REVIEW OF SECURE MENTAL HEALTH SERVICES
# CONTENTS

**EXECUTIVE SUMMARY AND STRATEGIC OBJECTIVES** 5

1 **INTRODUCTION** 13

1:1 Background to this report 13

1:2 The focus of this report 14

1:3 Existing strategic policy documents relating to secure care 14

1:4 Service user involvement 15

1:5 Mental health service reviews 16

1:6 External homicide inquires 16

1:7 Current provision of secure care 16

1:7:1 High secure care 17

1:7:2 Medium secure care 17

1:7:3 Low secure care 17

1:7:4 Psychiatric intensive care units (PICUs) and High Dependency Units (HDUs) 17

1:8 Prison health 18

1:9 Inter-agency collaboration 18

1:10 Acknowledgements 18

2 **Requirements for secure mental health services** 19

2:1 What security involves 19

2:2 The need to define secure services more clearly 20

2:3 High secure care 21

2:3:1 The views of service users in high secure hospitals 21

2:3:2 Trends affecting service planning 21

April 2009 2
2:3:3 Improving the high security hospital service for Welsh patients

2:4 Medium secure care

2:4:1 Current provision

2:4:2 Are patients placed at the appropriate level

2:5 Low secure care and step-down services

2:5:1 Systemic problems

2:6 Prisoners in Wales requiring mental health services

2:6:1 Development and commissioning of prison mental health care

3 Improved strategic planning for secure mental health

3:1 What do we need to improve?

3:2 Efficient planning of services

3:3 Efficient delivery of services

3:4 Case Managers

3:5 Managed Clinical Network

3:6 Managing effective transfers

3:7 Quality and cost

3:8 Resolving clinical conflicts

3:9 Interim arrangements

4 Safety for individuals and the public

4:1 The focus on prevention and de-escalation

4:2 Current partnership mechanisms

4:3 Assessing and managing risk

4:4 Risk management: the user and carer perspective

4:5 Research, teaching and training

April 2009
4:6 The Care Programme Approach (CPA) 46
4:7 A community mental health criminal justice system for Wales 46
4:8 Locality Mental Health Assessment Centres 48
4:9 Mental Health Crisis Resolution Teams 48
4:10 Sharing Information 49
4:11 Strengthening liaison at national level 50
4:12 Equality and empowerment for victims 51

5 Evidence-based interventions 53
5:1 The importance of developing and monitoring treatment in secure settings 53
5:2 Method of gathering evidence-based information 53
5:3 The use of medication 54
5:4 Psychological interventions 55
5:5 A skills shortage 56
5:6 Service users perspective 57
5:7 Physical health and wellbeing 57
5:8 Research, teaching and continuing professional development 58

6 Patient groups with specialist needs 60
6:1 Introduction 60
6:2 Black and minority ethnic (BME) groups 60
6:3 Secure services for women 61
6:3:1 Key issues affecting women’s services 61
6:3:2 Focusing on women’s needs 62
6:4 Secure services for people with a learning disability 63
6:4:1 Quantifying the need 63

April 2009
| 6:4:2 | Evidence-based practice | 64 |
| 6:4:3 | Current patterns of service delivery | 64 |
| 6:5 | Secure services for people with personality disorder | 65 |
| 6:5:1 | The challenge of personality disorder (PD) | 65 |
| 6:5:2 | How many people have a PD? | 66 |
| 6:5:3 | Dangerous and severe personality disorder (DSPD) | 67 |
| 6:5:4 | What services exist for PD? | 67 |
| 6:5:5 | Barriers to service development. | 68 |
| 6:5:6 | A tiered service model for PD | 68 |
| 6:6 | Secure services for young people | 69 |
| 6:6:1 | Modifications required | 69 |
| 6:6:2 | Transition arrangements | 69 |
| 6:6:3 | Services providing or provided in secure settings | 70 |
| 6:6:4 | The confirmation of roles and responsibilities | 70 |
| 6:6:5 | The forensic adolescent consultation team (FACT) for Wales | 70 |
| 6:6:6 | Specialist forensic CAMHS | 71 |
| 6:7 | Secure services for people requiring longer-term care | 73 |
| 6:7:1 | Specialist needs | 73 |
| 6:7:2 | How many longer-term patients are there in Wales | 73 |
| 6:7:3 | Assessment and referral | 73 |
| 6:7:4 | User group views | 74 |
Executive Summary and Strategic Objectives

This review of secure mental health services has been undertaken in order to ensure that an efficient interagency, multi-agency, multi disciplinary whole system is in place to deliver effective treatment, care and reablement for people with mental health problems, who require this care to be delivered in secure environments due to the risk they may pose to the safety of themselves or others.

The need to review and improve arrangements for secure service users was highlighted in two homicide inquiries published in 2005. The recommendations of these inquiries and three further inquiries published in 2008 have been addressed and incorporated within this review. Ensuring a balanced approach to public safety, whilst upholding the human rights of people with a mental illness is critical and has been central to this review.

All relevant health, local authority, justice, independent and third sector organisations together with service users and carers have participated in the review and will be required to participate in the implementation of its strategic objectives.

For the purposes of the review ‘security’ has been defined as comprising effective treatment for mental disorder that will deliver public safety as well as improve the health and wellbeing of individual service users together with one or more of the following three aspects:

- **Physical** security concerns the qualities in the hospital building, access points and perimeter.

- **Procedural** security relies on completion of systematic checks of the environment and the people living within it.

- **Relational** security requires detailed and specialist knowledge of each person at any time, in order that risk factors can be identified and management strategies implemented accordingly to prevent escalation of risk or harm occurring.

Importantly this definition of security illustrates that providing secure care is not solely the domain of specialist forensic services but of all mental health services operating in hospital and community settings.

Given the level of restriction placed upon the liberty of people cared for in secure environments it has been particularly important to incorporate the views of service users within the review. Hafal, an all Wales mental health voluntary sector service specialising in the care of people with severe and enduring mental health problems, undertook service user focus groups and surveys to elicit the views of service users who are or have been cared for in...
secure care settings. The learning disability Implementation Advisory Group (LDIAG) also undertook consultation.

The key findings from Hafal’s consultation are as follows:

1. There must be more support and much earlier intervention before admission to secure care.
2. Staff in secure care must engage more openly and trustingly with their patients.
3. There must be more rehabilitative activities to overcome the boredom experienced by service users.
4. There must be more encouragement and support for service users and their carers to be actively involved in their own care meetings. They should also receive regular feedback on their care and treatment from the clinician in charge of their treatment.
5. There must be improvement in aftercare and resettlement programmes.

The review’s strategic objectives have been drawn from a number of findings and data sources. The key findings are set out below.

The Review’s Key Findings

The Key Findings of this review are that

- Service users and their carers should influence more directly the development and delivery of services, whilst informing the processes created to achieve effective risk assessment and risk management so ensuring that vulnerable people are treated and cared for within the most appropriate and least restrictive environment.

- No one in acute distress from an active serious mental disorder should be held in prison.

- Reliance upon high and medium secure care could be safely minimised through the establishment of additional NHS low secure inpatient facilities, and bespoke community services. This will facilitate more efficient use of public money and where appropriate the delivery of care for service users at closer proximity to their families, home communities, local services and at levels of security no higher than is necessary.

- A new unified national whole system for strategic service planning is required overseen at an All Wales level. This system must remove the existing dislocation between local and national planning. These arrangements should be underpinned by enhanced and targeted performance management with rigorous inter-agency inspection to ensure the development of effective services with efficient pathways of care delivered against nationally agreed service standards.

April 2009
Increased service capacity is required, including for prison and community primary care services. Secondary care community teams with structured links to criminal justice services are also required to ensure the safe management of people within the community and that people avoid care in custodial settings. Where people in custody are identified as having a mental illness, specialist assessment and treatment should be readily available. Where it is appropriate patient transfer from these settings should be expedited as soon as is practicable.

A managed secure services clinical network should be established to facilitate consultation, liaison, education and training across various secure settings. This will improve inter and intra agency cooperation and more timely access to specialist assessment, advice and transfer between general mental health and specialist forensic services.

Improvements are required in arrangements for the regional and local strategic co-ordination of operational services within and between health, local government and justice agencies. This should include mechanisms to improve information sharing and enhance the collaborative assessment and management of risk through the use and enhancement of the mechanisms already established and in place.

The needs of specific patient groups should be targeted to ensure that services adequately meet their needs. These groups include; women, children and young people, people from black and minority ethnic groups (BME), people with a learning disability, a personality disorder or an acquired brain injury.

The whole workforce across all agencies delivering secure mental health service needs to reform and expand. Use should be made of the revised NHS workforce planning processes, new ways of working in mental health and the use of the Creating Capable Teams Approach. Continued professional development must underpin the development of appropriate skill sets drawing upon research and the most up to date evidence base.

Currently, most Welsh patients requiring high secure care are admitted to Ashworth Hospital in Merseyside. This reduces patient access to families and their local clinical team and places additional strain on South Wales services due to the considerable additional travel time required to visit Ashworth Hospital. Arrangements need to be explored which would allow patients from South Wales requiring high secure care to receive this care and treatment at Broadmoor Hospital in Berkshire.

Multi professional, academically verified research into effective assessment, treatment and care is essential to ensure the best clinical outcomes and continuing improvements to public and personal safety. This must include research into effective treatment and care interventions for personality disorder.
These key findings are set out in the strategic objectives that follow each chapter.

**Strategic Objectives**

**From Chapter 2 Requirements for Secure Mental Health Services**

**Strategic Objective 1**

To establish an all Wales Mental Health Board with responsibility for the unified strategic planning, oversight, development and delivery of a new model of secure mental services across Wales ensuring NHS developments are developed in partnership with local government and the justice agencies in line with the model described at Chapter 3 of this strategy. Interim arrangements should be established to ensure momentum of existing work is sustained whilst the National Board is established.

**Strategic Objective 2**

To establish robust mechanisms to ensure that the views of secure care service users and carers continue to be heard and acted upon at all stages in the service planning and delivery process.

**Strategic Objective 3**

To seek a reduction in the number of places required in the English high secure estate by establishing a specialist inpatient unit for women initially within an existing medium secure unit in Wales; repatriating people with learning disabilities to additional or augmented facilities in Wales; facilitating safe and timely transfer between high and lower levels of security; exploring the possibility for South Wales patients to receive treatment at Broadmoor hospital and developing a specialist all-Wales facility in the medium secure care estate to enable the repatriation and evidence-based treatment of Welsh patients with personality disorder.

**Strategic Objective 4**

To develop dedicated low secure and step down services within the NHS, Local Authorities and voluntary sector to reduce the current reliance on the independent for profit sector. The use of repatriation programmes supported with transitional funding and capital allocation will allow much to be achieved within existing revenue resources. Developments will include NHS provision in each of the three current health regions:

**Low secure inpatient wards** - (i) low secure forensic - assessment and rehabilitation up to two years and (ii) longer term low secure - slower stream rehabilitation.

**Low secure/high support accommodation** for both step down rehabilitation (up to two years) and longer term care, which may be lockable facilities with April 2009
high staff to resident ratios 24 hours a day providing high relational supervision.

**Dedicated Psychiatric Intensive Care Units (PICU)** in each of the newly established NHS bodies.

**Strategic Objective 5**

Low secure facilities should be supported by the provision of specialist community teams with forensic assessment and care management skills and expertise in each of the newly established NHS bodies. These multi-professional teams should provide a consultative liaison service to support CMHTS and other general mental health services and should integrate with local Criminal Justice Liaison Teams. They may function as a dedicated Low Secure Community Team or as an expanded function of each locality Assertive Outreach Service.

**Strategic Objective 6**

To produce clear Wales specific definitions for medium, low secure and step-down services in Wales reflecting all four elements of effective treatment—physical, procedural and relational security. Standards will include staff training levels and the skill requirements needed to deliver such services to the highest possible standard.

**Strategic Objective 7**

To ensure early implementation of improvements specified in the Prison Mental Health Pathway (October 2006) and that there is co-ordinated planning and service delivery for prisoners with mental health problems before, during and after transition from prison to the community, including primary care services.

**Strategic Objective 8**

To re-establish offender locality planning forums, updating the previous interagency Mentally Disordered Offender Planning Groups.

**From Chapter 3 Improved Strategic Planning for Secure Mental Health Services**

**Strategic Objective 9**

To introduce Case Managers to oversee the care of all Welsh patients in Secure Services and improve the communication between provider units and strategic service planners.
Strategic Objective 10

To establish a Managed Clinical Network for secure services in Wales with responsibility for developing access criteria, gate keeping and liaison arrangements and a conflict resolution procedure to resolve patient focused clinical conflicts.

Strategic Objective 11

To establish a formal structure of liaison at national level between Welsh Assembly Government, criminal justice, local authorities and other mental health agencies to develop and coordinate operational policy more effectively across all relevant agencies within the whole system.

Strategic Objective 12

To ensure that rapid and effective response mechanisms to help prevent and to de-escalate crises are available within local service provision and that these are based on closer working partnerships involving mental health, social services and criminal justice agencies.

From Chapter 4. Safety for individuals and the Public.

Strategic Objective 13

The NHS and Her Majesty Court Service should work together to develop Service Level Agreement for providing expert advice and reports to the courts.

Strategic Objective 14

To ensure that any risks posed by service users to other family members and most particularly to their children are adequately assessed in a timely manner and that child protection and or protection of vulnerable adult (POVA) processes are instigated where appropriate. This should include liaison with child protection services and local authority POVA leads. Staff must be fully trained on risk assessment.

Strategic Objective 15

To develop Mental Health Crisis Resolution Services delivering effective liaison with Criminal Justice services across Wales ensuring that the mental health needs of people in the criminal justice system are identified and, where necessary, treated at the earliest opportunity. This should include improving arrangements for providing training, information and advice to courts.

Strategic Objective 16

To develop locality Mental Health Assessment Centres with adequately skilled and trained staff to act as initial places of safety for people with mental health problems who are taken into custody by the police service. Staff in these
centres must have necessary clinical, control and restraint, de-escalatory and assessment skills. This will eliminate the use of police custody suites as places of safety for people with mental health problems.

**Strategic Objective 17**

To ensure the full implementation of court diversion schemes in Wales and until mental health assessment centres are established, that mental health nurses specially trained in risk assessment and supported and anchored by multidisciplinary clinical teams, are based at designated police stations across Wales as an interim measure.

**Strategic Objective 18**

To disseminate and promote the protocol for victims of service users in order to fully implement the Domestic Violence, Crime and Victims Act 2004.

**From chapter 5 Evidence-based to based Interventions**

**Strategic Objective 19**

To ensure that the future development of secure mental health services in Wales is underpinned by an evidence-based approach to assessment and treatment subjecting clinical activities to audit and academically credible research. Audit will monitor and adjust standards of practice. Research will offer the longer term view of the effectiveness of intervention and provide the foundation both from basic and from applied science for developing new and more effective treatments and services over time.

**Strategic Objective 20**

To ensure delivery of specific treatments and conventional security, the latter as a temporary part of that treatment at the most appropriate levels matching needs, as determined by the best available and recorded assessments. These assessments must take account of research evidence on similar cases and of individual features of the case. Together with strong, professional and trained clinical leadership working not only in close partnership with patients and their families, but also with other professionals working towards the safety of the community.

**Strategic Objective 21**

To develop, as a matter of urgency, a workable strategy for improving access within secure settings, community step-down services and prison in-reach services to psychotherapies and appropriate psychotherapeutic assessment and supervision. Offender management organisations should promote the adoption of readily available programmes such as ‘anger management’ to inform clinical practice within long-term secure units evaluating the impact of these initiatives.

April 2009
Strategic Objective 22

To establish a holistic approach to service users needs which takes account of physical health and wellbeing as well as mental health and wellbeing, and social opportunities and competencies. Services should provide accurate and accessible information about the side effects of medication, other health risks and how to promote good health and physical wellbeing.

Strategic Objective 23

To establish academic research training posts in the main clinical research disciplines, inclusive of the current time-limited posts in forensic psychiatry and to ensure a dedicated funding stream for forensic mental health research.

From Chapter 6 Patient Groups with Specialist Needs

Strategic Objective 24

To ensure that statutory agencies work together to plan and commission services sensitive to the needs of people from BME groups. Within provider services particular focus is required to create positive relationships between patients and ward staff based on good practice and staff training. Robust data collection and monitoring systems need to be established to facilitate mutual learning between BME-focused services and mainstream services.

Strategic Objective 25

To ensure Women’s secure services are provided in single sex environments with access to women-specific programmes of care and women-only secure outside space. These services should be delivered within the necessary range of female specific inpatient settings meeting women’s needs for intensive care, challenging behaviour and personality disorder services.

Strategic Objective 26

To provide women-only activities as the norm with the capacity for mixed sex activities as part of a recovery/rehabilitation process, determined by women’s capacity to make safe and informed choices and by risk assessment as to which male patients would be safe and appropriate for inclusion in mixed sex activity.

Strategic Objective 27

To develop a national framework for the planning and delivery of services for people with LD who have forensic and secure mental health needs. Implementation of the framework would include dedicated practitioners with skills drawn from learning disability, mental health and forensic practice. Future policy statements on mental health care for children and adults should be inclusive and promote integrated approaches preventing discrimination against people with a learning disability.

April 2009
**Strategic Objective 28**

To ensure the development of integrated comprehensive mental health services for children and adults with a learning disability modernising existing services to include practitioners with specialist competencies in meeting the mental health needs of people with developmental disorders including learning difficulties and autistic spectrum disorders. Consideration should be given to the development of specialist mental health teams for people with developmental disorders, and altering the configuration of current child and adult mental health teams.

**Strategic Objective 29**

To ensure that the NHS in Wales takes the lead in the creation of dedicated, responsive patient-focused services for people with a personality disorder ensuring that the exclusion of people who are diagnosed as having a personality disorder from treatment is no longer an option for local service providers.

**Strategic Objective 30**

To modify and upgrade provision of forensic CAMHS particularly regarding transition arrangements and plans for secure estate provision involving all stakeholders: Youth Justice Board, Local Authorities, criminal justice agencies, NHS Wales services and social services; and to confirm the roles and responsibilities of all stakeholders in this model.

**Strategic Objective 31**

To confirm the role and responsibilities of a single Forensic Adolescent Consultation Team (FACT) that has bases, sub-steams and staff in North and South Wales and is able to deliver services across Wales.

**Strategic Objective 32**

To co-locate specialist forensic CAMHS within specialist CAMHS units to provide advice to criminal justice agencies and Local Authorities and to liaise with adult forensic mental health services on transitions in patient care.

**Strategic Objective 33**

To ensure that robust CPA arrangements are in place enabling the development of a standardised Welsh patient data set which includes the level of security required by each patient and differentiates between those with delayed transfers and those with long term secure care needs.

April 2009
1. Introduction

1.1 Background to this report

In 2004 there was an independent inquiry into a homicide by a person in contact with mental health services during the preceding year. In 2005 there was another such inquiry. The national learning from these inquiries was incorporated into an action plan within the revised National Service Framework (NSF) “Raising the Standard” which was issued in October 2005.

This action plan stated that the Welsh Assembly Government should:

*Develop a Secure Mental Health Services Strategy which includes the relationship of criminal justice, health and social care services and takes account of the issues highlighted in the HIW/HCW review of medium secure units.*

This report has been developed in response to that commitment. Development of policy for this target patient group is complex since it requires an extremely broad range of stakeholder views to be taken into consideration. These include health, local government criminal justice agencies (including the police, courts, prison and probation systems); service users and carers; the voluntary sector; and housing organisations. The following project management arrangements were designed to engage with all these stakeholders.

- Ted Unsworth, who has a background in mental health services working at the interface between the NHS, local government, criminal justice and the voluntary sector, was appointed as the independent chair of the review.

- A project steering group was established containing representatives of the major stakeholders. A full list of steering group membership is included at Appendix 1.

- Twenty-two task and finish (T&F) groups were established drawing upon the expertise of the project steering group to develop the various specialist components of the strategy.

- A North Wales stakeholder workshop was held to ensure that the specific issues facing the North Wales health and social care community were embraced in the development of the strategy.

- A range of workshops were convened to ensure that complex topics were examined in depth.

- The independent chair undertook an extensive programme of visits to interested parties to assist the exchange of information during the process and to seek commitment to the strategic intent of the review.
Service users made a significant contribution to all this activity and have been influential throughout in shaping the Review.

1.2 The focus of this report

The membership of the review were clear that it should focus on the needs of patients and not on particular physical settings. It was also important to be clear about the specific patient population coming within the scope of the review. Therefore this report focuses on the needs of offenders and others requiring similar services, (such as those not yet convicted and those who are at risk of offending).

The common attributes within this patient group are risk of harm to themselves or to others; the degree of risk is medium to high and is of longer duration. The key issues considered were therefore those of public and patient safety.

The management of this risk of harm may require a physically secure treatment environment as well as skilled relational work by clinicians coupled with explicit procedures to limit risks for example preventing access to weapons, alcohol or drugs. People within this client group usually present with behaviour at a level of risk greater than general mental health services could safely contain.

1.3 Existing strategic policy documents relating to secure care.

The previous secure services strategic document was the report of the All-Wales Forensic Advisory Group published in 1992. The report recommended for this patient group the establishment within Wales of specialist low and medium secure facilities. As a direct result the interim secure unit at Glanrhyd Hospital was established in Bridgend, which has subsequently been replaced by the Caswell Clinic medium secure unit and the Ty Llewellyn medium secure unit in North Wales.

Since 1992 there have been very many major changes affecting secure services, most notably devolution and the establishment of the Welsh Assembly Government, changes in the structures of the NHS, changes in inter-agency planning and service developments, and changes to relevant criminal and mental health legislation.

The revised mental health NSF “Raising the Standard” established a number of strategic actions in respect of secure services, but inevitably as a document addressing generic adult mental health services, it did not provide a great deal of detail in respect of secure services.
The NSF had the following Key Actions which impact directly on secure services:

### NSF KEY ACTION 38

There are to be arrangements in place to support criminal justice services including prisons and youth offending teams. Other provision is to include diversion from custody and in-reach into prisons to ensure as seamless care as possible for offenders with mental health problems. There is to be clear protocols to manage individuals who have a history of offending.

<table>
<thead>
<tr>
<th>Performance Target</th>
<th>By March 2007 LAs/LHBs to ensure implementation of the Prison Mental Health Care Pathway.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>By March 2007 LAs/LHBs/Police to establish mentally disordered offenders (MDO) operational planning groups within each police force area with clear multi agency joint working protocols.</td>
</tr>
<tr>
<td></td>
<td>By March 2008 LAs/LHBS to ensure effective court diversion arrangements are established across Wales.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring Information</th>
<th>Monitoring by LHBs with prisons within their catchment of presence and make up of prison in-reach services and case loads.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Court diversion scheme activity figures.</td>
</tr>
<tr>
<td></td>
<td>Review of MDO protocols.</td>
</tr>
</tbody>
</table>

While the deadlines have been passed, these targets are still being pursued and most are close to full completion.

### 1.4 Service user involvement

From its establishment the Steering Group was very clear that its report must take account of the views of service users, and the involvement of service users and their carers has been centrally important to the review. One of the T&F groups established specifically considered the views of service users. It was led by a user with experience of secure services and facilitated by Hafal, a national Welsh mental health voluntary sector service provider. Two particular pieces of work were undertaken by this group:

- Service user and carer focus groups were held and an informal survey of service users was undertaken.
The Learning Disability Implementation Advisory Group also undertook consultation in this area.

The service user and carer groups sought that five key areas should be part of the objectives agreed by the Strategic Review Steering Group:

1. There must be more support and much earlier intervention before admission to secure care.
2. Staff in secure care must engage more openly and trustingly with their patients.
3. There must be more rehabilitative activities to overcome the boredom experienced by service users.
4. There must be more encouragement and support for service users and their carers to be actively involved in their own care meetings. They should also receive regular feedback on their care and treatment from the clinician in charge of their treatment.
5. There must be improvement in aftercare and resettlement programmes.

Hafal also undertook a specific survey of the views of the Welsh patients in the high secure estate. This involved 28 patients in Ashworth and Rampton and the findings of that report were:

1. Most patients expressed satisfaction regarding their physical health, recreational needs, education and training needs.
2. Some patients reported that they were usually well engaged in meaningful and therapeutic activities and felt the benefit of these.
3. Users with learning disabilities at Rampton were happy and reported that staff were helpful and kind.
4. Some patients had concerns surrounding the level of type of contact with clinicians.
5. Some patients expressed homesickness and problems of keeping in contact with family because of distances.
6. Some patients expressed concerns about the help they had received before they were placed in the high secure hospital.

1.5 Mental health service reviews

During the lifespan of this review two other reviews were conducted into the potential arrangements for the planning and delivery of mental health services. Both brought forward proposals to strengthen the strategic planning and delivery of services to improve the mental health and wellbeing of people in Wales.

This review of secure services takes account of these reviews but proposes specific strategic direction relating to specialist forensic services and general mental health inpatient and community services for people in need of enhanced security in the care and treatment that they receive.

1.6 External homicide inquiries
Two further independent homicide Inquiries were published by Health Inspectorate Wales in May 2008 and a further one in October 2008. The recommendations of these inquiries have been taken into account in the development of the strategic review.

### 1.7 Current provision of secure care

The current provision of secure services for Welsh patients is as follows:

#### 1.7.1 High Secure Care

There are three high secure hospitals for the populations of England and Wales, all situated in England. With the development of hospital services at other levels of security, the high secure hospitals have been substantially reduced in size. High secure care for Welsh patients is mainly provided by Ashworth Hospital in Merseyside, but services for particular specialised groups are provided within one particular hospital. Therefore care for Welsh patients with a learning disability, and for women, is provided by Rampton Hospital in Nottinghamshire.

There have been considerable changes in the commissioning of these services. In the late 1990s the previous arrangement of top-slicing high secure care ceased in England and Wales. This was part of a strategy to develop incentives for commissioners to deliver care at lower levels of security because assessments of the high secure population have indicated that many patients held in conditions of high security do not require this level of care. Welsh Assembly Government is seeking the transfer of treatment and care for patients from Ashworth to South Wales to Broadmoor Hospital in Berkshire for closer proximity to home services and families. It is acknowledged that this change will have significant impact on the organisation of catchment areas for all English Strategic Health Authorities admitting patients to the high secure estate.

#### 1.7.2 Medium Secure Care

NHS medium secure units (MSUs) have been developed in Llanfairfechan North Wales at Ty Lliewelyn and in South Wales at the Caswell Clinic in Bridgend. Further medium secure capacity is provided in Wales by independent sector providers, Llanarth Court, in Raglan (Partnerships in Care) and Cefn Carnau in Caerphilly (Craegmoor Healthcare). The critical factor of defining mental health security services is addressed in Chapter 2 of this report. A significant proportion (almost 40%) of MSU provision for patients from Wales is provided in England.

#### 1.7.3 Low Secure Care

There has been considerable growth in the provision of low secure inpatient provision in Wales but this is generally because of independent sector providers establishing services which rely upon spot contracting in a demand-
led market. Current NHS commissioning rarely activates such development. These independent providers do not exclusively serve Welsh patients but accept admissions from across the UK and beyond. Many Welsh mental health service users continue to be placed in facilities outside Wales and at considerable distance from their home communities.

1.7.4 Psychiatric Intensive Care Units (PICUs) and High Dependency Units (HDUs)

PICUs and HDUs have been developed to support general psychiatric services to assist in the management of extremely distressed and dependant service users who require increased support and security. They are generally looked after for short periods, not exceeding six weeks. Although they require staff with special skills in managing acute disturbance and higher than usual staff: patient ratios they are not designed for people who have longer-term needs for low security. However, because of a lack of low secure provision, they have often been used to provide care. The development of PICUs and HDUs has not been standardised across Wales.

1.8 Prison health

The NHS in Wales has responsibility for the primary healthcare at the public sector prisons, whilst at HMP Parc (which is operated by a private sector provider) this is the responsibility of that company working under contract. The NHS has responsibility for the secondary health needs of prisoners.

In-reach mental health services have been established at all Welsh prisons. These services were established in order to deliver secondary mental health care within prison environments, to assist transfers into NHS facilities where appropriate, and to coordinate transfers into community mental health services for prisoners on release from custody. The Prison Health Pathway which sets out the detailed model of service for prisons was formally launched in October 2006.

1.9 Inter-agency collaboration

A number of inter-agency partnerships have been established specifically to facilitate the coordination of activities across the health, social and criminal justice system including:

- Mentally Disordered Offender Planning Groups
- Multi Agency Public Protection Arrangements (MAPPA)
- Multi-agency Risk Assessment Committees (MARAC)
- Protection of Vulnerable Adults (POVA)
- Court diversion schemes
- Safer custody initiatives

These are explored more fully in chapter 4.

1.10 Acknowledgements

April 2009
We are greatly indebted to the wide range and number of people who contributed so generously of their time and expertise to this Review, helping to shape this final Report. Over five hundred service users and their family members together with clinicians, other front-line staff, volunteers, managers, directors and board members of all relevant agencies in both statutory and independent sectors have played their part.

Whilst they may not all agree with its conclusion in detail, we hope that they recognise their own contributions to our Report.

2. Requirements for Secure Mental Health Services

2.1 What security involves

Treatment for individuals is the most fundamental aspect of security for both the patient and the public. For many people with mental disorder who offend seriously, their disorder is directly relevant to that offending. It follows that effective treatment for the mental disorder will deliver public safety as well as improving the health and wellbeing of the service user.

Specialist secure mental health services should not be considered as any different from other tertiary level health services in one important sense – that of being equipped to assess and treat the most serious and intractable disorders of health in the field. Given the seriousness and complexity of many of the presentations of illness, this can rarely be achieved speedily. Even when treatment is quickly effective, a lengthy period of further observation and testing is generally needed before it may be possible to return a service user to a safeguarded environment in the community or to independent living. In such a circumstance everyone, the service user included, needs to understand how to recognise relapse indicators and how to manage them in order to prevent deterioration in the clinical condition and further harm.

Aside from the fundamental aspect of treatment, security per se in specialist mental hospitals is generally considered to have three main components: physical, procedural and relational.

- **Physical** security concerns qualities in the hospital building and any surrounding fences.

- **Procedural** security relies on completion of systematic checks of the environment and the people in it, including the staff, to make sure that nothing that could increase the risk of harm is introduced or remains there.

- **Relational** security requires detailed and specialist knowledge of each person in the specialist unit at any time. The purpose is to detect changes in the person’s illness or relationships at the earliest possible moment and manage strategies to minimise escalation or harm.
Relational security is also a means of assessing a service user’s readiness to step down to lower levels of security.

Relational security in particular and procedural security to an extent relies on the special skills and continued training and supervision of the staff, and on the quantity of expert staff available in relation to numbers of patients.

Security is provided by an appropriate balance of these components. In a high secure setting, all these security elements are provided to intense levels. Purpose-designed specialist medium and low security settings are differentiated from high security and from each other largely by the nature of the perimeter security. Ambiguity has arisen as to whether high and separate perimeter fences are required in order for a unit to be designated as one of medium security.

If other qualities in the physical security of the building are weak, if the staff are poorly trained or resourced, then adding additional perimeter height may make some people feel safer – although the better approach would be to ensure regular review of the other physical and staff standards to ensure that these are rigorously met.

2.2 The need to define secure services more clearly

The three levels of secure services – high, medium and low – are categories that effectively describe a reducing gradient of physical and procedural security, such as in the height of perimeter fences, although all levels have high relational security and equivalent treatment capacity. Unfortunately, some of the accepted definitions of security within the health service are inadequate. Definitions may be circular, suggesting what it may be hoped that the security can achieve while not defining the characteristics of the building and service:

**High Security** is the level of security necessary only for those service users 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 service users who represent a serious but less immediate danger to others. Service users 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 leave, 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 service users who present a less serious risk to others. A large proportion of people who are held in low secure units are solely a risk to themselves. They are often dealt with in the Magistrates Courts and identified by court assessment/diversion schemes or may be transferred into secure settings on civil sections of the Mental Health Act. Security measures are intended to impede rather than completely prevent absconding, with greater reliance on staffing arrangements and less reliance on physical security measures.

While a distinct specification exists for high secure provision, definitional problems beset medium and low secure services. One problem is that levels of security may only be defined in relation to other levels, or in terms of ‘what they are not’. The recent specification for adult medium secure units (MSU) by the Department of Health in July 2007: *Executive Summary – Best Practice Guidance: Specification for adult medium secure services* has used this model. As a result, some former medium security units have now been re-designated as low secure services.

In this context, the strategy review considers that the WAG should not simply adopt the DoH July 2007 specification for adult medium secure services which currently applies in England but should rather modify it to reflect specifications for both medium and low secure services that are distinct to the needs of people in Wales.

Low security should not be defined by default and there must be a clear differential between medium and low security. In terms of definition, greater emphasis should be placed on the *functions and treatment capabilities* of the hospital or secure hostel units. Other defining factors would be in the numbers, skill mix, training requirements and qualifications of the staff.

### 2.3 High secure care

There are no high secure hospital facilities in Wales as this service is currently provided in England. On 30 January 2007 there were 57 people from Wales in a high secure hospital bed, of whom 51 were men, a very small rise from 54 (49 men) six months previously. A majority had psychotic illness (30), with the next largest group having personality disorder (18) and just three with clinically significant learning disabilities. These patients were distributed between the three high secure hospitals, namely Broadmoor, Ashworth and Rampton.

The strategy review has established that some of these service users did not require treatment in conditions of high security. There is a prevailing view that people under the age of 18, women and people with learning disability should rarely if ever be admitted to a high security hospital. Concerns about the over-utilisation of the service also arise from delays in transfer to placements of lower security. There are two main reasons for this. The first is the location of the high secure patients in relation to their communities and services of origin: two-thirds of the group are in Ashworth, a minimum five to six hours journey.
for people from South Wales. The other reason is that 18, (about one-third), of these patients have a primary diagnosis of personality disorder, a condition for which there is no dedicated medium secure facility in Wales.

2.3.1 The views of service users in high secure hospitals

The relationship which patients have with their family and friends, and their community ties, is one of the foundations for successful resettlement and should be central to care planning. However, the survey of service users in the high secure estate commissioned by the review found that patients were often homesick and experiencing difficulty in maintaining contact with family and friends. There is a pressing need to ensure that wherever possible Welsh patients are located at whichever high secure hospital in England is closest to their home community to make regular access more possible for family, friends and visiting clinicians from their ‘home’ area who will eventually lead on repatriation and rehabilitation.

2.3.2 Trends affecting service planning

Various trends in high secure care over recent years affect planning for the future:

- The capacity of high security hospitals grew steadily until the 1980s but has been reducing ever since.
- As the number of high security beds has reduced, the cost per patient has increased substantially.
- During the same period there has been a substantial reduction in the number of general psychiatric beds, resulting from the closure of the old asylum system.
- There has been a rise in the number of specialist medium and low security health service beds.
- The prison population has escalated. There have been increased rates of prison transfers to both high and medium security but research indicates significant unmet need for prison transfers. Feedback from forensic psychiatrists and the prison service equally highlights substantial numbers of patients who should be transferred to hospital facilities.
- The average length of stay in high secure units is seven years; Once a patient’s security needs no longer require high security there is an expectation of moving to the appropriate level of lower security.

Other factors impact on the planning of future high secure services. These include the broadening of the definition of mental disorder in the Mental Health Act 2007; changes in the criminal justice system (including indeterminate sentences and lengthier sentences passed by the courts); and the need to
establish a Dangerous and Severe Personality Disorder (DSPD) programme (see 6.5 below).

2.3.3 Improving the high security hospital service for Welsh patients

If a policy of removing all women and all people with learning disability from high security hospital accommodation were to be agreed and feasible, then numbers would be reduced by between 7-10 patients. Provision of specialist personality disorder services in Wales could achieve a further reduction of up to 10 patients. This would mean, according to early 2007 figures, that already small numbers of people from Wales using high security would fall even further. Some consideration must be given to the possibility that, with the growth in the prison population and, in particular the numbers of those serving indefinite sentences, there may be an increase in demand for high security hospital places from Wales.

Taking likely achievable reductions together with the possibility of unmet need, it seems reasonable to project a figure of about 40 people and not more than 60 people from Wales needing a high security hospital placement in any one year.

On this basis, a free standing high security hospital building within Wales could not be justified. An alternative might be to build some high security provision in conjunction with one or more existing medium secure units. However, as the distinction between high and other levels of security is greater than the distinction between medium and lower levels of security, and they would have to be managed as separate institutions, this is unlikely to practical for management or clinical staff. An alternative may be the development of enhanced medium secure hospital provision.

Suggestions that the physical security of high security hospitals has much in common with prisons might indicate an alternative of creating a small high security hospital facility within the perimeter of a prison. But the same problems of need for entirely separate management functions and facilities would apply. It has been a struggle to ensure that high security hospitals really do function as hospitals, notwithstanding the levels of physical and procedural security. Therefore, siting such provision within the bounds of a prison would threaten this and compromise the ethical principles underpinning secure hospital provision in the UK.

Given all these factors, the strategy review believes that only modest changes are currently required for high security hospital provision for Wales. However, the following changes should all be treated as top priority:

- All those who are not deemed suitable for high security provision but who remain there should be moved to lower levels of security or to properly supported community provision as a matter of urgency.
Further reduction in use by women and by people with learning disability seems achievable and must be addressed as an immediate concern.

To facilitate timely transfer between high security and lower levels while maintaining safety, and allowing families to travel to visit patients, it is important to improve the geographical relationships of the services. People from North Wales requiring high secure in patient services should continue to be provided for in Ashworth hospital, whilst the needs of those from South Wales should be met at Broadmoor hospital. We recommend that this continues to be explored. However, we also recognised that current plans to develop Broadmoor Hospital do not include additional capacity for Welsh patients and that the change we propose would require the reorganisation of catchment areas in England for admitting patients to the high secure estates.

Tackling the backlog of people with personality disorder from Wales who are still resident in high security will require development of specialist medium security personality disorder services in Wales (see also below).

2.4 Medium secure care

2.4.1 Current provision

On 30 January 2007 there were 178 people in medium security, about 1 per 17,000 people in the Welsh total population. The majority of these patients, 114 of 178 (64%), were looked after within the independent sector (a combination of voluntary and private provider settings) and nearly 40% of the total were in placements in England.

There are two NHS medium secure units (MSUs) in Wales.

- **Caswell Clinic:** located within the grounds of Glanrhyd Hospital in Bridgend. Caswell provides assessment, intensive care and rehabilitation for up to 64 patients requiring both short- and long-term care.
- **Ty Llewelyn:** located in the grounds of Bryn y Neuadd Hospital at Llanfairfechan, Conwy and opened in 1998 as part of the North West Wales NHS Trust. It has 25 medium security beds and has wards for admission, intensive care and rehabilitation.

At the time of the review there were also two private sector establishments who classified themselves as MSUs.

- **Cefn Carnau Uchaf:** located on the outskirts of Cardiff is run by Craegmoor Healthcare and registered to take 22 patients with a learning disability/mental health and functional illness over the age of 18 years who are liable to be detained under the MHA. There are two separate units, one that specialises in the assessment and treatment of men with
Asperger’s Syndrome; the second which specialises in the assessment and treatment of male and female patients with mental health problems and functional illnesses.

**Llanarth Court:** located between Usk and Abergavenny and is part of Partnership in Care (PiC). Llanarth Court is registered to take 103 patients over the age of 18 and liable to be detained under the MHA. The hospital has 61 medium secure beds, 38 low secure beds and 4 open rehabilitation beds.

Services are provided for individuals with mental illness, ranging from enduring illnesses, acute illness or relapse, and for individuals with an assessment of personality disorder. One unit provides services for individuals with mild to moderate learning disability, mental disability, psychopathic disorder and/or mental illness. The women’s unit provides acute and rehabilitation services for women with mental illness.

Out-of-country placements in medium secure units (MSUs) place pressure on the capacity of clinicians, service planners and purchasers within Health Commission Wales to monitor the effective care of individual patients and to ensure that contracts are properly fulfilled. There are also pressures on patients and their families resulting from the patients’ considerable dislocation from home communities.

The review attempted to quantify the need for MSU beds. As indicated above, repatriating women and men with learning disabilities, and also providing suitable step-down services for people with personality disorders from high secure care, could add to the demand for medium secure beds in Wales. Such a programme would also require the development of enhanced services for both men and women either within existing hospitals or separately established. This would have specific implications on staff numbers, training requirements, the mix of skills and the number of qualified personnel involved.

In addition, research in the 90’s suggest that up to 50 men in Welsh prisons could require specialist hospital facilities. This figure is at the very top end of projections but does highlight that there is some unmet needs in prisons. Within the health service as a whole, the unmet need for people with personality disorder who may require MSU provision could amount to 30-35 beds for women and just over 100 for men, with a probable need of 10-15 dedicated places for youths. These numbers of beds may not be sufficient without the provision of more, appropriate step-down facilities for the current patients in MSUs who are already awaiting discharge or who may not require medium security clinical care.

### 2.4.2 Are patients placed at the appropriate level?

The strategy review is particularly concerned about the number of patients in MSUs who are held there inappropriately because of the lack of step-down services to lower secure and other facilities in the community. This has created tension between HCW and LHBs, the former resorting to invoicing the
latter for the cost of patients that it is unable to move into lower conditions of security. The report of the Wales Centre for Health (June 2008), *Health Commission Wales: A Review*, chaired by Professor Mansel Aylward, identified 17 patients who spent between three and six months longer in medium secure units than they should have done. One patient had been inappropriately retained in an MSU for more than three years. It is also noted that LHBs encountered challenges in placing patients appropriately in medium secure placements and in properly verifying step-down decisions.

The problem here, as the Aylward report makes clear, concerns a severe transgression of the patient’s right to equity of access to specialised and tertiary services and to equity of outcomes. Professor Aylward also raises the question of the higher financial cost of keeping patients at too high a level of care, but this is less clear. The greatest proportional cost in any specialist service lies in its staffing. Specialist low security care and treatment, and more intensive community placement facilities, may incur lower capital costs in their construction, but revenue costs are likely to be closer to those of MSUs than to general medical health service facilities.

To gain a reasonably accurate perception about the real need in adult medium security services for people with mental illness, all services providing hospital treatment within medium security were asked to provide clinical data to Health Commission Wales. The data were then interpreted from ratings made on the Health of the Nation Outcome Scales (HoNOS), applying both general clinical ratings and security need ratings. All medium security units inside and outside Wales provided data on their Welsh patients except for the North Wales NHS Unit (Ty Llewellyn). The ratings were made by two clinicians trained in the technique and concordant validity of the secure items for this sample was checked using the Secure Needs Assessment Profile (SNAPS). Setting aside Ty Llewellyn, the return rate was 76%.

The ratings took account of the range of need that services have to meet, such as substance abuse problems, cognitive problems, problems with relationships, or with accommodation and activities. Ratings were also used to assess the extent of these needs per person – i.e. the number of such problems that each individual presented. As an indicator of the relative complexity of presentation of patients in medium secure units, the range of clinical need within this group was extensive. Just six cases were recorded as having all their needs met at the time of the rating, one case had 10 out of the possible 12 needs, but the largest group had four or more.

Between 70 and 80% of patients in medium security still had a need for a specialist secure forensic hospital placement and there is no reason to believe that there was anything special about the time the assessment was made, so it is likely to be a typical estimation. There is therefore some scope for reducing bed occupancy at this specialist level, but only if there is adequate provision of appropriate step-down services. If these figures were to be replicated, perhaps 35-40 beds could be freed towards meeting the currently unmet needs of prisoners who require specialised mental health services in April 2009
hospital settings and of those currently in high secure hospital who should be cared for at a lower security level.

The indications are that considerable additional capital resources would be needed to meet the objective within the Welsh Assembly Government’s One Wales policy of moving towards full provision for these patients within NHS facilities.

2.5 Low secure care and step-down services

Low secure hospital services are provided both by the NHS and independent sector for patients detained under the Mental Health Act who pose a significant risk to themselves or others. Normally, low secure inpatient beds are used by those directly detained from the community or who have been ‘stepped-down’ from medium secure facilities. Surveys of LHB placements indicate that almost 300 working age adults are currently placed at and around low secure service level, mainly in the private sector. This is equivalent to 15-16 people per 100,000 adults aged 18-64 years.

These services are an essential part of the whole system for mental health care, treatment and rehabilitation, particularly in terms of their function to:

- promote step-down from medium and high secure service settings;
- enable admission to a locked secure ward when a medium secure placement is not appropriate; and
- to enable diversion from custody.

Low secure provision may also be provided in community facilities where there is still emphasis on high relational supervision and treatment, and the person using the service is not necessarily subject to an order under mental health legislation.

In their entirety, low secure services are commonly understood to represent a spectrum of provision including:

- low secure inpatient units;
- low secure nursing homes – ‘hospital wards in the community’; and
- high support accommodation – residential care homes with high 24-hour staff to resident ratios.

These facilities should emphasise patient access to community services and promote a philosophy of community integration. They require a specialist multi-professional community team with forensic skills and expertise. The team’s primary role is to support CMHTs and other general mental health services to provide effective treatment, support and supervision for people placed in community units or living in their own accommodation. Alongside the functions of education, training and liaison, these specialist teams may carry out assessments for service planners or for the courts; they may have a small caseload and, if so, will use assertive community treatment (ACT) methods as described in policy guidance for Assertive Outreach Services.
There has been some recent excellent planning in respect of low secure services.

Three regional low secure projects have been set up with WAG funding, these are initially mapping the funding placements and developing regional specifications for the whole system. A national database of all low secure placements is being developed collectively by these projects.

2.5.1 Systemic problems

The definition of low secure services is fluid; there is no national specification of service standards. Unfortunately, low secure provision is commonly understood more in terms of what it is not than in clear, positive terms. It offers physical security lower than that of medium security, although health service facilities are locked or lockable; it offers a higher level of security than an open, generic mental health ward, but here mainly in terms of staff: patient ratios and expertise. Perhaps the most important distinction is from a psychiatric intensive care unit (PICU). A PICU is for people who are acutely disturbed and need intensive care with an expectation that this will be fairly short. However, the lack of provision of purpose-designed low security units means that people who need such services may be placed in a PICU. Not only is this inappropriate but it is potentially disturbing for someone with long-term special low security needs to have to reside where others are acutely ill.

Only one NHS Trust in Wales, Cardiff and Vale NHS Trust, has a specialist low security unit, which is only for adult men. There is patchy or non-existent NHS provision for women with longer-term specialist low security needs, including women with personality disorder, women who have not been charged with a criminal offence but who have a serious behavioural disturbance and women needing slow-stream rehabilitation. There is also little provision for men and women with learning disabilities and an offending history.

Low secure services have not previously been considered an essential or core service component in NHS Trust provision in Wales and this has fuelled fast-expanding provision within the private sector across Wales and the UK. The market is led by commercial providers. This is a high-cost, low-volume healthcare market in which individual ‘spot’ contract commissioning predominates. There is wide variation in the type, nature and quality of environments and care being offered by providers. There are no nationally accepted standards or outcome measures and no apparent relationship between the quality of clinical care and the occupied bed/day price in different units.

The integrated planning, commissioning and case management of low secure care across Wales is fragmented and needs reorganising to include dedicated NHS capacity to become far more effective. Service planning arrangements vary in each locality and generally the LHBs do not have the critical mass or capacity to plan these services efficiently. The division of commissioning responsibility between HCW (for medium secure hospital provision) and the
22 LHBs (for low secure provision) means that no single agency in Wales has responsibility for commissioning a whole system of psychiatric care services – whether at national, regional or local level. The dislocation between HCW and the LHBs sometimes causes disputes over funding responsibility and delays in planned transfers of patients moving through levels of security or from criminal justice settings.

In response to the lack of strategic planning capacity within LHBs, three Regional Low Secure (LHB Commissioning Support) Projects have been established with LHB and WAG funding but these are at varying stages of development. As yet, there is no standardised national database for monitoring low secure placements or service planning activity across Wales, such as for performance management purposes, but one is being piloted.

Finally, strategic planning activity within Local Authority Housing and Supporting People units must be tied in to achieve effective planning of the full range of low secure and step-down services. Current structures do not facilitate this. For example, the Regional Low Secure Projects developed under LHBs have yet to establish formal joint executive decision-making structures embracing Local Authorities.

Other systemic problems include:

- escalating LHB continuing healthcare costs;
- most Welsh patients requiring low secure care being placed out of their home area and sometimes out of Wales, far from their family, friends and support networks;
- inefficient case management processes, often at considerable distance geographically and clinically, leading to delays in transfers of care including a lack of appropriate diversion from custodial settings; and
- occasional inappropriate use of general adult psychiatric inpatient wards for the assessment of patients who require a locked ward, leading to open wards being locked for all psychiatric inpatients.

2.6 Prisoners in Wales requiring mental health services

The National Offender Management Service Cymru (NOMS Cymru) is responsible for the delivery of offender management services in prison and probation in Wales. NOMS Cymru is part of the NOMS Agency structure that forms part of the Ministry of Justice. There is a close partnership working between WAG and NOMS Cymru which brings together the devolved and non-devolved responsibilities to provide services for offenders to assist in reducing re-offending and protecting the public.

There are four prisons in Wales

- HMP/YOI Parc at Bridgend,
- HMP Swansea,
- HMP Cardiff
- HMP Usk and Prescoed.
HMP Parc is contracted to Group 4 Securicor (G4S) and the others are public sector prisons. North Wales is also served by HMP Altcourse, a private sector-run prison on Merseyside. There is no prison in Wales for women. The total prison capacity in Wales was 2,834 in October 2008. Figures available in July 2006 show that of the 3,090 prisoners sentenced by Welsh courts, 1,342 (42%) were held in prisons in England.

Commissioning of all primary healthcare services in the public sector prisons transferred to the NHS in April 2006. Primary healthcare at HMP Parc remains the responsibility of the contractor. All secondary healthcare for prisoners is the responsibility of NHS Wales.

An underlying principle

Users and carers who have contributed significantly to this review have asked that we must adhere to the underlying principle that no one in acute distress from an active serious mental disorder should be held in prison. The strategy review supports this principle entirely and stresses the urgency of finding appropriate secure hospital places for prisoners who present with severe mental illnesses, while strengthening the provision of primary care in prisons so that the in-reach services are able to concentrate on those prisoners with more serious mental health problems. In the same vein, prisoners assessed to have serious mental health problems should be diverted from prison and placed in an appropriate therapeutic environment at the earliest opportunity transfer should not be delayed until late in their sentences, which has the effect of lengthening sentences considerably.

Findings from recent reviews

During the period of this review two reviews concerning Prisoners have taken place and have been published as public documents.

In May 2007 the House of Commons Welsh Affairs Committee published its report, Welsh Prisoners in the Prison Estate. The committee made 37 recommendations, mainly to NOMS, a number of which referred to mental health issues. These included:

- Better links with NHS services in Wales and training prison staff in mental health provision would improve services and help to promote easier transition from prison to community-based services.
- NOMS should work with the NHS to ensure that good practice in mental health care in prisons holding Welsh prisoners is promoted throughout the prison estate.

These and other recommendations were acknowledged by NOMS and inform this strategy review.
HM Chief Inspector of Prisons carried out the second review, *The Mental Health of Prisoners*, published in October 2007. The two main findings here were that:

- **There are still too many gaps in provision and too much unmet and sometimes unrecorded need in prisons.**

- **The need will always remain greater than the capacity unless mental health and community services outside prison are improved and people are appropriately directed to them: before, instead of, and after custody.**

One of the main strategic policies for addressing the mental health needs of prisoners in Wales is the *Prison Mental Health Pathway*, published in October 2006. It is a comprehensive document intended “to support decision-making for those who commission mental health services for prisoners, and to guide the practice of people who directly deliver services”.

It also identifies areas requiring improvement but, crucially, does not identify priorities, resources or target dates. Reported areas requiring improvement include; commissioning, patient information, mental health awareness training for staff, mental health assessment and the dissemination of best practice, joint working, primary and secondary healthcare and transfer of prisoners to and from hospital under mental health legislation.

A strategic approach is required to provide a high quality service to people in prison who have mental health needs. At present each prison in Wales has a different commissioning LHB which work to differing degrees with a variety of community services. The Prison Mental Health Pathway document acknowledges that areas requiring improvement could be dealt with at policy and strategic level while others could be addressed by commissioners, provider organisations and practitioners working collaboratively across Wales.

Lord Bradley is currently conducting an independent review jointly commissioned by English Ministers in the Departments of Health and Justice into ways of diverting people with mental disorder from the prison system across both countries. At the invitation of Welsh Ministers, early in November 2008 Lord Bradley conducted a stakeholder event for Wales. It is clear that there is strong resonance between the emerging themes from this review and that undertaken by Lord Bradley so common recommendations are likely to follow.

### 2.6.1 Development and commissioning of prison mental health care

As part of this review, a national workshop was held in March 2008 focusing on the development and commissioning of prison mental health care. It was acknowledged that improvements have been made in the delivery of mental health care services, particularly with the expansion of prison in-reach teams. But more needs to be done both in identifying and meeting the required needs in prisons and in the way mental health and community services outside
prison support people in their resettlement. It is recognised that unless services outside prison are enhanced and people who require them are directed to them at an early stage – for example as part of an appropriate diversion scheme from custody – health service input to prisons will not be able to keep pace with need. Among stakeholders involved in this review there is general support for the role of the previous multi-sector Mentally Disordered Offender Planning Groups. These groups had a positive effect at service delivery level but they have mostly lapsed. Their re-introduction would enable more focused collaboration and planning of services which would be able to be more responsive to changes in local requirements.

Conclusion

The shortfalls in low and medium secure provision outlined here, and the interfaces between these and high security provision and prison services are given closer attention in the chapters that follow. They point to the requirement to create a new and far more cohesive, nationally effective function for the strategic planning of low and medium secure services – an integrated function to set the course for the longer term. Such a model should be informed by the representative involvement of users and carers at each stage in the process. To ensure that the momentum for change is sustained, the strategy review team also identified the need to establish interim arrangements to guide the creation of a more effective all-Wales system for the longer-term. These approaches are proposed in Chapter 3.

Strategic Objective 1

To establish an all Wales Mental Health Board with responsibility for the unified strategic planning, oversight, development and delivery of a new model of secure mental services across Wales ensuring NHS developments are developed in partnership with local government and the justice agencies in line with the model described at Chapter 3 of this strategy. Interim arrangements should be established to ensure momentum of existing work is sustained whilst the National Board is established.

Strategic Objective 2

To establish robust mechanisms to ensure that the views of secure care service users and carers continue to be heard and acted upon at all stages in the service planning and delivery process.

Strategic Objective 3

To a seek a reduction in the number of places required in the English high secure estate by establishing a specialist inpatient unit for women initially within an existing medium secure unit in Wales; repatriating people with learning disabilities to additional or augmented facilities in Wales; facilitating safe and timely transfer between high and lower levels of security; exploring the possibility for South Wales patients to receive treatment at Broadmoor.
hospital and developing a specialist all-Wales facility in the medium secure
care estate to enable the repatriation and evidence-based treatment of Welsh
patients with personality disorder.

**Strategic Objective 4**

To develop dedicated low secure and step down services within the NHS,
Local Authorities and voluntary sector to reduce the current reliance on the
independent for profit sector. The use of repatriation programmes supported
with transitional funding and capital allocation will allow much to be achieved
within existing revenue resources. Developments will include NHS provision in
each of the three current health regions:

- **Low secure inpatient wards** - (i) low secure forensic - assessment and
  rehabilitation up to two years and (ii) longer term low secure - slower
  stream rehabilitation.

- **Low secure/high support accommodation** for both step down
  rehabilitation (up to two years) and longer term care, which may be
  lockable facilities with high staff to resident ratios 24 hours a day providing
  high relational supervision.

- **Dedicated Psychiatric Intensive Care Units (PICU)** in each of the newly
  established NHS bodies.

**Strategic Objective 5**

Low secure facilities should be supported by the provision of specialist
community teams with forensic assessment and care management skills and
expertise in each of the newly established NHS bodies. These multi-
professional teams should provide a consultative liaison service to support
CMHTS and other general mental health services and should integrate with
local Criminal Justice Liaison Teams. They may function as a dedicated Low
Secure Community Team or as an expanded function of each locality
Assertive Outreach Service.

**Strategic Objective 6**

To produce clear Wales specific definitions for medium, low secure and step-
down services in Wales reflecting all four elements of effective treatment–
physical, procedural and relational security. Standards will include staff
training levels and the skill requirements needed to deliver such services to
the highest possible standard.

**Strategic Objective 7**

To ensure early implementation of improvements specified in the Prison
Mental Health Pathway (October 2006) and that there is co-ordinated planning
and service delivery for prisoners with mental health problems before, during
and after transition from prison to the community, including primary care services.

**Strategic Objective 8**

To re-establish offender locality planning, modelled on the previous interagency Mentally Disordered Offender Planning Groups.

3. Improved strategic planning for secure mental health services

3.1 What do we need to improve?

**The current division in strategic planning:** As indicated in the previous chapter there is:

- no overarching and integrated process for planning secure mental services
- a lack of capacity at LHB level to ensure effective and efficient commissioning of services and proper case management
- a significant structural dislocation between Health Commission Wales and LHB’s in commissioning seamless services for people needing to move between low and medium secure services.

Whilst significant improvements have been made recently in ameliorating the dislocation set out in c above the fault-line is systemic and must be resolved. The lack of critical mass is particularly apparent in the provision of services for women and the provision of services specifically aimed at people with learning disabilities requiring treatment in secure conditions. There is also the need for further developments to ensure full adoption of the Prison Mental Health Pathway and prison in-reach services; and research and development to support safe implementation of treatment for people with personality disorders. All these areas of strategic policy-making and implementation need strengthening.

**Cultural change:** A new paradigm is required to cope with changes in demand across health, social care and criminal justice agencies; to build more sustainable NHS provision in Wales and to take account of the Mental Health Act 2007. In particular, there must be a focus on supporting pathways of secure care through transparent gate-keeping policies at each level of secure provision. There needs to be a clear set of core principles shared between and across service components to ensure that health and social care agencies develop partnership working based on trust. A key element of this cultural change is to strengthen the new local health boards more prominent in the management of secure care provider services within the NHS, seeking to embrace clinical change to improve the service user experience. Clinicians must be supported in the proactive management of risk, sometimes involving carefully weighted positive risk-taking, and must shift away from the defensive practices designed to avoid risk but which often lead to the unnecessary
exclusion of patients from local services. Of key importance, users and carers involved in this strategy review have made it clear that they seek improvements in the ‘contact’ they currently have with clinicians and require more involvement in planning their own care. Across all levels of security, users have also asked for their daily environments to be more stimulating to overcome boredom and the sense of futility that this brings, affecting their recovery.

**Improving contracts:** The process of contracting care for patients must involve service specifications, including quality standards and performance management arrangements agreed by strategic planning and providers. Services must move away from individual ‘spot-purchasing’ to proper contract placement, including – if appropriate – the tendering process as part of NHS procurement procedures. Essentially, service planning and purchasing must be focused more on outcomes. In particular, performance management is needed to ensure that outcomes are achieved by targeting improvements in care coordination and by applying the CPA.

Many people told us that the performance management function must be strengthened and extended. This will become even more important as the NHS in Wales moves away from ‘the market’ in health towards unified management of the planning, contracting and delivery of services. In addition, given the interagency complexity of arranging secure mental health services ways should be found by the various regulators to develop complimentary models for managing performance across the whole system.

**Treating more patients locally:** It is a strongly held view that far more patients could be treated locally in the best interest of themselves, their families and local community. To achieve this there needs to be a better understanding of the interfaces between secure and non-secure care and more fluidity between them. This will also involve building the confidence and capacity of local general mental health services by strengthening their PICU provision, improving acute services, crisis intervention and support and intervention in the community. There needs to be active exchange and support concerning assessment procedures, outreach services and partnership in planning specialist low security hospital services. Social and health services will need to work closely together to identify the need for more supervised hostel placements and to fill gaps in continuing care facilities in their areas.

**Information systems:** Wales requires a single national database for secure care services that spans health, social care and criminal justice agencies. This would both map the demand of services – to inform planning – and would track the supply of services to support operational management of patients who often require urgent placements. The strategy review has looked closely at the factors affecting the sharing of information between front-line public services, particularly at critical points in a person’s contact with the system. There is an urgent requirement to promote protocols of appropriate information-exchange in criminal justice agencies, health and social services. However, in several areas there are notable examples of good practice in
information exchange. The review has also highlighted a lack of unified information systems in place in Welsh NHS and social services to support the effective implementation of the Care Programme Approach (CPA).

**A separate plan required for people with learning disabilities (LD):** A new strategic plan is required for LD secure care and treatment services. This requires improved local capacity for managing risks in this group with the aim of avoiding reliance on out-of-area placements.

### 3.2 Efficient planning of services

Only a small proportion of the Welsh population are resident in secure hospitals, but each patient will have highly complex needs, these needs will best be met when services are planned at the all-Wales level.

Under the re-organisation proposals for the NHS in Wales it is proposed that there will be a National Board. At the time of drafting of this report, the specific functions of this National Board have not been announced; however it is assumed that it will have responsibilities for such functions as setting overall direction, approving standards and implementing the performance management arrangements.

This Review recommends that a National Mental Health Board is established, which reports directly to the National Board, and which has oversight and responsibility for all mental health services – including secure services. This would be an overarching function for directing and replicating best practice in service planning across Wales. It should have responsibility for establishing:

- the development plan for mental health services
- care pathways for mental health
- performance standards for mental health
- national targets in mental health
- the information needs for all of the above
- Managed clinical networks in secure services
- A means of sharing best practice among service providers
- Methods for identifying research needs
- Advisory mechanisms on resource allocation for mental health

The specific governance arrangements for the Mental Health Board will need to be determined when more details in respect of the National Board have been established. However in the area of secure services it will need to oversee the planning and provision of:

- High, medium, longer-term and low secure services;
- Offender mental health and wellbeing services;
- All step-down provision, including that provided by the NHS, independent sector and services commissioned for this target group by local authorities;
- Health input into MAPPA and MARAC arrangements;
• Court diversion schemes and NHS-supported custodial arrangements in police stations
• Forensic child and adolescent mental health services and
• Very specialist groups (eg secure services for people with a learning disability, for women etc)

This National Mental Health Board would therefore provide what does not currently exist; strategic planning for the care of all users of secure mental health services in Wales. It would provide leadership, governance, standard-setting, service monitoring and performance management and would aim to establish good practice in service planning throughout Wales. The National Mental Health Board would have membership which includes an All Wales clinical lead, Managed Clinical Network lead and national secure services planning lead. This would achieve

• An end to the current impediments to creating effective strategic planning of the whole system across forensic, secure and general mental health service provision. This would include lower supported accommodation and other community-based services.

• The development in the medium to long term of dedicated medium and low secure provision within NHS Wales which is required as a core and essential service component of NHS provision, alongside dedicated PICU facilities.

• The establishment of a central, standardised information base for monitoring all secure service activity across Wales to identify trends within secure care and associated care pathways. This would support strategic planning across both the NHS and independent sectors. This would also enable periodic health needs assessments of all individuals in secure care to support the planning of service developments that are most appropriate to the needs of the patients. This could result in outcome measures, using common and clear criteria for service users in transition between different levels of secure services, facilitating the establishment of explicit criteria for placements and for their contract monitoring with an agreed case definition, service specification and standards.

3.3 Efficient delivery of services

Even if excellent planning at the All Wales level were developed this would not resolve the entire problem. Other current problems identified within the review include:

• Delays resulting from clinical differences of opinion;
• Disputes over funding responsibility and escalating costs of bed placements;
• A lack of formal, coordinated liaison and effective relationships between forensic mental health services and generic mental health services;
• Lack of available beds at a lower or higher tier of clinically appropriate care for patients within secure settings;
• Limited case management and insufficient service planning skills, geared to secure service users, within LHBs; and
• Limited joint decision-making and collaboration between LHBs and LAs concerning the provision of hostel, community housing and Supporting People services as part of post-discharge care planning, though this is emerging well in some areas.

Some of these problems will be resolved by a National Mental Health Board but on its own that is not sufficient. The Review considered what needs to be established below the Mental Health Board to ensure that in practice services are delivered efficiently and patients move more readily through the system. To this end the Review believes that the following need to be established:

• A system of case managers for patients in the secure services
• A managed clinical network (MCN)
• Improved operational interface between services
• A system to resolve clinical disputes

3.4 Case Managers

Good Planning at the national level is not enough on its own. It needs to be enhanced by case management. Case management is a concept that was introduced into the NHS to improve care for vulnerable people who often experience gaps in services and to reduce demand on secondary care services. The placement of a patient in a secure environment represents a major financial investment and there is good evidence that intensive, on-going and personalised case management for such patients can improve outcomes for the patient and can move patients appropriately through the system as their need for secure care changes. Case managers should have an explicit role in assessing and monitoring the quality of placements, while ensuring that providers meet the standards included in contracts or Service Level Agreements (SLAs).

Individual case managers working in local health communities need to be networked as a single team to support centralised bed management and to allow specialisation across the diversity of the client mix – for example, one case manager may take the lead nationally on acquired brain injury placements, another on PD and so on. This would also facilitate information sharing and support mechanisms for case managers.

3.5 Managed Clinical Network

A MCN for secure services will bring together into a structure the clinicians who work in secure services, but they will be unconstrained by organisational boundaries. The ultimate aim of MCNs is to improve patient care in terms of quality, access and appropriateness. In Wales successful MCNs already exist in cancer, renal and cardiac services and the Review proposes that such a MCN be established for secure services and that it should be accountable to
the Mental Health Board. The MCN will:

- Advise the Mental Health Board on service developments.
- Ensuring that service users experience coordinated care without becoming aware of professional and administrative boundaries.
- Facilitate the implementation of the standards and care pathways established by the Mental Health Board.
- Reduce delays in delivering care and transfers between levels of security by looking at services from the service user’s perspective and ensuring that the care pathway is as smooth as possible between different levels of security.
- Improving quality by responding to the results of audit and the quality assurance programme.
- Addressing workforce issues by developing innovative roles and new ways of working for health and social care professionals.

3.6 Managing effective transfers

The lack of integration between current systems has already been described. The proposals set out above should assist in addressing these fractures. However the review identified further measures required to address impediments to effective transfer

- **The gate-keeping assessment**: There must be agreed gate-keeping arrangements established by the Mental Health Board and monitored by the MCN to ensure that patients receive effective and timely assessments and are moved when it is clinically indicated.
- **Criteria for determining referrals**: Admission Policies for all levels of security should be clear and agreed by the Mental Health Board.
- **Interim management pending transfer**: A series of formal arrangements should be brokered between different levels of security units and referring services (including local general psychiatric services). The focus should be on service liaison and the ability for the secure units to extend consultant community clinics, offer advice on patient management care plans and provide outpatient clinics. Medium secure units should assist in the assessment of risk and dangerousness.
- **Involvement in aftercare**: Where patients are to be discharged into the community directly from medium secure services, such services need to work with local mental health services to promote the timely step-down of service users and to monitor the quality of care they receive within the community.

3.7 Quality and cost

Wherever possible patient placements should only be made with provider units that have been assessed and are known to meet standards and outcome measures which have been agreed by the Mental Health Board. Any
emergency placements outside this framework would be prioritised for review within the first 14-28 days by the Case Manager. Robust contracts or SLAs should be monitored through assessment visits at regular intervals.

Supporting cost efficiency, national tariffs should be developed to standardise charges for placements in medium and low secure care.

Where block contract arrangements with providers are in place, lead commissioners should consider whether these promote the best possible outcomes for patients or whether needs might be more flexibly met on a cost per case basis. Any changes in these arrangements would need to take account of the potential impact on provider economics. There may be a resulting change in how services are costed and review may be needed on how this might impact on strategic planning costs in the future.

3.8 Resolving clinical conflicts

Clinical differences of opinion cause delays in the pathway of patient care in hospital settings and in transfers between different levels of secure service. This Review set out to consider existing models of conflict resolution between secure and general mental health services in the UK, and to advise on their use in Wales.

It is estimated that some form of conflict resolution is required to tackle between 10 and 15 cases each year. Clinical differences of opinion do not usually occur about the patient’s entry point to a new treatment pathway. Conflict more commonly arises over the appropriate level of security for the patient to start a further phase of treatment after a particular incident or threat has occurred. Disagreements also commonly occur at interfaces between secure units and step-down or step-up services. This strategy review identifies that conflict can be avoided if there is effective communication and clarity concerning gate-keeping and access criteria to the services.

The review proposes a solution that will function as part of the managed clinical networks proposed above. In the first stage of the process, there would be an initial meeting held between clinicians and managers (the core manager when this exists) from both the referring service and the receiving service. Either an agreement is reached and a course of action is organised, or both parties sign an agreed joint statement which details the agreements and disagreements of each side.

If there is a lack of agreement at the initial meeting then it is referred to the lead clinician in the managed clinical network who commissions two or three experts to carry out a review of each case and to report with a risk management plan. At least one of the experts will be a forensic consultant psychiatrist or responsible clinician. Timescales have to be realistic and must consider patient care, best interest wishes and locale issues.
3.9 Interim arrangements

Largely as a result of this review, there is significant momentum and energy focused on the development of a whole systems approach for the delivery of treatment, care and a journey to stability and/or reablement for services users in circumstances of appropriate security. In light of forthcoming substantial changes in the structure of the NHS in Wales, the review recommends that interim arrangements for planning and developing secure mental health services in Wales are set up with immediate affect.

The interim planning group would help to develop both strategic and operational plans for service users. These plans can be carried forward by successor bodies once Ministers have finalised and introduced a new structure for NHS Wales. It is proposed that the interim planning group encompasses high, medium, low secure and step-down services.

Strategic Objectives

Strategic Objective 9

To introduce Case Managers to oversee the care of all Welsh patients in Secure Services and improve the communication between provider units and strategic service planners.

Strategic Objective 10

To establish a Managed Clinical Network for secure services in Wales with responsibility for developing access criteria, gate keeping and liaison arrangements and a conflict resolution procedure to resolve patient focused clinical conflicts.

Strategic Objective 11

To establish a formal structure of liaison at national level between Welsh Assembly Government, criminal justice, local authorities and other mental health agencies to develop and coordinate operational policy more effectively across all relevant agencies within the whole system.

Strategic Objective 12

To ensure that rapid and effective response mechanisms to help prevent and to de-escalate crises are available within local service provision and that these are based on closer working partnerships involving mental health, social services and criminal justice agencies.
4 Safety for individuals and the Public

The review concludes that the principle of early intervention is key to the issue of safety. The basic principle has to be that people with mental illness receive the earliest possible support and risk assessment and that assessment is acted upon. This chapter sets out how this should be achieved.

It is well known that people with a mental illness have to face stigmatisation from the wider general public and in most cases this perception of mental illness is wrong. There are only a small number of violent crimes committed by people with a mental illness and where these do occur they have a significant impact on victims and their families as well, of course, on the perpetrator and their family. It has been estimated that around 40% of people who need ongoing supervision through MAPPA have a mental illness.

Therefore the following principles must underpin all considerations of safety:

- There must be a balanced approach to public safety which upholds the human rights of the patient.
- Preventing crisis points where only the police are able to respond for people with mental illness or drug or alcohol related issues must be the aim.
- Simplifying the sharing of information and empowering all public sector employees and indeed the general public to raise concerns regarding the mental health of individuals where this raises issues of public safety.
- Ensuring that people who appear to have a mental illness and are in crisis receive assessment, treatment and care within a health setting from appropriately qualified and trained professionals.
- Increased emphasis on reducing stigma for people with a mental illness who have entered the criminal justice system with an emphasis that such people have an illness rather than that they are criminal.
- Mental health services should see themselves as having a very key role in ensuring public safety as well as having a clinical responsibility to their patients.

4:1 The focus on prevention and de-escalation

Improved liaison between health and criminal justice agencies can play a highly significant part in the successful management of people with mental disorder who have the potential to self-harm or to harm others. Focusing attention on the individual needs and risks a person may pose and providing the support, care and treatment they require through an integrated care pathway will serve to promote their recovery and minimise their potential risk of self-harm, suicide or committing harm to others. By protecting the individual and delivering effective care services improve protection of the public.

Closer working partnerships need to be formed within the community to focus on the prevention and de-escalation of crisis. Where a person with mental
disorder is involved in an incident of violence or other criminal activity interventions will require partnership approaches between criminal justice agencies working in close collaboration with mental health service practitioners who may frequently take the lead. These interventions may require rapid, health and social care led responses delivering early intervention for assessment and treatment.

It is widely recognised that detention in a police cell can aggravate the symptoms of people with mental health problems and may elevate their risk of self-harm or suicide. The Independent Police Complaints Commission (IPPC) and The Joint Committee of the House of Lords both sought the avoidance of the use of police cells as places of safety. The Mental Health Act Code of Practice permits the use of a police cell as a place of safety for a person with a mental health problem. However this review recommends that police cells in Wales should only be used in very exceptional circumstances and for as short duration as possible in the short term and that more suitable alternatives should be found as a matter or urgency. Paragraph 4:8 proposes a longer term solution.

The Mental Health Act 2007 amended the Mental Health Act 1983 to allow for the transfer of a detainee from one place of safety to another. This was not previously possible within the Mental Health Act 1983. Whilst we would expect only a very small and decreasing number to be detained in police cells, this should facilitate the more rapid transfer to hospital of those small number of people admitted to police cells in psychiatric crisis.

Both service users and carers involved in this review have expressed the view that early intervention to prevent crises leading to a person committing an offence resulting in detention is vitally important. Where a person in crisis is taken into police custody exhibiting symptoms of mental disorder, the focus must be on de-escalating the situation through the intervention of competent mental health service practitioners properly trained to intervene in such crises. Service users who enter secure mental health services have highlighted that existing processes frequently result in long-term admission to a secure hospital setting where a short-term intervention may have been sufficient. The contention is that once in the system there are few routes of diversion away from the criminal justice system.

Enhancement of community-based partnerships with fully effective communication between criminal justice agencies, mental health and social care services, focused on prevention and able to provide de-escalation at times of crisis is essential. This will ensure the diversion, where appropriate, of mentally disordered people into appropriate health settings at the earliest opportunity, an underpinning principle of this review.

April 2009
4:2 Current partnership Mechanisms

The following partnership arrangements exist to ensure that services are there to help service users.

- **Mentally Disordered Offender Planning Groups** Mentally Disordered Offender Planning Groups were established to deliver the inter-agency collaboration required by Circulars 66/90 and 12/95. In Wales, these were set up under health authority jurisdiction and involved the participation of health, social care and criminal justice agencies within the catchment of their health authority. Since the abolition of health authorities in April 2003 these groups have, in many parts of Wales, lost momentum and have ceased to meet in some areas.

- **Court diversion schemes** have been developed to cover many of the benches in Wales, with the objective of fully establishing them across Wales. The schemes provide clinical input (in the form of mental health nurses fully supported by psychiatrists and clinical teams) to courts as a means of ensuring professional assessment and advice where the accused is suspected of having a mental disorder. Clinicians will advise on processing, transfer and disposal in such cases. Court diversion schemes are intended to reduce the number of people with serious mental health problems entering custodial environments, to reduce the time they spend in such environments and to ensure access to appropriate treatment, while taking into account the public interest.

The target for full implementation of Court Diversion Schemes to all benches in Wales by March 2008 was set within the adult mental health NSF.

In some areas of Wales the provision of court diversion schemes is of a higher standard than others. This variance needs to be minimised through the assurance of an established standard for court diversion. There is the potential for a perverse incentive to not divert people from the criminal justice system. This potential emerges from the fact that proceedings offer a better result for criminal justice agencies because of the need to maintain comparative detection rates in Wales and other existing national performance criteria. This potential disincentive could be removed by ensuring that, where mental health is the primary cause for offending, diversion from criminal justice processes becomes a sanctioned detection-and-brought-to-justice outcome.

Most of the sentencers interviewed would welcome improvements to existing arrangements for providing expert advice and reports to Courts in Wales about people appearing before them who may have mental health problems. This will result in more appropriate disposals and is likely to enable more timely and effective treatment of people with a mental disorder. The NHS in Wales and Her Majesty’s Court Service should work together in developing a service level agreement to achieve the desired improvements.
Safer custody initiatives - People with mental health problems are at increased risk of self-harm and suicide in custodial settings when compared to the general prisoner population. As a result the Home Office has required the police and prison service to improve the safety of people in custodial environments with specific reference to people with mental health or learning disabilities. This has required multi-agency collaboration, particularly involving the police and mental health services. Many areas within Wales have developed joint training initiatives to facilitate and enhance such collaboration. The suicide prevention action plan for Wales has also targeted improving safety in custody settings as a priority.

The Police and Criminal Evidence Act (PACE) 1984 requires that anybody believed to have a mental disorder should be examined by a forensic medical advisor (FME) and, where appropriate, that an appropriate adult is provided via the local authority. Throughout their custody period appropriate steps must be taken to review their custody, to ensure their safety and to safeguard their civil liberties.

4.3 Assessing and managing risk

Effective risk assessment and management is central to the delivery of care to people with secure care needs. These processes are critical at all stages of the patient journey including pre-admission, discharge-planning, transfers between hospital wards, between levels of security, and in step-down care to general mental health and community services. From the moment an individual presents to emergency, health, social, voluntary, criminal justice or other services, assessment of risk of harm to others is likely to be essential to the completion of a full clinical assessment. Early and effective risk assessment underlines the urgency of promoting and improving court diversion and custodial nurse schemes providing improved care and more effective partnership.

The Health Inspectorate Wales (HIW) Review reports (May and October 2008) of inquiries into the homicides committed by Ms A in October 2005 and Mr B in April 2006 and Mr C in October 2006 all highlight the need to strengthen risk assessment and risk management, including continual review of those considered to be at risk of committing violence to themselves or others. The reports are further examples of the complexity of the issue. In each case, the HIW view was that the homicides were not predictable or preventable. It is unwise to believe that such tragic situations are in fact preventable purely by improving risk assessments and ensuring all agencies involved understand and agree management plans. However, well judged and communicated risk assessment, coupled with appropriate treatment and proper review may increase the likelihood of preventing such tragedies.

With each incident of homicide or death in custody committed by a person with a mental disorder, pressure increases to develop improved means of predicting the risk of such untoward incidents. In Wales, the academic and clinical community has an international reputation for its research and
teaching in risk assessment and management models. There have been significant contributions made to the development and trial of new models to assist in the prediction of behaviour, including those that have specific relevance to given situations, such as domestic violence and sexual offending. Nevertheless, given the variables of an individual’s presentation in crisis, and the current lack of strong enough consensus about which model is best, even the most respected validated actuarial approaches can only be aids to professional clinical assessment; they cannot replace it. The strategy review believes the objective for Wales is to ensure that a balance is struck between risk assessment based on validated actuarial approaches and assessment based on clinical experience and expertise.

More particularly, attention must be given to appropriate, timely, case-managed interventions so that people with mental health problems, including those who may offend and those who already have, are offered sustained programmes of care. This significant challenge remains the fundamental requirement of secure care provision in Wales. Meeting this challenge will require that effective strategic planning, delivery of appropriate interventions, inter-agency and multi-disciplinary communication, discharge-planning, continued care post transfer, risk assessment and management models are integrated in the cycle of care.

“A risk management plan is only as good as the time and effort put into communicating its finding to other” Good Practice in Risk Management Appleby [DOH, 2007].

4:4  Risk management: the user and carer perspective

There are already a number of specific mechanisms in place for the purpose of protecting both the public and the individual service user or offender with mental health problems. These include strong partnerships that continue to develop for handling community and personal crisis.

- **Multi Agency Public Protection Arrangements (MAPPA)** established statutory requirements for agencies (police, prison, probation, health, and local authorities), to work in partnership and to put arrangements in place to protect the public at the point of discharge of high risk prisoners. These may also include people discharged from mental health services if they have been convicted of a serious offence. MAPPA requires these agencies to engage with health and social care services to deliver components of the risk-minimisation plan.

- **Multi-agency Risk Assessment Committees (MARAC)** arrangements are led by police and are intended to protect people involved in domestic violence. They have been established across Wales to provide a forum in which agencies can formally share information to develop risk management plans. Health, social care and criminal justice agencies agree contingencies to act where there is a risk that offenders known to them might become dangerous.
• **Protection of Vulnerable Adults (POVA)** arrangements have been established in each local authority in Wales under the chairmanship of the local social services authority. POVA arrangements have been established to protect vulnerable adults, including those with mental health problems, learning disabilities, acquired brain injuries and substance misuse problems who are at risk of self-harm, suicide, self-neglect, physical abuse or sexual or financial exploitation by other people. POVA can draw upon both civil and criminal proceedings to provide a means of protecting vulnerable adults.

• **Local Safeguarding Children Boards**
  Arrangements have been established in each area of Wales to protect children in need and children who are abused. The Local Safeguarding Childrens Board will contain representatives from key local agencies.

However, there remains a gap in provision for people with a mental health problem exhibiting aggressive behaviour or where there is an indication that they may be experiencing a mental disorder, and come into contact with criminal justice agencies or non mental health services and are not in receipt of specialist mental health services. It is at this interface that users and carers have a particular concern arguing the need for more rapid assistance from other mental health services in order to minimise the need for police intervention. Carers have reported that this response is frequently lacking when it is most required.

Risk monitoring in secure settings is an intrinsic part of the process of daily relational security, while formal and regular assessment is fundamental to the patient’s clinical treatment and, where possible, to their progress towards rehabilitation, discharge and recovery. This strategy review has assembled a strong body of opinion about these procedures from users of secure services and their carers. These are the key findings:

**There needs to be effective, evidence-based risk assessment tools.** Service users and carers questioned the validity of the risk assessment tools being used and how mental health professional reach decisions that someone presents a low or high risk. Users and carers also express disquiet about the conditions that could be imposed upon them under a community treatment order, which will primarily be based on an assessed risk of harm to self and others. Users require that where a restriction of their liberty is at stake, the tools used to assess risk must be validated and proven to be more effective and should not solely be the product of clinical judgement or static indicators.

**Staff must have regular and updated training.** Users and carers require that the recommendations of the *Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People With Mental Illness* (2006) must be adopted. The main messages of this document that require addressing are:

- poor recognition of risk by mental health services;
- 21% of homicides are considered by clinicians to be preventable;
• it is time to change the widespread view that individual deaths are inevitable – such a view is bound to discourage staff from taking steps to improve safety;
• in the week prior to homicide, 29% of patients were seen by services, 9% were thought to be short-term moderate or high risk of violent behaviour; and
• services should ensure that high risk patients receive CPA, backed up by peer review in the most high risk cases.

Users and carers considered that regular and updated staff training in the management of risk including suicide and violence prevention would improve staff and patient confidence.

More user/carer involvement in risk assessment: Users and carers want more involvement and collaboration in risk assessment and risk management meetings and plans. Best Practice in Managing Risk (Department of Health, 2007) strongly emphasises collaboration with service users: “Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service users and their social context, knowledge of the service users own experience, and clinical judgement”. This is considered to be a vital empowerment issue. Users and carers want and sometimes need to take responsibility for their behaviour; their empowerment is not served by not informing them of risk concerns.

Carers must be far more central to the process of risk assessment. Where there is a carer in a service user’s life they are a vital source of support to the user and an invaluable source of information about increasing risks. Carers usually know that the person they care for has become unwell and potentially dangerous but they often have no one to tell or no one who will listen. Carers need support, frequently they are the people most likely to be at risk from a user who is unwell. This relationship must therefore be handled with considerable sensitivity and skill. Many carers have asked for help but this was not forthcoming. This is a serious and important issue for carers. Engaging them in every aspect of the process may not always be practicable but in most cases it should be possible to achieve greater involvement and collaboration.

Staff confidence and clinical practice in relation to diversity, risk assessment and management needs strengthening. Sometimes staff can reinforce stigma and other forms of discrimination without realising they are doing so. People from certain minority groups are more likely to be subject to compulsion, while others are much less so than the indigenous white population. It is vitally important that both clinical and risk assessments are transparent and take account of cultural differences. Staff may also be afraid of being explicit about their concerns and are often, according to users and carers, unsure of their ground. But they must feel more confident to convey their concerns to users and carers. Public protection is not best served by a group of professionals convening meetings behind closed doors. Users and carers are realistic about the nature of the relationships they have with the professionals in their lives. They need more transparency and openness, not
They seek “Reflective practice, clinical supervision and a team approach” (Best Practice in Managing Risk, DOH 2007).

Building openness and trust into risk management. Users also suggest that a key to improving risk management is the development of relationships based as far as possible on warmth, openness and trust. More trust and openness in the relationship will lead to risk assessment that takes proper account of the capacity for a service user’s level of risk to change over time and recognises that each person needs a consistent and individualised approach.

4:5 Research, teaching and training

The identification, assessment, prediction and management of risk of harm to others is central to work in forensic mental health services and is recognised as of increasing importance in generic mental health services. The WAG is already supporting the Wales Applied Risk Research Network (WARRN) to improve performance in this arena. The aims of WARRN are:

- To support structures to produce internationally recognised multi-disciplinary research about risk assessment and risk management of future dangerousness.

- To ensure effective dissemination of research into evidenced-based practice and improved standards of care and public protection across all sectors in Wales.

WARRN has so far trained more than 700 practitioners from health and social care agencies in the evidenced-based practice of risk assessment and risk management. It has also informed the implementation of risk management strategies and organisational policies. A diverse training curriculum includes modules for improving basic clinical skills relevant to risk identification and formulation, and the use of structured clinical risk assessment for violence and sexual offending. WARRN also provides training to service-users, carers and support workers about the evidenced-based evaluation of risk and risk management approaches.

Research into the prediction of future offending behaviour has progressed considerably over the past 10 years, both in the domain of general offenders and in offenders with mental disorders, and Wales has contributed substantially to driving scientific developments in the field. Current research is now refining the instruments for use in specific domains, such as those of domestic violence, or for particular groups of offenders, for example child sex offenders. However, risk by definition implies uncertainty and assessments which may perform relatively well in discriminating groups according to risk of harm are much less reliable and valid when applied to a single case. It is the latter which is the focus of clinical practice.

Furthermore, advances in the prediction of future offending have not been mirrored by similar improvements in the intervention and management of violence. The field is held in a catch-22 position. There is little funding in the
area of intervention for offending behaviour and violence in the context of mental illness and randomised control trials (RCTs) are still a rarity in this field. As Wales has some of the best services in mental health and social care, allied to academics and clinical scientists with worldwide reputations, there is an opportunity for Wales to lead in this vital area. These services and models of care must be subjected to robust research designs, so as to provide a proper evidence-base for what works – and what does not. An evaluation of the health economics underpinning any such intervention or service is also important. It is essential to the fulfilment of the ideal that people with disorders of mental health who offend, often as a result, should be treated on a par with people with disorders of physical health, that evidence-based practice becomes the norm for the forensic mental health services, and that the research and development cycle becomes an integral part of practice.

4:6 The Care Programme Approach (CPA)

In Health and Social Care services the Care Programme Approach is the tool used to integrate assessments of need and risk into a formalised care plan and risk management plan. The CPA requires multi-agency and multi professional participation in cases of high risk and complexity. The full and consistent implementation of the Care Programme Approach (CPA) has yet to be achieved across Wales. Were it to be fully developed and include an initial assessment that identified the need to share information with partner agencies, the CPA may have more extensive effect as a vehicle for filling the gap within existing arrangements. More work is needed to embed and develop this system. Trusts have acknowledged that they currently use a wide variety of information systems and there is significant variability in the extent to which these systems are able to support CPA. Appropriate and unified information systems and effective protocols for information-sharing are vital to the development of effective communications both between and within mental health services and criminal justice agencies, and other partners in Wales.

4:7 A community mental health criminal justice system for Wales

A three-tiered model

The strategy review proposes a model for a community mental health criminal justice system for Wales that operates as a preventive collaboration bringing together community, criminal justice and mental health service resources to meet the needs of service users. The model would operate on the following three levels:
**Prevention in the community:** The aim is to maintain people in a state of good mental health and wellbeing. This requires public mental health community interventions delivered through the actions of Local Service Boards and Community Safety Partnerships supported by representatives of the police, social services and health professionals. Emphasis should be placed on early identification of risk including primary care alerting specialist mental health services or justice agencies where potential public safety issues arise. This identification of risk needs to be accompanied by early intervention by specialist mental health, social care and where necessary criminal justice agencies to prevent potential crisis.

**Crisis intervention:** This would be the point where formal action is requested or is necessary because of an unforeseen crisis. At this level, mental health service users and those exhibiting signs of mental distress may require rapid support and assessment. The local mental health service working in partnership where appropriate with justice agencies would take the lead in acting promptly to minimise risk in crisis situations.

**Risk Management and provision of care and treatment:** Mental health service professionals would lead in the assessment and delivery of treatment and of care and management of risk, directly supported, if required, by the police, probation and prison services. In order to develop this model a number of service developments are required.

### 4:8 Locality Mental Health Assessment Centres

In some areas of the United Kingdom, specialist facilities with dedicated staff have been established in a health setting to assess and treat ‘in a place of safety’ people with an apparent mental health problem who’s capacity is impaired (including mentally disorder people who may be affected by the misuse of substances). The establishment of Locality Mental Health Assessment Centres in Wales would provide a similar and more extensive joint service facility. Initially, the urgent requirement is to set up alternative places of safety to police cells to deal with the needs of people with or appearing to have a mental disorder health. Staff in these centres must possess the necessary assessment skills and also have training in control and restraint techniques. The main benefits would be to prevent self-harm, with multi-agency available at one site. There should be provision for detoxification and signposting to non-healthcare services such as housing and support mechanisms in the community. An early, health-led intervention of this kind also offers an increased likelihood of providing an effective care pathway for those people using the service.

At paragraph 4.1 it is acknowledged that the use of police cells should only be used in very exceptional circumstances, the establishment of locality centres would allow the discontinuation of their use. An interim arrangement is for mental health nurses to be available within designated police stations, supported by multidisciplinary clinical teams. The custody nurses will be able
to provide risk assessment, referral advice and advice to the CPS in the event of charges being considered.

4:9 Mental Health Crisis Resolutions Teams

At the point of crisis, closer working and liaison between health and criminal justice agencies is core to enabling proper assessment and minimising risk. All areas of Wales are currently required to have crisis resolution services although at the time of drafting this report they do not all meet the guidance issued by the Welsh Assembly Government.

The Mental Health Crisis Resolution Teams would have the objective of facilitating rapid and thorough risk assessment at crisis prevention and treatment and care levels. These teams together with criminal justice agencies would develop the protocols to deal effectively with crisis situations.

The Mental Health Crisis Resolution Team should seek to coordinate and liaise with providers of existing health service resources, including custody nurses, court diversion schemes and prison in-reach. They could channel pre-sentence reports and pre-charge advice to the CPS. They would build working relationships between existing staff and health-based management, develop nurse custody arrangements where none exist, provide training on mental health matters to non-medical staff including police, court and probation services staff.

4:10 Sharing information

The sharing of person specific information within and between agencies is a sensitive issue. There are various statutory and common law provisions that limit or prohibit the use of information in specific circumstances. Equally, there are statutory provisions and common law duties that require information to be disclosed appropriately in certain circumstances. These apparently conflicting duties and powers create the potential for tension between the need to share information for the benefit of the patient or the public and the need to respect the individual’s right to privacy and confidentiality.

In Wales the accepted protocol for exchanging information between health and social service agencies is the Welsh Accord for the Sharing of Personal Information (WASPI).

The purpose of WASPI is to:

- enable service providers and other organisations directly concerned with the wellbeing of an individual to share information between them in a lawful and intelligent way; and
- provide an accord to which all participating organisations can sign up.

WASPI provides a foundation for information-sharing because it includes:

- a common accord to which all organisations can sign up;
• exemplars of document design;
• the creation of a library:
  o to hold a list of organisations that have signed up to WASPI;
  o to make documents available to reduce duplication;
  o to manage the register of designated persons;
  o to raise awareness, including posters and leaflets for users;
• the establishment of monitoring arrangements:
  o to ensure agreements, protocols and policies are followed;
  o to provide a self-assessment toolkit for organisations to assess their
    own readiness;
  o to conduct reviews;
  o to raise awareness including training of users.

Within criminal justice agencies section 115 of the Crime and Disorder Act has
established a similar mechanism. This has been successfully operating since
the late 1990s. The Crime and disorder Act and the Human Rights Act allow
for the sharing of information to protect life/public safety.

The review seeks to promote improved practice in the sharing of information
from within existing arrangements. There is already sufficient legislation
permitting information sharing where public safety is concerned. However,
principles concerning the sharing of information in a critical situation should be
agreed by all parties concerned. The following basic principles are
recommended:

• Only the minimum dataset necessary will be shared for the purpose of the
  prevention of harm.
• This will be done where practicable with the agreement of the person
  concerned.
• If this is not possible, the person will be informed as soon as practicable
  the nature of the information that has been shared, and with whom.
• The recipients of this information will only use it for the purpose intended –
  to promote the safety of the person concerned and his/her potential
  victims.

Whilst protocols drawing upon this existing legislation may prove helpful the
position taken by the review is that more robust arrangements should be
developed in Wales to ensure the timely and effective exchange of information
between agencies in the interests of both patient and public safety.

4:11 Strengthening liaison at national level

The strategy review was tasked with reviewing the whole system of treatment,
care and reablement in whatever setting services are delivered. The criminal
justice agencies in Wales have been strong contributors in preparing the
findings and objectives in this review. Their active and continuing participation
in planning and delivering inter-agency services is essential if the quality of
outcomes for patients and their families is to be improved whilst sustaining
effective arrangements for public safety and protection.
As a means of providing inter-agency coordination and leadership, the review recommends that there should be a formal structure of liaison at the national level between the National Mental Health Board (see chapter 3) and criminal justice agencies. Such liaison would have the purpose of ensuring that:

- Specialist mental health services play a leading role, supported as necessary by the police, and National Offender Management Service, in the assessment and care management of offenders with mental health problems.

- There is greatly improved liaison and partnership between community, general and forensic mental health services and the police, probation service, the courts and youth justice boards, local authorities and key voluntary organisations.

- There is a structure in place to ensure rapid, evidenced-based risk assessment and management led by clinicians from the mental health services or by fully trained individuals in police, probation services and the courts in emergency situations.

- There is a unified and formally agreed structure in place between key public services to ensure the rapid sharing of key information about an individual to provide sufficiently comprehensive information for risk assessment and management.

4:12 Equality and empowerment for victims

This review has included analysis of the issues affecting the victims of offenders with a mental disorder. This analysis involved specific tasks:

- To consult with criminal justice, mental health and social care agencies.

- To produce a protocol for the victims of offender patients in Wales to assist the implementation of the Domestic Violence, Crime and Victims Act 2004 in Wales.

- To set up a process for audit and review of this protocol for Welsh victims.

The protocol establishes a number of specific duties for mental health services and **Victim Liaison Units**. These include identifying the victims of mentally disordered offenders at the point of sentence or when they are transferred into the mental health system and to offer a victim liaison service to these victims. It is important for the Victim Liaison Units to link with key professionals in the mental health system at this early stage.

They would also liaise with mental health services during hospital admission in order to be able to offer appropriate information to victims about the patient’s ‘journey’ through the system. The victims may also require Victim Liaison Units to represent them at Mental Health Review Tribunals;
representation may include the victim’s views on discharge planning and conditions of discharge.

The protocol provides guidance on issues of confidentiality and on the roles required to ensure victims are properly represented by mental health services, Mental Health Review Tribunals and the Ministry of Justice (Mental Health Unit). It also identifies a number of issues that are difficult to resolve, notably the gap that exists between the 2004 legislation for victims of offender patients and the inequitable nature of services for victims across Wales. Among other issues, the possible conflict between clinical confidentiality and public protection resonates with the findings of other task and finish groups involved in public safety and protection.

Conclusion

Ensuring the safety of people with a mental disorder and the wider public depends on timely and accurate assessment of the risk they may pose to themselves or others and treatment of their mental disorder. In order to conduct such assessment and effectively deliver treatment it is essential that mental health services are available, accessible and appropriate to the needs of service users and their families.

In most cases, there is negligible or only low risk of harm to others. In a few cases where significant risk is evident multi agency risk management strategies informed by a full clinical assessment of need and risk are required. Such a management strategy may include liaison with criminal justice agencies, including the police.

A consensus among stakeholders, including service users and carers, has emerged within this review that much more is achievable to address the needs of individuals with mental health problems and thereby to improve public safety. Current partnerships provide a good foundation upon which mechanisms for systemic improvements can be built by developing service structures to replicate current good practice within Wales. Full and careful support of victims of violence or abuse must be woven into the fabric of service provision. A consistent and cohesive approach is needed; one that does not reinvent the wheel nor require a programme of extensive bureaucratic reforms.

Strategic Objectives

Strategic Objective 13

The NHS and Her Majesty Court Service should work together to develop Service Level Agreement for providing expert advice and reports to the courts.

Strategic Objective 14

To ensure that any risks posed by service users to other family members and most particularly to their children are adequately assessed in a timely manner.
and that child protection and or protection of vulnerable adult (POVA) processes are instigated where appropriate. This should include liaison with child protection services and local authority POVA leads. Staff must be fully trained in risk assessment.

**Strategic Objective 15**

To develop Mental Health Crisis Resolution Services delivering effective liaison with Criminal Justice services across Wales ensuring that the mental health needs of people in the criminal justice system are identified and, where necessary, treated at the earliest opportunity. This should include improving arrangement and providing advice to courts. These services must meet existing guidance already issued by Welsh Assembly Government.

**Strategic Objective 16**

To develop locality Mental Health Assessment Centres with adequately skilled and trained staff to act as initial places of safety for people with mental health problems who are taken into custody by the police service. Staff in these centres must have necessary clinical, control and restraint, de-escalation and assessment skills. This will eliminate the use of police custody suites as places of safety for people with mental health problems.

**Strategic Objective 17**

To ensure the full implementation of court diversion schemes in Wales and until mental health assessment centres are established, that mental health nurses specially trained in risk assessment and supported and anchored by multidisciplinary clinical teams, are designated police stations across Wales as an interim measure.

**Strategic Objective 18**

To disseminate and promote the protocol for victims of service users in order to fully implement the Domestic Violence, Crime and Victims Act 2004.

5. Evidence-based Interventions

5:1 The importance of developing and monitoring treatment in secure settings

There is an ethical imperative to provide sound treatment in appropriate settings for people who suffer from distressing and disabling diseases. As long as specialist hospital services can provide some relief from suffering, or prevent deterioration, or reduce self-harm and its consequences, or reduce harm to others in its frequency or seriousness or both, it is appropriate to pursue these goals for people with mental disorder who also offend. If past behaviour, including criminal offending, and risk of repetition of such behaviour is judged to be serious – or if the risk of acts likely to cause serious harm to others is thought to be high and imminent – then such services have
to be provided in conditions of physical, procedural and relational security. For each individual, the nature and degree of security has to be determined by the nature and degree of the risk of harm.

Appropriate security measures not only increase safety for the patient, fellow patients and staff and the wider public, but they may also be an adjunct to treatment and change if appropriately delivered. The need for custodial style security, and in particular its duration, is partly determined by the nature of the relationship between the mental disorder and the offending, partly by treatment responsiveness and, for some patients, by other considerations. These include the nature and quality of relationships with the family or community in which the dangers have occurred or may occur. When offending is wholly or partly driven by symptoms of a mental disorder, and that disorder is treatable, it follows that introduction and maintenance of effective treatment for those symptoms is the best way of increasing all-round safety. Most treatments have a time lag before they are effective, so varying degrees of the more custodial styles of security may be essential supplements to treatment during this period. However, most change might be expected to come from specific treatments for specific diseases or problems.

As a key part of this strategy review evidence has been explored and assembled which indicates how various therapeutic approaches can enhance safety and/or bring about positive change in the mental state and behaviour of service users in secure settings. The aims of this approach were to:

- generate a list of treatments commonly used within secure hospitals or hospital units, noting any treatments rarely used but thought to offer potential for significant breakthrough in specified cases;
- generate a list of current official guidance on any such treatments, with an indication of the weight of such guidance; and
- identify any systematic reviews of such treatments and any more general reviews since 2000, and to list these together with additional references to effectiveness of the treatments in a range of circumstances.

5:2 Method of gathering evidence-based information

Treatment for the primary mental disorder will be determined both by evidence of its effectiveness for the particular disorder concerned, according to well conducted research, and by the history of the individual's previous treatment experiences and responses. There is extensive, high quality information on the effectiveness of some treatments for some disorders, and this strategy review’s T&F group report (see Appendix 1) provides a review of those. The report assembles evidence relating to commonly applied treatments for the most common disorders among people presenting to specialist forensic mental health services. It relies heavily on published reviews, published research reports and government guidance but does not cover every possible type of treatment – for example, many of the smaller schools of psychotherapy are not specifically covered. This should not be taken to imply that such treatments have no place in specialist secure services, but that the
Randomised controlled trials (RCTs) are accepted as providing the highest standard of evidence of effectiveness of any treatment. Usually these trials are conducted with people who have moderate degrees of illness and the capacity to be cooperative and altruistic. Such a description does not fit most people presenting to forensic mental health services. Most service users have illnesses which have not responded to treatment elsewhere; most have more than one mental disorder and many other serious psychosocial problems and many have, for various reasons, found it difficult to engage in and comply with treatment. The very extensive history and range of disorders and other problems that some people have experienced makes each of them almost unique.

In the light of this, the evidence assembled, and briefly summarised below, must be received with a certain amount of caution. Nevertheless, there is good evidence that many of the commonly available treatments considered do bring about substantial improvements in health and do reduce the risk of violent or other harmful behaviours associated with mental ill-health. This finding alone underlines the importance of applying appropriate treatment for all those in secure settings and of broadening the scope of treatment to ensure that those whose conditions have formerly been considered to be untreatable also receive appropriate interventions.

5:3 The use of medication

Medication has been extensively studied for a range of relevant conditions:

- Schizophrenia and similar functional psychoses
- The biological treatment of major depression
- The biological treatment of bi-polar disorder
- The biological treatment of generalised anxiety disorder (GAD), agoraphobia, social phobia and panic disorder
- The biological treatment of post-traumatic stress disorder (PTSD)
- The biological treatment of attention deficit hyperactivity disorder (ADHD)
- The biological treatment of autistic spectrum disorder
- Treating people with comorbid conditions

The evidence base for the effectiveness of antipsychotic drugs for schizophrenia and similar psychoses is relatively good, tending to favour so-called atypical or second generation antipsychotics, although a UK-based
study has challenged this. The same is true for antidepressant and mood-stabilising drugs for bipolar disorder or severe depressive illness, again tending to favour newer drugs. The National Institute for Health and Clinical Excellence (NICE) provides government guidance in these fields.

Appropriate medication is generally available and, for a range of psychiatric conditions it has been subject to extensive evaluation – probably more extensive evaluation than most other forms of treatment. However, its application in forensic mental health service environments is less of a known quantity if only because gold standard trials of treatment, the randomized controlled trials, tend to include people with relatively pure forms of illness and in the middle range of seriousness. By the time service users present to forensic services they have illnesses which have, at least partially, become resistant to treatment and many have at least one and often several comorbid conditions. It is particularly important that clinicians have the skills to interpret trial data and manage prescription in this context.

The greatest clinical challenge therefore lies first in monitoring and studying the use of these powerful drugs, particularly when used in combination with others and perhaps in the context of patients using non-prescribed drugs as well. Secondly, it is vital to maintain the physical health of people taking such medication, as many of these drugs, taken over time, can compound other health problems. Clinicians must also take pains to ensure the safe and appropriate maintenance of medication established as useful in individual cases.

5:4 Psychological interventions

Psychotherapies in the health service and psychotherapeutically based interventions in the criminal justice system have been extensively evaluated. The quality of the evidence is in some respects generally less good than that for medication. This is because of the greater potential both for variation in the delivery of the therapies and for external, coincidental events to be relevant to progress in this context. The question “which interventions, delivered under what conditions, work best for which mentally disordered offenders?” asked some 15 years ago (Howells & Hollins, 1993) still applies. However, research in this area is rapidly expanding, particularly in relation to personality disorder and offending.

The psychotherapies may be considered by theoretical approach, or ‘school’, and application. The former include cognitive behaviour therapy (CBT), dialectical behaviour therapy, transactional analysis, existential psychotherapy, the creative therapies and the psychodynamic psychotherapies. Applications include individual work, group therapy and family therapy.

CBT has been studied for a wide range of conditions, including schizophrenia, and is the main school of therapy underlying most interventions within the criminal justice system. CBT can assist in the management of mental health difficulties and improve an individual's ability to cope. Evidence of reducing
symptoms through CBT has to be considered disorder by disorder, and in some cases is good. In health services, CBT approaches have also been shown to be successful in promoting full engagement with treatment, including maintenance of medication.

For service user populations CBT programmes have been developed to deal with the core ‘skills deficits’ identified; these include poor problem-solving, anger regulation, social skills deficits and cognitive rigidity. In criminal justice services, there is good and growing evidence of reduced offending in some offender groups after completion of specific CBT-based programmes, such as reasoning and rehabilitation. The evidence is probably most equivocal in relation to sex offenders. It may be that some of the programmes designed for offenders without mental disorder may also assist those with a mental disorder to avoid re-offending. It is understood that there is some research currently being conducted on this and this is perhaps an area requiring more research endeavour in the short to medium term. Both relevant government-supported bodies – NICE and the National Offender Management Service (NOMS) – have published evidenced-based guidance on such approaches.

For people with disorders of personality and/or substance misuse disorders, there is good evidence for the effectiveness of residence in a therapeutic community (TC). TC-style approaches have been implemented in prisons as well as health service settings. One or two well conducted studies have endorsed the value of psychodynamic psychotherapeutic approaches within or outside TCs.

Although there is only a slight traditional evidence base for the value of support and supervision from psychodynamically trained therapists both at an individual staff and institutional service level, this is now generally regarded as important because of the risks inherent even in professional interpersonal relationships in the context of the most serious mental disorders, including psychosis and personality disorder. The risks may be to the integrity of the staff or the institution, but the risk of harming a patient through psychotherapy requires much more consideration than it has previously had. It is routine to study and report side effects of treatment in research into medication but evaluations of psychotherapeutic approaches very rarely make reference to side effects.

5:5  A skills shortage

Throughout Wales, psychotherapy is underprovided. This situation is not unique to Wales, but possibly more extreme here. There are practitioners trained in CBT and some of the more behaviourally oriented therapies, although probably still too few. There are people within the criminal justice system who have been trained to deliver the programmes recognised by NOMS but there is little dialogue between the two.

There is also a notable dearth of psychodynamically trained psychotherapists. The nature and extent of the core problems of most service users means that this is a situation which must be remedied. All of the women known to forensic
mental health services in Wales, and a substantial proportion of the men, have histories of prolonged and serious childhood physical and/or sexual abuse and neglect which are material to their presentation. Few if any forensic health service practitioners consider that they have the skills to assist adequately with the resultant burden of psychopathology. There is a risk that without such skills, or access to them, interventions may only maintain and could exacerbate these health difficulties. Further, in spite of the related extent of pathology in relationships within the families and social circles of such patients, and the disproportionately higher risk of serious harm to family members, almost no family therapy is available. This too should be remedied.

A workable strategy for improving access to psychotherapies and appropriate psychotherapeutic assessment and supervision is urgently needed, as is the evaluation of the impact of doing this. In the first instance, given the length of training necessary, and the wider shortage of such skills, the strategy will almost certainly have to be founded in modest recruitment of expertise and funding to support short courses and video-links with leading centres elsewhere.

5.6 Service user perspective

We were reminded of the evidence from service users and carers in the surveys undertaken on our behalf by Hafal. The patient daily life experience is often impoverished – too few opportunities for routine human contact with staff, a lack of stimulating, purposeful activity with insufficient opportunity to play a part in their own treatment and care planning. Mental well-being and recovery is enhanced by experiencing a decent quality of life.

5.7 Physical health and wellbeing

Physical health and health education are very important issues for people with disorders of mental health. Both lifestyle and the nature of specific drug treatments for the commonly experienced mental disorders contribute to the increased rate of physical health problems among forensic mental health service users, particularly including obesity, heart and lung diseases, liver and gastrointestinal diseases, and disorders of sexual health. Severity of the disorders and the extent of comorbidities among service users in forensic mental health services probably leaves them exceptionally vulnerable to such conditions. There is little research in this area which is specific to them, but there is enough evidence of the potential for such problems to indicate that this would probably not be a priority research topic.

The DRC report Equal Treatment: Closing the Gap (2006) presents stark figures illustrating the prevalence of major health problems among people with mental illnesses generally.

- Women with schizophrenia are 42% more likely to get breast cancer.
- People with schizophrenia are 90% more likely to get bowel cancer.
• People with schizophrenia or bipolar disorder are 60% more likely to have ischemic heart disease; 80% more likely to have a stroke; 30% more likely to have hypertension.

• 33% of people with schizophrenia and 30% with bipolar are obese, compared with 21% of the rest of the population.

• 61% of people with schizophrenia and 46% with bipolar disorder smoke, compared with 33% of the rest of the population.

• 22% of people with coronary heart disease and schizophrenia die after five years; 8% die in rest of the population.

• 19% of people with diabetes who have schizophrenia die after five years; 9% die in rest of the population.

• 28% of people who have had a stroke and have schizophrenia die after five years and 19% of people with bipolar disorder die in this period as against 12% of people with no serious mental health problems.

Strategies for improving physical health are therefore particularly important for this population of service users. There is some evidence that programmes directed at improving diet, increasing exercise and reducing obesity are not only effective in improving physical health but may also have a beneficial effect on mental health. This may be a direct effect but probably also results from improving compliance with medication which could otherwise be rejected on the grounds of its unwanted side effects on metabolism and weight. Interventions to reduce smoking and improve other aspects of physical health, such as dental health, have also been evaluated and shown to have likely benefits.

Within secure settings there needs to be education for patients about health risks and how to promote good health and physical wellbeing. There should also be plenty of access to details about the likely physical side effects of psychotropic medication and information about all medications, including those taken for non-psychiatric reasons. General population studies of education about medication have shown a positive effect on adherence.

5:8 Research, teaching and continuing professional development

Consensus about evidence-based interventions and their appropriate adoption in secure mental health services in Wales depends on properly funded research and the development and maintenance of substantive posts to support the continual professional development of academic clinicians. The strategy review upholds the following findings of the T&F group that focused on research, teaching and professional development.

• Wales has the foundations of a strong academic base to inform, support and evaluate the development of specialist secure hospital services as part of a comprehensive system of services promoting
recovery from the most serious mental disorders and improving patient and public safety. University staff work closely with clinicians and criminal justice service providers to inform research, training and continuing professional development in Wales. They have published research papers, other learned articles and books for home and worldwide audiences and present new research at international meetings.

- As a small but complete nation, Wales is well placed as an environment for a range of important studies from population-based counting to test relationships between mental disorder, social disadvantage and violence through to experimental work to establish the effectiveness of new treatments or other ways of working with service users and others in this target group.

- Research resources are scarce and the survival of specialist clinical academics is constantly under threat. Funds are particularly needed to consolidate a forensic mental health research alliance between academics in North and South Wales; to establish a confidential research register of all specialist secure service users; and to facilitate treatment trials. They are also needed to strengthen the senior academic teams and to develop a career pathway for academics for the future in all relevant disciplines.

**Strategic Objectives**

**Strategic Objective 19**

To ensure that the future development of secure mental health services in Wales is underpinned by an evidence-based approach to assessment and treatment subjecting clinical activities to audit and academically credible research. Audit will monitor and adjust standards of practice. Research will offer the longer term view of the effectiveness of intervention and provide the foundation both from basic and from applied science for developing new and more effective treatments and services over time.

**Strategic Objective 20**

To ensure delivery of specific treatments and conventional security, the latter as a temporary part of that treatment at the most appropriate levels matching needs, as determined by the best available and recorded assessments. These assessments must take account of research evidence on similar cases and of individual features of the case. Together with strong, professional and trained clinical leadership working not only in close partnership with patients and their families, but also with other professionals working towards the safety of the community.
Strategic Objective 21

To develop, as a matter of urgency, a workable strategy for improving access within secure settings, community step-down services and prison in-reach services to psychotherapies and appropriate psychotherapeutic assessment and supervision. Offender management organisations should promote the adoption of readily available programmes such as ‘anger management’ to inform clinical practice within long-term secure units evaluating the impact of these initiatives.

Strategic Objective 22

To establish a holistic approach to service users needs which takes account of physical health and wellbeing as well as mental health and wellbeing, and social opportunities and competencies. Services should provide accurate and accessible information about the side effects of medication, other health risks and how to promote good health and physical wellbeing.

Strategic Objective 23

To establish academic research training posts in the main clinical research disciplines, inclusive of the current time-limited posts in forensic psychiatry and to ensure a dedicated funding stream for forensic mental health research.

6 Patient Groups with Specialist Needs

6.1 Introduction

It can justifiably be argued that all people who require secure mental health services have specialist needs. Each individual will typically present with complex psychiatric, psychological, emotional and social problems. However, to develop appropriate health and community step-down provision at different levels of security, it is essential to understand and address the needs of specific groups of service users. For example, the requirements of adult service users with severe behavioural problems resulting from learning disabilities will be substantially different from the treatment and care required by young service users as they approach the age when they might be transferred to adult services. The characteristics of treatment, care and the environment required by women are significantly different in many ways to those generally required by men.

The Welsh Assembly Government and its partners must have a reasonable understanding of the needs of these groups in order to provide treatment and placements that are appropriate and to shape service developments for the future. In this chapter, the review reports specifically on services required for

- black and minority ethnic groups
- women
- people with a learning disability

April 2009
• individuals with a personality disorder
• young people requiring forensic psychiatric services
• service users who require services in the longer-term

6.2 Black and minority ethnic (BME) groups

Across the UK there are issues of health inequalities within BME group and, in particular more needs to be done to improve the mental health of people in these group. There is overwhelming evidence that black patients’ experiences in mental health settings are more negative than those of white patients. Racism, cultural ignorance and stereotypical views can often combine with the stigma and anxiety associated with mental illness to undermine the ways in which mental health services respond to people from black communities, affecting decisions about treatment, medication and restriction. Recent research confirms that there has been a sharp and disproportionate increase in the number of black women sent to prison; that 25% of the female prison population comes from BME communities; and that black people are three times more likely to be admitted to psychiatric hospitals than the rest of the population.

BME service users have a number of concerns which the strategy review wishes to bring to the fore. In particular, users consider there is a lack of engagement between themselves and ward staff because of mistrust and fear. They feel that discriminatory institutional processes and practices are often overlooked, left in place or go unchallenged. They perceive a need generally for mental health services to establish positive relationships with BME communities, so that services address the ‘lived’ experience of BME groups.

Statutory agencies need to work in partnership to plan and commission services to improve the pathways of care for BME groups. Within provider services particular focus is required on creating positive relationships between patients and ward staff. This must be based on good practice and staff training. Robust data collection and monitoring systems should also be established to facilitate mutual learning between BME-focused services and mainstream services.

6.3 Secure services for women

6.3.1 Key issues affecting women’s services

At present dedicated women only NHS secure provision is wholly absent in Wales. There is a requirement for better information on women’s secure mental health needs in order to most effectively develop these services in Wales. Not enough is known about how many of these women could be cared for safely in conditions of lesser security. More work is needed to specify the number of women currently requiring secure beds at all levels of provision and the factors likely to affect the numbers in the future, so that bed numbers can be adjusted sensitively. There is always a risk that if there is excess capacity that this overcapacity will be used. However the specific needs of women
need to be addressed to ensure compliance with the public sector duty on gender equality and human rights legislation.

A small number, approximately six to eight women in Wales, are estimated to require a relatively high level of care over a sustained period but how that care should be delivered is yet to be determined. Given the small number, a stand-alone women’s enhanced medium secure unit (WEMS) does not appear to be a viable option. However, a small intensive care facility within a woman’s medium secure unit may be suitable. This could be used for short-term intensive care for women in extreme crisis and longer-term care for those with the highest long-term needs. It may also be useful to develop an explicit relationship with another secure unit in the broad vicinity so that women could move between them at strategic times, or times of crisis.

An all Wales national reprovision process needs to be initiated to establish a dedicated network of secure services for women. Women’s specific healthcare needs and the specific differences in the social and offending profiles of women and men must be considered in the planning and provision of services.

- Women need a high level of relational security that will enable them to address the complexities of their mental distress including offences and risk behaviour. The level of environmental (or physical) security should be no greater than women require.

- Women with secure care needs are very likely to have experienced childhood sexual abuse or domestic violence.

- they are more likely than men to be either a single parent, to be the primary carer for their children, or to live in poverty.

- they are more likely to self-harm, experience anxiety and depression, have an eating disorder, have a diagnosis of borderline personality disorder and only women experience a postnatal illness.

- Women are more likely than men to seek help from primary care and less likely to enter services via a criminal justice route.

- Women value the opportunity to talk about their difficulties and have expressed the need for safety while under the care of mental health services.

Within inpatient units a number of issues have been highlighted through current studies, guidelines and service users’ comments.

- Most women find mental health wards unsafe. Incidents of sexual harassment and assault are acknowledged to be under-reported. There should be zero tolerance of sexual intimidation and violence.

- Staff skills and attitudes are not always appropriate to manage and modify challenging behaviour by such women, which is often used as a
means of communicating profound distress. They may not have sufficient skills to respond adequately to disclosure relating to sexual abuse. Women are often reluctant to access acute inpatient care when it is indicated and this can prolong their illness or hasten relapse. Women commonly need women-only private and social space within their ward or separate women-only wards. However, physical separation is only part of the solution. What a ward ‘feels like’ is as important as what it looks like.

- Staff should be aware of trouble spots – kitchen, mixed social areas, areas some distance from the ward office. Good relational security will promote recovery and encourage feelings of self-esteem, wellbeing, social inclusion and safety.

- Best practice requires a safe environment, in which women can experience relational security, where physical health needs, including sexual health, can be addressed and where staff understand the impact that observational practice can have in terms of re-traumatisation of earlier events.

### 6.3.2 Focusing on women’s needs

It is vital that women and men have equal access to individually appropriate treatment within secure mental health services. This is supported by the Equalities Act 2006, and the introduction in April 2007 of the Public Sector Gender Duty and the Revised Adult Mental Health National Service Framework and Action Plan for Wales (2005).

Key Action 21 in the Action Plan states that:

“By March 2008 LHBs/ NHS Trusts/ LAs to ensure existing inpatient and community care facilities are in fit for purpose environments, which are suitably staffed, offering privacy and dignity within units offering single sex environments.”

Women’s experiences of inequalities were described in an English policy initiative *Women’s Mental Health Strategy - Into the Mainstream* (DH 2001).

A significant focus of this strategy review is to continue to remove inequalities and to promote gender-sensitive service provision in Wales.

The key messages and recommendations made by the National Patient Safety Agency (NPSA) (2006) in relation to sexual safety are also of central importance:

- There needs to be greater awareness of the risks of sexual vulnerability of mental health inpatients and greater protection for patients.
- Risks of inappropriate sexual behaviour, or vulnerability to sexual harassment, should be considered as part of each patient’s initial assessment and be re-assessed on a regular basis.
• Patients’ reports of sexual harassment or inappropriate sexual behaviour should always be taken seriously.

• There should be clear information available within the service to staff and patients that rape and sexual assault are crimes that will be reported to police.

• All mental health units in Wales providing services for men and women should audit and review inpatient facilities to ensure that they are fully compliant with the WAG’s requirements in relation to the physical environment.

• Wards must not be pressurised into admitting patients of the opposite sex into single sex areas.

• Inpatient units should provide access to appropriate advice and services to deal with contraception, pregnancy and sexual health.

6.4 Secure services for people with a learning disability

6.4.1 Quantifying the need

The task of quantifying the need for secure services for people with learning disabilities is particularly difficult. There are few data sets on secure care for this population and those available are of poor quality. There were also significant issues in defining the ‘forensic’ learning disability (LD) client group. The category can include those with mild LD and severe mental illness and personality disorder or both, and people with severe learning disability with aggression towards themselves, to others or both.

Previous estimates of the numbers of the people who are in touch with LD services who come into contact with the criminal justice system each year in Wales vary between 270 in one 1995 study and 674 in another 1995 study. There is a smaller margin of difference in the estimation of the numbers of people in touch with LD services who have a known risk of offending: between 1,751 and 2,290. There is also little robust data held by HCW or local commissioning groups. Four LHBs were unable to provide any data for the HIW all-Wales review of learning disability services for young people and adults.

From evidence collated as part of this strategy review, it is estimated that approximately 150 people each year with serious antisocial behaviour and/or charged with a criminal offence could be referred to a Welsh forensic learning disability team.
6.4.2 Evidence-based practice

The key findings concerning this patient group are that:

- Interventions from ‘mainstream’ learning disability, mental health and offence related practices are all required. Across Wales there are no planning and service configuration structures to deliver and evaluate the outcome of the emerging intervention evidence base.

- Inpatient and residential settings across a wider security spectrum are required, acknowledging the diverse needs of environmental, procedural and relational security, to meet the needs of people who have offended, or had contact with the criminal justice system, or exhibited offending type behaviour.

- Inpatient secure settings need to practice within the same value base as community services including person-centred approaches, advocacy, preservation of family and social relationships, meaningful daytime opportunities.

- Meeting the forensic needs of people with LD in Wales requires significant workforce development, both through recruitment and skills acquisition, notably in risk assessment.

It was widely recognised by all those contributing to this strategy review that people in secure care also need particular attention paid to their physical health care. Among the overall group of service users, those with learning disability continue to have higher rates of physical health morbidity and mortality.

6.4.3 Current patterns of service delivery

WAG policy is that people with LD have good access to generic mental health services across Wales but also to specialist mental health/challenging behaviour (MH/CB) services. There are misconceptions that Community Teams Learning Disability (CTLDs) are equivalent to Community Mental Health Teams (CMHTs). In fact, CTLDs have a much wider remit including facilitation of primary and secondary physical health care. All CTLDs in Wales include input from specialist consultants in the psychiatry of learning disability. Some areas of Wales have specialist practitioners within their community services skilled in using applied behavioural and other psychological approaches usually with people with more severe learning disabilities and frequently having an additional diagnosis of autism. Thus, team structures for people with learning disability are not analogous to typical mental health teams for adults.

Currently CTLDs are under pressure from requests to support people with very complex needs without the necessary skills to do so. The majority of
specialist residential provision is within the independent sector, usually in
group homes or, more rarely, supported living arrangements. If specialist
residential provision is not available or a current placement breaks down there
are definite risks of referral to inpatient and sometimes secure services even
though the service user concerned may not have changed significantly from a
behavioural pattern stemming from childhood.

Most areas have access to a small assessment and treatment inpatient unit.
The function of these units becomes confused because of high numbers of
delayed transfers of care superimposed on an already diverse client group.
The HIW review confirmed the presence of high numbers of inpatients who
are ready for discharge or who no longer require treatment, but for whom
there are no appropriate community facilities or services. Because of the
diversity of presentation, and comorbidity, small units across Wales are
attempting to work with a wide range of needs but also acting by default as an
interim placement.

NHS trusts were commissioned to develop a limited number of continuing
care units as part of the hospital resettlement programme; some of these units
offer significant levels of relational security.

WAG policy recommends that local arrangements should be made to meet
the mental health needs of children with LD but there are no specialist
children and adult mental health services (CAMHS) for learning disability.
Conversely, some LD organisations provide lifespan services. Children
placed in specialist schools out of area or those who experience multiple
placement breakdowns are at high risk of requiring very specialist support as
they enter early adult life and may proceed inappropriately directly into
specialist residential and secure care.

6.5 Secure services for people with personality disorder

6.5.1 The challenge of personality disorder (PD)

Development and delivery of appropriate health services for offenders with
personality disorder will pose a particular challenge. This has been such a
neglected area in the health service that the range of primary and secondary
services needed is rudimentary, and any tertiary service development would
quickly fill and stagnate without developments at all tiers of the health service.

Attitudes to the treatment of people diagnosed as having a personality
disorder (PD) have fluctuated considerably over time, most recently having
been through a pessimistic and rejecting phase. This view is changing again
and new approaches are developing which makes it an ethical imperative to
plan and provide appropriate interventions in Wales for people with PD. Given
that a substantial proportion of people in secure services and also in prison
are diagnosed with PD, the sustained development of effective treatment for
people with PD, using a tiered service model, is also an issue of public safety.
All three of the HIW Inquiries published in 2008 made specific
recommendations on the need for training in the treatment of personality disorder and the enhancement of personality disorder services.

Personality disorders are long-standing, pervasive patterns of thinking, feeling and actions which are destructive, distressing and impair functioning. These developmental problems arise out of an interaction between the individual’s genetic, dispositional and physiological make up and the invalidating and sometimes traumatic environments in which they have grown up. There is some evidence of natural maturation over time if the individual can be sustained through the most difficult years, but the main goal is alleviation of distress, damage and dysfunction, with lasting change where possible.

Information on the effectiveness of a range of treatments for a range of personality disorders is accumulating, possibly at a greater rate than for many other disorders of mental health, as indicated in the chapter on the evidence base for treatment and its supporting report. Interpretation of findings is complicated by the fact that it is arguable that individual variation affects the nature and presentation of personality disorder more than it affects presentation of illness, that ongoing social and cultural factors may be more relevant to the maintenance or relief of the disorder even that with chronic illness, and also that so many people with personality disorder have co-morbid conditions, and it is not always clear which condition is being affected by any particular treatment approach. There is some dispute about the extent to which treatment has a principally holding function, allowing the individual under treatment to survive in safety until natural maturational processes occur, and the extent to which real and enduring change can be achieved. It is arguable that either is valuable and that both may occur. There is evidence that medication may help with underlying dysfunctional personality traits, such as impulsivity, and that psychotherapies, perhaps particularly in the context of a therapeutic community approach, are effective and important. In advocating the development of tiered services throughout Wales, however, an additional challenge arises because the numbers needing treatment at each tier are not precisely known. Reasonable estimates can be made, however, from what is known about the epidemiology of personality disorder among the general public, among people attending general practitioners and in prisons.

6.5.2 How many people have a PD?

- In the general population in the UK estimates range from 82,800 (4.4%) to 245,000 (13%). There is no reason to suppose that the proportion in Wales would differ.

In primary care, Figures indicate that the proportion of people with personality disorder who are registered with general practitioners is the same as in the general population, although the extent to which they consult about matters directly arising from their disorders of personality and the extent to which about more routing matters is less clear.

- In secondary mental health services, currently used figures indicate:
  - 50% of psychiatric inpatients or 570 per year;
- 50% of psychiatric outpatients or 10,000 per year;
- 52% of a CMHT's caseload in London had PD;
- There is a high level of dual diagnosis among PD patients, including schizoaffective (43%), schizophrenia (57%), bipolar disorder (63%) and depression (47%).

- One of the two specialist PD services in Wales is Gwent Health Care Trust. They received 55 PD referrals from 12 local CMHTs and 5 acute inpatient services covering a population of 600,000 in the first year of operation.

- No figures are available for local forensic services, drugs and alcohol services or specialist residential treatment centres.

- In low secure services, 19%, or 19 of 101 offender-patients were classified as having PD.

- In medium secure placements between 2003 and 2006, there were between 14 and 19 men and 9 and 10 women with PD each year, with more than half going to locations in England. However, more than 35% of patients in the HCW database have no diagnosis recorded so PDs in these services are likely to be under-counted.

- In the high secure estate between 2003 and 2006, there were between 12-13 men and 3-4 women with PD; again probably under-counted.

- In Welsh prisons, the literature indicates that in March 2006, 71 would have had a psychotic illness, 192 a major depression and 1,240 a personality disorder (there are no women in Welsh prisons).

As to the last statistic, the high incidence of prisoners with PD does not necessarily mean that their PD contributed to their offence or that they should not be in prison.

There is quite wide discrepancy in figures on the epidemiology of personality disorders among prisoners. This is mainly accounted for by differences in measurement. An approach which identifies personality disorder through interview and application of operational criteria derived from the diagnostic and statistical manuals gives a very high estimate of personality disorder – that not less than half of prisoners will have such a diagnosis, the actual figure dependent on whether anti-social personality disorder alone is more than a circular diagnosis. An approach which is more clinical, and adds consideration of need for treatment, produces very substantially lower figures. If the latter, most conservative figures are translated on to the population of prisoners from Wales as at September 2006, about 3-35 specialist secure health service beds for women and about 100 for men would be required. It is arguable that a number of beds offering similar treatment models should be provided for youths with the kind of conduct and/or emotional disorders that tend to precede personality disorder.
6.5.3 Dangerous and severe personality disorder (DSPD)

Focus in recent years has been on the provision of accommodation and, where possible, treatment for men with dangerous and severe personality disorder (DSPD): “To develop, pilot and deliver new services specifically for people who present a high risk of committing serious sexual and/or violent offences as a result of severe personality disorder” (from DSPD, High Secure Services for Men, DOH, HO & HM Prison Service, Oct 2005). Currently, 75 medium secure and hostel places are being developed for men with DSPD classification at six pilot sites in England, specifically with the aim of providing better treatment and seeking to improve mental health for this group. Most of the provision is in high security settings – in Broadmoor and Rampton – and in two prisons. These services are currently being evaluated.

Estimates for men with DSPD in Wales are currently:

- Serving prisoners: 77
- Detained under the MHA: 22
- In the community: 16-33
- Total: 115-132

Not all of these men would be appropriate for a medium secure placement.

6.5.4 What services exist for PD?

There are no hard epidemiological data on the nature of service request and receipt at any level of service, but there are grounds for suspicion that at primary care level, most response to people with personality disorder is for an immediate presenting problem rather than the personality disorder itself – this is often treatment for a physical injury or illness. When PD is recognised the individual is rarely referred to specialist services because there are few locally and PD generally cannot be helped by primary care counselling services. Much of the psychological therapy for PD is provided by clinical psychologists in general adult psychiatry services and is a substantial part of their casework. There are only two secondary level specialist PD services in Wales: Gwent Health Care Trust in South Wales and North East Wales NHS Trust, based in Wrexham and Flintshire. There is only one medium secure service for women (with borderline PD) at Llanarth Court Hospital. There are no specialist low secure PD Services in Wales. Patients who require intensive residential therapy for their PD and who cannot be contained in local services are referred to specialist units in England on a case by case basis. Prison in-reach mental health services are the only potential source of help for people in prison with a PD. These services are very limited and are typically focused on mental illnesses such as affective disorders and anxiety disorders.

6.5.5 Barriers to service development

There is a lack of policy regarding PD services in Wales. Some key
observations from this strategy review are as follows:

- PD patients sometimes stay for longer than they need in medium secure facilities because of the limited availability of step-down services.

- Many patients need treatment for PD but not in a locked environment. There are no therapeutic residential environments or outpatient services dedicated to the treatment of people with PD in Wales.

- There are no medium secure services available for the treatment of PD in Wales. Limited new facilities are being developed at Llanarth Court for women.

- Health and social services staff tend to have negative attitudes about PD, which adversely affects their capacity to assess and treat people who suffer from it.

- An unknown proportion of patients on a CMHT’s caseload with PD are being treated for other mental health problems and illnesses but not specifically for PD.

- Services offered by CMHTs to people with PD are variable – some are excellent – and depend on the skills of the staff and their ability to work together.

- Staff training in assessment and treatment of PD is limited and of unknown utility.

- A local specialist PD service can provide more intensive therapeutic services than CMHTs.

- Large sums of money are spent by LHBs on residential setting for people with PD, often of poor quality and far from home.

6.5.6 A tiered service model for PD

There is a consensus between service users, providers, commissioner and interagency partners that development of specialist secure mental health services in Wales for people with personality disorder is essential, but that it must be accompanied by commensurate development in generic mental health services and in primary care. A tiered model of service provision, with the largest availability in the wider community, and the smallest number of treatment places at the secure and most specialist levels is recommended. It is essential that the highest quality expertise is developed at the specialist secure level, not only to ensure effective treatment there, but to provide a resource to support, inform, train and advise as required in the other tiers; a consultation–liaison approach is likely to be the most efficient route to good service provision in this area. In developing such an approach, it must be recognized that there will probably need to be quite a lengthy developmental
phase as there is little relevant specialist expertise currently in Wales, or indeed in the rest of the UK, and capacity building of the relevant expertise will be an essential step. Robust research evaluation and audit must be integral to new service development, not only in the interests of effective service development in Wales, but also because such developments in Wales could have a substantial role in informing further developments elsewhere.

Relevant experience and learning from elsewhere in the United Kingdom can be usefully deployed to improve these services in Wales.

6.6 Secure services for young people

6.6.1 Modifications required

Secure mental health services are inevitably focussed on the adults who require them. So the observer could be forgiven for failing to recognise that these adults often live in families with their own children, or children of their current partner. These sometimes seem ‘unfriendly’ to families and consequently insufficient attention is paid to the needs of people in the wider family group, particularly children and young people.

In addition, a small number of children and young people require specialist secure mental health services in their own right. The review seeks to ensure that the Welsh Assembly Government upgrades its provision of forensic services for children and adolescent patients by modifying and updating the existing structure. Figure 1 indicates how policy should be aligned.

The modifications involve the following areas of focus set out in 6.6.2 to 6.6.6.

6.6.2 Transition arrangements

The Welsh Assembly Government should review the transition arrangements that it wishes to see implemented in Wales for young people who need to move between:

- specialist CAMHS and forensic mental health services for adults;
- the Forensic Adolescent Consultation Team (FACT) and forensic mental health services for adults;
- medium secure units for children and young people in England and the forensic mental health services for adults in Wales; and
- prisons and remand centres and the forensic mental health services for adults.
6.6.3 Services providing or provided in secure settings

The Welsh Assembly Government should lead preparation of a plan of secure estate provision, both inside and outside Wales, for minors ordinarily resident in Wales. This plan must involve all of the following services:

- the Youth Justice Board;
- Local Authorities in Wales, including:
  - residential services provided by social services departments; and
  - education services provided in conditions of security;
- the prison service;
- the police services; and
- NHS Wales-funded services including:
  - medium secure units;
  - secure facilities provided by non-secure units; and
  - services that are secure by virtue of their context and use of staff.

This requires a substantive assessment of places in NHS-funded medium secure units required by minors who are ordinarily resident in Wales. It is also important, as part of this plan, to stabilise access for minors in Wales to appropriate medium secure provision in England by:

- identifying the funding required to meet the assessed need;
- establishing agreed mechanisms for the strategic planning and purchasing of services with the responsible authorities in England; and
- improving the performance management of care pathways for young people within NHS Wales.

6.6.4 The confirmation of roles and responsibilities

Before implementing a modified and updated plan for forensic CAMHS, the WAG should confirm the relative roles and responsibilities within its policy and strategy that it wishes to see played by all health, YOTS, police and probation, and local authority services, including social care and education. It must also confirm the relative roles of FACT and specialist CAMHS at Tiers 2 and 3.

6.6.5 The Forensic Adolescent Consultation Team (FACT) for Wales

FACT will provide a key place in improving forensic CAMHS in Wales and the Welsh Assembly Government needs to confirm the roles and requirement for a single forensic adolescent consultation team in Wales that has bases, sub-teams and staff in North and South Wales and that is able to deliver services across Wales. To achieve this, the following work and principles are important.

- To review the needs for and size of the FACT and its constituent sub-teams and prepare a plan to develop and further refine the roles of the existing FACT.
• To confirm that the FACT is to provide in-reach services to the prisons and local authority secure premises in Wales.

• To confirm that the FACT is to provide the advisory, assessment, liaison and in-reach services for minors who are ordinarily resident in Wales and who are placed in the secure estate and in medium secure units in England.

• To confirm that the FACT is to provide in-reach, advisory, consultation and training services to the teams in specialist CAMHS that deliver Tier 3 functions with the forensic CAMHS.

6.6.6 Specialist Forensic CAMHS

The strategy review also proposes a far more integrated approach to the delivery of forensic specialist CAMHS locally by basing these Tier 3 staff within the specialist CAMHS units in each area. This co-location enables forensic CAMHS staff to advise on matters relating to minors who may need specialised forensic mental healthcare, including advice to local authorities concerning children in their care. Each unit would also be a base from which to provide a mental health adviser to each Youth Offending Team in its locality. Among the key responsibilities of forensic Tier 3 staff would be liaison with forensic mental health services for adults, particularly in leading transitions of patient care between specialist CAMHS and forensic mental health services.
Figure 2: Recommended Alignment of Child and Adolescent Mental Health Services with Other Services for Offenders who are Minors

<table>
<thead>
<tr>
<th>YJB</th>
<th>Local Authorities Social Service Departments</th>
<th>Local Authority Education Departments</th>
<th>NHS Wales</th>
<th>NHS Wales Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Offending Teams</td>
<td>Social Services Teams</td>
<td>Schools</td>
<td>Primary Health and Dental Care</td>
<td>Tier 1 Services for Children and Young People who are Distressed or have a Mental Health Problem</td>
</tr>
<tr>
<td></td>
<td>Children’s’ and Young People’s Services Teams</td>
<td>SENCOs</td>
<td>Mental Health Advisers to the YOTs (Outposted from Specialised Forensic CAMHS Teams)</td>
<td>Tier 2 Advisory, Consultation, Training and Support Services for the Staff who Deliver the Functions of Tier 1 for Children and Young People who are Distressed or have a Mental Health Problem</td>
</tr>
<tr>
<td></td>
<td>Education Support Services</td>
<td>Specialised Staff Outposted from Specialist CAMHS to the YOTs (Outposted from the Specialised Forensic CAMHS Teams)</td>
<td></td>
<td>Services for Children and Young People who have a Mental Disorder</td>
</tr>
<tr>
<td></td>
<td>Special Classes</td>
<td>Generic Specialist Teams in each Locality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YJB</td>
<td>Local Authorities Social Service Departments</td>
<td>Local Authority Education Departments</td>
<td>NHS Wales</td>
<td>NHS Wales Policy</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------</td>
<td>---------------------------------------</td>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(including generic specialist services for children and young people with learning impairments and learning disabilities and co-morbid mental disorders)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialised Forensic CAMHS Teams (led from Specialist NHS-funded CAMHS but with multi-agency contributions of role, staff and professional expertise)</td>
<td>Specialised Services for Children and Young People</td>
<td>Specialised Services for Children and Young People with Co-morbid Mental Disorders and Learning Impairments and Disabilities</td>
<td>Tier 3 Services for Children and Young People who have a Mental Disorder and who Require More Specialised Services</td>
</tr>
<tr>
<td></td>
<td>Day Centres and Services</td>
<td>Day Special Schools</td>
<td>Other More Specialised Teams within CAMHS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Secure Estate</td>
<td>Residential Schools</td>
<td>NHS-funded Adolescent Units</td>
<td>Tier 4 Services for Children and Young People who have a Mental Disorder and who Require Very Specialised Services</td>
</tr>
<tr>
<td></td>
<td>Foster Care</td>
<td>Residential Care</td>
<td>Medium Secure Units (in England)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialised Foster Care</td>
<td>Residential Care in Security (Hillside)</td>
<td>Forensic Adolescent Consultation Team for Wales (with sub-teams North and South)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential Care</td>
<td></td>
<td>(a) Consultation, training</td>
<td></td>
</tr>
<tr>
<td>YJB</td>
<td>Local Authorities Social Service Departments</td>
<td>Local Authority Education Departments</td>
<td>NHS Wales</td>
<td>NHS Wales Policy</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and advisory services for Specialised Forensic CAMHS and Specialist CAMHS Teams</td>
<td>(b) Consultation to Hillside</td>
</tr>
</tbody>
</table>
6.7 Secure services for people requiring longer-term care

6.7.1 Specialist needs

Longer-term care is defined by the review to involve the provision of services within a secure setting that lasts longer than two years. Patients requiring longer-term secure care are not a homogeneous group and they are among offender-patients and non-offending patients with the most intractable and challenging behaviour who require mental health services. Some require constant perimeter security; some need constant internal procedural security; and most have very complex needs. Almost all will have high relational security needs. They might have persistent delusions, or paraphilias and they might be serially aggressive to things or people.

Birmingham Eastern North PCT has tried to define patients who need long-term medium secure care as those who require the relational, procedural and physical security of medium secure units but who also have additional characteristics. These include resistance to treatments, limited potential for change, failed placements in lower levels of security, repeated violent behaviours within care. This patient group continues to show risk to others if resident within the community. The problems within this group include marked functional and social difficulties and a high prevalence of positive and negative symptoms.

Handling their care requires attention in a number of areas: improving motivation, symptom relief, social skills deficits, quality of life, need for space, cognitive deficits, problem-solving difficulties, problems with goal-setting and the need for optimal health promotion as well as risk management.

6.7.2 How many longer-term patients are there in Wales?

There are currently 42 longer-term Welsh patients in high secure care in England and of these about 15 are thought to need step-down services to long-term secure care during the next three years. Individual care pathways and the application of the CPA would determine whether they will be provided for in medium or low secure settings.

A factor that complicates the assessment of who is ‘truly’ a long-term secure care patient is that of delayed discharge into care in the cases of patients who become long-term by default. HCW has introduced a more robust data collection system to clarify this issue, drawing information on a monthly basis from provider units to review the clinical and security needs of the patients that HCW funds. Robust forensic case management might also help to differentiate those patients who require longer term care from those whose discharges are delayed.

6.7.3 Assessment and referral

Clinical Teams in discussion with commissioners determine the placement needs of each service user after consultation with all interested parties. Users themselves and their carers should be central to these discussions, plans and
timescales concerning placement in long-term secure care. For the procedure to be most effective the Care Programme Approach must be robustly applied. CPA meetings in any provider unit must ensure that the right people are present, combining service planners and clinicians and any step-down service providers to ensure smooth transitions in pathways of care.

Referral decisions need to be made on the basis of placements where the patient can receive good quality individualised care with the emphasis on maximising existing skills and introducing new ones, and promoting optimal levels of health and independent living. Assessments of outcomes are equally important in the determination of long-term secure care. Outcome evaluation is not just about symptom reduction but includes quality of life, physical health, social function, motivation, insights of management skills, as well as reducing risk behaviours. The use of the HoNOS secure version and Camberwell Assessment of Needs (forensic version – CANFORS) may be useful tools to support these assessments and, more particularly, the outcome of decisions.

6.7.4 User group views

Users who helped to inform this strategy review have drawn attention particularly to the importance of:

- improving treatment in forensic settings;
- earlier intervention to avoid the necessity of entering secure care;
- more engagement with patients by secure care staff;
- the need for more rehabilitative activities and other meaningful and worthwhile activities, as well as occupational therapy programmes;
- involvement with their own care planning;
- receiving regular feedback on their care and treatment from their responsible medical officer; and
- improvements in aftercare and resettlement arrangements.

Strategic Objectives

Strategic Objective 24

To ensure that statutory agencies work together to plan and commission services sensitive to the needs of people from BME groups. Within provider services particular focus is required to create positive relationships between patients and ward staff based on good practice and staff training. Robust data collection and monitoring systems need to be established to facilitate mutual learning between BME-focused services and mainstream services.

Strategic Objective 25

To ensure Women’s secure services are provided in single sex environments with access to women-specific programmes of care and women-only secure outside space. These services should be delivered within the necessary range of female specific inpatient settings meeting women’s needs for intensive care, challenging behaviour and personality disorder services.
Strategic Objective 26

To provide women-only activities as the norm with the capacity for mixed sex activities as part of a recovery/rehabilitation process, determined by women’s capacity to make safe and informed choices and by risk assessment as to which male patients would be safe and appropriate for inclusion in mixed sex activity.

Strategic Objective 27

To develop a national framework for the planning and delivery of services for people with LD who have forensic and secure mental health needs. Implementation of the framework would include dedicated practitioners with skills drawn from learning disability, mental health and forensic practice. Future policy statements on mental health care for children and adults should be inclusive and promote integrated approaches preventing discrimination against people with a learning disability.

Strategic Objective 28

To ensure the development of integrated comprehensive mental health services for children and adults with a learning disability modernising existing services to include practitioners with specialist competencies in meeting the mental health needs of people with developmental disorders including learning difficulties and autistic spectrum disorders. Consideration should be given to the development of specialist mental health teams for people with developmental disorders, and altering the configuration of current child and adult mental health teams.

Strategic Objective 29

To ensure that the NHS in Wales takes the lead in the creation of dedicated, responsive patient-focused services for people with a personality disorder ensuring that the exclusion of people who are diagnosed as having a personality disorder from treatment is no longer an option for local service providers.

Strategic Objective 30

To modify and upgrade provision of forensic CAMHS particularly regarding transition arrangements and plans for secure estate provision involving all stakeholders: Youth Justice Board, Local Authorities, criminal justice agencies, NHS Wales services and social services; and to confirm the roles and responsibilities of all stakeholders in this model.

Strategic Objective 31

To confirm the role and responsibilities of a single Forensic Adolescent Consultation Team (FACT) that has bases, sub-steams and staff in North and South Wales and is able to deliver services across Wales.

April 2009
Strategic Objective 32

To co-locate specialist forensic CAMHS within specialist CAMHS units to provide advice to criminal justice agencies and Local Authorities and to liaise with adult forensic mental health services on transitions in patient care.

Strategic Objective 33

To ensure that robust CPA arrangements are in place enabling the development of a standardised Welsh patient data set which includes the level of security required by each patient and differentiates between those with delayed transfers and those with long term secure care needs.
A Strategic Review of
Secure Mental Health Services in Wales

Terms of Reference
To create a strategy which will inform the future planning, development, operation, commissioning, delivery and monitoring of health, social care and other provision for adult offenders and those at risk of offending who require secure mental health services in Wales. Such a strategy will also need to describe the risk management services needed for those people who pose a risk to self and/or to others.

This Strategic Review will be

• undertaken by the Welsh Assembly Government in association with service users and their carers together with its partners in the NHS, local government, the criminal justice system, voluntary and community organisations, the private sector and with other key stakeholders.

• inclusive, encompassing the future need for secure mental health care services in Wales at all levels of security [low, medium and high secure] including services for people with

  ▪ a personality disorder
  ▪ serious mental illness
  ▪ learning disability
  ▪ any of the above who are inappropriately placed in prison
  ▪ any of the above who are in transition from CAMHS

In particular the Review will:

1. consider key issues highlighted in the joint Healthcare Inspectorate Wales/Health Commission Wales review of medium secure services, making recommendations for strategic service change if necessary

2. incorporate national learning points from independent reviews of homicides in Wales, and elsewhere when relevant

3. develop an integrated model for the clinical pathway required by patients – including post-discharge management arrangements – to ensure that entry and exit routes are clear and timely

4. evaluate the current utilisation of medium secures services both in Wales and also in those units elsewhere at which patents from Wales receive treatment to ensure the most effective deployment of available resources
5. make recommendations which ensure that patients are able to receive effective and timely assessment, treatment, rehabilitation and aftercare in conditions of security appropriate to their needs

6. consider the interface between secure mental health care services, the Criminal Justice System, local government and community mental health services suggesting improvements where required

7. assess the relationship between secure tertiary mental health services and primary and secondary mental health services, recommending ways of achieving better integration and greater cohesion where necessary

8. suggest ways of ensuring that evidenced-based treatments and interventions for both hospital services and those located in the community, are available to patients so that their effectiveness can be measured

9. provide working definitions for low, medium and longer term secure services to facilitate the most appropriate treatment for patients

10. review arrangements for commissioning and contracting secure care and treatment services suggesting improvements where identified so that best value is achieved from all providers

11. assess the information management requirements of agencies responsible for secure provision in Wales so that high quality information about patient need is available both to frontline practitioners and their managers together with those responsible for service commissioning and planning

12. ensure that the perspective and experiences of service users form an integral part of the Strategic Review process so that outcomes best meet their needs

April 2009
Appendix 1

Task and Finish Groups

1. Black and Minority Ethnic Groups
   Co-Chair: Suzanne Duval, Awetu and Rebecca Remigio, HAFAL

2. Child and Adolescent Mental Health Services
   Chair: Prof. Richard Williams, University of Glamorgan and Gwent NHS Trust.

3. Commissioning and Performance Management
   Co-Chairs: Stuart Davies, Health Commission Wales and Abigail Harris Vale of Glamorgan LHB.

4. Evidence-Based Interventions in Secure Mental Health Services
   Chair: Prof. Pamela Taylor, University of Cardiff.

5. Forensic Psychiatric Services
   Co-Chairs: Dr Tegwyn Williams, Abertawe Bro Morgannwg University NHS Trust; Dr Phil Huckle, Llanarth Court Hospital

6. High Secure Care Provision for Welsh Patients
   Chair: Dr Tegwyn Williams, Abertawe Bro Morgannwg University NHS Trust

7. Information Management
   Chair: Andrew Griffiths Informing Healthcare

8. Interface between Medium Secure Services and General Mental Health Services
   Chair: Dr Stephen Hunter Gwent NHS Trust.

9. Learning Disabilities
   Chair: Dr Helen Matthews

10. Long-Term Secure Care
    Chair: Dr Phil Huckle, Llanarth Court Hospital

11. Low Secure and Step-Down Services
    Joint Chairs: Les Rudd, Centre for Mental Health Service Development. Phill Chick, Welsh Assembly Government and Professor Paul Rogers, University of Glamorgan.

12. Managed Secure Clinical Networks
    Chair: Ted Unsworth, Independent Chair, Strategy Review of Secure Mental Health Services in Wales

13. Personality Disorder Services
    Chair: Dr Bob Colter, Gwent NHS Trust

April 2009
14. Prison Secure Mental Health Services  
   Chair: Geoffrey Hughes, HM Prison Service (until March 2008)

15. Public Safety and Protection  
   Chair: Superintendant Paul James, South Wales Police

16. Research, Teaching and Continuing Professional Development  
   Chair: Prof. Pamela Taylor, University of Cardiff.

17. Quantifying the Need: Capacity Planning for Specialist Secure Mental Health Services  
   Chair: Prof. Pamela Taylor, University of Cardiff.

18. Resolving Clinical Conflicts between Secure Mental Health and General Psychiatric Services in Wales  
   Chair: Dr Geoffrey Carroll, Health Commission Wales

19. Service Users and Carers  
   Chair: Rob Campbell, with support from Hafal

20. Victims  
   Chair: Heather Edwards, Bridgend County Borough Council Social Services

21. Provision for Women  
   Chair: Jeni Clarke-Moore, Welsh Assembly Government

22. Workforce Implications  
   Co-Chair: Prof. Pamela Taylor, University of Cardiff and, and Phill Chick, Welsh Assembly Government.
# Appendix 2

## Composition of Steering Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ted Unsworth</td>
<td>Chair</td>
</tr>
<tr>
<td>Barry Topping Morris</td>
<td>Project Manager, Health Commission Wales</td>
</tr>
<tr>
<td>Tom Atherton</td>
<td>CPS Cardiff [representing CPS in Wales]</td>
</tr>
<tr>
<td>Marc Boggett</td>
<td>Secretariat for the Review, Mental Health, Vulnerable Groups and Offenders Policy, WAG</td>
</tr>
<tr>
<td>Nick Bowler</td>
<td>Swansea University</td>
</tr>
<tr>
<td>Rob Campbell</td>
<td>Chair of User T&amp;F Group</td>
</tr>
<tr>
<td>Dr Geoffrey Carroll</td>
<td>HCW, Chair of Conflict Resolution T&amp;F Group</td>
</tr>
<tr>
<td>John Carter</td>
<td>WAG, Policy Lead for Learning Disability T&amp;F Group</td>
</tr>
<tr>
<td>Phill Chick</td>
<td>Head of Mental Health Development, NLIAH</td>
</tr>
<tr>
<td>Jeni Clarke-Moore</td>
<td>Consultant Nurse, Chair of Women’s T&amp;F Group</td>
</tr>
<tr>
<td>Bob Colter</td>
<td>Director Clinical Psychology Gwent NHS Trust, Chair of Personality Disorder T&amp;F Group</td>
</tr>
<tr>
<td>Ruth Coombs</td>
<td>Mind Cymru [representing Wales Alliance for Mental Health]</td>
</tr>
<tr>
<td>Sue Cooper</td>
<td>Bridgend County Borough Council</td>
</tr>
<tr>
<td>Barry Crosbie</td>
<td>Executive Director, Llanarth Court</td>
</tr>
<tr>
<td>Stuart Davies</td>
<td>HCW, Co-Chair of Commissioning T&amp;F Group</td>
</tr>
<tr>
<td>Suzanne Duval</td>
<td>AWETU</td>
</tr>
<tr>
<td>Heather Edwards</td>
<td>Chair of Victims T&amp;F Group</td>
</tr>
<tr>
<td>Robert Goodwin</td>
<td>Directorate Manager Mental Health, Abertawe Bro Morgannwg University NHS Trust</td>
</tr>
<tr>
<td>Nicola Gray</td>
<td>Consultant Clinical and Forensic Psychologist and Professor of Psychology, Caswell Clinic and School of Psychology Cardiff University</td>
</tr>
<tr>
<td>Stewart Greenwell</td>
<td>ADSS/WLGA and Director of Social Services Torfaen</td>
</tr>
<tr>
<td>Andrew Griffiths</td>
<td>Chair of Information Management T&amp;F Group</td>
</tr>
<tr>
<td>Abigail Harris</td>
<td>Co-Chair of Commissioning T&amp;F Group</td>
</tr>
<tr>
<td>Dr Lyn Harris</td>
<td>National Public Health Service for Wales</td>
</tr>
<tr>
<td>Sue Heatherington</td>
<td>Representing LHB’s</td>
</tr>
<tr>
<td>Rob Heaton-Jones</td>
<td>National Offenders Management Services</td>
</tr>
<tr>
<td>Dr Phil Huckle</td>
<td>Chair of Long Term Secure T&amp;F</td>
</tr>
<tr>
<td>Geoffrey Hughes</td>
<td>Chair of Prison T&amp;F Group (until April 2008)</td>
</tr>
<tr>
<td>Dr Stephen Hunter</td>
<td>Chair of Medium Secure T&amp;F Group</td>
</tr>
<tr>
<td>Paul James</td>
<td>Superintendent South Wales Police, Chair of the Public Safety Task and Finish Group</td>
</tr>
<tr>
<td>Robert Kidd</td>
<td>Consultant Forensic Psychologist</td>
</tr>
<tr>
<td>Ian Lankshear</td>
<td>South Wales Probation Service</td>
</tr>
<tr>
<td>Peter Lawler</td>
<td>Acting Head of Community, Primary Care and Health Services, WAG</td>
</tr>
<tr>
<td>Jo Leech</td>
<td>Department of Health, England</td>
</tr>
<tr>
<td>Jill Lewis</td>
<td>Care and Social Services Inspectorate, WAG</td>
</tr>
<tr>
<td>Dr Helen Matthews</td>
<td>Chair of Learning Disabilities T&amp;F Group</td>
</tr>
</tbody>
</table>

April 2009
Rebecca Remigio HAFAL
Phil Roberts Senior Nurse Manager, Ty Llewellyn NHS MSU
Les Rudd NLIAH, Co-chair of Low Secure T&F Group
Jenny Sanger WAG Regional Office representative
Julian Spurling Craegmoor Healthcare
Prof. Pam Taylor Advisor to Chief Medical Officer
Bill Walden-Jones HAFAL
Peter Vaughan Deputy Chief Constable, South Wales Police
Dr Sarah Watkins Senior Medical Officer, WAG
Andy Williams HCW (until July 2008)
Prof. Richard Williams Chair of CAMHS T&F
Rowena Williams NLIAH/WAG, Prison Healthcare
Dr Tegwyn Williams University NHS Trust Chair of High Secure T&F
Tom Woods Representing NHS Trust CEOs