# RCPsych in Scotland – response to the Barron Review of Forensic Mental Health Services

**14/05/21**

## Overall views

- **Support the objectives** – the College fully supports the objectives and aimed-for outcomes of the Review. These objectives have been advocated for by the College for a number of years, and there is a broad consensus in support of these. These include:
    - **Equity of provision** for female and child & adolescent offenders
    - **Mechanisms to avoid patient entrapment** and ensure people receive the right care in the right setting, with the right level of security
    - **Promoting human rights-based care** within the context of the Mental Health Act
    - **Multidisciplinary working** across different teams and specialties with clear patient involvement, while maintaining public safety
- **About the how** – the College joins other key partners in offering to constructively work to realise these objectives. Our points are therefore around the how of implementing the recommendations, highlighting the potential issues that will need to be overcome, and additional steps that may be needed.
- **Structural changes –** These include the structural changes proposed, which our members believe will present significant and potentially unforeseeable challenges that will need to be overcome. The national forensic board is seen within the Review as a critical part of delivering these objectives. We recognise that this board may facilitate the achievement of these objectives, but we would advocate that additional measures will be needed and, where possible, these should be implemented alongside and in addition to these structural changes.
- **Addressing gaps** – we recognise and support the aim to address gaps in service provision. These include the quality of care available in individual areas and people being left to wait in inappropriate settings while they wait for lower security spaces to open up. Further steps are acknowledged as needing to take place to actually deliver this, and we would recommend that the implementation of these steps should commence as soon as feasible.

- **Never been done before** – the uniqueness of the structural changes present challenges that have yet to be navigated before. It was felt by members that these needed to be fully understood, to ensure delays during the implementation process can be mitigated where possible.
- **A clear plan of delivery** – with that in mind, we as a College would urge and seek to positively engage with the development of a delivery plan that addresses some of the challenges ourselves and others have highlighted.
- **Care provision during the initial implementation** – it was stressed by many that there must be continued work with health boards to ensure they continue to invest in and provide care to the forensic population while the new forensic board is being set up.
- **National oversight, local delivery** – we would strongly urge that in establishing a national board, enabling local delivery for local need remains critical. This means continuing to enable clinicians on the frontline to make the best decisions around a person's care.

## Questions and responses

### 1. What comments do we have on the structural changes proposed?

- **A clear division between the Board and the State Hospital** – this was generally welcomed, but links to the State Hospital were still felt to need to exist where appropriate.
- **Smaller services** – There will be particular challenges for smaller forensic psychiatry services (sometimes single wards located in large hospital sites) currently located within Regional Health Boards. There will require to be considerable planning in relation to this new structural model.
- **Co-location** – there were some concerns expressed that the national remit of the board would see people having to relocate or work across large geographical area to fill staffing needs. This balancing act needs to be borne in mind when developing staffing arrangements in this new national board, to ensure that the Board's most valued resource are recognised and empowered.
- **Outwith the central belt** – We recognise the communication, recruitment and retention challenges this move seeks to address, but would stress that this move alone won't solve these. The challenges in maintaining links between the board's management and the likely hubs of expertise in the central belt will also need to be addressed.
- **Moving forward alongside implementation** – we would strongly advocate that steps that can be taken while the Forensic Board is being established are taken. To not do so would pause efforts to improve care outcomes which would not be to the benefit of patients.

- **Benefits to rural areas** – those rural health boards with a less established forensic setting were said to need greater support within this national board, to ensure that rural areas benefit.

## 2. What steps do we welcome from the Review?

- **Secure women's unit** – we have for a number of years called for such a unit, and welcome the delivery of this. Disparities in fulfilling the rights of this group can and must be addressed. We recognise the rationale for a 'pop up' high secure women's service, reflecting the low number of such individuals and that the expertise to deliver care for this group is disparate across Scotland.
- **Access to specialist expertise nationwide** –The benefits of being able to access specialist expertise in certain situations across Scotland was welcomed, provided that the Board's most valued resource, staff, are recognised and empowered in this process and this does not harm their wellbeing.
- **Community accommodation for LD patients** – we fully support this, but would suggest this commitment is extended to all LD patients where appropriate.
- **Greater roll-out of care standards** – there is a potential space a national board can provide for national care standards/specifications for forensic settings to be ore widely adopted. This could be based potentially around the College's Care Quality Improvement Collaborative and peer-led reviews, which is already in place in some health boards. The Forensic Mental Health Services Managed Care Network has also in place a continuous quality improvement cycle with peer review based on Health Improvement Scotland methodology. These could create a national baseline for delivering care that improves the outcomes for patients.

## 3. What challenges do you envisage for the implementation?

- **Crossovers** – the challenges around a national board continuing to work with other health boards was a primary point made. It was stressed patients criss-crossed across services, including low and medium secure LD services and adolescent services. The national board structure could, if not sufficiently integrated, lead to delays in providing care and, at worst, disincentivise such transfers due to stigma towards forensic patients.
- **General Adult/IPCU** – in particular, it was stressed that IPCUs and General Adult settings would still likely be providing care to forensic patients in some form. The interface between these services and the forensic board therefore needs to be integrated in some way to ensure the right care by the right person is provided.
- **Secure women's unit** – We did receive feedback that the pop-up service may, if not effectively managed, lead to a diminishing of clinical expertise, and there will be challenges in ramping up and ramping down a service like this for patients. It was also suggested that 'exceptional circumstance' female patients at the State Hospital would not potentially benefit from this pop-up service.

- **Training** – there were some concerns that, in separating out forensic services from other health boards, it would create a specialised workforce disconnected from the wider health service. This would impact the ability to take on trainees and other professionals interested in working for a time in forensic settings. As one of the lead trainers of specialist clinicians in the forensic setting, there must be that connectivity to ensure the supply of psychiatrists is retained.

## 4. What steps do you believe could complement the Review's recommendations?

- **Patient pathways** – with major structural changes coming alongside the Barron review's implementation, including the national care service, there must be clearly developed patient pathways that emerge for forensic patients. This has to address the concerns of patients and families on receiving the appropriate care in the appropriate setting, and for transfers between settings to take place in a timely fashion.
- **Connectedness** – in creating a national board, conversations, co-working and shared expertise from across medical specialities must continue. Implementing Barron's recommendations should avoid artificial barriers to such relationships wherever possible. In this, it was suggested lessons could be learned from previous national structural changes such as the integration of the Golden Jubilee into the NHS and the breakup of the Argyll & Clyde Regional Health Board.
- **Empowering the board** – on issues like housing, discharges and working with local authorities, the Forensic Board will need to be sufficiently empowered to act. This is a stigmatised group of patients who will not be prioritised if the forensic board is not sufficiently empowered.
- **Data** – a critical aspect of achieving the aims of the Review is data and its use. The variety of health boards' data systems already make it much harder for connected decisions to be made between health boards. There is a further danger that, in creating a new and separate data system for forensic patients, it creates an administrative hurdle to transfer between settings.
- **Intellectual disabilities (ID) and autism** – it was also stressed that, in a national board, the ID/autism population would be a small part of a larger population seeking care. There therefore needed to be continued retention of expertise and a continued focus on this population's specialist forensic care needs.
- **Personality disorders (PD)** – there was a sense that people with PD were 'over included' in the perceived applicability of forensic care to this population. It was added that people with PD should only be in contact with forensic mental health services where necessary, and that the stigma that can come with receiving care under the forensic banner should be avoided.

- **Formal prison healthcare review** – a number of respondents highlighted the need for this review to be followed by one focused on mental health care in prisons, to address gaps there.
- **Electronic patient record** – with the number of patient record systems across settings and health boards, it was stressed that any new system would need to be built in such a way that it interacted across these, to ease patient transfers. The potential impacts on providing care in a non-forensic setting when records aren't up to date and available mean this issue needs to be overcome prior to launch.
- **ID and autism** – there are further steps that can be taken to ensure that these with ID/Autism receive bespoke community care packages to enable their transfer form forensic settings. This could extend to introducing a duty on IJBs to deliver these.
- **Delayed discharges** – it was suggested there should be a firmer objective to deliver parity between forensic and general adult psychiatric wards, with similar time frames for discharge.