 2 systems, the Criminal Justice System and the Health and Social Services. These 2 systems have different purposes and cultures and it is inevitable that tensions will arise. Staff working across these interfaces must be sensitive to the ethical and practical problems that can arise for service users and carers and must be able to help negotiate solutions. Staff must be alert to the restrictions and controls that may be placed on service users that create an imbalance in power between staff and service users and may render service users liable, often in subtle ways, to infringement of their rights. Service users may be subject to discrimination from other service providers such as over-emphasising of risks to others related to mental disorder or by reluctance to offer appropriate community services.

1.6 Because of their multiple disadvantages service users often have difficulty identifying and articulating their needs. At present advocacy services are at early stages of development. Forensic service users and their carers do not at present come together as groups to voice their needs for improved services. These factors in turn make service users and their carers particularly vulnerable to receiving inadequate care. Stigma and discrimination may influence Government and commissioners of services, for example by failing to take adequate account of the needs of forensic service users and by failing to safeguard proper provision for them.

1.7 The challenges for the decision makers and for the rest of society are to recognise and respect service users and carers as fellow members of our society, to ensure that they receive appropriate therapeutic interventions and care which facilitate their journey towards productive and satisfying lives and their integration within society.

CHAPTER 2

INFORMATION, VALUES, PRINCIPLES AND STANDARDS

INTRODUCTION

2.1 It is essential that during the planning and delivery of Forensic Services full account is taken of the available information and evidence. Values and principles are also essential in directing our goals. A vision for services that combines an evidence-based approach and a values-based approach is essential[2]. There must be arrangements to take information from and contribute to the "evidence cycle" that gathers and evaluates the available evidence, identifies gaps in information, prioritises and implements research and generates and disseminates evidence. There must also be explicit statements of the values and principles upon which the development and delivery of future services should be founded. Both must be integrated into the planning of services and their delivery.

EVIDENCE

2.2 The need for local research and development has been identified in the Report by the Adult Mental Health Working Committee[83] (chapter 7.21) which has proposed a Northern Ireland Research and Development Strategy. That strategy must encompass forensic services. Priorities for Research and Development in Forensic Services are identified in subsequent chapters in this report.

VALUES AND PRINCIPLES

2.3 The vision of this Review is:

- valuing those of us with mental health needs, including rights to full citizenship, equality of opportunity and self-determination;
- addressing the challenges facing people with mental health needs; and
- a process of reform, renewal and modernisation of services that will make a real and meaningful difference to the lives of people with mental health problems, and to their carers and families.

2.4 The values of the Review state that people with mental health needs and their carers should receive services which:

- offer proper treatment and care to facilitate their journey towards productive and satisfying lives and their integration into our society;
- respect them as individuals – through openness in the providing of information, respect and courtesy in individual interactions with service users, true partnership and empowerment in service planning and provision – with Government, providers and the wider society each accepting their respective responsibilities; and

- demonstrate justice and fairness – resources for services should be allocated and managed according to criteria which are transparent, and which demonstrate equity.

2.5 The principles for the Review's Strategic Framework are:

- partnership with users and carers in the development, evaluation and monitoring of services;
- partnership with users in the individual assessment process and all therapeutic interventions of care and support;
- delivery of high quality, effective therapeutic interventions, care and support;
- equity of access and provision of services, including the needs of people from minority cultures, people with disabilities, people subject to the Criminal Justice System;
- provision of services which are readily accessible;
- delivery of continuity of care and support for as long as is needed;
- provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;
- taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;
- provision of comprehensive and equitable professional and peer advocacy, where required or requested;
- promotion of independence, self-esteem, social interaction and social inclusion through choice of services, facilitation of self management, opportunities for employment and social activities;
- promotion of safety for service users, carers, providers and members of the public;
- provision to staff of the necessary education, training and support; and
- services subject to quality control, informed by the evidence.

PRINCIPLES FOR FORENSIC SERVICES

2.6 The principle that people who are subject to the Criminal Justice System should have equity of access and provision of services adopted elsewhere has been referred to as the "Principle of Equivalence"[3]. It is of fundamental importance to service users, carers and service commissioners and providers. People who are in police stations, on bail, attending

court, in prison, on probation or otherwise subject to the Criminal Justice System must have equity of access and provision of the full range of statutory mental health and learning disability services. This principle creates a substantial agenda for change.

2.7 The Review recommends that 4 additional principles should be adopted in relation to forensic services:

1. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services (HPSS) and joint delivery of services in order to best meet the needs of service users and carers.

Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

2. as far as possible in the community, rather than in inpatient settings;

3. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

4. open, accountable and subject to external review.

STANDARDS FOR THE DEVELOPMENT AND DELIVERY OF FORENSIC SERVICES

2.8 The Review has developed the following 10 interconnected Standards that it believes should be applied to guide the planning and delivery of Forensic Mental Health and Learning Disability Services in Northern Ireland:

Standard 1. A Co-Ordinated Joint Strategic Approach

2.9 The development and delivery of comprehensive Forensic Mental Health and Learning Disability Services require contributions from many sources including service users and carers, commissioners and providers of services, representatives from forensic mental health and learning disability services, from Criminal Justice Agencies in the statutory, voluntary and community sectors and from the wider community. A shared approach must be adopted that respects the contributions of each organisation and each individual and co-ordinates service development and delivery at regional and local levels.

Standard 2. Evidence, Principles and Purposes

2.10 Forensic services should take account of the available evidence on efficacy of service models and interventions and contribute to the generation of further evidence. They should operate in accordance with explicit values and principles and have clear purposes. Forensic services should be developed and delivered in response to need. There must be robust mechanisms to assess and meet the needs of each individual, his or her carers and representatives, service providers and the wider community. There must also be mechanisms to assess the impact of service developments on need.

Standard 3. Organisational Structures and Interconnections

2.11 Forensic services comprise a range of components, such as services to people in prison, community forensic services and secure inpatient services. All components must have clear organisational structures, accountability and governance arrangements. Each component must be co-ordinated at regional and local levels to work together with all other interconnecting services in an efficient and effective manner. Forensic services should work flexibly in partnership and in support of interconnecting health and social services providers and with Criminal Justice Agencies in the statutory, voluntary and community sectors.

Standard 4. Comprehensive and Accessible Services

2.12 Forensic services should be comprehensive to include the provision of timely, accessible and high quality assessment of needs, treatment and care for service users and support for their carers with continuity of services for as long as required. Services should assess the full range of needs (physical, psychological and social) and should provide services to meet those needs in accordance with best practice. Forensic Services should be developed and delivered in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality. Information sharing protocols and joint working protocols should be developed between the Criminal Justice System and mental health and learning disability services.

Standard 5. Risk Assessment and Management

2.13 Forensic services should assess and manage the risks for which they have responsibility. They should make all reasonable efforts to reduce the relevant risks with the resources at their disposal but there must also be widespread recognition that risk is inherent in the work of forensic services and cannot be eliminated. The work of forensic services should be supported by the development of interagency and multi-disciplinary risk assessment and management protocols and procedures.

Standard 6. Quality Assurance

2.14 Forensic services must have robust and demonstrable quality assurance mechanisms that include setting standards and assessing the performance and quality of services. These should include internal mechanisms such as audit and also external review.

Standard 7. Mental Health Promotion and Education

2.15 Promotion of mental health is essential to prevention and reduction of need. Forensic services must help develop understanding of the routes whereby an individual may become a mentally disordered offender and the interventions that could be made to produce more favourable outcomes. Forensic services should liaise closely with the regional body responsible for mental health promotion[84]. In addition, forensic services should contribute

to public education to promote understanding and help prevent stigmatisation and discrimination.

Standard 8. Information, Research and Innovation

2.16 Forensic services should have information strategies that include contributing to evidence-gathering and research. Services should promote enquiry and innovation. Information Technology should be used where appropriate to enhance service quality and efficiency.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

2.17 The development and maintenance of forensic services must be supported by a workforce planning strategy that ensures the recruitment and retention of staff who are equipped with the appropriate personal qualities and professional qualifications. There must be a Learning and Development strategy to provide staff with the necessary knowledge, skills and support throughout forensic services and the interconnecting health and social services and in Criminal Justice Agencies. Service users and carers have learning and development needs that should be addressed.

Standard 10. Sustainable and Transparent Funding

2.18 The development and maintenance of forensic services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long term plans that ensure sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

ORGANISATIONAL STRUCTURES TO SUPPORT THE CO-ORDINATED PLANNING AND DELIVERY OF FORENSIC SERVICES

2.19 This Report makes recommendations for the development and delivery of forensic services in Northern Ireland over the next 15 years. Services must be provided to meet the needs of all service users and demonstrate efficient use of resources. Those who are charged with the duty of planning, implementing and delivering forensic services bear a heavy burden of responsibility to all the stakeholders including service users and carers, the wider public and staff in the Health and Social Services and in the Criminal Justice System.

2.20 The purpose of this Review is to provide a vision for the development of forensic and other mental health and learning disability services in Northern Ireland. It is essential that arrangements are established to revise and update plans in response to changing circumstances, while maintaining an overall strategic direction. The Review believes that strategic planning of services must be an ongoing process with the continuing development of strategic plans for short, medium and long time frames.

2.21 A Forensic Regional Advisory Group was established in 2005 to co-ordinate the development of forensic services in Northern Ireland. The Review welcomes this

development. Chapter 12 gives further details of the Review's recommendations on implementing the necessary changes to support the planning and development of forensic services. These include regional and local co-ordination through the formation of a Regional Forensic Network.

Recommendations

1. A Regional Forensic Network should co-ordinate and lead the strategic planning of forensic services in Northern Ireland.

2. Strategic planning must be guided by evidence and by values and principles. The Regional Forensic Network must establish systems of gathering the necessary information and evidence to inform the further development of services.

3. The Regional Forensic Network should establish explicit values and principles to guide the planning and development of forensic services. The values and principles adopted by this Review (see 2.3 - 2.5) are recommended. In addition the following principles are recommended for forensic services:

   i. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services and joint delivery of services in order to best meet the needs of service users and carers;

   Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

   ii. as far as possible in the community, rather than in inpatient settings;

   iii. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

   iv. open, accountable and subject to external review.

4. The planning and development of forensic services should take full account of the 10 Standards identified in this Report.

CHAPTER 3

POLICE STATIONS

INTRODUCTION

3.1 The police service is a major agency in contact with mentally disordered people in the community. It acts as an important 'gatekeeper' to the mental health and learning disability services, especially in relation to situations that arise in public places.

3.2 In police stations there are two main ethical reasons to ensure that individuals who are suffering from mental disorder are identified:

- the individual may be suffering from a mental disorder that interferes with his or her capacity to protect his or her rights and best interests while in the police station; and
- the individual may require treatment for his or her condition.

3.3 Thus services are required at police stations to:

- identify and assess the needs of people who are suspected or confirmed as suffering from mental disorder;
- offer appropriate support, treatment and care to service users;
- provide appropriate information and support to carers; and
- advise the Criminal Justice System, where appropriate, on the implications of the service user's condition.

CURRENT SERVICES

3.4 Police stations are provided with medical services by Forensic Medical Officers (FMOs) most of whom are general practitioners and who conduct most of the assessments of individuals suspected of suffering from mental disorder. In 1998 a police liaison scheme for Mentally Disordered Offenders (the "MDO Scheme") was established in Musgrave Street Police Station in Belfast. Two community mental health nurses are employed to screen custody records, carry out mental health assessments on selected individuals, provide health promotion and liaise with the appropriate agencies to arrange treatment and support. They also provide advice to FMOs, courts, legal representatives and others. In addition the nurses provide training to police to help them understand the nature of mental disorders and the problems experienced by those suffering from mental disorder. This MDO Scheme has remained in place and is expected to become part of the Eastern Health and Social Services Board Community Forensic Service. It remains confined to the Belfast area.

3.5 Key findings from the MDO Scheme[4] were:

- 16% of custody records met one or more assessment criteria for mental disorder;
- 91% of those who underwent assessment were judged to have a mental health problem;
- typically these were single unemployed males in their early 30s and living alone;
- two thirds had a history of having been in one or more health, social services or criminal justice institutions, 47% had received inpatient care; and
- almost half had been in prison.

3.6 The most commonly recorded diagnoses were:

- depression (44%);
- substance misuse (15%);
- schizophrenia/paranoid psychosis (11%); and
- anxiety (11%).

3.7 No information is available in relation to mentally disordered offenders presenting to police stations in other parts of Northern Ireland.

3.8 Users and carers made positive comments in relation to the MDO Scheme. Comments also included lack of understanding of mental health problems and the stigma associated with police escort. Other key issues highlighted in consultation with stakeholders were:

- the MDO Scheme was generally regarded as beneficial;
- the scheme was considered to be under-resourced;
- there were communication problems between organisations and difficulties sharing information;
- there was uncertainty in defining fitness for interview and the roles of appropriate adults;
- there were difficulties in managing people viewed as suffering from personality disorder; and
- there were difficulties admitting to hospital people who were suffering from temporary disorders.

3.9 The literature review by McCall[1] provides details of the characteristics of people detained in police stations and those placed in hospital as a place of safety, the use of the appropriate adult scheme, the needs of carers, police liaison schemes and the use of educational interventions for police officers. There is evidence to indicate that police liaison schemes and education of police officers are effective interventions.

STANDARDS

Application of Standards

3.10 The 10 standards identified in Chapter 2 have been applied to the consideration of planning and delivery of services in police stations.

Standard 1. A Co-Ordinated Joint Strategic Approach

3.11 There must be effective co-ordination between Criminal Justice and Health and Social Services Organisations and equity of access and provision of services for people subject to the Criminal Justice System. Mental health and learning disability services such as Community Mental Health Teams, Crisis Resolution Services, Community Forensic Teams, Learning Disability and Alcohol and Substance Misuse Services are being developed across Northern Ireland. It is essential that these developing services are co-ordinated at local and regional levels to provide a full range of mental health and learning disability services for mentally disordered people in police stations.

Recommendations

5. Service commissioners must commission a full range of statutory mental health and learning disability services to meet the needs of mentally disordered people detained in police stations.

6. Providers of statutory, voluntary and community mental health and learning disability services must ensure they provide equity of access and provision of services for people detained in police stations.

7. Mental health and learning disability services to people detained in police stations should be provided locally and co-ordinated regionally. The Department of Health, Social Services and Public Safety (DHSSPS) should lead this co-ordination in liaison with the Regional Forensic Network.

Standard 2. Evidence, Principles and Purposes

3.13 The planning of services requires good quality evidence and explicit principles and purposes. Although valuable information has been obtained from the MDO Scheme there remain substantial gaps in our knowledge of the needs of mentally disordered people and their carers in police stations throughout Northern Ireland.

3.14 The principles of this Review include the provision of advocacy services. At present there are various people who may adopt an advocacy role for service users in police stations,

including lawyers, appropriate adults, health, social services staff, probation staff and members of voluntary organisations. However, there is no-one specifically charged with the responsibility for acting as an advocate for mentally disordered service users within police stations. It is recommended that the advocacy services attached to community mental health and learning disability services should be extended to include police stations.

Recommendations

8. Research should be commissioned to assess the needs of mentally disordered people and their carers in police stations throughout Northern Ireland. This research should include recommendations leading to the establishment of systems to monitor ongoing need and the impact of services on need.

9. Advocacy services associated with community mental health and learning disability services should be extended to include police stations.

Standard 3. Organisational Structures and Interconnections

3.15 Mental health and learning disability services to police stations must have clear organisational structures, accountability and governance arrangements. Each component must be co-ordinated at regional and local levels to work together with all other interconnecting services in an efficient and effective manner. Statutory mental health services should work in partnership with voluntary and community sector providers. It is likely that different patterns of service delivery will be required to meet the different needs in individual police stations throughout Northern Ireland, for example, the model that has been developed for a large city centre police station in Belfast may not be appropriate for a smaller rural station.

Recommendation

10. Clear organisational structures, accountability and governance arrangements must be agreed for mental health and learning disability services to police stations.

Standard 4. Comprehensive and Accessible Services

Assessment of Health Needs

3.16 It can be a difficult task for the FMO to assess an individual in a police station. For example there may be very little background information available and the individual may be intoxicated, unco-operative, violent or emotionally disturbed by the circumstances that have brought him or her to the police station. Not all people are registered with a general practitioner, but for those who have current health records it would be helpful if these were accessible to the FMO. Ultimately it is expected that information technology systems will be developed throughout the National Health Service (NHS) that can provide appropriate access to staff providing assessment and healthcare in police stations, however, these systems may take a number of years to develop. In the interim it is essential to review and improve the existing systems.

Recommendation

11. Service providers should develop information systems that enable FM0s and staff working in mental health and learning disability services to gain appropriate access to the health records of people detained in police stations.

3.17 The current accuracy of the systems in police stations for identifying mental disorder and mental health needs is unknown. The arrangements depend upon police, lawyers, users, carers and others raising the suspicion of mental disorder and then the FMO, perhaps with the assistance of mental health staff, correctly identifying the mental disorder or need. At present there is very little scientific evidence to inform practitioners on the most efficient and effective methods of assessing suspects in police stations for the presence of mental disorder. Screening procedures should be directed towards explicit objectives such as identifying mental disorders that may place the individual at risk of causing harm to themselves or others or being unable to protect their best interests. Screening tools must be evidence-based for the environment of a police station. Research should be commissioned to establish an appropriate evidence base.

Recommendation

12. Research should be commissioned to evaluate the methodology of assessing suspects in police stations with a view to ensuring the accurate identification of specified forms of mental disorder and need.

Fitness for Interview

3.18 FMOs are frequently asked to determine whether an individual is fit to be interviewed. The Code of Practice for the Police and Criminal Evidence (Northern Ireland) Order 1989[5] acknowledges that a person may be unfit to be questioned on account of being under the influence of drink or drugs, but it does not address the needs of people who may be unfit for interview on account of mental disorder.

3.19 The Association of Forensic Medical Officers of Northern Ireland and the Association of Forensic Physicians in England, Scotland and Wales have agreed to work on the basis that, for a person to be fit to be interviewed he or she must:

- able to understand the questions that are being put to them;
- understand why particular questions are being put to them, and to understand the nuances behind the questions; and
- be able to give a good account of themselves in their answer.

3.20 FMOs and Forensic Physicians have defined unfitness for interview as follows:

'A detained person may be unfit for interview when conducting an interview could worsen any existing physical or mental illness to a significant degree, and/or anything said or done by the detained person at the time of interview may be considered unreliable in subsequent court proceedings, because of the physical or mental state of the detainee.'

3.21 There is a need for clear and approved guidance on this issue of fitness for interview and related issues such as:

- the appropriate disposal(s) for an individual found unfit to be interviewed;
- whether a person may be deemed permanently unfit for interview; and
- whether a person who is being charged without interview may be unfit to be charged.

Recommendation

13. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to produce guidance on assessment of fitness for interview and related matters.

The Appropriate Adult Scheme

3.22 When a police officer has any suspicion that a person due to be interviewed as witness, victim or suspect may be mentally disordered, he must contact an appropriate adult[6]. The appropriate adult scheme provides certain safeguards for mentally disordered people in police stations. However, a number of concerns have been raised about the scheme. These include:

- the criteria for suspected mental disorder are potentially very broad and do not appear to be adequately targeted at those who are most vulnerable;
- research[7] has indicated that in practice there is a failure by police to identify mental disorder and this implies that the interests of mentally disordered people have not been demonstrably safeguarded;
- there are difficulties in finding people to act as appropriate adults. Social workers may perform this function, but Trusts have not been provided with the resources to meet these considerable potential demands;
- in Northern Ireland there is a lack of detailed guidance for those acting as appropriate adults;
- there has been insufficient training for staff acting in the role of appropriate adult; and
- an appropriate adult may be a parent, guardian or relative or other person responsible for the care or custody of the person who is suspected of suffering from mental disorder. However, concerns have been expressed that relatives and carers may not be best placed to represent the interviewee.

Recommendation

14. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising representatives of all the relevant stakeholders to review the appropriate adult scheme. The group should consider the effectiveness, efficiency and practical working of the scheme, including the criteria invoking the use of appropriate adults.

Assessment and Management of Mentally Disordered People in Police Stations, Including Those with Behaviour Disorder

3.23 Joint protocols should be developed for the arrangements to assess and manage mentally disordered people in police stations. Particular problems can arise with individuals whose behaviour is disturbed, for example those who are violent or who harm themselves. These behaviours may be related to factors such as intoxication, negative attitudes towards the police or emotional distress at the circumstances that have brought the individual to the police station. Such behaviours do not automatically or necessarily indicate the presence of mental disorder that requires admission to a psychiatric hospital. Behaviourally disturbed individuals may also have physical health needs, but nurses and other staff in Accident and Emergency departments understandably do not feel they should be subjected to violence or abuse. Police officers are not trained as nurses and there are very real concerns that someone may become seriously ill or die in police custody despite the efforts of those concerned to help them. The safe and appropriate care of such individuals is a major challenge. At present each case is dealt with on an individual basis, but there remain concerns that the situation is unsatisfactory.

3.24 In Queensland, Australia, Mullen and Chettleburgh (2002)[8] recognised a similar problem and recommended liaison between police and health services and consideration of a short-term assessment and detoxification centre co-located with a general hospital. The Review recommends that there should be discussions between the relevant stakeholders to consider the services that should be put in place and to ensure that agreed protocols are developed for the management of intoxicated and disturbed individuals in each locality.

Recommendations

15. Commissioners should commission services for the safe assessment, treatment and care of mentally disordered offenders in police stations.

16. Service providers and other stakeholders should agree joint protocols for the assessment and management of mentally disordered people in police stations, including those whose behaviour is disturbed.

Advice to Police

3.25 Where it appears to police that a person is suffering from mental disorder and that he or she has committed a minor criminal offence, police may exercise their discretion not to proceed further with the matter. Offending behaviour may be a manifestation of a relapse in illness and require treatment or it may be that the most appropriate response is for the individual to take responsibility for his or her behaviour. It is important that in such situations police should have ready access to advice from a suitably qualified health professional.

Recommendation

17. Commissioners should commission services that provide police with ready access to advice from suitably qualified health professionals.

Standard 5. Risk Assessment and Management

3.26 There are many risks associated with mentally disordered people in police stations. A co-ordinated risk assessment and management framework should be developed that extends across the Criminal Justice System and the HPSS. This should include the assessment of both individual and organisational risks and the development and implementation of risk management strategies. Key stakeholders should be involved in the development and implementation of this framework, including its application to the assessment, treatment and care of mentally people in police stations.

Recommendation

18. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in police stations.

Standard 6. Quality Assurance

3.27 In view of the potentially high vulnerability of mentally disordered people in police stations it is essential that quality standards are developed and audited.

Recommendation

19. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services must ensure that quality standards are developed for mental health and learning disability services in police stations and that services are audited and subject to external independent inspection.

Standard 7. Mental Health Promotion and Education

3.28 People are often brought to police stations at times of crisis in their lives, for example a pattern of substance abuse may bring individuals into conflict with the law and may cause them to re-evaluate their behaviour. These occasions may, therefore, represent opportunities for the promotion of good mental health. Brief, but timely intervention may itself have therapeutic effect or it may direct the individual to another source of help where his problems can be addressed in more depth. A number of so-called arrest referral schemes have been established[9]. There are two main approaches. In one, police officers provide information about drug and other relevant services to those who have been arrested. In the other, mental health staff have access to prisoners in custody suites and provide either an assessment on site or at a subsequent meeting.

Recommendation

20. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion within police stations and ensure that appropriate services are provided and their impact evaluated.

Standard 8. Information, Research and Innovation

3.29 Detailed information was gathered on the functioning of the MDO Scheme[4]. There remains a need for basic epidemiological research and also for gathering information on the functioning and efficacy of mental health and learning disability services to police stations.

3.30 Information systems are currently being developed within the HPSS. These developments should take account of the need to provide health and social services to people in police stations.

Recommendations

21. The DHSSPS should ensure that research programmes are commissioned to examine the efficacy of different models of services to mentally disordered offenders in police stations with a view to informing further service planning.

22. The DHSSPS should ensure that development of Information Systems within the HPSS takes account of the need to provide health and social services to people in police stations.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

3.31 Service planning should consider the workforce requirements to deliver services to mentally disordered people in police stations. Training needs assessment should consider the needs of all stakeholders including, police, FMOs, lawyers and health and social services staff.

Recommendations

23. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including police, FMO's, lawyers and health and social services staff.

24. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

Standard 10. Sustainable and Transparent Funding

Recommendation

25. The development and maintenance of services for mentally disordered people in police stations across the province requires appropriate funding from the relevant sources. Funding should be delivered in accordance with a long term plan that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

CHAPTER 4

BAIL

INTRODUCTION

4.1 A person may be released on bail by police after being charged with an offence or may be granted bail by a court. Mentally disordered offenders have the same rights as others to be considered for bail. Conditions may be attached to bail such as residence in an approved bail hostel.

CURRENT SERVICES

4.2 There are no specific services for those on bail with mental health problems. It is assumed that most service users obtain mental health services through primary and community services, both statutory and non-statutory.

NEEDS ASSESSMENT

4.3 There is a lack of information on the mental health problems experienced by those on bail, how effectively they avail of services and how effectively these services meet their needs. Some mentally disordered prisoners are granted bail subject to certain conditions such as having appropriate accommodation. Inability to meet such conditions may result in the individual having to remain in custody. Anecdotal evidence suggests there is a lack of suitable accommodation available for mentally disordered people who have been granted bail, leading to unnecessary imprisonment. In particular the provision in the community of a wider range of bail facilities with joint input by Criminal Justice staff and health and social services staff could offer different levels of supervision and therapy. Such facilities may be suitable for people with various mental health and learning disability problems including personality problems and alcohol and substance misuse problems. These could have the potential to significantly reduce the numbers on remand in prison. Facilities of this type may also be suitable for step-down of pre-release sentenced prisoners. At present, however, it is unknown how many mentally disordered people could be placed in such statutory services.

APPLICATION OF STANDARDS

4.4 In view of the lack of information on mentally disordered people on bail and the lack of specific services, the 10 Standards identified in Chapter 2 have not been considered in detail. As information becomes available and services develop the standards should be taken into full account.

Recommendation

26. The Northern Ireland Prison Service (NIPS) should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community. The research should address the mental health and social needs of male and female remand prisoners as well as the requirements of the Criminal Justice System. It should consider the potential utility of facilities with joint input by Criminal Justice staff and health and social services staff to offer different levels of supervision and therapy for a wide range of mental disorders including mental illness, learning disability, personality disorders and alcohol and substance misuse.

CHAPTER 5

COURTS

INTRODUCTION

5.1 Services are required at court to:

- identify and assess the needs of people who are suspected or confirmed as suffering from mental disorder;
- offer appropriate support, treatment and care to service users;
- provide appropriate information and support to carers; and
- advise the Criminal Justice System, where appropriate on the implications of the service user's condition.

CURRENT SERVICES

5.2 The MDO Scheme operates an open referral system and provides assessment and advice in Belfast Magistrates Court. There is no similar service to other courts in Northern Ireland.

5.3 McCall[1] found that user and carer views were generally positive in relation to the MDO Scheme, particularly in relation to solicitors and judges having an understanding of mental illness although some views were expressed that few solicitors had experience in dealing with mental health issues.

5.4 There is no formal psychiatric liaison service to the courts in Northern Ireland, nor any duty psychiatrist service to provide urgent assessments. Most psychiatric and psychological reports are requested by solicitors acting for the defence and only a few reports (0-5 reports *per annum* in Northern Ireland) are requested directly by the courts. Concerns have been raised that reports prepared on behalf of the defence may be limited in a number of respects, for example the remit given to the author of the report may be restricted and the report may not include important details such as the risks associated with any identified mental disorder. In many cases the author of the report may make recommendations in relation to the management of the offender but assumes no responsibility for providing services. Concerns have also been raised that the advice offered to the courts appears to be of variable quality.

5.5 Article 22 of the Criminal Justice (Northern Ireland) Order 1996[10] states that in any case where the offender is or appears to be mentally disordered, the court shall obtain and consider a medical report before passing a custodial sentence other than one fixed by law. It is not known whether the current systems effectively identify those suffering from mental disorder. Article 22 (5) requires that the report is prepared by a medical practitioner approved for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986[11].

5.6 There are concerns that certain potentially useful court disposals are substantially under-used, such as probation orders with conditions of psychiatric treatment (Chapter 7 - Probation).

5.7 The international literature on the prevalence of mental disorder among those appearing before the courts is very limited and probably has little direct relevance to the current situation in Northern Ireland[1].

5.8 Birmingham (2001)[9] reviewed psychiatric court liaison schemes in England and Wales and concluded that the following were features of successful schemes:

- owned by mainstream general or forensic services;
- staffed by senior psychiatrists;
- nurse-led and closely linked to local psychiatric services;
- good working relationship with magistrates and the prosecution;
- good methods for obtaining health, social services and criminal records;
- access to suitable interview facilities;
- use of structured screening assessments;
- direct access to hospital beds;
- ready access to secure beds; and
- access to specialised community facilities.

APPLICATION OF STANDARDS FOR THE DEVELOPMENT AND DELIVERY OF FORENSIC SERVICES

5.9 The lack of information on mental health and learning disability services to the courts and the paucity of court liaison services means that it is difficult to apply the full detail of the standards identified in Chapter 2 to the existing services. However, the standards can still serve to guide future service developments.

Standard 1. A Co-Ordinated Joint Strategic Approach

5.10 While there is some information available on the MDO Scheme in Belfast, little is known about the efficiency or effectiveness of the current systems in the remainder of courts in Northern Ireland as regards their capacity to detect mental disorder or arrange appropriate services to meet the needs of mentally disordered people. There is a need to study these arrangements and to consider the strategic options that would be suitable for the courts.

5.11 It is a fundamental principle of this review that people who are subject to the Criminal Justice System should have equity of access and provision of services. Thus health and social services commissioners must commission a full range of statutory, voluntary and community sector mental health and learning disability services to meet the needs of mentally disordered people attending courts. Providers of community mental health and learning disability services must ensure they provide equity of access and provision of services for people attending courts.

5.12 It is expected that as mental health and learning disability services are developed for offenders, the courts will increasingly wish to receive information primarily from those who are involved in assessing and treating the individual. As mental health and learning disability services develop increased capacity the Court Service may wish to make service level agreements with health and social services providers to include, for example the provision of assessments, the availability of staff to act as appropriate adults and the provision of training to court staff.

Recommendations

27. Service commissioners should commission a full range of statutory, voluntary and community mental health and learning disability services to meet the needs of mentally disordered people attending courts.

28. Providers of community mental health and learning disability services should ensure they provide equality of access and provision of services for people attending courts.

29. In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity, a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

Standard 2. Evidence, Principles and Purposes

5.13 Future court liaison schemes should be developed in response to assessed need. They should have explicit purposes and operate in accordance with agreed principles.

Standard 3. Organisational Structures and Interconnections

5.14 There is a need to ensure that there is appropriate liaison between courts and mental health and learning disability services. At present mentally disordered prisoners may be discharged at court without the necessary arrangements being made to ensure the provision of services in the community. This issue is considered further in Chapter 6 – Prisons.

Standard 4. Comprehensive and Accessible Services

5.15 The following issues have arisen in relation to current court procedures:

- Fitness to Attend Court;
- Prisoners Attending Court; and
- Court Procedures.

Fitness to Attend Court

5.16 Psychiatrists and others may find themselves being asked whether a witness in a criminal case is fit to attend court. There are established legal criteria to assist doctors in determining whether an accused person is fit to plead at court or fit to be tried. In practice these legal criteria may cause difficulties for doctors because there is little guidance on their exact medical meaning. However, there are no legal criteria at all to assist a doctor in determining whether a person is fit to attend court to give evidence. In Chapter 4 it was recommended that guidance should be developed on the assessment of fitness for interview in a police station and related matters. It would seem appropriate for the issue of fitness to attend court to be considered as part of that same process.

Recommendation

30. The DHSSPS in partnership with Criminal Justice Agencies should establish a group of relevant stakeholders to produce guidance on the assessment of fitness to attend court.

Prisoners Attending Court

5.17 Not infrequently, prisoners who are attending court complain of medical symptoms and ask to see a doctor. It can be difficult for doctors in such situations to know how to respond to the individual's complaints, particularly when the doctor does not have access to the healthcare records held in prison. A system should be devised whereby doctors placed in this situation can have appropriate access to the relevant information.

Recommendation

31. Service providers must ensure that healthcare staff assessing and treating prisoners attending court have ready and appropriate access to existing healthcare information

Court Procedures

5.18 The procedures for the making of certain mental health disposals such as hospital orders involve the co-ordination of a number of different elements such as ensuring there is the requisite written or oral evidence from two appropriately qualified medical practitioners, ensuring that the receiving Trust has been given an opportunity to make representation to court and that a suitable place is available in hospital. In practice difficulties often arise because one or more of the necessary elements is missing or delayed.

5.19 Concern has also arisen that on a number of occasions individuals have continued to be treated in hospital as if they remained the subject of a Restriction Order, yet the court had dealt with the legal case and terminated the Restriction Order, but this information had not been communicated to the Responsible Medical Officer.

5.20 There is also a need to review policies and procedures in relation to escorting service users between court and mental health and learning disability facilities, including the use of video link facilities.

Recommendation

32. The DHSSPS should establish a group with the Court Service and other relevant stakeholders to review and develop procedures and protocols in relation to mentally disordered offenders to ensure efficient and effective operation.

Standard 5. Risk Assessment and Management

5.21 The courts often require information in relation to the assessment and management of risk related to mental disorder. There is a need to develop accredited standards in relation to risk assessment and management. This issue is discussed further in Chapter 11.

Standard 6. Quality Assurance

5.22 Court liaison schemes should develop robust performance, quality assurance and clinical governance mechanisms.

5.23 Secure inpatient forensic services should develop joint protocols and procedures in relation to escorting service users to and from court. These should be subject to audit.

Recommendation

33. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services should ensure that quality standards are developed for mental health and learning disability services in courts and that services are audited and subject to external independent inspection.

Standard 7. Mental Health Promotion and Education

5.24 The MDO Scheme provides an opportunity to promote mental health among mentally disordered offenders. Future court liaison schemes should incorporate mental health promotion.

Recommendation

34. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion at courts and ensure that appropriate services are provided and their impact evaluated.

Standard 8. Information, Research and Innovation

5.25 Further information is required about the mental health needs of people attending court.

5.26 The use of technology such as video-links may help reduce the number and expense of escorted visits to court by service users in secure forensic services.

Standard 9. Recruiting, Retaining and Developing a Skilled Workforce

5.27 There is a need to provide interagency training that ensures that staff working in the health and social services have a good understanding of court procedures and that staff in the court service understand the needs, and respond appropriately to, individuals suffering from mental disorder.

Recommendations

35. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including court staff, lawyers, judiciary and health and social services staff.

36. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

Standard 10. Sustainable and Transparent Funding

Recommendation

37. The proposed review of options for mental health and learning disability services to the courts should include consideration of funding mechanisms.

CHAPTER 6

PRISONS

INTRODUCTION

SERVICE USERS AND CARERS AND THEIR NEEDS

6.1 It is a major challenge to provide effective healthcare within a prison environment. Life in prison is very different from life in the community or in hospital[12]. Many prisoners have emotional difficulties and may have been subjected during their earlier lives to trauma and neglect. In adult years they may have difficulty coping, have impaired relationships and poor integration into society arising from underlying personality difficulties or disorders. Alcohol or other substance misuse, self-harm and frequent previous contact with mental health and learning disability services are common.

6.2 Imprisonment inevitably entails loss of liberty, autonomy and right to self-determination. Some prisoners will experience withdrawal from substances they had previously abused or they may be exposed in prison to further substances of abuse. Prisoners may find themselves placed in the company of others they would not normally choose and they may be subject to bullying and harassment, perhaps from sectarian, paramilitary or racist elements. They may find particular difficulty coping with loss of contact with their families and children and they may find themselves lonely and isolated. Prisoners will also have to deal with the stresses related to the circumstances that have placed them in prison, including, for those not yet sentenced, the uncertainty of their disposal at court. Some may find that imprisonment provokes them to examine their previous lifestyle and the behaviours that led to their imprisonment and they may experience a range of emotions including anger, guilt, remorse or self-pity.

6.3 Understandably, most inmates resent being in prison. There is a lack of purposeful and satisfying activities and many prisoners are confined to their cells for prolonged periods. The high turnover of prisoners may make it difficult to establish supportive relationships with other inmates. It can also be difficult for staff and inmates to establish constructive relationships with each other. Staff may feel their systems of working do not support the development of such relationships and they may not feel adequately trained or supported. It can be difficult for staff to maintain good morale. Staff may consider the difficulty of their job is not appreciated or understood by wider society and that they may be too easily subjected to criticism. Some staff may reflect the antagonistic views towards prisoners that can readily be found elsewhere in our society.

6.4 Carers also experience a range of emotions and difficulties related to imprisonment. Relationships are often strained and carers may feel excluded.

6.5 McClelland and colleagues conducted a Review of Non-natural Deaths in Northern Ireland Prison Service Establishments (2005)[13]. They identified unique features of the Northern Ireland Prison Service (NIPS) in 2004. These included the separation of paramilitary affiliated prisoners; the threats, attacks and murder of staff during the course of the

Troubles; the severe industrial relations climate; antiquated staffing practices in comparison to other UK prison systems; high staff to prisoner ratios and the apparent parochial nature of the prison service. They considered that the management of vulnerable prisoners was not high enough on the agenda of NIPS and that the prison regimes appeared to be over controlled and therefore negatively impacting on the mental health and care of vulnerable offenders.

6.6 McClelland and colleagues also noted that since the reviews in 2004 a number of relevant initiatives had been taken and commitments to action made by both NIPS and DHSSPS. These developments were welcomed by the McClelland Committee.

6.7 This chapter examines in more detail the needs of mentally disordered adult prisoners. Improvement of the mental health of prisoners must comprise 2 elements: both

- creation of a prison environment that actively promotes mental health; and
- provision of a range of mental health and learning disability services.

6.8 These elements must be delivered by a partnership between NIPS and the HPSS which supports a joint co-operative approach. In addition to measure to promote mental health, prisoners require regular input from primary care services, general adult psychiatry, learning disability, psychotherapy, forensic services, adolescent and addiction services. Additional recommendations are made in Chapter 10 in relation to learning disability services. Chapter 11 also elaborate on services for women, people suffering from personality disorder and from Autistic Spectrum Disorder and also the assessment and management of risk. Recommendations are also made in the reports by the Alcohol and Substance Misuse Committee and the Child and Adolescent Mental Health Committee which are relevant to people in prison.

CURRENT SERVICES

The Prison Estate

6.9 The prison state in Northern Ireland comprises:

- Maghaberry;
- Magilligan;
- Hydebank Wood;
- Prison Service College, Millisle; and
- Prison Service Headquarters.

6.10 Maghaberry is a high secure prison housing adult male long-term, sentenced and remand prisoners, both in separated and integrated conditions. Maghaberry also has responsibility for male immigration detainees who are accommodated in a facility at Belfast prison. The overall responsibility for immigration detainees rest with the Immigration and Nationality Department of the Home Office.

6.11 Magilligan is a medium security prison, housing shorter-term sentenced adult male prisoners. It also has low security accommodation for selected prisoners nearing the end of their sentence who are being prepared for return to the community.

6.12 Hydebank Wood is a young offenders centre and prison for male remands and sentenced young offenders between the ages of 17 and 21, in some circumstances up to age 23, and all female prisoners including young offenders and female immigration detainees. Sometimes young offenders under 17 are sent to Hydebank because of the lack of services elsewhere.

6.13 The average daily population in the Northern Ireland prisons has varied considerably over the past 35 years and currently is close to 1,400 with a total throughout per year of approximately 5,000. Further details can be found at www.niprisonservice.gov.uk

Mental Health in Prisons

6.14 Mental health problems, and mental illness, are the most prominent single health challenge in the prison environment. In a recent study by Blaauw 2004[14], an estimated 63% of prisoners had a psychiatric disorder, compared with 16% of the general population. These disorders included affective disorders, anxiety, psychosis, alcohol and substance misuse and personality disorder. Although no comprehensive similar study has been carried out in Northern Ireland, the evidence suggests that if anything the figure is even higher. There is an urgent requirement for detailed assessment of mental health needs of prisoners in Northern Ireland.

CURRENT MENTAL HEALTH AND LEARNING DISABILITY SERVICES IN NORTHERN IRELAND PRISONS

6.15 In Northern Ireland prisons, primary care services are provided by nurses, healthcare officers and medical officers (who are mostly general practitioners) who refer to secondary psychiatric and psychological services. Prisoners undergo an initial nursing and medical assessment on committal to prison and those with identified mental health problems are referred for comprehensive mental health nursing assessment. Prisoners may subsequently refer themselves or be referred to a range of mental health care services.

6.16 Specific provision is made for mental health services by sessions from a Forensic Psychiatrist, a General Adult Psychiatrist with an interest in substance misuse, two recently appointed Mental Health Nurse Therapists, an Occupational Therapist from an HSS Trust, and from mental health nurses and psychologists employed by NIPS. Counselling services are provided by voluntary organisations such as the Samaritans and are accessed by a confidential phone line. A listener service has been established in Magilligan.

6.17 Prisoners receive treatment in normal prison location and in prison healthcare centres. There is an inpatient psychiatric unit in Maghaberry. Prisoners with mental illness or severe mental impairment may be transferred to health service facilities under the provisions of the Mental Health (Northern Ireland) Order 1986[11]. There are, however, legal problems which currently make it impossible to transfer unsentenced prisoners to high

secure hospitals. Moreover, there are no dedicated treatment facilities for prisoners with personality disorders.

6.18 One of the key areas of recent development in NIPS has been the development and implementation of the Multi-Agency Prisoner Resettlement Strategy. A key issue in the Strategy is 'Promoting a healthier and pro-social lifestyle'. This will involve agencies within and out, with the prison working in close partnership to address issues which impact on mental health and well-being such as housing and employment.

SERVICE DEVELOPMENT

6.19 Various reviews have contributed to the growing body of evidence and opinion that prison healthcare should no longer be the sole responsibility of the NIPS:

- Review of the Provision of Healthcare Services to Prisoners (2002)[15];
- Healthcare Needs Assessment (2004)[16];
- Human Rights Commission Report on Women Prisoners (2004)[17];
- HM Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland Report on Female Prisoners at Ash House, Hydebank Wood Prison (2004)[18]; and
- Review of Non-natural Deaths by Professor McClelland and colleagues (2005)[13].

6.20 The Review of the Provision of Healthcare Services to Prisoners 2002[15] stated that it was satisfied that healthcare standards in Northern Ireland prisons were broadly comparable to those in prisons elsewhere throughout the United Kingdom.

6.21 Since 2000, Her Majesty's Prison Service and the Department of Health in England have been working in formal partnership to improve health services for prisoners[19], culminating in the transfer of commissioning responsibility for those services to the NHS.

6.22 In the light of this, and the various Review recommendations, the then Health and Prisons Ministers accepted a joint NIPS and DHSSPS submission in April 2005 recommending the transfer of lead responsibility for prisoner healthcare from the NIPS to the DHSSPS by April 2007. A project management framework has been established with responsibility to achieve this objective, taking account of the needs of Northern Ireland prisoners and experience in other jurisdictions. This transfer is thus an important development with major implications for DHSSPS and for the NIPS.

STANDARDS

Standard 1. A Co-ordinated Joint Strategic Approach

6.23 Many of the organisational difficulties experienced over the years in attempting to provide healthcare within the prison environment have been related to the separating of prisoners from the health services in the rest of the community and to the creation of separate health services for prisoners. The transfer of responsibility to DHSSPS should help ensure that prisons are not viewed as being separate from the communities in which they are situated.

6.24 The decision to transfer responsibility is fully consistent with the principle of this Review that people subject to the Criminal Justice System should have equity of access and provision of services. There are many potential advantages to this arrangement, for example it should offer to prisoners the full range of statutory, voluntary and community sector services available in the community, including assessment and treatment services. It should assist information sharing, ensure that services come under similar quality assurance and governance arrangements and facilitate the use of shared risk assessment and management systems and the extension of Health and Social Services information technology services to prisoners. It should support common approaches to research, to workforce planning, staff training and development.

6.25 It is essential that these arrangements for service provision are taken forward jointly by NIPS and DHSSPS working in partnership. Commissioners of services must understand the needs of people within prison environments and service providers must be enabled to develop sufficient capacity to provide the full range of services required. Services must work together in an integrated manner to meet the needs of service users and carers. There must be robust quality assurance mechanisms including independent external review.

6.26 The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland, including the joint strategic approach co-ordinated by the Regional Forensic Network.

Recommendations

38. Improvement of the mental health of prisoners requires a partnership between the DHSSPS and the NIPS to ensure:

- development of a prison environment that actively promotes mental health and well-being; and
- provision of a comprehensive range of mental health and learning disability services which address the needs of prisoners and are integrated with other community and prison services to ensure effective through care.

39. The Review welcomes the decision to transfer responsibility for the healthcare of prisoners to DHSSPS and emphasises that it must be supported by robust quality assurance mechanisms and by sufficient resources to meet the needs.

40. The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland including the joint strategic approach co-ordinated by the Regional Forensic Network.

Standard 2. Evidence, Principles and Purposes

Assessment and Monitoring of Need

6.27 Effective service planning requires detailed information in relation to the needs of prisoners and their carers. This is an essential component of the project overseeing the transfer of responsibility. The assessment of need must take account of the full range of mental disorders. It should also consider the need to support the work of criminal justice staff, for example, by assessing and providing appropriate treatment and care for people engaged in offending behaviour programmes.

Recommendations

41. The joint DHSSPS/NIPS project to transfer responsibility must ensure that a detailed assessment of the needs of mentally disordered prisoners and their carers is completed by the end of 2006. The assessment of need must encompass all those suffering from mental disorder including mental illness, learning disability, personality disorder and alcohol and substance misuse. It must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff.

42. The needs assessment must lead to the provision for service commissioners of systems to monitor and evaluate in an ongoing manner the needs of service users and carers and the impact of services on need.

Values, Principles, Culture and Ethos

6.28 The Review recommends that, following joint consultation, explicit values and principles are agreed for prison mental health and learning disability services that link with those for other prison staff and community health services. These values and principles should guide the creation of prison environments that promote mental health and they should also guide the development and delivery of mental health and learning disability services. It will be essential that these values and principles are developed jointly by the DHSSPS and by the NIPS and that they are placed at the heart of all developments to promote mental health within the prison environment and to deliver a range of mental health and learning disability services. Thus the principles and values should form the centre of induction and training for all staff and they should be translated rigorously into the day-to-day activities of the services to help create a culture and ethos that supports mental well-being.

Recommendations

43. The DHSSPS and NIPS in partnership should develop explicit values and principles for mental health and learning disability services and Criminal Justice Services for prisoners that guide the development of a prison environment that actively promotes mental health and well-being and that provides a comprehensive range of mental health and learning disability services.

44. The DHSSPS and NIPS in partnership should agree arrangements to develop strong and cooperative working relationships between prison staff, health and social services staff, and Criminal Justice Agencies at operational and managerial levels. These should include the supporting organisational structures, training and the development of joint policies, protocols and procedures.

Involvement of Service Users, Carers and the Provision of Advocacy

6.29 The principles of this Review require the involvement of service users and carers in service development and delivery. There is also a need for the provision of advocacy services.

6.30 Those who currently advocate for service users include legal representatives, the Prisoner Ombudsman, members of the Independent Monitoring Boards, chaplains, probation officers, mental health and learning disability service providers and others. Advocacy services and complaints procedures can be an important safeguard for service users and a driver for change in attitudes, practice and culture. These services are an essential component of in-reach mental health and learning disability services.

Recommendations

45. Commissioners of mental health and learning disability services in prisons must ensure that service users and carers are involved in the development, delivery and monitoring of services.

46. Commissioners of mental health and learning disability services in prisons must ensure that advocacy services and complaints procedures are developed for service users in prisons, building on those already in place.

Standard 3. Organisational Structures and Interconnections

6.31 Organisational structures must support the delivery of the full range of mental health and learning disability services in a multi-disciplinary and interagency manner. Regular input is required from statutory, voluntary and community sector providers of forensic, adult mental health, alcohol and substance misuse, learning disability and adolescent services with ready access to other mental health services that are more specialised or less frequently required. Services must be configured in ways that support key objectives, for example, there should be close linkages between Maghaberry and the regional secure unit to support the early identification of prisoners who require inpatient treatment in conditions of medium security and to facilitate their transfer at the earliest possible opportunity. There should be linkages between prison and the community that maximise continuity of treatment, care and support. It is essential that these services are planned carefully by the transfer project in a coherent and strategic manner rather than being allowed to develop in an in an unco-ordinated way. They will require consultation and co-ordination with a wide range of service providers.

6.32 The DHSSPS has published guidance on “Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of

Serious Physical Harm to Themselves or Others" (May 2004)[20]. Paragraph 12 states that when a person suffering from mental disorder, including personality disorder and who could represent such a risk, is discharged from prison a clear duty rests with NIPS to ensure that the relevant Health and Social Services Trust is notified so that arrangements for the service user's care in the community can be put into effect without delay. However, currently there are not sufficiently detailed information systems, nor are there enough services in the community, particularly for those suffering from personality disorder, to be satisfied that there are adequate arrangements to provide appropriate support, treatment and care for mentally disordered prisoners on their discharge from prison.

Recommendation

47. The project overseeing the transfer of lead responsibility must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published before April 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs, including the needs of prisoners and discharged prisoners who are suffering from mental illness, learning disability, personality disorder and alcohol and substance misuse. The arrangements must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff in relation to prisoners and discharged prisoners.

Standard 4. Comprehensive and Accessible Services

Assessment on Committal to Prison

6.33 Assessment of the physical and mental state and the needs of each individual on committal to prison is conducted by nurses and medical officers. Professor McClelland and colleagues (2005)[13] in a report on six non-natural deaths in prison have identified a number of improvements that need to be made to the process of receiving prisoners into custody and assessing their health needs. The Review fully supports those recommendations. The NIPS is implementing a Practice Development Programme at Maghaberry with support from the Royal College of Nursing and the University of Ulster to improve committal services. The transfer project should ensure that these changes continue and are further developed as necessary following transfer of responsibility.

Recommendation

48. The Review supports the recommendations made by Professor McClelland and colleagues (2005)[13] in relation to the assessment, treatment and care of prisoners on committal to prison. The transfer project should ensure that work continues as quickly as possible to address these recommendations and that arrangements are made to complete any outstanding work following transfer of responsibility.

Assessment and Management of People Suffering from Personality Disorder

6.34 Personality disorder is a major issue for the NIPS, the wider Criminal Justice System, the HPSS and for society generally. A full range of appropriate interventions is required. Services should be evidence-based. Where there is inadequate evidence on the effectiveness, research should be incorporated into services to add to the available evidence. The Review recommends that the following services should be developed:

- a range of therapeutic interventions, including the development of therapeutic community approaches, both in secure settings and in the community;
- day patient and outpatient services provided by forensic and other mental health and learning disability services; and
- input from forensic and other mental health and learning disability services to the assessment and management of prisoners attending offender behaviour programmes.

6.35 The services required for prisoners suffering from personality disorder are considered further in Chapter 11, but the following recommendations are made here:

Recommendations

49. Commissioners of mental health and learning disability services for prisoners must ensure that services provide assessment, treatment and care for all people suffering from mental disorder including those suffering from personality disorder.

50. DHSSPS should take the lead in developing, in partnership with the Criminal Justice Agencies, an inclusive model of assessment, treatment and care of people suffering from personality disorder.

Healthcare Centres and Mentally Disordered Prisoners

6.36 There are healthcare centres in each prison establishment which admit prisoners with physical and mental healthcare needs, including people with complex mental health needs who have been accepted and are awaiting transfer to a high or medium secure hospital. However, some patients with mental disorders who are admitted to these units would not meet the criteria for admission to a psychiatric hospital; instead, if they were outside prison, they would receive treatment and care in the community. It appears that some prisoners could be supported in ordinary prison location by in-reach mental health services working in partnership with prison staff.

6.37 The Review considers that a range of measures including diversifying ordinary prison accommodation, supporting mentally disordered prisoners in ordinary location and rapidly transferring to secure inpatient services those who require such placement may provide more appropriate services to service users and also reduce the need for places in healthcare centres. Over the years prisons have found the healthcare centre environment useful in the management of people suffering from a wide range of disorders such as those undergoing

detoxification from drugs and alcohol, those suffering from stress reactions and other neurotic disorders and those awaiting transfer to outside hospitals. As more appropriate services are developed, the need for health centre places and mental illness beds should be reduced, as in the Scottish Prison Service, although it is unlikely that the need for mental illness places could be eliminated altogether, at least not in the short term. It may also be appropriate to centralise the main healthcare centre facility in one establishment.

6.38 It is recommended that a specific mental health needs assessment is conducted to consider the needs of service users and the need for healthcare beds in prison.

Recommendation

51. A specific mental health needs assessment should be commissioned as part of the programme of the transfer of lead responsibility to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements. This should be completed by the end of 2006.

The Needs of Women Prisoners

6.39 Women prisoners often demonstrate high levels of mental health problems. For the small numbers of women prisoners with continuing behavioural disturbance there are particular needs for joint co-operative interagency working. It is imperative to identify better arrangements to provide alternatives to custody. The NIPS has commissioned an assessment of the needs of women prisoners. This should consider alternative placements including those at lower levels of security.

Recommendations

52. Services should be commissioned for women prisoners that are gender sensitive and that have the capacity to respond appropriately to the range of their mental health and learning disability needs, including substance misuse and personality disorder.

53. NIPS should commission a research project into alternatives to prison for mentally disordered women, including placements at lower levels of security.

The Needs of Young Offenders

6.40 The male and female young offenders' centres at Hydebank admit young offenders between the ages of 17 and 21 and these detainees may remain there until the age of 23. There is a need to ensure the provision of adolescent mental health and learning disability services to those who are under the age of 18 and to ensure the appropriate transfer to adult services of all relevant information and the treatment and care of individuals who attain the age of 18. Joint management plans should be agreed in the case of each individual suffering from mental disorder.

Recommendations

54. A full range of mental health and learning disability services including adolescent, psychotherapy and personality disorder, alcohol and substance misuse should be commissioned. Community service providers must ensure that a full range of co-ordinated services is developed and provided to those who are under the age of 18, and DHSSPS must play its part in ensuring adequate provision of the necessary expertise.

55. Service providers must develop protocols and procedures so that management plans are jointly agreed in the case of each adolescent suffering from mental disorder when transferring to adult prison services or healthcare services in the community.

On-call Services

6.41 The principles adopted by this Review require that there should be equity of access and provision of services to prisoners; there should therefore be formal on-call arrangements for each prison establishment to deal with out of hours mental health emergencies.

Recommendation

56. The transfer project team should define requirements and, together with service commissioners and providers, put such arrangements in place before April 2007.

Treatment Issues

6.42 Mentally disordered prisoners should have access to treatment and care from a range of statutory and voluntary services. In a prison environment certain circumstances arise that require further consideration.

(a) Providing treatment to mentally disordered prisoners who lack capacity

6.43 Most mentally disordered prisoners have the mental capacity to decide whether or not to accept any treatment that is offered to them. However, some prisoners may be suffering from or may develop severe mental disorder that renders them incapable of deciding whether or not to accept treatment. Such individuals should, if they satisfy the relevant criteria, generally be transferred to a HPSS hospital under the provisions of Part III of the Mental Health (Northern Ireland) Order 1986[11] ("the Order"). However, there may be delays in transfer caused, for example, by the difficulties in transferring remand prisoners to high security, the lack of availability of a bed in hospital or the delays inherent in current assessment and transfer procedures. The healthcare centres in the prison establishments are not recognised as hospitals under the Order, and people cannot be detained there and given treatment under the provisions of the Order. People who are suffering from severe mental disorder and who are not receiving appropriate treatment may pose a serious risk of harm to themselves or others. Such individuals may be treated under common law in emergency situations. Earthrowl and colleagues (2003)[21] have proposed guidance on providing courses of treatment to prisoners who lack mental capacity, however these measures do not negate the underlying imperative that such prisoners should be transferred to hospital.

6.44 The Review does not recommend powers to permit compulsory treatment of mentally disordered people in prison without their consent. The Review believes that such cases must be addressed by the provision of adequate resources and procedures that ensure timely transfer to hospital of those who require such treatment.

(b) Transfer of Prisoners to Inpatient Hospital Services

6.45 It should be noted that when a person outside of prison is suffering from severe mental disorder and requires admission to a psychiatric hospital he or she is generally admitted without delay, usually on the same day as the decision has been made to admit. The same standard should apply to prisoners.

6.46 When prisoners require transfer from prison to hospital to receive inpatient treatment for mental disorder they generally require secure inpatient services. There are gaps in current provisions resulting in unacceptable delays. At present mentally disordered prisoners remain in prison when they should be in hospital.

6.47 There are particular difficulties in obtaining inpatient treatment for mentally disordered prisoners who are on remand and who require treatment in a high security facility. These difficulties, and options to address them, have been considered more fully in Chapter 8 and by the Forensic Sub Committee of the Legal Issues Committee.

6.48 For those prisoners who require treatment in conditions of medium security it will be important to develop close working links between the prisons and the Regional Secure Unit and to ensure that high priority by management of the Regional Secure Unit is given to the transfer of prisoners. In order to ensure that places are made available to prisoners it will be essential to ensure that there are adequate long–stay medium secure places, low secure places and step-down facilities in the community.

Recommendations

57. People who require admission to hospital for assessment or treatment under the provisions of the mental health legislation must have equal access and priority whether they originate in prison or in the community. The application of this standard in practice should be subject to external audit by the appropriate health care inspection body.

58. The transfer project should ensure that specific joint working arrangements between service providers, the Prison Service and the DHSSPS are agreed and published before April 2007.

Standard 5. Risk Assessment and Management

6.49 There are currently no standardised risk assessment and management systems in routine clinical use in the mental health and learning disability services within the prisons. It is recommended that a multi-disciplinary and interagency operational group should identify policies and procedures. These policies and procedures should encompass risk assessment and management for service users in prison and also for the discharge of individuals to the community.

6.50 The operational group should also identify organisational risks and liabilities through its clinical governance mechanisms and should formulate and implement appropriate plans to address them.

6.51 The development of risk assessment and management systems for mentally disordered prisoners should proceed in consultation with criminal justice agencies, taking account of recent and proposed developments such as the extension of MASRAM to include violent offenders.

Recommendation

59. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in prisons. The framework must not discriminate unjustifiably against people suffering from mental disorder.

Standard 6. Quality Assurance

6.52 The Review has recommended the principle that services should be open, accountable and subject to external review. It is essential that the services available for mentally disordered people in prisons have robust clinical governance and internal quality assurance mechanisms and are subject to external independent inspection and review.

6.53 Measures of service quality may include assessment and monitoring of need, the capacity of the services to identify and respond to the needs of individuals with mental disorder, the capacity to transfer to outside hospitals those who require such treatment and the capacity to work in a joint interagency manner to address problems such as behavioural disturbance and offending behaviour.

6.54 It is also important to identify and remedy obstacles to performance such as delays for visiting staff in gaining access to prisoners and inadequate interview facilities.

6.55 Where adverse or untoward incidents or events occur, these should be investigated by methods, which not only establish the facts of what happened, but also examine the underlying processes, procedures and systems. The National Patient Safety Agency favours the use of root cause analysis in this regard. Robust mechanisms must be put in place to ensure there is learning from such incidents and that this learning is translated into relevant practical changes. Serious untoward incidents should be independently reviewed.

Recommendation

60. Mental health and learning disability services and Criminal Justice Agencies should develop joint co-ordinated interagency standards that encompass both the creation of a prison environment that promotes mental health and the provision of a full range of mental health and learning disability services. These standards should be supported by clinical governance arrangements, internal quality assurance mechanisms, external independent inspection and systems of learning from adverse events. NIPS and DHSSPS should jointly set up an effective operational group in 2006.

Standard 7. Mental Health Promotion and Education

6.56 The World Health Organisation (WHO) Regional Office for Europe produced a Consensus Statement on Mental Health Promotion in Prisons (1998)[22]. It recognised that although most mental disorders may have been present before imprisonment these disorders could also be made worse by the conditions of imprisonment and thus prison has the potential to cause significant mental harm. It agreed that the fundamental rights of prisoners entailed the provision of preventive treatment and healthcare equivalent to those provided in the general community, that the concept of care, positive expectations and respect should permeate all prisons and that the promotion of the mental well-being of prisoners and prison staff is vital in prisons. In addition to its detailed statement, the WHO also produced a management checklist to assist mental health promotion in prisons[23].

6.57 Health promotion initiatives are being undertaken jointly by the Prison Services and the National Health Service in Scotland[24] and in England and Wales[25]. The Healthcare Needs Assessment (2004)[16] recommended development of Health Promotion in the Northern Ireland prisons, and limited progress has been made.

6.58 It is essential that Health Promotion initiatives include specific measures to promote mental health and well-being that become instilled within the culture and ethos of the prison establishments. They cannot be seen as the sole preserve of Mental Health and Learning Disability Services, but rather they must be owned and led in partnership with the body with regional responsibility for mental health promotion, the wider health sector bodies and the Prison Service and developed in partnership with a range of users' and carers' representatives, voluntary and community sector and statutory Mental Health and Learning Disability services.

6.59 It is recommended that a Regional Prison Mental Health Promotion group is established that is centrally led and co-ordinated and that is sensitive to the circumstances of each prison establishment. This group should liaise closely with the regional body with responsibility for mental health promotion. The group should identify the needs in Northern Ireland and the efficacy of developments elsewhere and it should formulate and implement a range of proactive measures for prisoners as well as providing education, training and support for prison and healthcare staff. There should be evaluation of the impact of the group's activities.

Suicide and Other Self-Harm

6.60 Suicide and self-harm are major concerns in prison, as in the rest of society. Prisoners show high rates of mental health problems and are subject to the stresses related to offending behaviour and imprisonment. It is imperative to ensure that measures are put in place to address the identified suicide risks. The WHO[22] (2000) has produced guidance on the prevention of suicide in prisons. The Royal College of Psychiatrists (2002)[26] has published a Council Report on Suicide in Prisons, which made 26 recommendations and provided guidance on the assessment of prisoners. These include recommendations on resources, services, and procedures for assessment and staff training. Although the Report

relates primarily to the situation in England and Wales, its recommendations are highly relevant to Northern Ireland.

6.61 The NIPS has introduced a suicide and self-harm policy in 2004, which has been a positive step. The report by Professor McClelland and colleagues (2005)[13] reviewed 6 non-natural deaths in prison prior to that policy and made additional recommendations which are supported by the Review.

Recommendation

61. The DHSSPS, involving the body with regional responsibility for mental health promotion, in partnership with NIPS, service providers and representatives of users and carers should establish a Regional Prison Mental Health Promotion group to address mental health promotion and suicide prevention. The group should build upon the existing policy and formulate a strategy that sets explicit standards. It should seek to establish a culture and ethos in the prisons that promotes mental health and well-being for prisoners and staff and that further reduces the risks of suicide. The goal should be for the initial strategy to be implemented by 2007. Work should continue in conjunction with the regional body with responsibility for mental health promotion and should include evaluation of its effects.

Standard 8. Information, Research and Innovation

6.62 In order to work in an efficient co-ordinated multi-disciplinary and interagency manner, mental health and learning disability services in the prisons must have comprehensive information strategies that include, for example, the gathering of information on need, service performance and quality. There is a need to develop Information Technology systems that are integrated with the HPSS systems and that support service delivery. Consideration should be given to co-ordination with relevant components of criminal justice information systems.

Recommendations

62. The transfer project should ensure that information systems are established before April 2007 to meet the needs of mentally disordered prisoners. Information systems for prisoners should integrate and evolve with the HPSS systems and should be developed, where appropriate, to integrate with criminal justice systems in support of joint working.

63. The DHSSPS should commission and promote ethically approved research in relation to the needs and services for mentally disordered prisoners, for example research should be undertaken into the needs for healthcare centre places, the transfer of prisoners to Health Service, bail and community step-down facilities, the efficacy of offender management programmes and the efficacy of mental health promotion strategies.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

6.63 Workforce planning strategies and processes that are supported by both the Health and Social Services and by the Criminal Justice System must support the development and

maintenance of the required range of mental health and learning disability services. These must ensure the recruitment and retention of staff. There must also be Learning and Development arrangements to provide staff with the necessary knowledge, skills, support and opportunities for further learning and personal development. The needs for Learning and Development include not only staff working in prison mental health and learning disability services, but also other staff working in interconnecting health and social services and in criminal justice agencies. There is a need for interagency training to help promote understanding of the different, but interconnected roles. In addition service users and carers have learning and development needs that should be addressed. Consideration should also be given to the emotionally demanding nature of much of the work in prisons and the consequent needs of staff for psychological support.

6.64 There is a particular need, for all agencies, to develop expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. All of these services require close and co-operative working relationships between criminal justice staff, forensic and other mental health and learning disability services, supported by flexible working patterns, joint policies, procedures and protocols, agreed standards, joint research and audit, and shared learning and development. It is proposed that a Consortium is developed to bring together Criminal Justice Agencies, health and social services agencies and the prisons, to link community services and develop expertise in the psychotherapeutic aspects of assessment, therapy and risk management.

6.65 Learning and development mechanisms must be closely aligned to service development. Robust systems must be put in place to ensure there is learning from adverse incidents and that this learning is translated into relevant practical changes.

Recommendations

64. The DHSSPS must ensure that development and maintenance of services for mentally disordered prisoners are supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

65. Service providers must ensure that learning and development strategies for all staff are closely linked to service development and to governance arrangements.

66. A multi-agency consortium should be formed in 2006 to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by DHSSPS with input from criminal justice agencies and the relevant health sector bodies.

Standard 10. Sustainable and Transparent Funding

6.66 The transfer of lead responsibility for prisoner healthcare to DHSSPS by April 2007 will include transfer of current funding from NIPS. In England the similar transfer of responsibility was accompanied by substantial additional funding (an increase of approximately 40%).

The current Review is highlighting major current under-funding of mental health and learning disability services throughout the HPSS and is recommending additional resources. Additional funding is highly likely to be required to ensure both the development of services on the basis set out in this Review and their effective delivery.

Recommendation

67. The strategic development of mental health and learning disability services for prisoners requires sustainable additional funding. Funding arrangements must support the joint co-ordinated multi-agency planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

CHAPTER 7

PROBATION

INTRODUCTION

7.1 The Probation Board for Northern Ireland (PBNI) has a statutory responsibility for assessing and supervising offenders in the community in order to protect the public from risk of harm and to rehabilitate offenders. Many of these offenders have one or more mental health needs related to mental illness, learning disability, personality disorder and alcohol and substance misuse. There are, therefore, clear overlaps between the work of PBNI and mental health and learning disability services and thus, in accordance with the principles proposed in Chapter 2, there should be joint co-operative planning and delivery of services in order to best meet the needs of service users and carers. People who are on probation must have equity of access and provision of mental health and learning disability services.

7.2 This chapter considers the relationship between PBNI and mental health and learning disability services for adults with mental illness, personality disorder and learning disability and it makes recommendations for the future development of services. Additional recommendations in relation to learning disability are contained in Chapter 10 and further recommendations on specific issues including personality disorder, risk and the Multiagency Procedures for the Assessment and Management of Sex Offenders (MASRAM) are contained in Chapter 11. Interfaces with Alcohol and Substance Misuse Services, with Child and Adolescent Mental Health Services and with Legal Issues are addressed in the respective reports of this Review.

BACKGROUND

Probation Services

7.3 Since the introduction of the Criminal Justice (Northern Ireland) Order 1996, the offender population supervised by PBNI has not only increased, but the crime profile has shifted towards more serious, difficult and potentially dangerous and disturbed offenders. On 31 March 2005 PBNI supervised 1,253 Probation Orders, 804 Community Service Orders, 803 Custody Probation Orders and 31 Supervised Life Licensees. Probation staff conduct thorough risk assessments during each stage of contact with the offender, including the preparation of Pre-Sentence Reports, case management and programme delivery. Often this work is conducted in the absence of involvement of health and social services agencies. Sentences such as the Custody Probation Order (introduced 1 January 1998) have led to PBNI supervising offenders previously given custodial sentences.

7.4 During 2004/05 the courts requested 8,228 Pre-Sentence Reports from PBNI. A review in 2004 of Pre-Sentence Reports over a 6 month period found that 60% of these reports were written for offenders where the index offence was one of violence. More than half of those reports written on violent offenders were for an offence of Assault Occasioning Actual Bodily Harm or a more serious violent offence. In addition 42% of these offenders had 3

or more previous convictions, indicating a pattern of ongoing offending behaviour rather than an isolated incident. Some of these individuals were not engaged with or had been excluded from primary care, mental health and learning disability services, social services and housing authorities and were deemed unsuitable for safe supervision by probation alone. Concerns have been raised that such patterns of exclusion and marginalisation by services may be associated with increased risks of self harm and further offending.

7.5 There are also concerns that currently there are not sufficient mental health and learning disability services working with PBNI to contribute to assessment of individuals and their mental health needs, to advise criminal justice agencies and to arrange or provide treatment and care.

7.6 As regards supervision of offenders by probation, current standards require that offenders are supervised according to their likelihood of re-offending as well as the level of risk of harm they pose to the public. Offenders on community supervision orders are required to report to a probation officer in accordance with instructions and to notify any change of address. At 31 March 2005, PBNI managed 330 offenders in custody on Custody Probation Orders, which was one third of the prison population and 473 in the community. Many of these offenders had committed serious offences of violence and sexual violence, and had previously had contact with psychiatric and psychological services. Many also had serious personality deficiencies and difficulties. However, there was a lack of joint working between PBNI and mental health and learning disability services. At 2005 there were 115 PBNI "listed cases" which were deemed to pose a high risk of potential harm to the public. Analysis of these cases indicated that one third had convictions of a sexual nature, including rape, unlawful carnal knowledge, gross indecency and abduction, one third had convictions for violence, including Assault Occasioning Actual Bodily Harm, Grievous Bodily Harm and use of a firearm and the convictions of the remaining one third included burglary, robbery, arson and motoring offences.

7.7 PBNI programmes are delivered throughout Northern Ireland for offenders who commit serious violent offences including sexual offences and domestic violence. A new community programme commenced in January 2006 to address serious violent offending, for example, at the PBNI Integrated Supervision Unit, Alderwood House, Belfast, probation staff deliver sex offender treatment programmes, domestic violence programmes and other programmes, again with limited input from mental health and learning disability services.

7.8 There are currently 4 probation hostels in Northern Ireland that allocate beds to bailees. McCall (2005)[1] found that unmet need had been identified in the Western Health and Social Services Board where there were 12 beds in a community supervised hostel, but it was considered that a minimum of 24 beds was required to meet the current needs. There are significant and well established working partnerships with voluntary agencies in Northern Ireland. These services provide accommodation, vocational training, skill development and employment opportunities for offenders with mental health problems, learning disabilities and personality disorders.

7.9 McCall (2005)[1] found little information about mentally disordered offenders on probation. The main findings were:

- male probationers had higher death rates and suicide rates than the general population (1 cohort study);
- the majority of referrals from a probation hostel to a forensic psychiatry department were for complaints of depression and concerns regarding self-harm; and
- the quality of probation officer-probationer relationships can colour the use of strategies to monitor and enforce treatment compliance. A respectful, personal approach was perceived as being more effective than those that were more authoritarian.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

7.10 Current experience indicates that many service users in contact with probation welcome a joint and co-ordinated approach between probation and mental health and learning disability services that addresses both the mental and the criminal justice needs of the individual and his or her carers. In order to effectively carry out their functions probation staff should be aware of the presence and nature of any mental health needs that are relevant to:

- the risks of harm the individual poses to him or herself or to others, including the risks of reoffending; and
- the monitoring, supervision and rehabilitation of the individual.

7.11 Probation staff require access to timely assessment, advice, treatment and care provided by mental health and learning disability services. These services are required when individuals are undergoing assessment for the courts or for the Life Sentence Review Commission or when individuals are subject to Probation Orders and Custody Probation Orders. The sources of assessment and advice must be independent – psychological or psychiatric assessments commissioned by the defence may be given a limited and incomplete remit, for example they may not adequately address issues of risk.

7.12 Mental health and learning disability services may also benefit from information from probation services, for example, to help understand the legal circumstances of service users. There are opportunities for service providers to jointly address identified problems.

7.13 At present mental health and learning disability services are neither configured nor resourced to provide the services that are envisaged and there are a number of perceived or actual obstacles to joint approaches. Joint strategies must address these issues.

Recommendations

68. Strategies should be developed to ensure effective joint working between PBNI and the full range of mental health and learning disability services in relation to the assessment, treatment and care of mentally disordered people who are undergoing assessment by Probation or are subject to a Probation Order.

69. The Regional Forensic Network should co-ordinate the development of services at the interfaces between PBNI and:

- community forensic mental health and learning disability services;
- prison forensic services; and
- inpatient secure services.

70. The DHSSPS should, in partnership with PBNI, co-ordinate the development of services at the interfaces between PBNI and other mental health services.

Standard 2. Evidence, Principles and Purposes

7.14 There is a need for more detailed information on the mental health needs of service users and carers in contact with probation services and the Review recommends that detailed needs assessments should be commissioned. However, the current service needs are so substantial that the results of a full needs assessment are not required before service development can begin.

7.15 The joint services should have clearly defined purposes, should contribute to evidence gathering and should be consistent with the values and principles advocated by the Review. These services should assess the needs of each individual, his or her carers, their representatives, service providers and the wider community. The services should not only seek to identify, assess and provide treatment and care for those with mental health problems, but they should also target those causing greatest concern, developing particular expertise in relation to the assessment and management of problems and needs related to personality disorder.

Recommendation

71. PBNI, the Regional Forensic Network and the DHSSPS should agree joint arrangements to assess and monitor the needs of mentally disordered individuals, their carers, their representatives, service providers and the wider community. The results of ongoing assessment should inform service planning.

Standard 3. Organisational Structures and Interconnections

7.16 In these joint services staff should work flexibly in partnership with each other and in support of interconnecting health and social services providers and with criminal justice agencies in the statutory, voluntary and community sectors. The services should develop

models of good practice, including clear organisational structures and lines of accountability and also policies, protocols and procedures for joint working and information sharing.

Recommendation

72. PBNI, the Regional Forensic Network and the DHSSPS should agree joint purposes, clear organisational structures and lines of accountability and should develop policies, protocols and procedures for joint working and information sharing.

Standard 4. Comprehensive and Accessible Services

7.17 Comprehensive services should be developed jointly by PBNI and forensic and other mental health and learning disability services to provide timely, accessible and high quality assessment of needs, treatment and care for service users and support for their carers with continuity of services for as long as required. Arrangements for joint working must address the full range of biological, psychological and social needs and in particular services should be developed in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality.

Recommendation

73. PBNI, the Regional Forensic Network and the DHSSPS should develop comprehensive and accessible joint services to assess and provide treatment and care for mentally disordered people in contact with probation. There are particular needs to develop joint psychotherapeutic approaches.

Standard 5. Risk Assessment and Management

7.18 The pilot services should contribute to the assessment and management of risk, including the development of joint policies, protocols and procedures.

Recommendation

74. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people undergoing assessment by Probation or subject to a Probation Order.

Standard 6. Quality Assurance

Recommendation

75. PBNI, the Regional Forensic Network and the DHSSPS should agree standards for joint working. Services should be subject to internal and external evaluation of performance and quality.

Standard 7. Mental Health Promotion and Education

7.20 There are substantial opportunities to promote the mental health of those in contact with probation. The joint services should examine the services that may be developed and the potential benefits, including promoting continuity of mental health promotion when individuals are discharged from prison to the community.

Recommendation

76. PBNI and mental health and learning disability services should identify opportunities for mental health promotion and agree appropriate services.

Standard 8. Information, Research and Innovation

7.21 The needs assessment and joint services should add to the available information and should indicate future directions for research. Services should explore the possible uses of information technology including possible interfaces between mental health information systems and criminal justice information systems such as Causeway.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

7.22 There are needs to ensure that mental health and learning disability staff become familiar with the work of probation and that probation staff develop their capacities in recognising and responding to mental health needs. Following assessment of needs, inter-agency learning and development should be established for professionals working with offenders with mental illness, learning disability, personality disorder and alcohol and substance misuse.

7.23 Workforce planning is essential to ensure that developments in Forensic Services are supported by the recruitment and retention of appropriate numbers of staff.

Recommendation

77. Inter-agency learning and development arrangements should be established to support joint working between PBNI and forensic and other mental health and learning disability services.

Standard 10. Sustainable and Transparent Funding

7.24 **Recommendation**

78. The development of forensic and other mental health and learning disability services to support the work of PBNI requires sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

CHAPTER 8

SECURE INPATIENT SERVICES

INTRODUCTION

8.1 Inpatient services are essential components in the range of Forensic Services. Service users should have timely access to safe inpatient environments that provide treatment and care to meet the needs of each individual thus maximising his or her prospects of experiencing improvement in mental health and a safe return to the community.

8.2 Inpatient forensic services are stratified according to the risk the service users present[27]. Security is considered according to environmental, relational and procedural aspects and is often described as comprising high, medium and low levels of security.

These levels of security have been described as follows[28]:

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

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

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

8.3 Inpatient services can be further subdivided according to length of stay, for example into the following classification (adapted from Kennedy 2002[27]):

- High security;
- Medium term medium security;
- Long term medium security;
- Acute/medium term low security; and
- Long term low security.

8.4 Although these descriptions help give some understanding of the different levels of security there is a need to develop more objective criteria based on the characteristics of service users and their needs.

8.5 Work has progressed to set standards for the care of service users in secure facilitiesx[29]. It is essential that services are person-centred, of high quality and that they have internal quality assurance mechanisms and independent external scrutiny.

8.6 All the services at different levels of security must work in concert with each other and with interconnecting forensic and other mental health and learning disability services. It is essential that services have the capacity to admit each service user in a timely manner to a facility that meets his or her needs and that service users are not subject to any greater restriction than their condition or legal status requires.

8.7 It has been demonstrated that well developed adult mental health services, including low secure services, correlate with reduced demand for services at higher levels of security[30]. Secure places inevitably entail restriction of the liberty of service users as well as significant financial costs for society. The Review believes that secure inpatient services are necessary and that places must be made available to all who require them. Investment in interconnecting and step-down mental health and learning disability services is required to help keep the total number of such secure places at a minimum.

8.8 This chapter considers primarily the secure inpatient needs of adults with mental illness. The needs of those with learning disability are considered in Chapter 10, those with personality disorder in Chapter 11 and the needs of children and adolescents are considered in the report by the Child and Adolescent Mental Health Committee[86].

HIGH SECURE SERVICES

Introduction

8.9 There is no high secure hospital in Northern Ireland. The State Hospital, Carstairs, Scotland, has provided most of the care and treatment in conditions of high security for adults from Northern Ireland with mental illness or severe mental impairment who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.

8.10 Service users have been transferred to the State Hospital from hospitals in Northern Ireland and some of these service users have originated from the courts and prisons. Once it is agreed that a service user has made sufficient progress at the State Hospital he or she generally returns to the referring hospital in Northern Ireland. Until Shannon Clinic, Northern Ireland's Regional Medium Secure Unit, was opened in April 2005 there was a gap between the high security provision at the State Hospital and the low security of the Psychiatric Intensive Care and other units in Northern Ireland. This meant that patients in the State Hospital needed to have made sufficient improvement to be returned to a low security environment before they were likely to be accepted back to Northern Ireland. It will be essential that any service users who have been transferred to facilities outside Northern Ireland are returned at the earliest appropriate opportunity. Current capacity must be further developed to meet this objective.

BACKGROUND

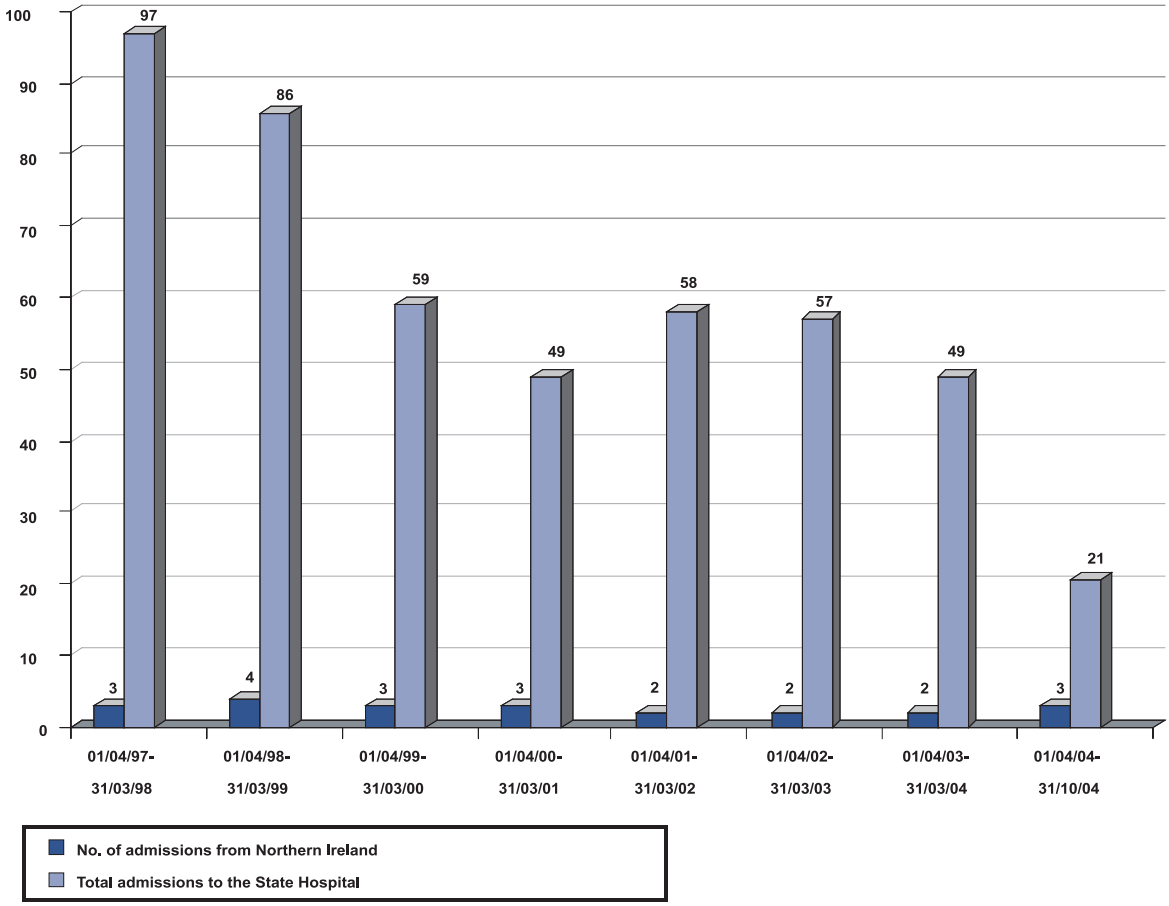
8.11 McCall (2005)[1] has reviewed the literature in relation to high secure services. Badger (1999)[31] found that there were about 33 patients in special hospitals per million of the

population in Britain, with 4 times as many men as women. The average age was in the 30's but with a wide age range. About two thirds of patients were legally classified as mentally ill and a one quarter had a personality disorder. The average length of stay was 8 years with rather longer periods of stay for women. About two thirds of patients had an index offence of violence against the person, with about a quarter of all patients having committed homicide. Substantial ethnic differences have been observed among admissions[32]. It has been estimated that at least half of the patients in special hospitals do not require the highest level of security. The average length of stay at the State Hospital between 1992-1997 was 5 years with a readmission rate of 22.3%, mostly due to violence[33].

CURRENT NEEDS AND SERVICES

8.12 The State Hospital provides care and treatment for around 240 patients from Scotland and Northern Ireland.

Admissions from Northern Ireland to the State Hospital, 2004



8.13 The State Hospital rarely admits patients with a primary diagnosis of personality disorder[34].

8.14 The number of mentally ill patients in the State Hospital who originated from Northern Ireland reduced substantially following the opening of the Shannon Clinic Regional Secure Unit in April 2005.

8.15 Northern Ireland has traditionally admitted fewer patients to high secure care than Scotland and England despite a lower resource base. These low numbers of admissions to the State Hospital from Northern Ireland may be an indicator that need is not being adequately met.

8.16 There are substantial obstacles to admission to the State Hospital for service users from Northern Ireland. Currently people who are remanded to prison and who are suffering from mental disorder that warrants transfer to a high secure service cannot be remanded to a hospital outside the Northern Ireland jurisdiction and thus cannot receive appropriate treatment in conditions of high security until their case has been dealt with by the courts. The provision of psychiatric treatment in prison is strictly limited, for example, a prisoner who is so mentally ill that he or she does not appreciate the need for treatment cannot be given treatment in prison under the protection of mental health legislation. Such a prisoner may have to remain on remand in prison for a prolonged period, perhaps a year or more, without receiving adequate treatment. Similarly individuals whose circumstances may warrant an interim hospital order to the State Hospital cannot be transferred outside of the Northern Ireland jurisdiction. Section 81 of the Mental Health (Scotland) Act 1984[35] (as amended by The Mental Health (Northern Ireland) (Consequential Amendments) Order 1986[36] specifically excludes people subject to remand for assessment or treatment or to an interim hospital order (Articles 42, 43 and 45 of the Mental Health (Northern Ireland) Order 1986) from the arrangements for removal to Scotland of patients in Northern Ireland. It is a highly unsatisfactory situation that service users from Northern Ireland are unable to have access to treatment and care in conditions of high security when their condition requires it.

8.17 Obstacles have also arisen to the return to Northern Ireland of service users whose diagnosis has changed while undergoing assessment and treatment in Scotland. Uncertainty has arisen in relation to the meaning of the term "severe mental handicap" in the Mental Health (Northern Ireland) Order 1986[11]. These issues are discussed further in Chapter 10 and in the report on Legal Issues by this Review.

APPEALS AGAINST LEVELS OF SECURITY

8.18 Provisions are included in the Mental Health (Care and Treatment) (Scotland) Act 2003[37] to allow for appeal against detention in conditions of excessive security. Service users from Northern Ireland who are detained inappropriately in conditions of excessive security at the State Hospital will be able to avail of the provisions in the Scottish legislation when they come into effect in May 2006. This is likely to result in pressure to admit to Shannon Clinic service users whose requirements are for longer term medium security rather than the medium term treatment, for which the Shannon Clinic was originally planned. If such service users are admitted to Shannon Clinic, the capacity of the clinic to respond to service users who need short and medium term care will be reduced.

WOMEN IN HIGH SECURE SERVICES

8.19 Historically very low numbers of women service users from Northern Ireland have required treatment in conditions of high security. At the time of writing this Report there

are no women service users from Northern Ireland in the State Hospital. A report for the Forensic Mental Health Services Managed Care Network in Scotland[38] has recommended that dedicated multi-disciplinary teams responsible for providing forensic psychiatry services for women should be established within local forensic services across Scotland. It also recommended that until Secure Services for Women are available Scotland-wide, the Women's Service at the State Hospital should continue and that only once there is clearly no need for the service should it be closed.

NEEDS OF USERS AND CARERS

8.20 The State Hospital has introduced a number of measures to improve the experiences of service users and carers such as improvements in information and communication, the implementation of Integrated Care Pathways, the provision of a Patients' Advocacy Service and the formation of a Patient Partnership Forum and a Carers' Reference Group[39].

STAKEHOLDER VIEWS AND USER/CARER VIEWS

8.21 McCall (2005)[1] found mixed views in relation to the service provided by the State Hospital for service users and carers in Northern Ireland. There were concerns about the geographical distance and separation from families and also, about the secure environment, but there was also appreciation of the treatments and facilities available there.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.22 At present, in the absence of more suitable alternative provision, service users in Northern Ireland continue to require high secure services from the State Hospital in Carstairs. While these arrangements continue Forensic Services in Northern Ireland should co-ordinate with Forensic Services in Scotland, both in relation to the provision of effective clinical services and also in relation to sharing and developing best practice. This co-ordination should occur through various mechanisms such as regular liaison between the Northern Ireland Forensic Managed Network and the Scottish Forensic Mental Health Services Managed Care Network and between Shannon Clinic and the State Hospital. Arrangements should be put in place to ensure that co-ordination occurs between all relevant parties, including multi-disciplinary staff and user and carer advocates.

Recommendation

79. The Regional Forensic Network should promote co-ordination of forensic service provision for the people of Northern Ireland, including with high security services at the State Hospital, Carstairs, Scotland.

Standard 2. Evidence, Principles and Purposes

8.23 The principles of this Review require that all service users have ready access to high quality care. It is, therefore, essential that all service users have access to assessment,

treatment and care in conditions of high security if their condition requires it. However, certain service users are denied this option, namely prisoners on remand and people who may benefit from assessment and treatment in a high secure service while the subject of an interim hospital order. There are substantially fewer admissions to high secure services from Northern Ireland than from other jurisdictions in the United Kingdom. Certain service users in Northern Ireland remain inappropriately placed in prison when they should be in hospital. The Review considers that the current arrangements are highly unsatisfactory. It strongly urges that a solution is found urgently and as a matter of priority.

8.24 The Review has discussed a number of ways in which this situation might be resolved. These options include:

(i) arrangements to "fast-track" the legal cases of mentally disordered people;

(ii) changes in the legislation to enable people whose condition requires treatment in high security to receive such treatment either in Scotland or elsewhere;

(iii) changing the use of the Shannon Clinic Regional Secure Unit so that in some circumstances it provides treatment and care in conditions equivalent to high security; and

(iv) building a high secure hospital in Northern Ireland.

8.25 Option 1 the "fast-tracking" of legal cases would require agreements with the Public Prosecution Service and the Court Services to process more speedily cases where it appears that the accused is suffering from mental disorder and cannot be provided with appropriate treatment while in prison. Such arrangements may help shorten the period an individual may spend in prison on remand or awaiting sentencing, but these periods are still likely to remain unacceptably long. Such arrangements could not offer the individual the benefit of being assessed and treated in hospital before disposal by the courts. Therefore, this option is unlikely to present a complete or satisfactory solution to the identified problem.

8.26 Option 2 involves changes in primary legislation to facilitate transfers to high secure services in Scotland or other jurisdictions. There are likely to be substantial legal and practical difficulties in transferring service users outside of the jurisdiction while they are still subject to the Northern Ireland courts. It should also be noted that there are high secure services in England and in the Republic of Ireland. The current mental health legislation allows for transfer of service users between Northern Ireland and other parts of the United Kingdom, but there is currently no reciprocal mental health legislation that allows transfers between Northern Ireland and the Republic of Ireland. There are substantial potential opportunities for the development of forensic services on an all-Ireland basis.

8.27 Option 3 was considered by the DHSS/NIO review of secure provision (1994)[40]. It debated whether Northern Ireland should manage all its patients, including those requiring high security facilities, but it decided that the services at the State Hospital would continue to be required. It suggested the Regional Secure Unit could have its security level upgraded at a later stage. However, the building was specified and designed as a medium secure unit and is likely to require very substantial modification to upgrade it to high secure levels, if indeed that is feasible. The Regional Secure Unit was also specified at a level of 20 beds per million of the population, which is lower than the levels subsequently recommended elsewhere. The

lack of provision for service users requiring long stay medium security and the lack of 'step-down' facilities from Shannon Clinic are likely to create a very high demand for the places in the Clinic. Converting part of the unit to high secure usage would compromise the capacity of the Unit to provide the medium secure service that was originally intended.

8.28 Option 4 involves building an additional secure facility in Northern Ireland to accommodate service users who require treatment and care in conditions of high security. On the face of it this option may not seem feasible on account of the small numbers of service users from Northern Ireland who are currently in high security. However, it should be noted that the numbers of service users from Northern Ireland who are receiving treatment in conditions of high security are substantially lower than in other jurisdictions. Current usage of high secure services does not reflect actual need because the legal and other obstacles prevent service users gaining access to the high security conditions they require.

8.29 At present there are a number of major gaps in high and medium secure provision for service users in Northern Ireland:

- unsentenced prisoners suffering from mental illness or severe mental impairment are denied the treatment they require as they cannot be transferred to a high security service;
- there is no provision for long stay medium secure places leading to inefficient usage of resources at Shannon Clinic;
- facilities for women at Shannon Clinic are limited. Women would benefit from a separate facility and the places at Shannon Clinic could be used by men;
- there is a need to provide treatment in conditions of high security for individuals suffering from personality disorder (see Chapter 11); and
- there are no secure facilities for adolescents.

8.30 An additional secure facility could provide a comprehensive solution to the high and medium secure needs of service users from Northern Ireland. Consideration should be given to providing these specialist services within an all-Ireland framework.

Recommendations

80. The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. All people in Northern Ireland must have access to high secure services when they require them. The DHSSPS must take the lead in urgently finding solutions to the current obstacles to treatment and care in conditions of high security.

81. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high and medium security. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

82. This assessment of high and medium secure needs should be combined with an assessment of the needs for low secure and step-down community services (Chapter 9) and the needs for forensic learning disability services (Chapter 10).

83. The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community step-down facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users.

Standards 3-9

8.31 In developing new secure services consideration should be given to each aspect of the care standards proposed in Chapter 2 including the development of policies, procedures and protocols, risk assessment and management, quality standards and assurance mechanisms, the development of information systems, joint research and contributions to mental health promotion and public education. There are also many opportunities for sharing of good practice, for example, in relation to advocacy and clinical services, and there are opportunities for innovation such as the use of video-links to improve contact between carers and service users. In addition, consideration should also be given to developing joint training between Northern Ireland Forensic Services and those available in adjacent jurisdictions.

Recommendations

84. New secure services should be developed in accordance with the standards proposed by this Review.

85. The Regional Forensic Network should explore the range of opportunities to co-ordinate training for staff in Forensic Mental Health and Learning Disability Services in Northern Ireland with the training available in adjacent jurisdictions.

MEDIUM SECURE SERVICES

Introduction and Current Services

8.32 The Shannon Clinic Regional Secure Unit (the Clinic) at Knockbracken Healthcare Park, Belfast, was opened in April 2005. When fully operational it will provide 34 medium secure places for the assessment and treatment of adults suffering from mental illness. Shannon Clinic takes admissions from prisons, courts, high secure services and other mental health services. Admissions generally warrant detention under the Mental Health (Northern Ireland) Order 1986[11] and comprise individuals who are a serious and enduring risk to others and prisoners who are mentally ill and require treatment in a medium secure setting. The Clinic primarily takes admissions ranging from several weeks to approximately 2 years. There is currently no provision in Northern Ireland for service users requiring longer stay treatment in conditions of medium security.

8.33 Facilities are available in Shannon Clinic for a small number of women to reside in part of a ward area that is separate from the facilities for men, but with access to shared activities and rehabilitation facilities.

8.34 The Clinic has an established a model of care that guides its activities and operations:

- A Bio-Psycho-Social Model;
- Patient Centred Approach;
- Multi-disciplinary Team Approach;
- Supports Patient Recovery;
- Safe, Secure and Therapeutic Environment;
- Promotes a Learning Ethos for Staff and Patients; and
- Involving Patients and Families in the Care Planning Process.

8.35 Service users and carers are also supported by user and carer advocates.

8.36 The Clinic has formulated many policies, procedures and protocols and is developing integrated care pathways, needs assessment, care planning, risk assessment and management procedures, standards, audit and quality assurance systems. The Clinic is also using computerised notes and records and video-links.

8.37 The Clinic has developed networks with interconnecting services and has also established an extensive staff training programme.

8.38 This chapter considers the future development of medium secure services for mentally ill adults in Northern Ireland.

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.39 The development of the Clinic has been overseen by a regional project board. It is expected that the function of regional co-ordination will be adopted by a Regional Forensic Network which will have links to the Scottish Forensic Mental Health Services Managed Care Network.

Recommendation

86. The Regional Forensic Network should promote the development and delivery of regional medium secure services and their co-ordination with interconnecting services.

Standard 2. Evidence, Principles and Purposes

8.40 The Clinic has been commissioned as a short and medium term facility for adults with mental illness, providing assessment and medium term treatment for periods of up to 2 years. The capacity of the Clinic to effectively provide this service will depend heavily on

the provision of interconnecting services throughout Northern Ireland to act in concert with the Clinic by providing long term medium secure services and step down low secure and community forensic services. Unless these facilities are made available there is a very real danger that service users will spend longer in the Clinic than is clinically necessary and that the Clinic will not be able to offer places to those in urgent need such as mentally ill people in prison. Such an outcome would also represent an inefficient use of the taxpayers' investment in this facility.

8.41 Kennedy[27] has stated that "Patients who are failing to progress despite appropriate trials of treatment need not continue to occupy scarce intensive therapeutic placements." He has suggested that such individuals may become frustrated by their lack of progress and that after detailed review of treatments and needs these individuals should be allocated to a long term placements where they are kept under regular review and may from time to time benefit from a return to a more intensive treatment setting.

8.42 It is essential that a detailed assessment of need is carried out and that adequate long term medium secure, low secure and community services are provided to support the efficient functioning of the Clinic.

8.43 In addition to the detailed needs assessment exercise the Clinic should contribute to the understanding of the needs for service provision by analysing both the needs of each service user and also the constraints on their progress. The Clinic should explore the development of a standardised Analysis of Constraints methodology[41] to identify the obstacles that are blocking the progress of each service user towards reduced restriction and greater autonomy. Identified constraints might include, for example, specific features of the service user's mental condition and lack of services to meet the identified needs.

8.44 The Regional Forensic Network should establish systems to monitor ongoing need for forensic services, including places in conditions of medium security. This information should inform planning for high, medium and low secure services and step-down community services for service users with short, medium and longer stay needs. The aim must be to create detailed information systems that inform the planning and delivery of an interconnected range of secure inpatient and community services to meet the needs of service users.

Recommendations

87. The DHSSPS must take account of the assessment of need for secure services and it must plan and develop long stay medium secure services and step-down low secure and community services.

88. In order to inform service planning and development Shannon Clinic staff should analyse the needs of each service user and the constraints on his or her progress.

89. The Regional Forensic Network should establish systems to monitor ongoing need for high, medium and low secure services and step-down community services for forensic service users with short, medium and longer stay needs. This information should contribute to the planning and delivery of forensic services.

Standard 3. Organisational Structures and Interconnections

8.45 The service based at the Clinic is closely connected to community forensic services which are at an early stage of development. Staff work across organisational boundaries to promote co-ordination. The Clinic has also been working in close collaboration with the State Hospital. It is essential that similar close connections are established between the Clinic and the prisons. These should be agreed at an early stage to ensure that robust systems are put in place to identify and transfer mentally ill prisoners in need of assessment and treatment in conditions of medium security. Previous experience in the Northern Ireland prisons demonstrated the benefits of staff working jointly between an inpatient hospital unit and the prison healthcare centre – greater numbers of transfers to hospital occurred and in shorter periods of time, compared with other parts of the province that did not operate such an arrangement.

Recommendation

90. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer to hospital of mentally disordered people who require treatment in conditions of medium security.

Standard 4. Comprehensive and Accessible Services

8.46 Comprehensive arrangements have been made at the Clinic to assess and meet the needs of service users and carers. Partnerships have been developed with many relevant parties and joint protocols are being produced in partnership with Criminal Justice Agencies. A range of psychotherapeutic approaches is being developed including group and individual therapy and staff supervision and support.

Standard 5. Risk Assessment and Management

8.47 Each mental health and learning disability service must develop risk assessment and management systems that are generically similar and that are tailored to the needs and circumstances of the individual service user. The Clinic is developing expertise, policies, procedures and protocols. These should draw upon best practice.

Recommendation

91. Service providers should develop regional expertise at Shannon Clinic in the assessment and management of risk in relation to service users who require assessment, treatment and care in conditions of medium security.

Standard 6. Quality Assurance

8.48 The Clinic is introducing systems to assess performance and assure quality and clinical governance.

8.49 One of the criteria used to assess the efficacy of the Clinic should be its capacity to take service users at short notice, including mentally ill prisoners in need of assessment and treatment in conditions of medium security. This criterion is not under the control of the Clinic service alone – it will depend heavily on the ability of interconnecting services throughout Northern Ireland to act in concert with the Clinic by providing long term, step-down and community forensic services.

Recommendation

92. Shannon Clinic should develop explicit quality standards and quality assurance mechanisms, including audit and independent external inspection by the relevant regional body.

Standard 7. Mental Health Promotion and Education

8.50 The Clinic is developing arrangements to promote the physical and mental health of service users and has also contributed to public education.

Recommendation

93. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure inpatient services to mental health promotion and public education.

Standard 8. Information, Research and Innovation

8.51 The Clinic has sought to develop an ethos of enquiry that promotes information-gathering and research and this ethos is supported by internal organisational structures. It will be important to develop a research strategy that includes links with relevant research bodies.

8.52 Information Technology systems have been introduced to the Clinic and are undergoing further development as part of a wider project.

Recommendations

94. The Regional Forensic Network should develop information and research strategies and promote the involvement of secure inpatient services.

95. The Regional Forensic Network should promote the integration of Information Technology systems between medium secure services and interconnecting services to help ensure the effective transfer of information.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

8.53 The Clinic has developed an extensive learning and development programme that is closely related to clinical practice. This should be developed further by increasing links with

universities and other training organisations and by working with other developing forensic services and the Regional Forensic Network.

8.54 Staff working with mentally disordered offenders also require psychotherapeutic support and arrangements have been made to provide psychotherapy services.

8.55 At the time of writing this Report, shortages of key trained staff have prevented the Clinic from opening to full capacity and they have impeded the development of community forensic services. These obstacles demonstrate the crucial importance of developing workforce strategies to ensure the recruitment, training and retention of all the necessary staff to support service developments.

Recommendations

96. The model used by Shannon Clinic of closely integrating training with clinical practice should extended to other forensic services.

97. The DHSSPS must ensure that development and maintenance of secure inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

8.56 The further development of medium secure services to meet the needs of service users for short, medium and long stay treatment and care will require appropriate funding in accordance with a long term plan.

Recommendation

98. The development and maintenance of medium secure services requires appropriate funding in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

LOW SECURE SERVICES

Introduction

8.57 Low secure services include Psychiatric Intensive Care Units, challenging behaviour wards and acute and longer term forensic low secure units.

8.58 The DHSS/NIO Review of Secure Provision[40] noted there were then 150 locked ward (low secure) beds in Northern Ireland. The Review recommended building a Medium Secure Unit for the province and rationalising locked ward provision.

8.59 The Northern Ireland Hospital Advisory Service inspected the 6 Psychiatric Intensive Care Units in the mid 1990's. It found substantially different practices in these units.

8.60 The Report of the Adult Mental Health Services Committee[83] (Chapter 4.125) has recommended, as part of a comprehensive package of services, that there should be 25 challenging behaviour beds per 250,000 of the population, which equates to a total of 170 for the province.

8.61 Low secure services are essential to support users in community and inpatient adult mental health services, to provide step-down facilities for service users in medium and high security and to provide support to users of community forensic services. Low secure services must function in a co-ordinated manner with all other interconnected services in order to meet the needs of service users. Inadequate capacity in low secure services may have a number of knock-on effects on interconnected services, for example, if a low secure place is unavailable to a service user in medium security he or she may be forced to spend a longer period than necessary at that higher level of security and may render that place unavailable for other service users in urgent need.

BACKGROUND

Current Services

8.62 The table below shows current provision of low secure beds in Northern Ireland. There are 6 Psychiatric Intensive Care Units (PICUs) which have provided a number of different functions including the short, medium and longer term treatment of mentally ill adults. In some cases these units have provided care for some mentally ill adolescents and accepted transfers from prisons and high secure services.

8.63 There are also challenging behaviour wards which typically provide for longer stay patients and where the emphasis is on rehabilitation.

Current provision of low secure beds in Northern Ireland

Hospital	Number of PICU beds	Number of long stay on locked/lockable wards	Total beds on locked/lockable wards
Knockbracken	16	24	40
Downshire	16	0	16
Holywell	18	22	40
Tyrone and Fermanagh	10	0	10
Gransha	8	0	8
St Lukes	13	17	30
Total	81	63	144

8.64 There are substantial variations in provision between different geographical areas. Many wards are in old buildings and offer dormitory accommodation and limited facilities and activities.

Literature Review

8.65 McCall (2005)[1] has reviewed the limited literature on the efficacy of low secure units and the epidemiological features of patients in low secure care. The main findings were as follows:

- wide variation in the provision and nature of low secure care reflecting idiosyncratic and localised development of services;
- almost complete lack of research evidence on the efficacy of low secure care for particular types of patients and problems;
- offenders were significantly less likely to be aggressive to others than non-offenders, but significantly more likely to self-harm, however, treatment outcomes were similar for both groups (results of 1 study[42]); and
- enhanced availability of local low secure reduces demand for medium and high secure services[30].

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

8.66 Low secure services are essential components of adult mental health and forensic services and must work in co-ordination with interconnecting services. It is essential that future services are planned jointly by all relevant parties.

Recommendation

99. The DHSSPS should ensure the development and delivery of low secure forensic services including step-down rehabilitation and long-stay services.

Standard 2. Evidence, Principles and Purposes

8.67 There is a lack of detailed information on the needs of service users in Northern Ireland for low secure accommodation. There is a requirement for a needs assessment and service mapping exercise. This should consider the needs of service users who are currently in low secure accommodation and those who may require low secure accommodation, for example, some service users in high and medium security, in prison, in acute admission wards, in longer stay wards and in the community. The exercise should take account of different admission criteria to current low secure services. Having identified the detailed needs of service users, options for services should be considered that will ensure adequate capacity to meet current and projected future needs. The appropriate occupancy rates should be calculated that will meet needs and ensure availability of places when required. The assessment of needs for low secure places should be integrated with assessment of need for medium and high secure places. Low secure services will also require linkages to accommodation and services in the community to ensure these are available once service users are ready to move there.

8.68 Options for the future development of low secure services should consider the quality of the services that are required, including the standard of physical accommodation and the levels of therapy and care. If service users spend significant periods in locked or restricted accommodation there is a clear need to provide a wide range of facilities such as therapeutic, occupational, recreational and outdoor activities. Other factors to be considered include:

- the number of categories of low secure services;
- the specific needs of certain groups such as women; and
- the key linkages of services, for example, PICU's may be more closely linked to admission units and low secure forensic units may be more closely linked to forensic services. It is generally inappropriate to place in PICU's individuals who require rehabilitation in a secure and low stimulus environment.

8.69 Different arrangements may be developed in different localities, but the essential features are that services should be developed in partnership with all the relevant parties and they should provide the number of places and quality of services required to allow service users to be placed in good quality accommodation and according to their needs rather than according to the availability or otherwise of a place. Substantial new provision of low secure inpatient facilities is likely to be required to meet current and projected needs.

Recommendations

100. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of low security. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

101. The needs assessment should consider the optimal configuration of low secure services, including the needs of specific groups such as women.

102. The needs assessment should lead to the development of low secure services that are fit for purpose. This is likely to require substantial new provision.

Standards 3-10.

8.70 Future low secure services should be developed following assessment of need and in accordance with the principles advocated in this report.

Recommendation

103. It is recommended that future low secure services, including low secure forensic services are developed in accordance with the standards advocated in Chapter 2.

CHAPTER 9

COMMUNITY FORENSIC SERVICES

INTRODUCTION

9.1 Community Forensic Services are an essential component of co-ordinated regional forensic services. They provide a range of community resources for service users and carers, the Criminal Justice System and for other mental health and learning disability services.

9.2 The sources of referral may include:

- inpatient forensic services;
- other inpatient and community mental health and learning disability services;
- police stations and courts;
- prison services; and
- probation services.

9.3 Community forensic services have crucial roles in meeting the needs of service users and carers, for example, in supporting the timely discharge of service users from secure inpatient services to appropriate accommodation in the community, in providing follow-up treatment and care for mentally disordered people discharged from prison or in providing assessment and therapeutic support to probation or to other mental health and learning disability services.

9.4 This Chapter primarily considers the service arrangements for adults with mental illness or severe personality disorder. Services for women and for people with learning disability are considered in greater detail in Chapter 11 and Chapter 10 respectively.

THE SERVICE USERS

9.5 The DHSSPS (2003)[43] proposed that the client group for community forensic services would be defined as:

"People with a categorical mental illness, severe personality disorder or who engage in dangerous or persistently challenging, aggressive behaviour and who may be in contact with the Criminal Justice System."

9.6 A submission to the Forensic Mental Health Services Managed Care Network in Scotland[44] has proposed the following definition:

"People suffering, or appearing to suffer, from a major mental disorder 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. In addition 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 have been convicted of an offence".

9.7 It is apparent from definitions such as these that there can be no precise or exact cut-off point between those service users who may fall within the remit of community forensic services and those who fall within the remit of other interconnected services. There is a need for local agreement between service providers that takes account of the functions and capacities of the relevant services and ensures that the needs of service users are met.

BACKGROUND

9.8 Two models of community forensic services have been described[45] - the integrated model (forensic specialists working within community mental health teams) and the parallel model (forensic specialists working on a separate specialist team). Characteristics of both models are shown in the Table below.

Characteristics of parallel teams	Characteristics of integrated teams
Own team base	Close links with community mental health services
Separate referral meetings	Acceptance of more referrals from primary care
Specialist management line	
Specialist supervision	
Protected funding	
Forensic psychology	
Good links with Criminal Justice Systems	
Capped caseloads	

9.9 In practice many services have developed features of both parallel and integrated models.

Current Services

9.10 Until 2003-4, Community Forensic Services in Northern Ireland were very limited - they have been described by McCall (2005)[1]. In 2004 funding was allocated for the partial development of community forensic services in each of the 4 Health and Social Services Boards. It was recommended that the Community Forensic Teams ('CFTs') would work in a 4 level model:

"Level 1 - a one off assessment/consultation with the CFT;

Level 2 - a short period of assessment by the CFT with the referring team retaining responsibility;

Level 3 - agreed period of shared responsibility - (a) to assess risk, (b) to evaluate interplay/operation of known risk factors, and (c) to assess efficacy of risk reducing strategies;

Level 4 - CFT taking full responsibility for duration of need;

It would be assumed that the majority of CFT's work would be at level 1 with only a small minority at level 4".

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

9.11 As with other components of Forensic Services it is proposed that community forensic services should be developed in a planned strategic manner by partnerships comprising service users and carers, commissioners and providers of services, representatives from forensic and interconnecting mental health and learning disability services and from Criminal Justice Agencies in the statutory, voluntary and community sectors, and also representatives from the wider community. It is expected that the Regional Forensic Network will lead and co-ordinate the planning and development of community forensic services.

9.12 The development of capacity to meet the needs of service users in the community must include both supporting and building upon the capabilities of current services, as well as developing and integrating new specialist services.

Recommendation

104. The Regional Forensic Network should lead and co-ordinate the planning and development of community forensic services. It should both support and build upon the capabilities of current services as well as developing and integrating new specialist services.

Standard 2. Evidence, Principles and Purposes

9.13 It will be essential to ensure that the plans for community forensic services have explicit purposes that take full account of the needs of all the interested parties, including the needs of service users and carers, other mental health and learning disability services and also the Criminal Justice System. Community forensic services must be planned on a multi-disciplinary and interagency basis and their purposes should include:

- assessing local referrals to secure inpatient services;
- supporting the discharge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;
- liaison with police stations and courts;
- in-reach to prisons and support of discharged prisoners with mental disorder;
- assessments at the request of probation;

- input to offender therapy programmes; and

- supporting the work of the Multiagency Procedures for the Assessment and Management of Sex Offenders (MASRAM) or its successor.

9.14 The current information on need is inadequate and systems must be devised to regularly assess need as well as the performance of services and their impact on need. The DHSSPS[43] noted in 2003 that comprehensive assessment of need *"would….be time consuming, and for the purpose of consideration of service model proposals any benefits that would be achieved over using …..(current) estimates ….. may not outweigh the delays incurred, especially as starting from such a low baseline service any developments may well be incremental and thus offer the opportunity for more accurate ongoing assessment of service demand."*

9.15 At the time of writing this Report the CFT's are not fully staffed or developed. The Review supports the current DHSSPS plans to initially develop 5 CFT's in Northern Ireland which equates to approximately one CFT per 350,000 of the population (in one or more cases 2 teams may amalgamate to form one enlarged team). It is recommended that these teams are supported by workforce planning and funding that they can reach full operating capacity as soon as possible.

9.16 It is recommended that the Regional Forensic Network commissions assessments of need to guide further planning and development. In particular it should be noted that the need for forensic services is recognised to be substantially greater in urban rather than rural areas[27]. Further developments are likely to require that services are aligned more closely to need rather than being provided on a simple *per capita* basis. The assessment of need must include not only the staffing requirements, but also resources such as accommodation suitable to meet the needs of service users. There is a need to assess the types of accommodation required and also the most appropriate locations to best meet the needs and wishes of service users and carers.

Recommendations

105. The 5 CFT's that are currently partly staffed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity by 2010. Thereafter teams should be developed in response to need to ensure that they have capacity to fulfill the range of services required by service commissioners and service users.

106. Commissioners must commission a full range of community forensic services with the following purposes:

- assessing local referrals to secure inpatient services;
- supporting the discharge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;

- liaison with police stations and courts;
- in-reach to prisons and support of discharged prisoners with mental disorder;
- assessments at the request of probation;
- input to offender therapy programmes; and
- supporting the work of the MASRAM or its successor.

107. The CFT's should produce information on their workload and performance which, combined with needs assessments should help guide the future planning of CFT's including suitable accommodation in the community.

Standard 3. Organisational Structures and Interconnections

9.17 Community forensic services will need to work closely with other forensic services, with primary care services and with all other mental health and learning disability services including particularly:

- adult mental health including Community Mental Health Teams, Home Treatment/Crisis Resolution services and Assertive Outreach services, the psychotherapy services and the special needs services;
- alcohol and substance misuse;
- learning disability; and
- child and adolescent mental health services.

9.18 It will be important to consider the key linkages between the developing CFT's and secure inpatient forensic services in order to maximise joint working and to facilitate timely discharge of service users to the community.

9.19 In addition community forensic services will need to establish appropriate linkages with components of the Criminal Justice System such as:

- Police stations;
- Courts;
- Prison;
- Probation; and
- MASRAM or its successor (see Chapter 11).

9.20 Community forensic services will require a range of suitable accommodation to meet the needs of service users. These will include[27]:

- 24-hour nursed care;
- Hostel; and
- Independent community placements.

9.21 In addition there will be a requirement for day care facilities to provide a range of therapies and activities to ensure the provision of a purposeful day.

Service Models

9.22 The model currently being implemented in Northern Ireland is of CFTs working according to the model described at 9.10.

9.23 The Review places emphasis on flexible and dynamic groups of statutory, voluntary and community sector services being formed or dissolved in accordance with the needs of service users and carers. Services must work across organisational boundaries to address needs rather than being structured rigidly into organisational groupings.

9.24 All staff will require the ability to work in complementary and often overlapping roles. While emphasising the need for staff to work flexibly in response to need, there must also be careful co-ordination between CFT members to ensure there is clear agreement on the roles, responsibility, accountability and lines of communication of each member of staff.

9.25 The development of these services will require improvements in inter-agency communication and co-working to ensure that staff understand their respective roles and responsibilities and that they co-ordinate their efforts to meet the needs of service users and carers. There will be a need for joint policies, protocols and procedures on issues such as working in partnership and information sharing. There may also be a need for shared or interconnected information technology systems.

Service Capacity

9.26 It will be important to agree with all relevant parties the expected workload and capacity of each CFT. It would be easy for CFTs to become overwhelmed by large numbers of referrals from the many potential sources so that they became unable to provide the quality of service required.

9.27 It is proposed that the CFTs will spend a substantial proportion of their time working in support of other services and that the numbers of individuals for whom the CFTs have primary responsibility for treatment and care will be kept small.

Recommendation

108. Community Forensic Services should develop specific service models and structures and agreed methods of working with interconnecting services.

Staffing

9.28 It is recognised that the exact remit and workload of CFT's will vary with local circumstances. Nevertheless, the Review recommends the following as an appropriate typical composition for a CFT, as an indication of the resources required.

Recommendation

109. A CFT should comprise a range of staff with the necessary skills to meet the needs of users and carers. The following is considered representative of the skills and funding levels required:

1 Consultant Forensic Psychiatrist
1 Consultant Chartered Forensic Psychologist
1 Forensic Psychologist
1 Psychotherapist
2 Social Workers
1 Occupational Therapist
5 Nurses
2 Administrative Staff
User and carer advocacy services

The composition of CFTs should be adjusted in response to information on need and service performance.

Standard 4. Comprehensive and Accessible Services

9.29 As community forensic services develop they will need to agree arrangements for their core activities such as the gathering of information, assessment of needs, the assessment and management of risk and the provision of a range of therapies. There are particular needs to develop and maintain psychotherapeutic expertise in the assessment and treatment of these challenging service users. It is recommended that the Regional Forensic Network facilitates co-ordination of these developments, both within Northern Ireland and with other similar services outside the province.

Recommendation

110. The Regional Forensic Network should co-ordinate the development and delivery of community forensic services, including the development of policies, procedures and protocols.

Standard 5. Risk Assessment and Management

9.30 Community forensic services should develop risk assessment and management policies, procedures and protocols that should draw upon best practice and co-ordinate with the arrangements of interconnecting services.

Recommendation

111. The Regional Forensic Network should co-ordinate the development of risk assessment and management policies, procedures and protocols by community forensic services.

Standard 6. Quality Assurance

9.31 Community forensic services must have robust and demonstrable quality assurance mechanisms that involve service users and carers and include setting standards and assessing the quality of services. These should include internal mechanisms such as audit and also external review. Performance standards should include the quality of information-gathering, compliance with values and principles, and capacity to meet the needs of service users and carers, other mental health and learning disability services and Criminal Justice Agencies.

Recommendation

112. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

9.32 Community forensic services should contribute to wider programmes of mental health promotion and public education.[84]

Recommendation

113. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic services contribute to mental health promotion and public education.

Standard 8. Information, Research and Innovation

9.33 Community forensic services should develop information strategies that include contributing to evidence-gathering, research and innovation. Information Technology should be used where appropriate to enhance service quality and delivery.

Recommendation

114. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

9.34 Staff will require training to ensure a broad range of relevant competencies to meet the needs of service users and carers and to comply with agreed policies, protocols and procedures. There are needs to develop skills in forensic psychotherapy, in offender

therapies and in risk assessment and management. There are also needs for interagency training.

9.35 At the time of writing this Report, shortages of key trained staff have prevented community forensic services from developing to full capacity, thus demonstrating the crucial importance of developing workforce strategies to ensure the recruitment, training and retention of all the necessary staff to support service developments.

Recommendation

115. The DHSSPS must ensure that development and maintenance of community forensic services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

9.36 The development and maintenance of community forensic services requires appropriate funding from the relevant agencies in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

Recommendation

116. The development of community forensic services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

CHAPTER 10

FORENSIC LEARNING DISABILITY SERVICES

INTRODUCTION

10.1 People with learning disability are among the most vulnerable individuals who come into contact with the Criminal Justice System and the Mental Health and Learning Disability Services. These individuals may experience fundamental difficulties in comprehending and communicating effectively with the world around them. Some individuals also present substantial risks of causing serious harm to themselves or to others.

10.2 Despite these vulnerabilities and risks, dedicated forensic services for people with a learning disability in Northern Ireland are very limited and those services that are available are primarily inpatient based.

10.3 Recommendations in relation to forensic services for people with a learning disability have been included in Chapter 3 (Police Stations), Chapter 4 (Bail), Chapter 5 (Courts), Chapter 6 (Prisons) and Chapter 7 (Probation). In addition Chapter 11 (Specific Issues) also relates to forensic service users with a learning disability. The current Chapter relates primarily to the provision of specialist Forensic Learning Disability Inpatient and Community Services. This Chapter should also be read in conjunction with the Equal Lives Report[85] which gives broader recommendations on services for people with a learning disability.

10.4 It is difficult to estimate the prevalence of offending by people with a learning disability with any degree of accuracy. Walker and McCabe (1973)[46] indicated that, as a result of deficits in intelligence and social skills, people with a learning disability are probably more likely to be apprehended by the police than other offenders. Generally, however, studies show large variations in rates depending on inclusion criteria, types of assessment, sample type, study design and methodology. Additionally it is not clear whether people with learning disability are over or under represented in the offender population, or indeed if offending is more prevalent among people with a learning disability than in the general population (Davy, 1993[47]; Simpson and Hogg, 2001[48]).

INPATIENT SERVICES

INTRODUCTION

10.5 Recent research (Slevin et al, 2005[49]) conducted in Northern Ireland has shown that up to 65% of admissions to a learning disability hospital had been attributable to some form of severe challenging behaviour. Whilst not all this behaviour would be classified as offending behaviour a significant proportion is likely to fall into this category.

CURRENT SERVICES

10.6 Northern Ireland is served by 3 learning disability hospitals. The Northern & Eastern Health and Social Services Board areas are served by Muckamore Abbey Hospital, the

Southern Board by Longstone Hospital and the Western Board by Lakeview Hospital. Muckamore Abbey Hospital provides an inpatient forensic service mainly to the Eastern and Northern Boards, although historically it also has a regional inpatient function of admitting patients who are subject to Part III of the Mental Health (Northern Ireland) Order 1986[11]. However, there are currently marked difficulties in obtaining places at Muckamore Abbey Hospital due to a lack of rehabilitation services and supporting community services that would promote the return of service users to the community. This situation is highly unsatisfactory as it results in some service users being denied admission to the service they require and other service users being kept in hospital and unduly restricted longer than their condition requires.

10.7 A 19 bed dedicated inpatient forensic unit will open at Muckamore Abbey Hospital in 2006. The unit will provide medium and low secure services. Currently there are no low secure beds on the other learning disability hospital sites.

10.8 Service users with learning disability who require treatment in conditions of high security are transferred to the State Hospital, Carstairs, although there are currently unacceptable delays in the transfer of unsentenced prisoners (see Chapters 6 and 8).

DISCUSSION AND RECOMMENDATIONS

Standard 1. A Co-Ordinated Joint Strategic Approach

10.9 The development and delivery of comprehensive forensic learning disability services requires contributions from many sources including service users and carers, commissioners and providers of services, representatives from forensic and interconnecting mental health and learning disability services and from Criminal Justice Agencies and both the statutory and non-statutory sectors, and also representatives from the wider community. A shared strategic and proactive approach must be adopted that ensures that needs for high, medium and low levels of security are met by the provision of a range of services. It is recommended that services are co-ordinated by the Regional Forensic Network and the Learning Disability Implementation Group. These bodies should co-ordinate with other forensic services outside of the province such as the Scottish Forensic Mental Health Services Managed Care Network and with the State Hospital, Carstairs.

Recommendation

117. The Regional Forensic Network should lead the development of forensic learning disability services in Northern Ireland, in co-ordination with the Learning Disability Implementation Group. Forensic Learning Disability Services should link with forensic services outside the province, including the State Hospital Carstairs and the Scottish Forensic Mental Health Services Managed Care Network. Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security.

Standard 2. Evidence, Principles and Purposes

10.10 It is essential that all service users have access to assessment, treatment and care in conditions of high, medium or low security as their condition requires. At present, however, there are restrictions on the transfer of certain patients from Northern Ireland to conditions of high security (see Chapters 6 and 8). Similarly the lack of rehabilitation and "step down" services results in service users staying for longer periods in conditions of higher security than their clinical condition requires. A needs assessment and service mapping should be commissioned to examine the requirements for secure provision for forensic service users with learning disability. The results of this exercise should lead to the construction of a plan for a comprehensive range of forensic learning disability services at high, medium and low levels of security for service users with short, medium and longer term needs. The plan should take account of both current and future needs and should allow for the placement of service users in the most appropriate facility in accordance with their need, rather than being constrained or delayed by the lack of available places. Rehabilitation of service users will also require the provision of a range of community facilities including day care services.

Recommendations

118. The needs assessment and service mapping exercise advocated at 8.28 and 9.17 should include a detailed assessment of the needs for forensic learning disability services. This should lead to the development of a comprehensive plan and the development of a full range of inpatient and community forensic learning disability facilities and services. The Review advocates the provision of additional high and medium security services for people with learning disability in the proposed new unit (Recommendation 83). There is also a need for local low security services and community forensic learning disability services.

119. The forensic learning disability services in Northern Ireland are currently so patently inadequate that their initial development does not need to await the completion of a needs assessment exercise. A regional forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

Standard 3. Organisational Structures and Interconnections

10.11 The secure inpatient services at Carstairs and Muckamore Abbey Hospital must co-ordinate closely with other inpatient learning disability services, with community forensic learning disability services, with mental health services and with the prisons, probation and other components of the Criminal Justice System. There are particular needs to identify prisoners who are suffering from learning disability and who require transfer to inpatient facilities. At present there are substantial obstacles to the transfer of prisoners with learning disability to inpatient facilities. Uncertainty about the meaning of the term "severe mental handicap" under the Mental Health (Northern Ireland) Order 1986[11] has led to service providers in Scotland becoming reluctant to accept service users from Northern Ireland in case they cannot be returned at a later date. The lack of step-down facilities to support secure inpatient services in Northern Ireland has led to places becoming unavailable to other service users in acute need, including individuals who are inappropriately placed in prison.

Recommendations

120. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer of people who require assessment, treatment and care in forensic learning disability inpatient services.

121. The DHSSPS must address the current obstacles to service users with learning disability receiving inpatient care, including uncertainty over the definition of the term "severe mental handicap" and the lack of step-down services at low security and in the community.

Standard 4. Comprehensive and Accessible Services

10.12 Forensic services for people with learning disability should assess the full range of biological, psychological and social needs and should provide services to meet those needs in accordance with best practice. There are particular needs to develop psychotherapeutic approaches. Services should be developed and delivered in a manner that promotes openness and good communication between all relevant people, while respecting the rights of the individual for privacy and confidentiality. Appropriate information should be provided to service users and carers. Information sharing protocols and other joint working protocols should be developed between forensic learning disability services, the Criminal Justice System and other mental health and learning disability services.

Recommendation

122. The Regional Forensic Network should promote the development of joint working policies, procedures and protocols between forensic learning disability services and interconnecting mental health and learning disability services and services in the Criminal Justice System.

Standard 5. Risk Assessment and Management

Recommendation

123. The Regional Forensic Network should promote the development by forensic learning disability inpatient services of risk assessment and management polices, procedures and protocols that co-ordinate with mental health services and with the Criminal Justice System (see Chapter 11).

Standard 6. Quality Assurance

10.13 Forensic learning disability inpatient services should develop robust systems to assess performance and assurance quality and clinical governance. One of the criteria used to assess the efficacy of forensic learning disability inpatient services should be their capacity to take service users at short notice, including prisoners in need of assessment, treatment and care. Services should analyse the constraints to the progress of service users and should formulate plans to remove or overcome the obstacles that are identified.

Recommendation

124. The Regional Forensic Network should co-ordinate the development of robust systems to assess performance and assure quality and clinical governance for forensic learning disability inpatient services.

Standard 7. Mental Health Promotion and Education

Recommendation

125. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure forensic learning disability inpatient services to mental health promotion and public education.

Standard 8. Information, Research and Innovation

10.14 Services should develop an ethos of inquiry that promotes information gathering, research and innovation. They should be supported by internal organisational structures. Information technology systems should be developed to support service planning and delivery and co-ordination of information sharing.

Recommendations

126. The Regional Forensic Network should co-ordinate the development of information systems and research in forensic learning disability services.

127. The Regional Forensic Network should promote the integration of Information Technology systems between forensic learning disability services and interconnecting services to help ensure the effective transfer of information.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

10.15 The development and maintenance of forensic learning disability services must be supported by workforce planning strategies and mechanisms that ensure the recruitment and retention of staff who are equipped with the appropriate personal qualities and professional qualifications. There must be learning and development arrangements to provide staff with the necessary knowledge, skills, support and opportunities for further learning, professional and personal development. The needs for learning and development include not only staff working in forensic learning disability services, but other staff working in interconnecting health and social services and in Criminal Justice Agencies. Forensic learning disability services must co-ordinate with other services to meet their general and specific learning and development needs.

Recommendation

128. The DHSSPS must ensure that development and maintenance of forensic learning disability inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

Recommendation

129. The development and maintenance of forensic learning disability services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long-term plans that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

COMMUNITY FORENSIC LEARNING DISABILITY SERVICES

CURRENT SERVICES

10.16 At present there are no dedicated forensic services for people with learning disability in the community in Northern Ireland. For those individuals whose needs have been identified and who are currently receiving services, they may receive them from various sources including Community Learning Disability Teams (CLDT's), Behaviour Support Services (BSS), psychology services or from Autistic Spectrum Disorder (ASD) services for adults.

Standard 1. A Co-Ordinated Joint Strategic Approach.

10.17 The development of capacity to meet the needs of service users in the community must include both supporting and building upon capabilities of current services as well as developing and integrating new specialist services. As with other components of forensic services, community forensic learning disability services should be developed in a strategic manner through inclusive partnerships. It is proposed that the Regional Forensic Network, in partnership with the Learning Disability Implementation Group, co-ordinates the planning and development of community forensic learning disability services. Service providers will need to develop and maintain specialist expertise in assessing and providing treatment to forensic service users with learning disability. This will require and, at times, joint working with community forensic service providers.

Recommendation

130. The Regional Forensic Network should liaise with the Learning Disability Implementation Team and take the lead role in promoting the planning and development of community forensic learning disability services.

Standard 2. Evidence, Principles and Purposes

10.18 Community forensic learning disability services should be developed in accordance with the principles advocated by this Review and services should have clear explicit purposes. Service planning must be informed by detailed assessment of need.

Recommendation

131. The proposed needs assessment and service mapping exercise (Chapter 8) should include the gathering of information to guide the further development of community forensic learning disability services, following the initial development of a regional service.

Standard 3. Organisational Structures and Inter-Connections

10.19 Community forensic learning disability services must work closely in co-ordination with all interconnecting services including inpatient services, Criminal Justice Agencies and mental health services. Community forensic learning disability services will need to develop close connections with police stations, courts, prisons, probation and MASRAM. Community forensic services will require a range of suitable accommodation to meet the needs of service users, including:

- 24 hour nurse care;
- hostels; and
- independent community placements.

10.20 Services will also require a range of day care facilities.

10.21 As with community forensic services, it is expected that community forensic learning disability services will adopt a tiered approach. It will be important to agree with all relevant parties the expected workload and capacity of each team.

Recommendation

132. Immediate measures should be taken to create a regional community forensic learning disability service linked to an inpatient assessment and treatment service. This regional service should support the development of 5 locally based and regionally co-ordinated community forensic learning disability teams. These teams must have sufficient capacity to fulfill the same purposes as those identified for other community forensic services (Chapter 9).

Standard 4. Comprehensive and Accessible Services

10.22 Community forensic learning disability services should co-ordinate with interconnecting services to provide a comprehensive range of timely, accessible and high quality services that assess needs and provide treatment and care for service users and support for their carers with continuity of services for as long as required.

Recommendation

133. Community Forensic Learning Disability Teams must be developed with the necessary staffing levels and range of skills to meet the needs of users and carers. The proposed regional team is likely to require similar staffing levels and resources to the Community Forensic Teams proposed at Chapter 9, with the addition of access to speech and language therapy services.

Standard 5. Risk Assessment and Management

Recommendation

134. The Regional Forensic Network should ensure that community forensic learning disability services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the arrangements of interconnecting services.

Standard 6. Quality Assurance

Recommendation

135. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic learning disability services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

Recommendation

136. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic learning disability services contribute to mental health promotion and public education.

Standard 8. Information, Research and Innovation

10.23 Community forensic learning disability services should contribute to evidence gathering and promote research and innovation. Information technology should assist the development and delivery of services and should co-ordinate with interconnecting services.

Recommendation

137. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic learning disability services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

10.24 As with other forensic services, community forensic learning disability services require robust recruitment and retention procedures and learning and development systems that ensure the provision of a skilled workforce.

Recommendation

138. The DHSSPS must ensure that development and maintenance of community forensic learning disability services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

Standard 10. Sustainable and Transparent Funding

Recommendation

139. The development of community forensic learning disability services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

CHAPTER 11

SPECIFIC ISSUES

INTRODUCTION

11.1 This Chapter examines 5 further issues that have been identified as requiring particular attention in order to promote the development of comprehensive forensic services in Northern Ireland. These are:

(i) The Assessment and Management of Risk;
(ii) Personality Disorder;
(iii) Autistic Spectrum Disorder;
(iv) Services for Women; and
(v) Forensic Psychotherapy.

11.2 It is recognised that potentially a great number of other special groups could be considered, such as Forensic Service Users with eating disorders, acquired brain injury, deafness or adult Attention Deficit and Hyperactivity Disorder. Ultimately each forensic service user is an individual with unique needs. Thus the Review has recommended a flexible model of services that is built upon assessing the needs of each individual service user and his or her carers and then providing services to address those needs. As forensic services are developed and new scientific discoveries are made, there will be a continuing need to review services to ensure they properly meet the needs of individual and groups of service users and carers.

THE ASSESSMENT AND MANAGEMENT OF RISK

1) Introduction - Developments in Forensic Services and Criminal Justice

11.3 The assessment and management of risk is one of the central activities of forensic mental health and learning disability services and of the Criminal Justice System. In Northern Ireland and other parts of the United Kingdom there have recently been important developments in Criminal Justice in relation to the management of risks posed by violent and sexual offenders. These developments in Criminal Justice extend beyond the remit of the Review, which is concerned with making recommendations in relation to people suffering from mental disorder, but they are relevant to the assessment and management of some mentally disordered offenders and also to the development of interagency practices at the interfaces between criminal justice and health and social services agencies.

i) Multi-Agency Public Protection Arrangements (MAPPA)

11.4 In England and Wales, the Criminal Justice and Court Services Act (2000)[50] established the Multi-Agency Public Protection Arrangements (MAPPA) which were re-enacted and strengthened by the Criminal Justice Act (2003)[51]. These require the police, prison and probation services to work together to assess and manage the risks posed by sexual and violent offenders. Multi-Agency Protection Panels (MAPPs) have 4 main functions:

- identification of mappa offenders;
- sharing of relevant information;
- assessment of risk of serious harm; and
- management of risk of serious harm.

ii) Multi-agency Procedures for the Assessment and Management of Sex Offenders (MASRAM)

11.5 In Northern Ireland Multi-agency Procedures for the Assessment and Management of Sex Offenders (MASRAM) were launched in 2001. At present MASRAM is an interagency response to sex offending that comprises four core agencies – the Police Service, the Probation Board, the Prison Service and Social Services. It is an administrative arrangement and does not have a statutory basis. The Criminal Justice Inspection (Northern Ireland) reviewed MASRAM (2005)[52] and recommended that it should be placed on a statutory footing with guidance to underpin its activity, that its remit should be extended to include violent offenders and that it should organise its activities to target those posing the highest levels of risk. The report also recommended that the process for discharging restricted hospital patients should incorporate a thorough criminal justice risk assessment and plan for appropriate post-discharge support.

iii) Review of the Sentencing Framework in Northern Ireland

11.6 The Northern Ireland Office has published a consultation document on the Review of the Sentencing Framework (2005)[53]. Options discussed include wider use of compulsory supervision following custody, a discretionary release to ensure that dangerous offenders are not released until their risk is such that they can be safely supervised in the community and mechanisms to ensure that a released offender can be rapidly recalled to prison if he either causes harm or evidences the likelihood that he will cause harm.

iv) Life Sentence Review Commission

11.7 In Northern Ireland, the Life Sentence Review Commission is an independent judicial body which considers the release of life sentence prisoners once the tariff period is completed. Prisoners must satisfy the panel that it is no longer necessary for the protection of the public from serious harm that he or she is confined. It must be established that the risk of the prisoner committing serious harm if released on licence is no more than minimal. The panel may make recommendations about licence conditions attached to the prisoner's release.

v) Risk Management Authority (RMA) and Order for Lifelong Restriction (OLR)

11.8 In Scotland there is no equivalent of MASRAM or MAPPA. The Report of the Committee on Serious Violent and Sexual Offenders chaired by Lord MacLean[54] made a series of recommendations in relation to the assessment and management of 'high risk offenders'. These included the establishment of a Risk Management Authority (RMA) and the introduction of a Risk Assessment Order that enables a formal risk assessment to be

conducted after conviction and before sentencing. A new sentence, the Order for Lifelong Restriction (OLR) may be imposed on certain offenders who are assessed as presenting a substantial and continuing risk to the public. Such offenders are supervised and managed in accordance with a Risk Management Plan.

11.9 The RMA was established by the Criminal Justice (Scotland) Act 2003[55]. The remit of the RMA includes:

- developing policy and carrying out research into the risk assessment and risk management of offenders whose liberty presents a risk to the public at large;
- setting standards for and issuing guidance to those involved in the assessment and management of risk; and
- accrediting practitioners and risk management plans and monitoring risk management plans for those offenders who receive an OLR sentence from the High Court.

2) Some Concepts in Relation to the Assessment and Management of Risk in Mentally Disordered Offenders

11.10 Forensic services are concerned with mentally disordered offenders and others with similar needs. Service users pose risks of harm to themselves and others that will vary in nature and degree at different times and in different circumstances. Service providers must ensure that arrangements are put in place to identify and respond appropriately to these risks. These responses must also take into account the mental capacity of the individual and his or her responsibility and rights to self-determination.

11.11 The varying risks posed by forensic service users must be placed within the broader context of the risks posed by many other individuals in our society. There must be consistent approaches across society that identify and respond to risk, but do not discriminate unjustifiably against those suffering from mental disorder.

11.12 Risk assessment and management procedures must be evidence based and fully acknowledge the considerable limitations of current risk prediction methods. The failure to correctly predict harm ("false negative" prediction) results in missed opportunities to prevent harm if the prediction methods had been more accurate. The prediction of harm when, in fact, it would not have occurred ("false positive" prediction) can result in service users being unnecessarily restricted, for example, by being kept in hospital for longer than required[56]. Such false positive predictions may also incur unnecessary and substantial public financial expenditure.

11.13 There are dangers that a 'culture of blame' will lead to an unwarranted preoccupation with risk that discriminates those with mental disorder and makes service providers reluctant to take even small risks. The concepts of risk taking and risk appetite are of fundamental importance. HM Treasury (2004)[57] has stated:

"The resources available for managing risk are finite and so the aim is to achieve an optimum response, prioritised in accordance with an evaluation of the risks. Some amount of risk taking is necessary – the only way to avoid risk is to do nothing at all which is guaranteed to ensure that nothing is achieved. The amount of risk which is judged to be tolerable and justifiable is the "risk appetite".

11.14 The risk appetite of our society will be a significant influence on the overall size of developing forensic services. A relatively small risk appetite could result in the development of large forensic services, high financial costs for society and high personal costs for service users who will be subject to greater restriction and deprivation of liberty. A relatively large risk appetite would result in substantially lower public expense, service users would be rehabilitated more quickly and they would be subject to less restriction. There may be some increase in incidents of harm, although the small contribution of mental illness to the overall levels of offending indicates that the total number of such incidents is likely to be small.

11.15 Increasingly adverse incidents have come to be viewed as the outcome of a number of influencing and causal factors within systems of care. Rather than automatically blaming or scapegoating the individual service provider who last had contact with the perpetrator before an incident was committed, approaches such as root cause analysis attempt to identify and improve underlying systemic factors such as service organisation and workload, training, policies and procedures. Robust quality assurance and clinical governance mechanisms must be developed that take a proactive and systemic approach to risk assessment and management and that incorporate learning from incidents and "near-miss" events.

3) Approaches to Risk Assessment and Management

i) The Care Programme Approach and Discharge Guidance

11.16 Systematic approaches to risk assessment and management have been adopted in England and Wales and in Scotland through the Care Programme Approach[58] and the Enhanced Care Programme Approach[44]. Essentially these processes bring together the relevant parties (users, carers and service providers) at Care Programme meetings to agree the identified needs and risks and to develop co-ordinated care plans and risk management plans. The outcome of these meetings is documented and circulated to all relevant parties to ensure that there is clarity in relation to the roles, responsibilities and actions to be taken to support the treatment and care of the service user.

11.17 In Northern Ireland, the Department of Health and Social Services introduced guidance entitled "Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Physical Harm to Themselves or Others". The guidance was introduced in 1996 and revised in 2004[20]. The guidance seeks to improve standards of care and has similarities to the Care Programme Approach. Although the guidance has a number of commendable features concerns have been raised that it does not adequately respect the autonomy of individual service users, that it stigmatizes those with mental disorder, that it places unrealistic expectations on

service providers and that it places liability on service providers for the actions of some people who are mentally competent to take responsibility for themselves. Unlike the Care Programme Approach, it has been introduced without additional resources or training to support implementation.

ii) Clinical Practice

11.18 In practice forensic services in the rest of the United Kingdom and elsewhere have developed risk assessment and management procedures and protocols that include:

- information gathering;
- information sharing;
- risk evaluation; and
- risk management plans.

11.19 Procedures often include the systematic use of risk assessment tools that combine actuarial and clinical features and are relevant to the context of the service user. Psychodynamic assessments also assist in understanding the individual and his or her characteristic patterns of thoughts, feelings and behaviours.

4) Discussion

The Assessment and Management of High Risk Offenders

11.20 Recent developments within the Criminal Justice System have supported an interagency approach to the assessment and management of risk of violent or sexual offending. This Review seeks to promote interagency co-operation at the interfaces between Criminal Justice and Mental Health and Learning Disability Services. The Review also supports approaches to risk assessment and management in the Criminal Justice System that are applied equitably across the population and do not discriminate unjustifiably against those suffering from mental disorder.

11.21 The Review supports the development of a risk assessment and management framework to help offenders reduce their risks of offending and to protect the public from high risk offenders while restricting the freedoms of such individuals no more than is necessary in the public interest. This risk assessment and management framework should apply to all offenders who pose the prescribed level of risk and irrespective of whether these individuals suffer from mental disorder such as mental illness, severe learning disability or personality disorder, or whether there is no such mental disorder.

11.22 Such a framework is likely to interface with the work of other bodies such as MASRAM, the Life Sentence Review Commission, the proposed Parole Board and, in relation to Restriction Order patients, the Northern Ireland Office and the Mental Health Review Tribunal.

11.23 These issues relate to many areas of the Criminal Justice System and encompass many individuals who do not suffer from mental disorder. Thus they extend substantially beyond the remit of this Review. Similarly, although the Criminal Justice Inspectorate made helpful recommendations in respect of many aspects of the assessment and management of the risks posed by offenders, the remit of its inspection of the MASRAM process did not include the full range of issues identified by this Review. Likewise the Review of Sentencing Framework has considered some issues such as sentencing options for dangerous offenders, but these have not been integrated into a comprehensive framework for Northern Ireland. This Review recommends that these elements are drawn together by another body which comprises the relevant stakeholders and considers the range of options and measures required to produce a comprehensive interagency and community response to help offenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders.

11.24 The Review supports the creation of a service, run jointly by the Criminal Justice System and the HPSS the assessment and management of high risk offenders. It envisages a joint co-operative response to offenders that assesses the needs of each individual, his or her carers and also takes account of the needs of the public for protection. The Review recognises that in order to reduce the risk to the public to acceptable levels there may be a requirement for some offenders to be treated, managed or placed in specialised institutional settings. The Review envisages a range of services including a high secure facility, one of more facilities at lower levels of security and also services in the community. Offenders would be admitted to such facilities not primarily on the basis of mental disorder, but rather because of the risk they pose to public safety. These services would be similar to the pilot therapy programmes that have been developed for high risk offenders in England.

Recommendation

140. The DHSSPS and the Northern Ireland Office and relevant Criminal Justice Agencies should produce a comprehensive interagency and community response to help offenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder. This Risk Assessment and Management Framework should include:

- the legislative framework, including options to provide courts with risk assessments such as a risk assessment order and sentencing options such as an order for lifelong restriction;
- processes, methods and standards of risk assessment, risk management and offender therapy programmes;
- interagency strategies and working arrangements, including information sharing and other joint protocols and procedures;
- development of best practice, guidance and quality assurance mechanisms;
- training in risk assessment, risk management and offender therapy methods;
- accreditation of practitioners;
- the services required for the assessment and management of risk and the provision of offender therapies, including specialist facilities in conditions of security and in the community;
- the development of research strategies and methods of research and evaluation; and
- assessment of the workforce requirements and the provision of appropriate workforce planning and funding to meet the identified needs.

The Assessment and Management of Mentally Disordered Offenders

11.25 Forensic Mental Health and Learning Disability Services in Northern Ireland should develop standardised risk assessment and procedures and management protocols in relation to:

- information gathering;
- information sharing;
- risk evaluation; and
- risk management plans.

11.26 These should be co-ordinated by the Regional Forensic Network and integrate with the proposed Risk Assessment and Management Framework and with local clinical governance arrangements. They must recognise what can reasonably be achieved within the resources available and set standards that are monitored.

Recommendations

141. The Regional Forensic Network should ensure that all inpatient and community forensic services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the Risk Assessment and Management Framework.

142. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for risk assessment and management by forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external review.

143. The DHSSPS should revise current Discharge Guidance to ensure that it is compatible with the principles recommended by this Review and is supported by training and other appropriate resources.

PERSONALITY DISORDER

Introduction

11.27 Personality disorder is a major source of suffering for individuals and those in contact with them. It is also perhaps the most controversial, emotive and poorly understood issue at the interface between the Criminal Justice System and the Health and Social Services. The recommendations in this section interlink with those contained in many other parts of this Report but, it was considered fundamentally important to focus specifically on the issue of personality disorder in order to promote a positive and coherent vision for the future development of services, based on a partnership approach.

Definitions

11.28 The World Health Organization (WHO) (1992)[59] has defined personality disorder as:

> *"Deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual of a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance".*

11.29 The WHO (1992)[59] has classified specific personality disorders into:

- Paranoid;
- Schizoid;
- Dissocial;
- Emotionally unstable – impulsive type;
- Emotionally unstable – borderline type;
- Histrionic;
- Anxious (avoidant);
- Anankastic;
- Dependent; and
- Others.

11.30 The majority of specific personality disorders are not related to an increased likelihood of offending. Rates of personality disorder are high among certain groups of offenders, for example Singleton (1998)[60] found that 78% of male remand prisoners had personality disorder.

11.31 Mental illness is diagnosed on a separate axis or dimension from personality disorder. There is no objective measure of personality disorder and no clearly defined cut-off between normal and abnormal personality. An individual can be diagnosed as suffering from several personality disorders. Combinations of diagnoses are not uncommon in forensic practice, for example an individual may be diagnosed as suffering from schizophrenia, dissocial personality disorder and alcohol dependence syndrome.

11.32 In order to make a diagnosis of personality disorder a detailed process of assessment is required that considers the account and presentation of the individual and also generally additional information from other sources, for example, family members, health and social services and Criminal Justices Agencies. Structured and standardised psychological assessment may aid the diagnostic process. Personality disorder should not be diagnosed on the basis of specific behavioural problems alone, but rather there must be detailed consideration of the individual's characteristic patterns of perceiving, thinking, feeling and relating to others. In current clinical practice in Northern Ireland a lack of standardised approaches to the diagnosis of personality disorder means that the diagnosis may be made

without adequate information or the diagnosis may be missed, for example when personality disorder is present in addition to other mental disorders such as mental illness or substance misuse.

11.33 It is generally considered that personality disorder is caused by a combination and interaction of genetic propensities and adverse early experiences such as abuse and neglect. Adverse experiences in adult life may also contribute to personality deterioration. Personality disorders are by definition deeply ingrained, enduring and stable and thus they are not readily amenable to change. It is, therefore, important that research is commissioned into understanding how personality disorders develop and the most effective ways of preventing them. Forensic Services should contribute to those efforts.

11.34 In Scotland the Committee on Serious Violent and Sexual Offenders[54] noted that there are many types of personality disorder, the majority of which are not related to an increased likelihood of offending. The Committee emphasised the importance of the identification and management of high risk offenders, whether personality disordered or not.

The Committee stated that:

"Present understanding does not support compulsory hospitalisation and medical treatment for severe anti-social personality disorder."

11.35 In many respects the concept of personality disorder has limited utility. The term is so broad and the different types of personality disorder may have such different manifestations that the term "personality disorder" by itself conveys little meaning. It is often more appropriate to take a problem-orientated approach, in other words, an approach that seeks to identify and modify specific behaviours or behavioural deficiencies rather than attempting to change the whole personality of the individual. Such an approach also generally reflects the wishes of service users who tend to present to services complaining of specific problems or difficulties rather than "personality disorder".

Current Services

11.36 There are no specific services for forensic service users in Northern Ireland that are dedicated to the assessment and treatment of personality disorder - there are no residential facilities such as therapeutic communities, special prison units or secure hospital units, nor are there dedicated services in the community.

11.37 Thompson and colleagues[34] have described the current situation in Scotland where "At the present time it is routine psychiatric practice in Scotland **not** to admit individuals with a primary diagnosis of personality disorder to forensic psychiatric units". Although personality disorder is specifically included in the Mental Health (Care and Treatment) (Scotland) Act 2003[37], detention under that Act requires that an individual has significantly impaired ability to make decisions about treatment. Generally people with a primary diagnosis of personality disorder are considered not to have such impairment and thus they are not considered detainable for treatment under the Scottish mental health legislation. Although community forensic mental health service provision is rudimentary in most parts

of Scotland, most forensic psychiatrists have a small cohort of outpatients with a primary diagnosis of personality disorder.

11.38 In England personality disorder has been rejected as a diagnosis of exclusion[61] and there has been substantial financial investment in forensic services for people suffering from personality disorder.

11.39 The pilot schemes in England are being closely evaluated[34]. These include:

- the development of pilot inpatient and community forensic personality disorder services;
- the development of pilot units to treat people with "Dangerous and Severe Personality Disorder" - 2 units in prison and 2 units in high security hospitals; and
- the continuing use of HMP Grendon as a therapeutic community for prisoners with challenging behaviours within the prison service.

STANDARDS

Standard 1. A Co-Ordinated Joint Strategic Approach

11.40 The Review recommends a combined approach by the Criminal Justice System and Health and Social Services to the assessment and management of offenders who suffer from personality disorder. This approach must recognise the huge morbidity associated with personality disorder and the legitimate wishes of those with personality disorder and their carers to have access to assessment and treatment services.

11.41 People with personality disorder who are subject to the Criminal Justice System should not be excluded on the basis of that diagnosis from assessment or from receiving clinically appropriate therapeutic interventions by mental health and learning disability services. Similarly people with personality disorder who are subject to the Criminal Justice System should not be excluded from Criminal Justice Services, nor should assessment and management of their problems and needs be regarded as the sole responsibility of mental health and learning disability services.

11.42 The approach should ensure that the unique contributions of forensic mental health and learning disability services are utilized in assessment and treatment. The Criminal Justice System must also accept its major role in the management of offenders with personality disorder as these individuals are almost invariably considered to have criminal responsibility for their actions.

Recommendation

144. The DHSSPS and NIPS must ensure that services are developed for people with personality disorder, including offenders. The services require co-ordinated joint approaches by both the Criminal Justice System and the Health and Social Services. Service users, carers and their advocates must be involved in service planning and delivery.

Standard 2. Evidence, Principles and Purposes

11.43 The Review urges an explicit ethical basis to the assessment, treatment and care of people suffering from personality disorder. Evidence based services should be offered to individuals who wish to avail of them, whether or not they are subject to the Criminal Justice System. The Review does not consider it is ethical for mental health legislation to be used to enforce compulsory treatment on individuals who are mentally competent to refuse it.

11.44 The issue of personality disorder should not be confused with the issue of offenders who are at high risk of committing serious violent or sexual offences. The Review recognises the wishes of society to receive protection from high risk offenders and it has supported the development of a comprehensive interagency and community response, irrespective of whether or not such high risk offenders suffer from mental disorder. Society should not discriminate unjustifiably against those who suffer from mental disorder, for example, it should not introduce compulsory powers against high risk offenders who suffer from mental disorder that are more restrictive than the powers against offenders who pose an equally high level of risk, but do not suffer from mental disorder.

Standard 3 and Standard 4. Organisational Structures and Interconnections and Comprehensive Accessible Services

11.45 The Review envisages the provision of the following services for Northern Ireland:

In the community:

- residential therapeutic community facilities for forensic service users in Northern Ireland;
- day patient and outpatient services provided by each community forensic service; and
- input from each community forensic service into offender therapy programmes led by probation.

In the prisons:

- day patient and outpatient services provided in by prison forensic services; and
- input from prison forensic mental health and learning disability services to the assessment and management of prisoners attending the offender therapy programmes.

11.46 In addition consideration should be given to the development of a secure service for the management of prisoners whose personality disorder makes them unmanageable in an ordinary prison environment and those who would benefit from management in a therapeutic community. It is proposed that the Criminal Justice System and the Health and Social Services would jointly develop this service. It would offer detailed interagency and multi-disciplinary assessment, including:

- history of the individuals' life experiences;
- needs;
- mental state;
- psychological assessment;
- functional assessment;
- medical diagnoses;
- mental capacity; and
- risk assessment.

11.47 The service would require clear criteria for admission and discharge that would be subject to appeal. The service should offer a therapeutic ethos, including evidence-based therapies that are linked to research on therapeutic efficacy. The service should not offer perverse incentives to prisoners to behave in a disturbed manner with a view to securing admission to a more favourable service than the ordinary prison environment. The service would require one or more new facilities, both at high security and at lower levels of security with linkages to community services. The Review has noted the probable need for additional secure provision and this proposed new service for offenders may form a component of this additional provision. The service would need to be linked to a robust risk management framework operate according to explicit standards and be open to external inspection. The service would require high levels of psychotherapeutic input combined with high levels of training and support for staff.

11.48 At present there is not sufficient information on needs to make detailed recommendations on the size of these services.

Recommendations

145. The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community. Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed.

146. The DHSSPS should commission a detailed assessment of needs to inform the planning of services for offenders with personality disorder.

Standard 5. Risk Assessment and Management

11.49 It will be essential to support the development of these services by explicit policies on risk and responsibility. Within the current 'culture of blame'[62] guidance from the DHSSPS places responsibility on mental health and learning disability services for the actions of individuals who are mentally competent to make decisions for themselves. These obstacles to service delivery must be removed. Risk assessment and management arrangements for mentally disordered offenders should co-ordinate with those for other offenders and must not discriminate unjustifiably against those suffering from mental disorder. Also policies, procedures and protocols should be developed to take account of the needs to preserve medical confidentiality and to share information.

Recommendation

147. Service providers must ensure that services for the assessment and management of personality disorder are supported by the development of policies, procedures and protocols that recognise the respective responsibilities of all key stakeholders and that co-ordinate with the proposed Risk Assessment and Management Framework.

Standard 6. Quality Assurance

11.50 Forensic services must have robust and demonstrable quality assurance and governance mechanisms that include setting standards and assessing the quality of services. These should include internal mechanisms such as audit and also external review.

Recommendation

148. The commissioners and providers of services for offenders with personality disorder must ensure that services have strong quality assurance and governance arrangements including internal audit and independent external inspection and review.

Standard 7. Mental Health Promotion and Education

Recommendation

149. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that forensic services for people with personality disorder contribute to mental health promotion and public education, including contributing to understanding of the development of personality disorders and the most effective ways of preventing them.

Standard 8. Information, Research and Innovation

Recommendations

150. The Regional Forensic Network should promote the development of information and research strategies for forensic services for people with personality disorder. Research should be conducted into the needs of offenders with personality disorder and into the efficacy of therapeutic interventions.

151. The Regional Forensic Network should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

Standard 9. Recruitment, Retention and Developing a Skilled Workforce

Recommendation

152. The DHSSPS must ensure that robust workforce planning systems are developed to ensure the recruitment, training support and retention of suitable staff to support the development of services for offenders with personality disorder.

Standard 10. Sustainable and Transparent Funding

Recommendation

153. The development and maintenance of forensic services for the assessment and treatment of high risk offenders and individuals suffering from severe personality disorder requires appropriate funding from the relevant agencies. This should be delivered in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

OFFENDING BY ADULTS WITH ASPERGER'S SYNDROME OR HIGH FUNCTIONING AUTISM (AS/HFA)

INTRODUCTION

11.51 Current trends in prevalence[63] confirm an increase in the number of individuals in the general population receiving a diagnosis of an ASD, including Asperger's Syndrome or High Functioning Autism (AS/HFA). Recommendations for services for these individuals are contained in the Strategic Framework for Adult Mental Health Services[83]. Professionals in forensic services are increasingly likely to encounter individuals with AS/HFA. There is a need to increase our understanding of the relationship between AS/HFA and offending and to improve the identification and assessment of such individuals and their management within the Criminal Justice and Health and Social Services Systems.

Prevalence of AS/HFA within Forensic Services

11.52 While the majority of persons with AS/HFA are scrupulously law abiding[64], a small subset does come into contact with the legal system. Those with AS/HFA may behave in socially deviant and destructive ways with consequent police involvement. Due to poor diagnostic expertise in many countries, it is not clear how commonly violent and potentially criminal behaviour occurs by people with AS/HFA. Kohn et al (1998)[65] suggested that the prevalence of aggression in the population of AS/HFA persons is around 20% with many cases not being reported to police authorities.

11.53 A study of 135 young offenders assessed by the Forensic Psychiatry Department in Stockholm[66] found 30% with probable AS/HFA and a strong association with arson. Scragg and Shah (1994)[67] screened the entire population of Broadmoor Hospital, finding a rate for AS/HFA of 2.3% In 1999 the National Autistic Society[68] screened 1305 patients (96% of the total population) in three Special Hospitals in England and identified 31 cases (2.4%).

There were a further 31 'equivocal' cases who displayed some features of AS/HFA, but for whom the screening process was insufficient to be definitive and they would have required a full diagnostic evaluation to obtain a certain diagnosis. Wing (2003)[69] also reported 2.4 – 5.3% prevalence in a Special Hospital population, with over half of these having a co-morbid diagnosis of schizophrenia. The prevalence of adults with AS/HFA within the prison system or detained under the mental health legislation is unknown, as is the prevalence of females with AS/HFA involved with forensic services.

11.54 In a local community service for adults with AS or HFA, 18% of the individuals had been involved with the police and/or court services for offences including stalking behaviour, sexual offences, theft, fire setting and anti-social behaviour[70]. Of the Trust's sample, 25% of individuals known to the service had been detained in a psychiatric hospital under the Mental Health (Northern Ireland) Order 1986 at some time. Out of the 6 individuals with a forensic history, 5 had been admitted, 2 of who were formally detained - but not necessarily as a direct result of their offending behaviour. None had received a prison sentence.

Relationship between AS/HFA and Offending

11.55 Direct relationships between the offending behaviour and the clinical features of the disorder have been identified, particularly deficits in social relatedness or rigidity in thought and behaviour[71]. Case reports have noted connections between offending behaviour and core impairments of AS/HFA including:

- deficient empathy and consequent failure to recognise the impact of behaviours on others;
- problems with social understanding such as reacting negatively to actual or perceived rejection and bullying;
- an over sensitivity to sensory stimuli leading to a violent reaction;
- having a rigid interpretation of rules; and
- an obsessional pursuit or interest.

11.56 Also highlighted by Wing (1997)[72] is the social naivety and lack of common sense often seen in individuals with AS/HFA, which can make them easy targets for being manipulated by others with criminal intentions and malice. Such conspicuous interpersonal idiosyncrasies make those with AS/HFA particularly vulnerable to victimisation[73].

11.57 Murrie et al (2002)[74] observed that those with AS/HFA may have little or no experience with alcohol or drugs, little previous criminal contact and may be quick to confess to the police. They stated that this last aspect reflected a variety of traits from deficient shame, poor judgement, lack of experience, or an impaired appreciation of the social and legal consequences of a confession, to simple forthrightness, rule-abiding behaviour or honesty.

11.58 Murrie et al (2002)[74] emphasised the need for full assessment of AS/HFA and its legal implications so that courts could make properly informed decisions on issues such as treatment and disposal.

Need for Services

11.59 Although in the minority of people diagnosed with AS/HFA, those who are within the forensic system "represent a highly unique population with specialised needs"[75].

11.60 The Reed Report (1992)[76] devoted a volume to the special needs of mentally disordered offenders with AS/HFA and the services required to meet those needs. The Scottish Executive Development Centre for Mental Health (2004)[77] has published an extensive document on the needs of people with Learning Disabilities and/or Autistic Spectrum Disorders in secure, forensic and other specialist settings. Recommendations common to both were that:

11.61 Agencies should take account of the specialised and varying needs of offenders with autism, including the importance of co-operation between different services:

- such agencies should train their staff to recognise and, where possible, respond to the special challenges presented by people with autistic disorders; and

- research is required into meet the needs of autistic people who offend or have severe behavioural problems.

11.62 The National Autistic Society[78] made a series of recommendations including:

- changes to definitions in mental health legislation;

- early assessment of cases suspected of having an autistic spectrum disorder where the police have arrested an individual;

- a code of practice or guidelines on evidence-based intervention, including medication, for individuals with autistic spectrum disorders; and

- the introduction of an enforceable legal right to an independent advocate for all patients formally and informally detained.

11.63 There are substantial deficiencies in the provision of Forensic Services for individuals with autistic spectrum disorders in Northern Ireland. This reflects the low levels of forensic services and also the shortfall in the provision of adequate and appropriate services for adults with AS/HFA in the general population[79]. There is only a limited number of specialised units in the UK.

11.64 There should be individual assessment of the needs of forensic service users with AS/HFA and their carers, followed by combining the available resources in a flexible manner to address those needs. Those resources are likely to include staff with appropriate expertise in Forensic Services and in assessing and managing AS/HFA. Good communication, co-ordination and co-operation between service providers is essential.

Recommendations

154. The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suffering from Asperger's Syndrome or High Functioning Autism (AS/HFA) in Forensic Mental Health and Learning Disability Services and the Criminal Justice System.

155. The DHSSPS in partnership with Criminal Justice Agencies should commission a regional needs assessment to ascertain the prevalence of AS/HFA within the Criminal Justice and Forensic Services in Northern Ireland and to assess the needs of users and carers.

156. The DHSSPS should promote research into AS/HFA, including its relationship with offending behaviour, the effectiveness of specific psychological and environmental interventions, the development of models of service models and the definition of acceptable outcomes.

SERVICES FOR WOMEN

11.65 The Criminal Justice System and mental health and learning disability services must be gender sensitive and recognise the specific needs of both male and female service users. People who are subject to the Criminal Justice System and the users of forensic mental health and learning disability services are predominantly male and thus there are particular dangers that the specific needs of women are not adequately addressed.

11.66 The Department of Health in England reviewed many issues relating to women's mental health[80]. As regards women offenders it was noted that:

- men commit more crime than women; less than 5% of the prison population are women;
- men start their criminal careers at an earlier age than women and are more likely than women to have lengthy criminal careers;
- women are more likely than men to commit acquisitive offences and are less likely to commit arson, violent or sexual offences;
- women are more likely than men to say that financial hardship, particularly in relation to their children, contributed to their crime;
- there has been a recent dramatic rise in the number of women in prison compared to men; and
- women in prison have experience of high levels of violence and abuse as children and as adults.

11.67 Women prisoners are:

- twice as likely as men to have received help for a mental/emotional problem in the 12 months before entering prison;
- less likely than men to receive a diagnosis of antisocial personality disorder and more likely to receive a diagnosis of borderline personality disorder;

- more likely to have severe mental illness;
- twice as likely as men to have symptoms associated with post-traumatic stress disorder; and
- more likely than men to have a history of self harm.

11.68 The Department recommended that the following principles should apply across all service settings:

- access to a same sex member of staff;
- access to a female doctor for physical healthcare;
- physical examinations to be undertaken by a female member of staff or with a female chaperone present;
- a female member of staff present if restraint is used;
- access to women-only therapy groups, particularly for issues such as violence and abuse;
- access to women-only social activities; and
- acknowledgement of caring responsibilities, for example through provision of childcare facilities, transport and flexible appointment times.

11.69 It also advocated the provision of single-sex forensic units, predominantly at medium and low security. In addition it recommended training for mental health practitioners on gender-related issues.

11.70 In England, a number of separate women's secure services have been developed. In Scotland it has been proposed that comprehensive Forensic Psychiatry Services for Women should be provided in each of the 4 regional groupings that would meet all the treatment needs of women service users. These services would comprise dedicated multi-disciplinary teams with access to secure beds and easy progression to non-secure inpatient facilities or community services.

11.71 In Northern Ireland, there are no dedicated forensic mental health and learning disability services for women. The transfer of female prisoners from Mourne House, Maghaberry to Ash House at Hydebank Wood in June 2004 has been criticised[81]. An inspection of facilities at Ash House in November 2004 led to recommendations for a policy and strategic plan for the treatment of women in custody based on a full assessment of their specific needs. A separate prison was recommended for women in Northern Ireland and also the development of separate policies specific to women, the provision of therapeutic responses to self-harm and increased constructive activity. McClelland and colleagues (2005)[13] praised improvements in the services for women in Ash House. A full health needs assessment of the women in Ash House was completed in 2005.

11.72 At the time of writing this Report there are not known to be any women from Northern Ireland who are receiving treatment in high secure inpatient facilities, either in Northern Ireland or in other parts of the UK. Shannon Clinic provides accommodation that may be

used by women and is partly separate from the facilities used by men, but with access to shared activities and rehabilitation facilities. There are no separate community forensic mental health and learning disability services for women.

DISCUSSION

11.73 The Criminal Justice System and mental health and learning disability services must be gender sensitive and recognise the specific needs and preferences of both male and female service users.

11.74 Several facilities for female forensic service users from Northern Ireland provide substantial or significant separation from male service users – the prison, Carstairs and Shannon Clinic.

11.75 There is a need to work closely with female service users and their advocates and carers to gain greater understanding of their needs and preferences and to develop and deliver services that are sensitive to and that respect these needs and wishes. It is particularly important to be clear about the reasons to either separate or integrate male and female service users. For example, much of the therapeutic work to address the effects of sexual abuse and trauma may be better carried out in a single sex environment. In other situations an integrated environment may facilitate work on social skills. Policies on these issues should be developed in all forensic services.

11.76 The relatively small numbers of women forensic service users may limit the range of facilities that can realistically be made available locally. In other regions it has been suggested that services should be combined, for example, at low and medium levels of security. There may also be benefit in providing services jointly with other service providers, for example, with Scotland or the Republic of Ireland.

11.77 Women forensic service users from Northern Ireland can generally receive assessment and treatment in a single sex environment in Carstairs and in the prisons. Shannon Clinic offers a degree of separation, combined with opportunities for integration. The assessment of the future needs for secure provision may well indicate that a separate low secure facility is more appropriate to the needs of women service users.

11.78 The Review has considered the provision of a separate community forensic service for women service users. Current needs would probably require a regional service to meet the needs of women service users. The Review considers that the individual needs of service users, both male and female, should be met by local community forensic services and that all such services should be gender sensitive.

11.79 Training should be provided for all staff in Forensic Services to ensure gender sensitivity.

Recommendations

157. Service commissioners and providers must ensure that services are gender sensitive. Planning and development of forensic services must take account of the needs and wishes of service users, their advocates and carers.

158. The Regional Forensic Network should co-ordinate the development of gender sensitive policies in all forensic services.

159. The proposed assessment of needs for secure provision (Chapter 8) should consider options to meet the needs of service users in a manner that is gender sensitive. This should include consideration of whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic.

160. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

161. Service providers must ensure that staff in all Forensic Services receive training to ensure that services are gender sensitive.

FORENSIC PSYCHOTHERAPY

11.80 In order to provide comprehensive assessment, treatment and care, Forensic Services should take account of biological, psychological and social factors. Psychotherapy Services are particularly poorly developed at present and require specific consideration because of their fundamental importance in understanding and responding appropriately to the problems and needs of service users and their carers. There is a need to develop knowledge and skills in many areas of psychotherapy such as group analytic, family, systemic and individual psychoanalytical and cognitive behavioural approaches. Knowledge of the following should be developed:

- understanding the need for psychotherapeutic intervention as an important element in the treatment of psychosis and chronic mental disorders, including personality disorder, particularly where service users are in an institution or receiving other treatment and care for a long period of time;
- developing an understanding of the nature of personality disorder, particularly when there is a history of antisocial and criminal activity;
- awareness of the importance of personality disorder in service users with a diagnosis of major mental illness who have committed criminal acts;
- developing an understanding of the effects of psychopathology on abnormal and criminal behaviours, particularly aggression and sexual violence;
- understanding of group and institutional processes and the dynamics of the institutions involved in forensic settings including prisons and secure inpatient facilities;
- recognition of the personal impact of working with forensic service users and thus moderating the potential for a negative impact on clinical practice, management and multi-disciplinary working;
- recognition of the impact of offending and abusive experiences on service users, their victims and the institutions in which they are housed;
- understanding of criminological issues, including ethnicity, gender and culture; and
- aiding risk assessment and management by understanding the meaning of criminal activity to service users.

11.81 Forensic Psychotherapists require a wide range of skills including the following:

- expertise in assessment for Psychotherapy;
- expertise in one or more branches of Psychotherapy and knowledge of other branches of Psychotherapy, including the indications and contraindications in order to match therapy to the needs of service users;
- expertise in the use of security as part of treatment;
- understanding of the nature of risk and dangerousness and risk management, including appropriate communication with professional colleagues;
- expertise in the rehabilitation of service users who present potential risk to others;
- the ability to formulate problems from a systemic and organisational viewpoint, including understanding the effect of particular behaviours and teams and systems;
- expertise in clinical supervision;
- ability to evaluate the outcome of therapies; and
- the ability to formulate and communicate opinions clearly.

11.82 The Review recommends development of a range of multi-disciplinary therapeutic services that are integrated within Forensic Services. All staff working in Forensic Services should aim to develop high levels of knowledge and skill. They should be supported by specialist practitioners who have developed further knowledge and skills of psychotherapeutic practices and they should have strong links with psychotherapy departments.

11.83 Psychotherapeutic services should be provided to a broad range of forensic settings including high, medium and low secure inpatient facilities, prisons, community and outpatient facilities including therapeutic communities, hostels and community offender programmes.

11.84 Chapter 6 has noted the need for the DHSSPS to take the lead, in partnership with Criminal Justice Agencies to form a multi-agency consortium to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour.

Recommendations

162. The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches.

163. All clinical staff working in forensic services must be provided with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill.

164. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

165. The DHSSPS must ensure that development and maintenance of forensic mental health and learning disability inpatient and community services is supported by robust workforce planning that takes account of the need to recruit and retain specialist Psychotherapists and Forensic Psychotherapists and to provide supervision, support and training to staff working in forensic services.

CHAPTER 12

IMPLEMENTING CHANGE

CO-ORDINATING DEVELOPMENTS AT REGIONAL AND LOCAL LEVELS – A REGIONAL FORENSIC NETWORK

12.1 Forensic Services in Northern Ireland must be developed to meet the needs of service users and carers at a local level and they must be co-ordinated across the region. The Review does not propose a fully detailed and prescriptive plan, but rather it advocates a process that is dynamic and interactive and which co-ordinates planning and development in an ongoing and strategic manner. It is proposed that Forensic Services should develop through partnerships between a regional co-ordinating group which sets the overall directions, priorities and sequence of change and local groups which implement change and ensure its integration with related services.

12.2 In recent years a number of organisational structures referred to as Managed Clinical Networks[82] have been developed to address problems similar to those faced by Forensic Services in Northern Ireland. These networks are regional or national organisations that bring together the key stakeholders to work in partnership to promote service development. Examples include the Northern Ireland Cancer Network and the Scottish Forensic Mental Health Services Managed Care Network.

12.3 In Scotland the national development of Forensic Mental Health Services is co-ordinated by a Managed Care Network Advisory Board which is chaired by the Head of the Mental Health Division in the Health Department. The Board comprises representatives from all the key organisations and provides dedicated time to its Chief Executive and Lead Clinician. The Advisory Board relates to the State Hospital and 4 regional groups which in turn relate to local services. The Board has commissioned a number of working groups to produce regional guidance and is developing regional multi-agency structures with links to NHS Regional Planning Groups. Thus the Scottish Network is an organisation with representation from the key stakeholders and with the capacity to co-ordinate functions at national, regional and local level.

12.4 The Review considers that a Northern Ireland Forensic Services Managed Network would be a logical development to advance the development of Forensic Services in Northern Ireland in accordance with the principles espoused by this Review. This Network would not only link together the developing services in Northern Ireland, but it could also establish useful connections with other developing forensic services in the rest of the United Kingdom, Ireland and further afield. Such external connections could, for example, lead to the sharing of service plans, experiences of service delivery and also staff training and development.

PURPOSES OF THE REGIONAL FORENSIC NETWORK

12.5 It is envisaged that the Forensic Services Managed Network (the Network) would have the following purposes:

> to plan, implement and evaluate the development and delivery of co-ordinated statutory and independent mental health and learning disability services for mentally disordered offenders and those with similar needs and to contribute to the prevention of mental disorder and associated harm.

12.6 It is considered essential that the remit of the Network should not focus narrowly or exclusively on the development and delivery of specialised Forensic Services. Instead it should be explicitly acknowledged that many service users with forensic needs currently have those needs met by a range of interconnecting services in primary and secondary care. There is a need both to support and develop these interconnecting services and at the same time to develop specialised forensic services. The Network should actively pursue both purposes in order to increase the capacity to meet needs and to enhance the quality of the services that are delivered.

THE REGIONAL FORENSIC NETWORK BOARD

12.7 The Network Board (the Board) should have appropriate accountability to Government and authority to resolve conflicts where these arise. The membership of the Board should comprise relevant commissioners and providers of mental health and learning disability services, representatives of service users and carers and associated organisations such as the Probation Board, the Police Service, the Prison Service, Housing and the Courts. The Board should include user and carer representation. Consideration should also be given to developing links with other developing forensic services outside Northern Ireland.

12.8 The functions of the Board should include:

- strategic planning;
- promoting and co-ordinating the development of systems to assess need and gather the information and evidence required for service planning;
- promotion of values and principles;
- promotion and development of comprehensive interconnected services;
- overseeing the development of co-ordinated systems of risk assessment and management;
- overseeing the development of quality assurance mechanisms that include setting and auditing standards and assessing the performance and quality of services;
- co-ordinating contributions to mental health promotion and education;
- co-ordinating developments in information systems and promoting research and innovation; advising the DHSSPS on recruitment and retention;

- promoting a co-ordinated approach to learning and development; and
- advising the DHSSPS on funding requirements.

12.9 The Board will require resources such as a Chair and Project Manager to carry out its tasks.

12.10 The Review envisages that the Regional Forensic Network will be part of the regional mental health and learning disability implementation process chaired by a Regional Director. In view of factors such as the specialised nature of the services, the potential high costs of some elements and the need to provide equity, the Review strongly favours the regional commissioning of forensic services.

Recommendations

166. The Review recommends the establishment of a Regional Forensic Network to co-ordinate the planning and delivery of Forensic Services at regional and local levels.

167. Forensic Services should be commissioned on a regional basis.

DEVELOPING CO-ORDINATED FORENSIC SERVICES

12.11 Although this Report has considered in separate chapters the services that should be delivered at different locations, it is essential that services are developed in a co-ordinated manner. Staff must work across locations in a manner that best meets the needs of service users and carers and supports the development of therapeutic relationships and continuity of care. For example, some staff will work both in inpatient settings and in community services; community forensic teams may provide in-reach forensic services to prisoners including preparation for return to the community and support following discharge from prison. As services grow and develop their structures will change, for example, it is proposed that community forensic learning disability services should begin as a regional service and then, following further assessment of needs and as resources become available, services should become more locally based and more closely integrated with other local services. Staff must work flexibly and co-operatively to support the growth and differentiation of services. At times staff will need to come together to learn from each other, to share information and resources such as protocols and training. At times there will be a need to pool all the relevant and available expertise, for example, in the assessment and management of particularly problematic or difficult cases. Forensic Services will also need to develop in an open manner, recognising and supporting the invaluable work of many other services in supporting mentally disordered offenders. Services must share information on service performance and quality and they must not become fragmented or isolated because of the high risks that can develop in those situations. Forensic services should also contribute to wider developments in the HPSS and in the Criminal Justice System.

12.12 Forensic Services in Northern Ireland are at the start-up of a process that will continue to evolve over many years. At this early stage, even though there is a great lack of information about the detailed needs of service users and their carers, there is an obvious and compelling case to urgently provide a number of components of a regional forensic

service, as has been recommended in this Report. These initial developments should not be delayed by procedures to assess the needs, but nor should these initial developments distract from the underlying requirement to assess and monitor need and service performance. Thus the first phase of developing forensic services must include both the initial development of services and the detailed assessment of needs. After this initial phase, further developments must increasingly take account of assessed need and service performance. Services should continue to be developed to meet the needs, however, Forensic Services should not expand indefinitely and unthinkingly. Research must be conducted into the routes whereby individuals become mentally disordered offenders or forensic service users. Where possible, preventive measures should be introduced that help promote mental health and wellbeing. If our society is to address the challenges posed by mentally disordered offenders it must invest in the necessary long-term research and preventive strategies.

12.13 Thus the Review envisages an iterative process of development of Forensic Services, driven by assessed need, guided by principles and values, delivering quality-assured services to meet the needs and contributing through research to the reduction of need.

WORKFORCE PLANNING

12.14 The development of Forensic Services must be supported by effective workforce planning. This element is so fundamental to the successful development of services that its importance could hardly be overstated. A Workforce Strategy must be developed for Forensic Services that is similar to and co-ordinated with that for Adult Mental Health Services[83]. The workforce plan must address the recruitment and retention of staff in Forensic and interconnecting services.

12.15 There must also be learning and development strategies to provide staff with the necessary knowledge and skills. There must be arrangements for the training of new staff and the continuing professional development of existing staff. The training needs of staff working in Forensic Services and in interconnecting services must be analysed and training strategies devised to meet the needs. Users and carers should also be included in a comprehensive learning and development strategy, both to help in the training of staff and to meet their own needs. Training should be closely linked to the needs of the developing services. There are particular needs to provide training in psychotherapy and also psychotherapeutic support for staff who are working in this emotionally demanding field. Services should work together co-operatively to share training locally and regionally.

INFORMATION SYSTEMS

12.16 Similarly the Adult Mental Health Services Report[83] has identified the need for comprehensive and integrated information systems. The arrangements for information systems must extend across mental health and learning disability services encompassing Forensic Services and making the necessary links with the Criminal Justice System.

RESEARCH AND DEVELOPMENT

12.17 The development of Forensic Services must be supported by a Research and Development strategy. Priorities include:

- an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high, medium and low security and in community facilities should be commissioned by the DHSSPS. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder and other developmental disorders. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care;

- a detailed assessment of the needs of mentally disordered prisoners and their carers should be commissioned by the joint DHSSPS/NIPS project to transfer responsibility for prison healthcare to the NHS;

- an assessment should also be commissioned to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements;

- NIPS should commission research on the feasibility of reducing the number of people in prison by providing a broader range of facilities in the community, including lower security placements for mentally disordered women;

- research should also be commissioned to evaluate the methodology of assessing people in police stations and prisons with a view to ensuring the accurate identification of specified forms of mental disorder and need;

- epidemiological research should also be conducted into the needs of the population for forensic services;

- Research should also be incorporated into the developing services for offender therapy and personality disorder; and

- There are a number of clinical conditions that are poorly recognised or understood that require research priority such as AS/HFA and Attention Deficit Hyperactivity Disorder (ADHD) in adulthood.

THE PROCESSES OF CHANGE

12.18 The following outline sequence for the implementation of its recommendations proposes:

YEAR 1

12.19 The Regional Forensic Network should be established and its structures, resources, principles and purposes should be agreed. The Network should develop strategies for workforce planning, information systems and research.

12.20 An ongoing Workforce planning process should be developed for Forensic Services.

12.21 In Year 1 a detailed needs assessment should be commissioned to examine current and projected needs for high, medium and low security inpatient services and community facilities for people suffering from mental illness, learning disability and personality disorder and other developmental disorders. The results of this needs assessment should inform decisions on the needs for future services such as a high security service, additional medium secure places (particularly for longer stay), the numbers of new low secure places and the number and range of community facilities.

12.22 In addition the DHSSPS should examine the current obstacles to high secure care that are experienced by unsentenced prisoners and certain others and it should decide its strategy to resolve this highly unsatisfactory situation.

12.23 In Year 1 it is expected that responsibility for the healthcare of prisoners will transfer to the NHS. This will require agreement of the organisational structures and the range of services to be provided, and consideration of the assessed needs of prisoners including women and prisoners in healthcare centres.

12.24 A prison mental health promotion group should be established and also a consortium to provide therapies for offenders.

12.25 The Community Forensic Services should be developed further and a regional forensic learning disability service should be initiated.

12.26 Work should commence on developing an interagency framework for the assessment and management of risk.

YEAR 2

12.27 Further needs assessment should be commissioned to establish the needs of the population for Forensic Services. The assessments should also include specific examination of the needs of mentally disordered people in police stations, on bail, at court and on probation and the needs of their carers.

12.28 A strategy should be agreed on the future profile and development of high, medium and low secure provision and related community facilities.

12.29 Proposals should be published on an interagency risk framework.

12.30 Work should begin to develop regional guidance on fitness for interview, fitness to attend court, and to review the appropriate adult scheme.

12.31 The Regional Forensic Network should agree quality standards for mental health and learning disability services to people in the Criminal Justice System and for forensic inpatient and community services.

12.32 Health promotion opportunities should be identified in the Criminal Justice System and for forensic inpatient and community services.

YEAR 3

12.33 Commissioners should use the results of the needs assessments to commission a full range of mental health and learning disability services to people in police stations and also local Community Forensic Learning Disability Teams.

12.34 Five CFT's should be resourced and fully operational.

12.35 A regional strategy should be agreed on the future assessment, treatment and care of people with personality disorder.

12.36 Psychotherapy services should be fully integrated within inpatient and community forensic services.

12.37 The regional body with responsibility for quality assurance should agree quality standards for mental health and learning disability services to people in the Criminal Justice System and for forensic inpatient and community services.

12.38 A health promotion strategy should be agreed and implemented for the Criminal Justice System and for forensic inpatient and community services.

YEAR 5

12.39 Further assessment should be undertaken of the needs of the population for Forensic Services, including examination of the needs of people in the Criminal Justice System and forensic inpatient and community services.

12.40 A comprehensive offender therapy consortium should be in place.

12.41 Regional guidance should be completed.

YEAR 7

12.42 Low secure services should be in place to meet the assessed needs.

YEAR 10

12.43 Further assessment should be undertaken of the needs of the population, including people in the Criminal Justice System and forensic inpatient and community services.

12.44 Additional high secure and medium secure places should be provided to meet the needs.

PERFORMANCE INDICATORS

12.45 The following tables provide further details of the performance indicators, targets, milestones, responsibilities and the sources of information that will confirm implementation:

1. Regional Planning and Co-Ordination to Include Service Users and Carers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Regional Forensic Network to be established and to include user & carer representatives	Network established User & carer representatives appointed	Year 1 Year 1	DHSSPS	Network structures, values, principles and plans
DHSSPS & NIPS to agree organisational structures in prisons, to include user & carer representatives	Structures agreed User & carer representatives appointed	Year 1 Year 1	Transfer project	DHSSPS & NIPS

2. Assessment and Monitoring of the Needs of Service Users and Carers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Assessment of the needs of prisoners, including the needs of carers, women and prisoners in healthcare centres	Information for service planning and funding Information on need and service impact, to aid service planning	Year 1 Repeat at years 5 & 10	NIPS/DHSSPS transfer project	Transfer Project Local Service Providers
Assessment of the needs of people in police stations, on bail, at court and on probation	Information for service planning Information on need and service impact, to aid service planning	Year 2 Repeat at years 5 & 10	DHSSPS	DHSSPS
Assessment of needs for high, medium & low security & community placements for short, medium and long stay for people with mental illness & learning disability	Information for service planning Information on need and service impact, to aid service planning	Year 1 Repeat at years 5 & 10	DHSSPS	DHSSPS
Assessment of needs for secure & community placement for people with personality disorder & other developmental disorders	Information for service planning Information on need and service impact, to aid service planning	Year 2 Repeat at years 5 & 10	DHSSPS	DHSSPS
Service information from Community Forensic Services & Regional Secure Unit	Information for service planning	Annual	Local Service Providers	Local Service Providers

3. Effective Mental Health and Learning Disability Services for People Subject to the Criminal Justice System

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Full range of mental health and learning disability services arranged for prisoners	All services in place before transfer of responsibility in April 2007	Year 1	Transfer project	Information published by Transfer project
Commissioners to commission a full range of mental health & learning disability services to people in police stations, on bail, at court and on probation	Completed following needs assessment	Year 3	DHSSPS	DHSSPS
Service providers to provide a full range of mental health & learning disability services to people in police stations, on bail, at court and on probation	Protocols and services in place to provide access to full range of services	Year 5	Local Service Providers	Local Service Providers
Development of an offender therapy consortium	Basic structure established Resource needs agreed Comprehensive services in place	Year 1 Year 2 Year 5	DHSSPS	DHSSPS
Regional guidance on fitness for interview, fitness to attend court, review of appropriate adult scheme etc	Group(s) formed All work completed	Year 2 Year 5	DHSSPS	Regional guidance issued and appropriate training & resources provided

4. Effective Inpatient and Community Forensic Mental Health and Learning Disability Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Review of options and formulation of strategy for high security provision	High secure services must be available to all people in N Ireland who require them. Follows needs assessment in Year 1	Year 2	DHSSPS	DHSSPS
Strategy for high, medium & low security & community placements for short, medium and long stay for people with mental illness & learning disability	Full range of places must be available to meet needs Strategy follows needs assessment in Year 1 Provision of low secure and community facilities Provision of high security and long stay medium security	Year 2 Year 7 Year 10	DHSSPS	DHSSPS
Development of community forensic teams Initial development Further development	5 fully operational teams Further developments following service information and needs assessment	Year 3 Year 7	DHSSPS	DHSSPS
Development of a regional forensic learning disability service	Regional inpatient and community service	Year 1	DHSSPS	DHSSPS

4. Effective Inpatient and Community Forensic Mental Health and Learning Disability Services

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Development of local forensic learning disability teams	5 local teams	Year 3	DHSSPS	DHSSPS
Services for people with personality disorder	Needs assessment	Regional strategy	Year 2	Year 3
Psychotherapy services	A full range of psychotherapy services fully integrated within all inpatient & community forensic services	Year 3		

5. Assessing and, Where Possible, Minimising the Risks of Harm that are Associated with Mental Disorder

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
DHSSPS & NIO to develop a risk assessment and management framework	Group constituted Proposals published Framework implemented	Year 1 Year 2 Year 3	DHSSPS	DHSSPS
Inpatient and community forensic services to develop risk assessment and management policies, procedures and protocols	Policies, procedures and protocols in place. Regular updates	Year 1	Regional Forensic Network	Regional Forensic Network

6. Continuing Quality Improvement

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
DHSSPS & NIPS to agree clinical governance and internal quality assurance mechanisms for prisons	Clinical governance and internal quality assurance mechanisms agreed and implemented before transfer	Year 1	Transfer Project	Transfer Project
Clinical governance and internal quality assurance mechanisms to be agreed for inpatient & community forensic services	Clinical governance and internal quality assurance mechanisms agreed	Year 1	Local Service Providers	Local Service Providers
Development of regional standards for mental health and learning disability services to the criminal justice system and for forensic inpatient & community services	Standards agreed Year 2	Regional Forensic Network	Regional Forensic Network	
Regional quality assurance body to develop quality standards for mental health and learning disability services to the criminal justice system and for forensic inpatient & community services	Quality standards agreed	Year 3	RQIA Regulation and Quality Improvement Authority	RQIA Regulation and Quality Improvement Authority

7. Promoting Mental Health

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Establish a regional prison mental health promotion group	Agree and implement strategy before transfer of responsibility	Year 1	Transfer project	Transfer project
Identify opportunities for mental health promotion for people in police stations, on bail, in court and on probation	Assess opportunities Agree and implement strategy	Year 2 Year 3	DHSSPS	DHSSPS
Identify opportunities for mental health promotion for people in inpatient & community forensic services	Assess opportunities Agree and implement strategy	Year 2 Year 3	Regional Forensic Network	Regional Forensic Network

8. Meeting the Information Needs of Service Users, Carers and Service Providers

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
Healthcare information systems to be established in prisons to meet the needs of mentally disordered prisoners	Completed before transfer of responsibility	Year 1	Transfer project	Transfer project
HPSS information systems should extend to people in police stations and courts	Appropriate HPSS information accessible to healthcare staff working in the Criminal Justice System	Year 3	DHSSPS	DHSSPS
Promoting communication with all relevant parties	Forensic inpatient & community services to develop information strategies	Year 2	Regional Forensic Network	Regional Forensic Network
Promoting research	Forensic inpatient & community services to develop research strategies	Year 2	Regional Forensic Network	Regional Forensic Network

9. Delivering an Effective, Competent and Confident Workforce

Performance Indicators	Targets	Milestones	Lead Responsibility	Information & Sources
A comprehensive workforce strategy for forensic services	Agreed strategy	Year 1	DHSSPS	DHSSPS
A strategy for workforce recruitment	Strategy implementation targets to be agreed	To be agreed	DHSSPS	DHSSPS
A strategy for training needs analysis and workforce training	Agreed strategy	To be agreed	DHSSPS	DHSSPS
A strategy for training in psychotherapies	Agreed strategy for training in psychotherapies	Year 1	DHSSPS	DHSSPS

Recommendations

1. A Regional Forensic Network should co-ordinate and lead the strategic planning of forensic services in Northern Ireland.

2. Strategic planning must be guided by evidence and by values and principles. The Regional Forensic Network must establish systems of gathering the necessary information and evidence to inform the further development of services.

3. The Regional Forensic Network should establish explicit values and principles to guide the planning and development of forensic services. The values and principles adopted by this Review (see 2.3-2.5) are recommended. In addition the following principles are recommended for forensic services:

   i. there should be joint co-operative planning between the Criminal Justice Agencies and the Health and Personal Social Services and joint delivery of services in order to best meet the needs of service users and carers;

   Mentally disordered offenders and others with similar needs should receive treatment, care and support for their mental disorder that is:

   ii. as far as possible in the community, rather than in inpatient settings;

   iii. under conditions of security and restriction no greater than as is justified by the degree of danger they present to themselves or others; and

   iv. open, accountable and subject to external review.

4. The planning and development of forensic services should take full account of the 10 Standards identified in this Report.

5. Service commissioners must commission a full range of statutory mental health and learning disability services to meet the needs of mentally disordered people detained in police stations.

6. Providers of statutory, voluntary and community mental health and learning disability services must ensure they provide equity of access and provision of services for people detained in police stations.

7. Mental health and learning disability services to people detained in police stations should be provided locally and co-ordinated regionally. The Department of Health, Social Services and Public Safety (DHSSPS) should lead this co-ordination in liaison with the Regional Forensic Network.

8. Research should be commissioned to assess the needs of mentally disordered people and their carers in police stations throughout Northern Ireland. This research should include recommendations leading to the establishment of systems to monitor ongoing need and the impact of services on need.

9. Advocacy services associated with community mental health and learning disability services should be extended to include police stations.

10. Clear organisational structures, accountability and governance arrangements must be agreed for mental health and learning disability services to police stations.

11. Service providers should develop information systems that enable FM0s and staff working in mental health and learning disability services to gain appropriate access to the health records of people detained in police stations.

12. Research should be commissioned to evaluate the methodology of assessing suspects in police stations with a view to ensuring the accurate identification of specified forms of mental disorder and need.

13. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to produce guidance on assessment of fitness for interview and related matters.

14. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising representatives of all the relevant stakeholders to review the appropriate adult scheme. The group should consider the effectiveness, efficiency and practical working of the scheme, including the criteria invoking the use of appropriate adults.

15. Commissioners should commission services for the safe assessment, treatment and care of mentally disordered offenders in police stations.

16. Service providers and other stakeholders should agree joint protocols for the assessment and management of mentally disordered people in police stations, including those whose behaviour is disturbed.

17. Commissioners should commission services that provide police with ready access to advice from suitably qualified health professionals.

18. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in police stations.

19. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services must ensure that quality standards are developed for mental health and learning disability services in police stations and that services are audited and subject to external independent inspection.

20. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion within police stations and ensure that appropriate services are provided and their impact evaluated.

21. The DHSSPS should ensure that research programmes are commissioned to examine the efficacy of different models of services to mentally disordered offenders in police stations with a view to informing further service planning.

22. The DHSSPS should ensure that development of Information Systems within the HPSS takes account of the need to provide health and social services to people in police stations.

23. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including police, FMO's, lawyers and health and social services staff.

24. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

25. The development and maintenance of services for mentally disordered people in police stations across the province requires appropriate funding from the relevant sources. Funding should be delivered in accordance with a long term plan that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

26. The Northern Ireland Prison Service (NIPS) should commission research on the feasibility of reducing the number of mentally disordered people in prison by providing a broader range of facilities in the community. The research should address the mental health and social needs of male and female remand prisoners as well as the requirements of the Criminal Justice System. It should consider the potential utility of facilities with joint input by criminal justice staff and health and social services staff to offer different levels of supervision and therapy for a wide range of mental disorders including mental illness, learning disability, personality disorders and alcohol and substance misuse.

27. Service commissioners should commission a full range of statutory, voluntary and community mental health and learning disability services to meet the needs of mentally disordered people attending courts.

28. Providers of community mental health and learning disability services should ensure they provide equality of access and provision of services for people attending courts.

29. In Year 5, when forensic mental health and learning disability services in Northern Ireland have increased in size and capacity, a detailed option appraisal should be undertaken to consider the provision of assessments and other services for the courts by alternative means, including by service level agreements.

30. The DHSSPS in partnership with Criminal Justice Agencies should establish a group of relevant stakeholders to produce guidance on the assessment of fitness to attend court.

31. Service providers must ensure that healthcare staff assessing and treating prisoners attending court have ready and appropriate access to existing healthcare information

32. The DHSSPS should establish a group with the Court Service and other relevant stakeholders to review and develop procedures and protocols in relation to mentally disordered offenders to ensure efficient and effective operation.

33. The relevant regional body with responsibility for assuring the quality of mental health and learning disability services should ensure that quality standards are developed for mental health and learning disability services in courts and that services are audited and subject to external independent inspection.

34. Service commissioners and providers should liaise with the regional body with responsibility for mental health promotion to identify opportunities for mental health promotion at courts and ensure that appropriate services are provided and their impact evaluated.

35. The DHSSPS in partnership with Criminal Justice Agencies should ensure that an assessment is undertaken of the learning and development needs of stakeholders including court staff, lawyers, judiciary and health and social services staff.

36. Appropriate training strategies should be devised and implemented to meet the identified needs for both induction training and for continuing professional development.

37. The proposed review of options for mental health and learning disability services to the courts should include consideration of funding mechanisms.

38. Improvement of the mental health of prisoners requires a partnership between the DHSSPS and the NIPS to ensure:

- development of a prison environment that actively promotes mental health and well-being; and
- provision of a comprehensive range of mental health and learning disability services which address the needs of prisoners and are integrated with other community and prison services to ensure effective through care.

39. The Review welcomes the decision to transfer responsibility for the healthcare of prisoners to DHSSPS and emphasises that it must be supported by robust quality assurance mechanisms and by sufficient resources to meet the needs.

40. The Review recommends that planning the future of mental health and learning disability services for prisoners is integrated with the planning of mental health and learning disability services throughout Northern Ireland including the joint strategic approach co-ordinated by the Regional Forensic Network.

41. The joint DHSSPS/NIPS project to transfer responsibility must ensure that a detailed assessment of the needs of mentally disordered prisoners and their carers is completed by the end of 2006. The assessment of need must encompass all those suffering from mental disorder including mental illness, learning disability, personality disorder and alcohol and substance misuse. It must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff.

42. The needs assessment must lead to the provision for service commissioners of systems to monitor and evaluate in an ongoing manner the needs of service users and carers and the impact of services on need.

43. The DHSSPS and NIPS in partnership should develop explicit values and principles for mental health and learning disability services and Criminal Justice Services for prisoners that guide the development of a prison environment that actively promotes mental health and well-being and that provides a comprehensive range of mental health and learning disability services.

44. The DHSSPS and NIPS in partnership should agree arrangements to develop strong and cooperative working relationships between prison staff, health and social services staff, and Criminal Justice Agencies at operational and managerial levels. These should include the supporting organisational structures, training and the development of joint policies, protocols and procedures.

45. Commissioners of mental health and learning disability services in prisons must ensure that service users and carers are involved in the development, delivery and monitoring of services.

46. Commissioners of mental health and learning disability services in prisons must ensure that advocacy services and complaints procedures are developed for service users in prisons, building on those already in place.

47. The project overseeing the transfer of lead responsibility must ensure that joint working arrangements with all relevant mental health and learning disability service providers are agreed and published before April 2007. It must be demonstrated that service providers have sufficient resources and capacity to meet the identified needs, including the needs of prisoners and discharged prisoners who are suffering from mental illness, learning disability, personality disorder and alcohol and substance misuse. The arrangements must take full account of the resources required by health and social services staff to work co-operatively in support of criminal justice staff in relation to prisoners and discharged prisoners.

48. The Review supports the recommendations made by Professor McClelland and colleagues (2005) in relation to the assessment, treatment and care of prisoners on committal to prison. The transfer project should ensure that work continues as quickly as possible to address these recommendations and that arrangements are made to complete any outstanding work following transfer of responsibility.

49. Commissioners of mental health and learning disability services for prisoners must ensure that services provide assessment, treatment and care for all people suffering from mental disorder including those suffering from personality disorder.

50. DHSSPS should take the lead in developing, in partnership with the Criminal Justice Agencies, an inclusive model of assessment, treatment and care of people suffering from personality disorder.

51. A specific mental health needs assessment should be commissioned as part of the programme of the transfer of lead responsibility to examine the needs of service users who are placed in prison healthcare centres and the options for alternative services and placements. This should be completed by the end of 2006.

52. Services should be commissioned for women prisoners that are gender sensitive and that have the capacity to respond appropriately to the range of their mental health and learning disability needs, including substance misuse and personality disorder.

53. NIPS should commission a research project into alternatives to prison for mentally disordered women, including placements at lower levels of security.

54. A full range of mental health and learning disability services including adolescent, psychotherapy and personality disorder, alcohol and substance misuse should be commissioned. Community service providers must ensure that a full range of co-ordinated services is developed and provided to those who are under the age of 18, and DHSSPS must play its part in ensuring adequate provision of the necessary expertise.

55. Service providers must develop protocols and procedures so that management plans are jointly agreed in the case of each adolescent suffering from mental disorder when transferring to adult prison services or healthcare services in the community.

56. The transfer project team should define requirements and, together with service commissioners and providers, put such arrangements in place before April 2007.

57. People who require admission to hospital for assessment or treatment under the provisions of the mental health legislation must have equal access and priority whether they originate in prison or in the community. The application of this standard in practice should be subject to external audit by the appropriate health care inspection body.

58. The transfer project should ensure that specific joint working arrangements between service providers, the Prison Service and the DHSSPS are agreed and published before April 2007.

59. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people in prisons. The framework must not discriminate unjustifiably against people suffering from mental disorder.

60. Mental health and learning disability services and Criminal Justice Agencies should develop joint co-ordinated interagency standards that encompass both the creation of a prison environment that promotes mental health and the provision of a full range of mental health and learning disability services. These standards should be supported by clinical governance arrangements, internal quality assurance mechanisms, external independent inspection and systems of learning from adverse events. NIPS and DHSSPS should jointly set up an effective operational group in 2006.

61. The DHSSPS, involving the body with regional responsibility for mental health promotion, in partnership with NIPS, service providers and representatives of users and carers should establish a Regional Prison Mental Health Promotion group to address mental health promotion and suicide prevention. The group should build upon the existing policy and formulate a strategy that sets explicit standards. It should seek to establish a culture and ethos in the prisons that promotes mental health and well-being for prisoners and staff and that further reduces the risks of suicide. The goal should be for the initial strategy to be implemented by 2007. Work should continue in conjunction with the regional body with responsibility for mental health promotion and should include evaluation of its effects.

62. The transfer project should ensure that information systems are established before April 2007 to meet the needs of mentally disordered prisoners. Information systems for prisoners should integrate and evolve with the HPSS systems and should be developed, where appropriate, to integrate with criminal justice systems in support of joint working.

63. The DHSSPS should commission and promote ethically approved research in relation to the needs and services for mentally disordered prisoners, for example research should be undertaken into the needs for healthcare centre places, the transfer of prisoners to Health Service, bail and community step-down facilities, the efficacy of offender management programmes and the efficacy of mental health promotion strategies.

64. The DHSSPS must ensure that development and maintenance of services for mentally disordered prisoners are supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

65. Service providers must ensure that learning and development strategies for all staff are closely linked to service development and to governance arrangements.

66. A multi-agency consortium should be formed in 2006 to promote psychotherapeutic expertise in the assessment and management of behavioural disturbance, personality disorder and offending behaviour. The lead should be taken by DHSSPS with input from criminal justice agencies and the relevant health sector bodies.

67. The strategic development of mental health and learning disability services for prisoners requires sustainable additional funding. Funding arrangements must support the joint co-ordinated multi-agency planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

68. Strategies should be developed to ensure effective joint working between PBNI and the full range of mental health and learning disability services in relation to the assessment, treatment and care of mentally disordered people who are undergoing assessment by Probation or are subject to a Probation Order.

69. The Regional Forensic Network should co-ordinate the development of services at the interfaces between PBNI and:

- community forensic mental health and learning disability services;
- prison forensic services; and
- inpatient secure services.

70. The DHSSPS should, in partnership with PBNI, co-ordinate the development of services at the interfaces between PBNI and other mental health services.

71. PBNI, the Regional Forensic Network and the DHSSPS should agree joint arrangements to assess and monitor the needs of mentally disordered individuals, their carers, their representatives, service providers and the wider community. The results of ongoing assessment should inform service planning.

72. PBNI, the Regional Forensic Network and the DHSSPS should agree joint purposes, clear organisational structures and lines of accountability and should develop policies, protocols and procedures for joint working and information sharing.

73. PBNI, the Regional Forensic Network and the DHSSPS should develop comprehensive and accessible joint services to assess and provide treatment and care for mentally disordered people in contact with probation. There are particular needs to develop joint psychotherapeutic approaches.

74. The DHSSPS in partnership with Criminal Justice Agencies should establish a group comprising relevant stakeholders to develop a risk assessment and management framework that extends across the Criminal Justice System and the HPSS and that applies to mentally disordered people undergoing assessment by Probation or subject to a Probation Order.

75. PBNI, the Regional Forensic Network and the DHSSPS should agree standards for joint working. Services should be subject to internal and external evaluation of performance and quality.

76. PBNI and mental health and learning disability services should identify opportunities for mental health promotion and agree appropriate services.

77. Inter-agency learning and development arrangements should be established to support joint working between PBNI and forensic and other mental health and learning disability services.

78. The development of forensic and other mental health and learning disability services to support the work of PBNI requires sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

79. The Regional Forensic Network should promote co-ordination of forensic service provision for the people of Northern Ireland, including with high security services at the State Hospital, Carstairs, Scotland.

80. The current arrangements for high secure services for people in Northern Ireland have unacceptable gaps in service provision. All people in Northern Ireland must have access to high secure services when they require them. The DHSSPS must take the lead in urgently finding solutions to the current obstacles to treatment and care in conditions of high security.

81. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of high and medium security. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

82. This assessment of high and medium secure needs should be combined with an assessment of the needs for low secure and step-down community services (Chapter 9) and the needs for forensic learning disability services (Chapter 10).

83. The Review recommends the provision of an additional secure facility in Northern Ireland to meet the identified high and medium secure needs of service users. The regional high and medium secure facilities should be complemented by local low secure facilities and community step-down facilities to form a range of short, medium and longer stay facilities that meet the needs of forensic service users.

84. New secure services should be developed in accordance with the standards proposed by this Review.

85. The Regional Forensic Network should explore the range of opportunities to co-ordinate training for staff in Forensic Mental Health and Learning Disability Services in Northern Ireland with the training available in adjacent jurisdictions.

86. The Regional Forensic Network should promote the development and delivery of regional medium secure services and their co-ordination with interconnecting services.

87. The DHSSPS must take account of the assessment of need for secure services and it must plan and develop long stay medium secure services and step-down low secure and community services

88. In order to inform service planning and development Shannon Clinic staff should analyse the needs of each service user and the constraints on his or her progress.

89. The Regional Forensic Network should establish systems to monitor ongoing need for high, medium and low secure services and step-down community services for forensic service users with short, medium and longer stay needs. This information should contribute to the planning and delivery of forensic services.

90. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer to hospital of mentally disordered people who require treatment in conditions of medium security.

91. Service providers should develop regional expertise at Shannon Clinic in the assessment and management of risk in relation to service users who require assessment, treatment and care in conditions of medium security.

92. Shannon Clinic should develop explicit quality standards and quality assurance mechanisms, including audit and independent external inspection by the relevant regional body.

93. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure inpatient services to mental health promotion and public education.

94. The Regional Forensic Network should develop information and research strategies and promote the involvement of secure inpatient services.

95. The Regional Forensic Network should promote the integration of Information Technology systems between medium secure services and interconnecting services to help ensure the effective transfer of information.

96. The model used by Shannon Clinic of closely integrating training with clinical practice should extended to other forensic services.

97. The DHSSPS must ensure that development and maintenance of secure inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

98. The development and maintenance of medium secure services requires appropriate funding in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

99. The DHSSPS should ensure the development and delivery of low secure forensic services including step-down rehabilitation and long-stay services.

100. The DHSSPS must commission an assessment of needs to determine the numbers of people from Northern Ireland who require treatment in conditions of low security. The assessment should include people suffering from mental illness, severe mental impairment and from personality disorder. It should encompass those who are currently receiving services and those who are currently unable for legal or other reasons to avail of such assessment, treatment and care.

101. The needs assessment should consider the optimal configuration of low secure services, including the needs of specific groups such as women.

102. The needs assessment should lead to the development of low secure services that are fit for purpose. This is likely to require substantial new provision.

103. It is recommended that future low secure services, including low secure forensic services are developed in accordance with the standards advocated in Chapter 2.

104. The Regional Forensic Network should lead and co-ordinate the planning and development of community forensic services. It should both support and build upon the capabilities of current services as well as developing and integrating new specialist services.

105. The 5 CFT's that are currently partly staffed and funded require the necessary funding and workforce planning from the DHSSPS to ensure they are developed to full operational capacity by 2010. Thereafter teams should be developed in response to need to ensure that they have capacity to fulfill the range of services required by service commissioners and service users.

106. Commissioners must commission a full range of community forensic services with the following purposes:

- assessing local referrals to secure inpatient services;
- supporting the discharge of service users from inpatient secure services to the community, facilitating self management, opportunities for employment and engagement in social activities;
- working jointly with other mental health and learning disability services to provide consultation, assessment, and support and, in some cases, shared or sole treatment and care;
- liaison with police stations and courts;
- in-reach to prisons and support of discharged prisoners with mental disorder;
- assessments at the request of probation;
- input to offender therapy programmes; and
- supporting the work of the MASRAM or its successor.

107. The CFT's should produce information on their workload and performance which, combined with needs assessments should help guide the future planning of CFT's including suitable accommodation in the community.

108. Community Forensic Services should develop specific service models and structures and agreed methods of working with interconnecting services.

109. A CFT should comprise a range of staff with the necessary skills to meet the needs of users and carers. The following is considered representative of the skills and funding levels required:

1	Consultant Forensic Psychiatrist
1	Consultant Chartered Forensic Psychologist
1	Forensic Psychologist
1	Psychotherapist
2	Social Workers
1	Occupational Therapist
5	Nurses
2	Administrative Staff
User and carer advocacy services	

The composition of CFTs should be adjusted in response to information on need and service performance.

110. The Regional Forensic Network should co-ordinate the development and delivery of community forensic services, including the development of policies, procedures and protocols.

111. The Regional Forensic Network should co-ordinate the development of risk assessment and management policies, procedures and protocols by community forensic services.

112. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

113. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic services contribute to mental health promotion and public education.

114. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

115. The DHSSPS must ensure that development and maintenance of community forensic services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

116. The development of community forensic services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

117. The Regional Forensic Network should lead the development of forensic learning disability services in Northern Ireland, in co-ordination with the Learning Disability Implementation Group. Forensic Learning Disability Services should link with forensic services outside the province, including the State Hospital Carstairs and the Scottish Forensic Mental Health Services Managed Care Network. Co-ordinated services must be planned and developed to meet the short, medium and longer term needs of service users at high, medium and low levels of security.

118. The needs assessment and service mapping exercise advocated at 8.28 and 9.17 should include a detailed assessment of the needs for forensic learning disability services. This should lead to the development of a comprehensive plan and the development of a full range of inpatient and community forensic learning disability facilities and services. The Review advocates the provision of additional high and medium security services for people with learning disability in the proposed new unit (Recommendation 83). There is also a need for local low security services and community forensic learning disability services.

119. The forensic learning disability services in Northern Ireland are currently so patently inadequate that their initial development does not need to await the completion of a needs assessment exercise. A regional forensic learning disability service should be developed immediately which supports the further development of 5 localised and regionally co-ordinated teams.

120. Commissioners of mental health and learning disability services to the prisons should ensure that arrangements facilitate the early identification and transfer of people who require assessment, treatment and care in forensic learning disability inpatient services.

121. The DHSSPS must address the current obstacles to service users with learning disability receiving inpatient care, including uncertainty over the definition of the term "severe mental handicap" and the lack of step-down services at low security and in the community.

122. The Regional Forensic Network should promote the development of joint working policies, procedures and protocols between forensic learning disability services and interconnecting mental health and learning disability services and services in the Criminal Justice System.

123. The Regional Forensic Network should promote the development by forensic learning disability inpatient services of risk assessment and management polices, procedures and protocols that co-ordinate with mental health services and with the Criminal Justice System (see Chapter 11).

124. The Regional Forensic Network should co-ordinate the development of robust systems to assess performance and assure quality and clinical governance for forensic learning disability inpatient services.

125. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to facilitate the contribution of secure forensic learning disability inpatient services to mental health promotion and public education.

126. The Regional Forensic Network should co-ordinate the development of information systems and research in forensic learning disability services.

127. The Regional Forensic Network should promote the integration of Information Technology systems between forensic learning disability services and interconnecting services to help ensure the effective transfer of information.

128. The DHSSPS must ensure that development and maintenance of forensic learning disability inpatient services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

129. The development and maintenance of forensic learning disability services requires appropriate funding from the relevant sources. Funding should be delivered in accordance with long-term plans that ensures sustainable development of services. Funding arrangements must support the joint co-ordinated planning and delivery of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

130. The Regional Forensic Network should liaise with the Learning Disability Implementation Team and take the lead role in promoting the planning and development of community forensic learning disability services.

131. The proposed needs assessment and service mapping exercise (Chapter 8) should include the gathering of information to guide the further development of community forensic learning disability services, following the initial development of a regional service.

132. Immediate measures should be taken to create a regional community forensic learning disability service linked to an inpatient assessment and treatment service. This regional service should support the development of 5 locally based and regionally co-ordinated community forensic learning disability teams. These teams must have sufficient capacity to fulfill the same purposes as those identified for other community forensic services (Chapter 9).

133. Community Forensic Learning Disability Teams must be developed with the necessary staffing levels and range of skills to meet the needs of users and carers. The proposed regional team is likely to require similar staffing levels and resources to the Community Forensic Teams proposed at Chapter 9, with the addition of access to speech and language therapy services.

134. The Regional Forensic Network should ensure that community forensic learning disability services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the arrangements of interconnecting services.

135. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for community forensic learning disability services and

ensure that there are robust quality assurance mechanisms including internal audit and independent external inspection and review.

136. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that community forensic learning disability services contribute to mental health promotion and public education.

137. The Regional Forensic Network should co-ordinate the development of information and research strategies for community forensic learning disability services. It should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

138. The DHSSPS must ensure that development and maintenance of community forensic learning disability services is supported by robust workforce planning and provision of opportunities for staff to avail of learning, development and support.

139. The development of community forensic learning disability services requires additional sustainable funding from the relevant sources. Funding arrangements must support the joint co-ordinated planning and delivery of services. There should be mechanisms to demonstrate that monies made available to services have reached their intended targets.

140. The DHSSPS and the Northern Ireland Office and relevant Criminal Justice Agencies should produce a comprehensive interagency and community response to help offenders reduce their risks of offending and to provide protection to the public from high risk sexual and violent offenders, irrespective of whether or not they suffer from mental disorder. This Risk Assessment and Management Framework should include:

- the legislative framework, including options to provide courts with risk assessments such as a risk assessment order and sentencing options such as an order for lifelong restriction;
- processes, methods and standards of risk assessment, risk management and offender therapy programmes;
- interagency strategies and working arrangements, including information sharing and other joint protocols and procedures;
- development of best practice, guidance and quality assurance mechanisms;
- training in risk assessment, risk management and offender therapy methods;
- accreditation of practitioners;
- the services required for the assessment and management of risk and the provision of offender therapies, including specialist facilities in conditions of security and in the community;
- the development of research strategies and methods of research and evaluation; and
- assessment of the workforce requirements and the provision of appropriate workforce planning and funding to meet the identified needs.

141. The Regional Forensic Network should ensure that all inpatient and community forensic services in Northern Ireland develop risk assessment and management policies, procedures and protocols that represent best practice and co-ordinate with the Risk Assessment and Management Framework.

142. The Regional Forensic Network should promote and co-ordinate the development of performance and quality standards for risk assessment and management by forensic services and ensure that there are robust quality assurance mechanisms including internal audit and independent external review.

143. The DHSSPS should revise current Discharge Guidance to ensure that it is compatible with the principles recommended by this Review and is supported by training and other appropriate resources.

144. The DHSSPS and NIPS must ensure that services are developed for people with personality disorder, including offenders. The services require co-ordinated joint approaches by both the Criminal Justice System and the Health and Social Services. Service users, carers and their advocates must be involved in service planning and delivery.

145. The DHSSPS should ensure that assessment and treatment services are made available to offenders suffering from personality disorder along with support for their carers. Services should be provided in prisons and in the community. Services in the community should comprise outpatient, day patient and therapeutic community services. In the prisons outpatient and day patient services should be provided. A residential secure service should also be developed.

146. The DHSSPS should commission a detailed assessment of needs to inform the planning of services for offenders with personality disorder.

147. Service providers must ensure that services for the assessment and management of personality disorder are supported by the development of policies, procedures and protocols that recognise the respective responsibilities of all key stakeholders and that coordinate with the proposed Risk Assessment and Management Framework.

148. The commissioners and providers of services for offenders with personality disorder must ensure that services have strong quality assurance and governance arrangements including internal audit and independent external inspection and review.

149. The Regional Forensic Network should co-ordinate with the regional body with responsibility for mental health promotion to ensure that forensic services for people with personality disorder contribute to mental health promotion and public education, including contributing to understanding of the development of personality disorders and the most effective ways of preventing them.

150. The Regional Forensic Network should promote the development of information and research strategies for forensic services for people with personality disorder. Research should be conducted into the needs of offenders with personality disorder and into the efficacy of therapeutic interventions.

151. The Regional Forensic Network should promote the use of information technology to support and enhance multi-disciplinary and inter-agency communication and information-sharing, in accordance with agreed protocols.

152. The DHSSPS must ensure that robust workforce planning systems are developed to ensure the recruitment, training support and retention of suitable staff to support the development of services for offenders with personality disorder.

153. The development and maintenance of forensic services for the assessment and treatment of high risk offenders and individuals suffering from severe personality disorder requires appropriate funding from the relevant agencies. This should be delivered in accordance with a long term plan that ensures sustainable development of services. There must be mechanisms that demonstrate that monies made available to services have reached their intended targets.

154. The Regional Forensic Network should co-ordinate a programme of training for staff in the identification, assessment, treatment and care of people suffering from Asperger's Syndrome or High Functioning Autism (AS/HFA) in Forensic Mental Health and Learning Disability Services and the Criminal Justice System.

155. The DHSSPS in partnership with Criminal Justice Agencies should commission a regional needs assessment to ascertain the prevalence of AS/HFA within the Criminal Justice and Forensic Services in Northern Ireland and to assess the needs of users and carers.

156. The DHSSPS should promote research into AS/HFA, including its relationship with offending behaviour, the effectiveness of specific psychological and environmental interventions, the development of models of service models and the definition of acceptable outcomes.

157. Service commissioners and providers must ensure that services are gender sensitive. Planning and development of forensic services must take account of the needs and wishes of service users, their advocates and carers.

158. The Regional Forensic Network should co-ordinate the development of gender sensitive policies in all forensic services.

159. The proposed assessment of needs for secure provision (Chapter 8) should consider options to meet the needs of service users in a manner that is gender sensitive. This should include consideration of whether a separate low secure facility is more appropriate to the needs of women service users than the current provision in Shannon Clinic.

160. Community services should be provided individually to male and female users on the basis of individual needs and must be gender sensitive.

161. Service providers must ensure that staff in all Forensic Services receive training to ensure that services are gender sensitive.

162. The DHSSPS, the Regional Forensic Network, service commissioners and providers must ensure that planning and development of all inpatient and community mental health and learning disability forensic services incorporate and integrate a range of multi-disciplinary psychotherapeutic approaches.

163. All clinical staff working in forensic services must be provided with the appropriate opportunities and support to develop high levels of psychotherapeutic knowledge and skill.

164. The planning and delivery of forensic services must also include the provision of services by specialist Psychotherapists and Forensic Psychotherapists.

165. The DHSSPS must ensure that development and maintenance of forensic mental health and learning disability inpatient and community services is supported by robust workforce planning that takes account of the need to recruit and retain specialist Psychotherapists and Forensic Psychotherapists and to provide supervision, support and training to staff working in forensic services.

168. The Review recommends the establishment of a Regional Forensic Network to co-ordinate the planning and delivery of Forensic Services at regional and local levels.

169. Forensic Services should be commissioned on a regional basis.

APPENDIX

The Bamford Review of Mental Health and Learning Disability Services (Northern Ireland)

In October 2002, the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review with the following terms of reference:

(i) To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

(ii) To take into account:

- the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a learning disability and their carers;
- the need to promote positive mental health in society;
- relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;
- evidence-based best practice developments in assessment, treatment and care regionally, nationally and internationally;
- the need for collaborative working among all relevant stakeholders both within and outside the health and personal social services sector;
- the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at high risk of offending; and
- issues relating to incapacity.

(iii) To make recommendations regarding future policy, strategy, service priorities and legislation to reflect the needs of users and carers.

The Review was structure into a Steering Committee and 10 Expert Working Committees:

- Social Justice and Citizenship;
- Legal Issues;
- Learning Disability;
- Adult Mental Health;
- Mental Health Promotion;
- Child and Adolescent Mental Health;
- Dementia and Mental Health Issues of Older People;
- Alcohol and Substance Misuse;
- Forensic Services; and
- Needs and Resources.

Remit of the Forensic Services Committee

The Forensic Services Committee adopted the following remit:

'To examine the needs and make recommendations for services for mentally disordered adult offenders and those with similar needs including mentally disordered people:

- *In police stations*
- *Attending court*
- *On bail*
- *In prisons and young offenders' centres*
- *In contact with probation services*
- *Requiring specialised forensic services:*
  - *high, medium & low security inpatient settings*
  - *community forensic services, including both statutory and independent services'*

The Methods Adopted by the Forensic Services Committee

The membership of the Forensic Services Committee (the Committee) includes broad representation from service users and carers, the wider community, Criminal Justice Agencies and health and social services in both the statutory and independent sectors.

The members of the Committee met regularly and also consulted with other key stakeholders. The Committee arranged a series of one – day meetings to which there was an open invitation. These meetings examined key issues with the assistance of presentations and discussion from national and international experts. In addition it commissioned a review of the published scientific literature to ensure that its recommendations were evidence-based and it commissioned a survey of stakeholder views. That review of the scientific literature and of stakeholder views has been published separately[1] and its key findings have been incorporated within this report.

The Committee considered and made recommendations on the values and principles that should guide the development and delivery of forensic services. From these it developed standards which it then applied to the current components of forensic services in Northern Ireland. This process helped highlight service needs. The Committee then collated the identified needs and formulated recommendations to remedy them, considering the components of forensic services individually and collectively, as an interconnecting system. The Committee prioritised its recommendations, identifying the key elements for change and the sequences in which such changes should be made. This draft report has been compiled and submitted for public consultation before the Committee report was finalised.

FORENSIC SERVICES WORKING COMMITTEE

Membership:

Convenor: Dr Fred Browne - Consultant Forensic Psychiatrist

- Prof David Bamford - Chair of MH & LD Review & UU
- DS Andrew Bailey - PSNI
- Dr John Farnan - Forensic Medical Officer
- Dr Bill Lockhart – Youth Justice Service
- Dr Colin Milliken - Consultant Psychiatrist
- Brendan Fulton - Probation Board NI
- Cathy McPhillips - SHSSB
- Raymond Kitson – Public Prosecution Service
- Dr Jackie McCall – EHSSB
- George Keatley - Court Service
- Dr Philip McClements – NI Prison Service
- Anne Rafferty - Criminal Justice Policy Division, NIO
- Winston McCartney - Advocate
- Deborah Devaney - Carer
- Dr Ian Bownes - Consultant Forensic Psychiatrist
- Dr Harry Kennedy - Consultant Forensic Psychiatrist
- Dr Geraldine Henry - Consultant Psychiatrist
- Geraldine O'Hare - Probation Board NI
- Rev Trevor Williams
- Maureen Warner - Occupational Therapist
- Emmet Murray – Forensic Psychologist
- Brian Simpson - WHSSB
- DS Andrew Thompson - PSNI
- Dr Ian McMaster - DHSSPS
- David McCrum – Service User
- DI Gary Mullan – PSNI
- Sally Newton – NI Prison Service
- Prof Jackie Bates-Gaston – NI Prison Service
- Noel McKenna – Independent Monitoring Board

GLOSSARY

'Forensic', 'Services' and 'Forensic Service Users'

The word '*forensic'* is derived from the Latin word '*forum*', meaning 'the court' and thus the word '*forensic'* means 'relating to the courts' or, more widely, 'relating to the Criminal Justice System'. This report examines the needs of mentally disordered offenders and those with similar needs, such as those who suffer from mental illness or personality disorder and who engage in dangerous, persistently challenging or aggressive behaviour. Forensic Services comprise a range of components, such as services to people in prison, community forensic services and secure inpatient services. In keeping with the other reports from this Review the term 'service user' is used in preference to other terms such as 'patient' or 'client'. Within the context of this report 'service user' has been used to refer to certain individuals who suffer from mental disorder and who require forensic services to meet their needs. It should be noted that forensic health and social services are not yet well developed in Northern Ireland and that the use of the term 'service user' does not necessarily indicate that a forensic service currently exists to adequately meet their needs.

Psychiatric Hospital

The term 'Psychiatric Hospital' is used to include hospitals that provide inpatient treatment and care for those suffering from mental illness and from learning disability.

BIBLIOGRAPHY

1 McCall J. Forensic Services in Northern Ireland: A Literature Review and Needs Assessment. Belfast: Eastern Health and Social Services Board, 2005.

2 Fulford KWM. Ten principles of values-based medicine. In: Radden J, editor. *The Philosophy of Psychiatry: A Companion*. New York: Oxford University Press, 2004:205-234.

3 Wilson S. The principle of equivalence and the future of mental health care in prisons. *The British Journal of Psychiatry* 2004;184:5-7.

4 McGilloway S, Donnelly M. Mental Illness in the UK criminal justice system: A police liaison scheme for mentally disordered offenders in Belfast. *Journal of Mental Health* 2004;13(3):263-275.

5 Police and Criminal Evidence (Northern Ireland) Order 1989 (Codes of Practice) (No. 2) Order 1996. *Statutory Rule 1996 No. 261*, 1996.

6 The Police and Criminal Evidence (Northern Ireland) Order 1989. *Statutory Instrument 1989 No. 1341 (N.I. 12)*, 1989.

7 Bean P, Nemitz T. Out of Depth and Out of Sight. Loughborough: Midlands Centre for Criminology, University of Loughborough, 1995.

8 Mullen P, Chettleburgh K. Review of Queensland Forensic Mental Health Services. Victoria: Victorian Institute of Forensic Mental Health, 2002.

9 Birmingham L. Diversion from custody. *Advances in Psychiatric Treatment* 2001;7:198-207.

10 The Criminal Justice (Northern Ireland) Order 1996. *Statutory Instrument 1996 No. 3160 (N.I. 24)* 1996.

11 The Mental Health (Northern Ireland) Order 1986 *Statutory Instrument 1986/595 (N.I. 4))*, 1986.

12 Nurse J, Woodcock P, Ormsby J. Influence of environmental factors on mental health within prisons: focus group study. *BMJ* 2003;327:327480.

13 McClelland R. A Review of Non-natural Deaths in Northern Ireland Prison Service Establishments (June 2002 - March 2004). Belfast: Northern Ireland Prison Service, 2005.

14 Blaauw E, Kerkhof AJFM, Hayes LM. Identification of suicide vulnerability in inmates on the basis of demographic and criminal characteristics and indicators of psychiatric problems, 2004.

15 Review of the Provision of Healthcare Services to Prisoners: Northern Ireland Prison Service.

16 McCall J. Improving the Health of Prisoners in Northern Ireland: A Health Needs Assessment. Belfast: Department of Health, Social Services and Public Safety, 2004.

17 Scraton P, Moore L. The Hurt Inside. The imprisonment of women and girls in Northern Ireland. Belfast: Northern Ireland Human Rights Commission, 2004.

18 HM Chief Inspector of Prisons and the Chief Inspector of Criminal Justice in Northern Ireland. Report of an unannounced inspection of the imprisonment of women in Northern Ireland, Ash House, Hydebank Wood Prison. London: Her Majesty's Inspectorate of Prisons, 2005

19 Joint Prison Service and National Health Service Executive Working Group. The future organisation of prison health care, 1999.

20 Department of Health, Social Services and Public Safety. Discharge from hospital and the continuing care in the community of people with a mental disorder who could represent a risk of serious physical harm to themselves or others. Belfast, 2004.

21 Earthrowl M, O'Grady J, Birmingham L. Providing treatment to prisoners with mental health disorders: development of a policy. *British Journal of Psychiatry* 2003;182:299-302.

22 World Health Organization. Mental Health Promotion in Prisons. Copenhagen, 1998.

23 World Health Organization Regional Office for Europe. Mental Health Promotion in Prisons. Copenhagen: World Health Organization 1999.

24 Scottish Prison Service. Positive Mental Health: Scottish Prison Service, 2002.

25 Department of Health. Health Promoting Prisons: A Shared Approach. London: Department of Health, 2002.

26 Royal College of Psychiatrists. Suicide in Prisons, 2002.

27 Kennedy HG. Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment* 2002;8:433-443.

28 Forensic Mental Health Services Managed Care Network. Definition of security levels in psychiatric inpatient facilities in Scotland: Forensic Mental Health Services Managed Care Network, NHS Scotland, 2004.

29 Forensic Mental Health Services Managed Care Network. Care Standards for Forensic Mental Health Inpatient Facilities in Scotland: Forensic Mental Health Services Managed Care Network, NHS Scotland, 2005.

30 McCrone L, Leese M, Glover G, Thornicroft G. Social deprivation and the use of secure psychiatric beds. *Journal of Forensic Psychiatry* 2001;12:434-445.

31 Badger D, Vaughan P, Woodward M, Williams P. Planning to meet the needs of offenders with mental disorders in the United Kingdom. *Psychiatric Services* 1999;50(12):1624 - 1627.

32 Coid J, Kahtan N, Gault S, Jarman B. Ethnic differences in admissions to secure forensic psychiatry services: I Comparison of men and women. *British Journal of Psychiatry* 2000;1777:241-247.

33 Duncan JM, Short A, Lewis JS, Barrett Pt. Readmissions to the State Hospital at Carstairs. *Health Bulletin (Edinburgh)* 2002;60(1):70-82.

34 Forensic Mental Health Services Managed Care Network. Report of the Working Group on Services for People with Personality Disorder: Forensic Mental Health Services Managed Care Network, NHS Scotland, 2005.

35 Mental Health (Scotland) Act 1984 1984.

36 The Mental Health (Northern Ireland) (Consequential Amendments) Order 1986 1986

37 Mental Health (Care and Treatment) (Scotland) Act 2003. *2003 asp 13*, 2003.

38 Black W, Robertson A. Report of the Services for Women Working Group: Forensic Mental Health Services Managed Care Network: Forensic Mental Health Services Managed Care Network, NHS Scotland, 2005.

39 The State Hospitals Board for Scotland. Annual Report 2003-4: The State Hospitals Board for Scotland,, 2004.

40 Department of Health and Social Services and Northern Ireland Office. Report of the working group on secure accommodation: a review of the need for hospital accommodation for mentally disordered patients requiring treatment under conditions of special security. Belfast: Department of Health and Social Services 1994.

41 Scheinkopf L. *Thinking for a Change: Putting the TOC Thinking Processes to Use*. Boca Raton, Florida: CRC Press, 1999.

42 Reed S, Russell A, Xenitidis K, Murphy DG. People with learning disabilities in a low secure in-patient unit: comparison of offenders with non-offenders. *British Journal of Psychiatry* 2004;185:499-504.

43 Department of Health Social Services and Public Safety. Community Forensic Services: a Discussion Paper. Belfast: Department of Health Social Services and Public Safety, 2003.

44 Forensic Mental Health Services Managed Care Network. Community Services for Mentally Disordered Offenders in Scotland: Forensic Mental Health Services Managed Care Network, NHS Scotland, 2005.

45 Tighe J, Henderson C, Thornicroft G. Mentally disordered offenders and models of community care provision. In: Buchanan A, editor. *Care of the mentally disordered offender in the community*. Oxford: Oxford University Press, 2002:89-110.

46 Walker, N., McCabe, S. (1973). *Crime and Insanity in England.* Edinburgh: University Press

47 Davey, J. (1993) From Birth to Death. Institute of Policy studies, Victoria University, Wellington

48 Simpson, M. & Hogg, J. (2001). Patterns of offending among people with intellectual disability: a systematic review. Part I: methodology and prevalence data. Journal of Intellectual Disability Research, 45(5), 384-396.

49 Slevin, E., McConkey, R. Truesdale-Kennedy, M., Taggart, L. & Christie, J. (2005) *An investigation of the Assessment & Treatment Unit in Longstone Hospital in Armagh: admission trends, assessments & treatments and views on function & effectiveness.* Southern Health and Social Services Board & University of Ulster, Northern Ireland

50 Criminal Justice and Court Services Act 2000. *2000 Chapter 43,* 2000.

51 Criminal Justice Act 2003. *2003 Chapter 44,* 2003.

52 Criminal Justice Inspection Northern Ireland. The Management of Sex Offenders in Northern Ireland. Belfast: Criminal Justice Inspection Northern Ireland, 2005.

53 Northern Ireland Office. Review of the Sentencing Framework in Northern Ireland. Belfast: Northern Ireland Office, 2005.

54 Lord Maclean. Report of the Committee on Serious Violent and Sexual Offenders. Edinburgh: Scottish Executive, 2000.

55 Criminal Justice (Scotland) Act 2003. *2003 asp* 2003.

56 Szmukler G. Homicide inquiries: What sense do they make? . *Psychiatric Bulletin* 2000;24:6-10.

57 HM Treasury. The Orange Book. Management of risk - principles and concepts. Norwich: HMSO, 2004.

58 Department of Health. Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. London: Department of Health, 1999.

59 World Health Organization. *The ICD-10 Classification of Mental and Behavioural Disorders*. Geneva: World Health Organization, 1992.

60 Singleton N, Meltzer H, Gatwood R, J C, Deasy D. Psychiatric Morbidity among Prisoners in England and Wales. London: Office for National Statistics, 1998.

61 England NIfMHf. Personality Disorder: No longer a diagnosis of exclusion. Policy implementation guidance for the development of services for people with personality disorder. London: National Institute for Mental Health for England, 2003

62 Appleby L, Shaw J, T A. Safer Services, Summary Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Department of Health, 1999.

63 Prior M. Is there an increase in the prevalence of autistic spectrum disorders? *Journal of Paediatrics and Child Health* 2003;39(2):81-82.

64 Tantam D. Psychological disorder in adolescents and adults with Asperger's Syndrome. *Autism* 2000;4:47-62.

65 Kohn Y, Fahum T, Ratzoni G, Apter A. Aggression and sexual offence in Asperger's Syndrome. *Israeli Journal of Psychiatry and Related Sciences* 1998;4(293-299).

66 Siponmaa L, Kristiannsson M, Jonson C, Nyden A, Gillberg C. Juvenile and young mentally disordered offenders: the role of child neuropsychiatric disorders. *Journal of the American Academy of Psychiatry and the Law* 2001;29:420-426.

67 Scragg P, Shah A. Prevalence of Asperger's Syndrome in a secure hospital. *British Journal of Psychiatry* 1994;165:679-682.

68 National Autistic Society. Prevalence of Asperger's Syndrome in three special hospitals. London: National Autistic Society, 1999.

69 Wing L. A study of individuals with ASD in three special hospitals. London: National Autistic Society, 2003.

70 Sherrard E. Down Lisburn Health & Social Services Trust: Community Service for adults with Asperger's Syndrome of High Functioning Autism, 2005.

71 Barry-Walsh JB, Mullen PE. Forensic aspects of Asperger's Syndrome. *The Journal of Forensic Psychiatry and Psychology* 2004;15(1):96-107.

72 Wing L. Asperger's Syndrome: management requires diagnosis. *Journal of Forensic Psychiatry* 1997;2:253-257.

73 American Psychiatric Association. *The Diagnostic and Statistical Manual of Mental Disorders (4th Edition, Text Revision)*. Washington DC: American Psychiatric Association, 2000.

74 Murrie DC, Warren JI, Kristiansson M, Dietz PE. Asperger's Syndrome in forensic settings. *International Journal of of Forensic Mental Health* 2002;1(1):59-70.

75 Murphy D. Admission details and cognitive characteristics of male patients diagnosed with Asperger's Syndrome detained in a special hospital: comparison with a schizophrenic and personality disorder sample. *Autism: The International Journal of Research and Practice* 2003.

76 Reed J. People with learning disabilities (mental handicap) or with autism. (Chapter 7). *Review of Health and Social Services for Mentally Disordered Offenders: Final Summary Report*. London: Department of Health/Home Office Cm2088, HMSO, London, 1993.

77 Scottish Development Centre for Mental Health. On the Borderline? People with Learning Disabilities and / or Autistic Spectrum Disorders in Secure, Forensic and other specialist settings. Edinburgh: Scottish Executive, 2004.

78 National Autistic Society. consultation response: Reform of the Mental Health Act. London: National Autistic Society, 2001.

79 Barnard J, Harvey V, Potter D, Prior A. Ignored or ineligible? The reality for adults with autistic spectrum disorders. London: National Autistic Society, 2001.

80 Department of Health. Women's Mental Health: Into the Mainstream. London: Department of Health, 2002.

81 Scraton P, Moore L. Report on the transfer of women from the Mourne House Unit to Hydebank Wood Young Offenders Unit. Belfast: Northern Ireland Human Rights Commission, 2004.

82 Jones T, Armstrong EM. Promoting the development of managed clinical networks in NHS Scotland: Scottish Executive Health Department, 2002.

83 The Bamford Review (Northern Ireland) 2005, A Strategic Framework for Adult Mental Health Services.

84 The Bamford Review (Northern Ireland) 2006, Mental Health Improvement and Well-Being – A Personal, Public and Political Issue.

85 The Bamford Review (Northern Ireland) 2005, Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland.

86 The Bamford Review (Northern Ireland) 2006, A Vision of a Comprehensive Child and Adolescent Mental Health Service.