Introduction

We welcome the invitation to be involved with this process, and in particular, the forensic aspects of the review. For those of us working in forensic mental health settings, our aim is supporting those we work with to engage with legal processes in mental health and in the justice system; enabling them to exercise their rights in these domains; and ensuring their safety and that of the wider public by engaging them in care and treatment in a timely way and in the most appropriate setting. The principles of the act are key to this and open the way for consideration of the positive-rights based approach advocated through the UNCRPD.

In considering these additional proposals, we have held in mind the principles of the act and the UNCRPD's approach and used them to inform our thoughts and responses. It is worth noting that Barron's review of Forensic Mental Health Services across Scotland was led with a rights-based approach. We include our response to that here.

Summary points:

- The use of intermediaries in supporting those involved in criminal proceedings is in keeping with this approach. Careful consideration of how a model can be developed to promote engagement in criminal justice proceedings in an inclusive way will be key to this.
- Ensuring that there are appropriate safe and secure hospital settings that can be accessed in a timely way will be best enabled by adequate resources – financial, people and physical.
- The use of supervision and treatment orders is not common. Consideration of the numbers, how they are currently used and the involvement of Victim Organisations will inform this.
- Diversion to appropriate services does not need to be limited to a legal basis. Clear standards and commissioning guidance would also benefit this area. This was highlighted in Barron's Review and requires resourcing.
- The term "mental disorder" should have a clear diagnostic basis. The diagnostic criteria, required by article 5 in the ECHR and its acknowledgement, is fundamental in this regard.
- When considering "SIDMA", it is important to highlight the purpose of "forensic" orders and the importance of managing risk to self, others and the public at large.
- The inclusion of "risk to self" as part of forensic mental health law is critical and inclusive. It ensures patient-centred care.
- Forensic orders should be considered where an individual's mental disorder (as defined by the act) is related to offending behaviours. This allows for consideration of risks regardless of the nature/severity of the offence.
- Changes to the criteria for a CORO, should be considered with care and close involvement from relevant bodies. There are differences between the approach to OLRs and that to COROs which reflect differences in their legal origins, differences

in the population being considered for the orders and differences in the purposes they were originally designed for. Keeping in mind the principles of the act, balancing safety of individuals and the public is critical when looking at this.

- The idea of "treatability" is broad and carries expectation – of the patient, who is expected to engage, and of the service delivering care. For this reason, there are serious ethical implications in the "serious harm test". Changes should be carefully considered.
- Ensuring that all those in forensic setting can exercise their rights to care and treatment in any setting should be a clear focus for the review. The patients we work with are in the community, open wards, secure wards of varying levels, courts, custody and prisons. The Scott Review should consider patients in all settings.

Scottish Mental Health Law Review consultation (the Scott Review) – Questions for additional proposals

Questions

Chapter 3: Forensic

1. **Do you agree that we should introduce intermediaries to support people who need them in criminal proceedings? (Section 1)**

- Looking to the Northern Ireland model, it is felt that intermediaries are a positive extension of support and delivering this in Scotland is to be welcomed. Their system provides a range of supports for those with more severe communication difficulties (such as speech and language therapists) do extensive engagement to provide reports to the court to enable full engagement. These are very resource intensive but are an ambitious delivery of their rights.
- The arrangements around triggering this provision lacks clarity. It assumes the mental disorder is established, but that is not the case with many people who initially present in forensic settings. Who it applies to is said to be difficult to establish. A clearer definition of who qualifies would be helpful.
- It has been suggested that the 'appropriate adults' system offered an initial basis to build on. This would reflect that support is already there for those with general communication difficulties and expand the provision available. Current issues with the scheme can be addressed. It also covers a person from arrest to court, rather than simply the formal court process.
- In looking at the appropriate adults scheme, the registered intermediary scheme in Northern Ireland offers an additional model for those whose ability

to give evidence is compromised by their ability to communicate. The Registered Intermediary's role is a more specialised one and requires expertise in assessing the vulnerable person and advising on communication strategies. They are also neutral in the process, and are able to assist any vulnerable person, regardless of whether they are a defendant, defence witness, prosecution witness or victim (though not a victim and the accused at the same time).

- We recognise this would help us incorporate a positive-rights based approach, as advocated for in the UNCRPD.
- Appropriate support to manage poor wellbeing and anxiety can ensure people who could be fit to stand trial can do so and should be inclusive as part of this wider support.
- In making these proposals wide ranging, efforts must be made to ensure that those with severe and enduring mental health conditions have equity in access to support.
- Simplifying the application process for such an intermediary would address barriers to accessing this support.

2. **What do you think about courts being given the power to require that appropriate medical provision is found for any remanded prisoner? (Section 2)**

    - We recognise the issues this seeks to address and that the principle that these patients would benefit from care in the right setting is one that should guide these discussions.
    - There is a real danger if this proposal was put in place that individuals will be sent to hospital without the necessary provision in place leading to serious adverse outcomes - including death.
    - If no appropriate hospital place for a s52 remand or for a TTD is found within a reasonable time the courts should have the ability to eventually place a statutory duty on the Health Board - similar to the excessive security measures - and have the ability prior to that to cite senior managers to account for what action is being taken to remedy a shortage of necessary provision. There must be reporting of difficulties to Scottish Ministers and MWC.
    - This should take place in a manner that does not stigmatise this patient group and recognises that those presenting with severe mental health conditions should have access to supports.
    - Our members have consistently engaged with the review around the necessity to consider risk to a patient and to others. This proposal potentially creates situations whereby unnecessary, substantial, and real

risk is created in the provision of care without appropriate safeguards, staffing and security.

- There needs to be borne in mind that this proposal assumes limitless capacity in the system. In order drive that capacity, any such proposal would need to have teeth to ensure provision is available.
- In ensuring these proposals have teeth, expectations should not fall on clinicians to be able to leverage resources to meet a person's needs. The responsibility should fall on the bodies providing care, who can meaningfully seek to address gaps in provision.
- The ambition of meeting the Short-Term Detention Certificate timetable of 72 hours to provide appropriate care would be a worthwhile ambition, but needs to bear in mind not all mental health settings will be equipped to meet the needs of forensic patients.
- Any proposal for this would need to hold the responsible health board accountable for a lack of provision, rather than individual services.
- The proposals need to also bear in mind any systemic changes to the structure of forensic mental health provision delivered by the Barron Review.
- We would also need to ensure an assessment by an appropriate clinician of the person's care needs drives the provision.
- There also needs to be a mechanism for systemic failures to meet the needs of remanded patients in mental health settings. There should be a clear process which brings the health board to account, involving the Tribunal and Mental Welfare Commission.

3. What are your views about whether supervision and treatment orders continue to be needed or not? (Section 3)

- These orders are not said to be widely used, though there are a small number of cases where a person does not fit the criteria for guardianship or welfare order where they may be called on by the court. We would therefore suggest this should be retained at this time.
- They are useful only in so far as it enables the court to make some sort of order even if it has no teeth. Before making changes, we recommend consulting victim organisations. There is a risk that without the order a more restrictive disposal will be utilised by the court.
- Information on the number of these orders should be called on to inform discussions.
- Reflecting that guardianship processes are likely to change, there is the potential that any people who fall into current gaps in the system could be minimised.

- It has been suggested a “lack of teeth” for these orders meant they were not abided by, thus limiting the willingness of clinicians to apply. Any efforts to retain them should come with expanded efforts to examine how to ensure they are upheld.
- Consulting victims organisations as part of the imposition of these orders would also be valuable before proceeding with changes. Their views must be accounted for as part of the implementation of these, reflecting their experiences and the negative consequences of the action against them.

4. Do you think there are specific legal changes that could support more appropriate diversion of offenders into the mental health system? (Section 4)

- It should not have to be purely legal duties that can address issues with providing a more appropriate diversion.
- The resources and wider strategising under way across mental health should be inclusive of these patients, and the need to provide them the most appropriate care. While difficult, this would fulfil the universalism principle of mental health legislation and reflect that, in meeting the needs of all Scots, this should include those in forensic settings.
- Failures to do so should be addressed in a meaningful way, but legal duties to meet the needs of this patient group already exist. What is missing is the enforceability of these measures.
- In terms of identifying diversions for mentally disordered offenders, we would urge that Crown Prosecution Service guidance around offenders with a diagnosable mental health condition be republished.
- We need a better solution to the intoxicated individual who may be mentally unwell and who poses a risk to themselves or others, who may end up being taken into police custody due to health services being unable to engage them in their current state.
- National standards and commissioning guidance as there is in England would help.
- We also need to be much clearer about the effects of bed and staffing shortages in Scotland (as reflected in our response to the Barron Review).

5. What do we need to be aware of from a forensic mental health point of view when considering the continued use of ‘mental disorder’ within our mental health and incapacity law more generally? (Section 4.1)

- The diagnostic criteria, required by article 5 in the ECHR and its acknowledgement, is fundamental in this regard.

- As acknowledged in our response to the wider Scott Review consultation, while recognising the need to reduce stigma and reduce it around defined mental health conditions, removing the criterion within legislation of a mental health diagnosis or condition is not the way forward. The use of diagnostic criteria allows a link to be made between a condition, its effects, potential interventions, and the use of legal frameworks to provide said interventions. It allows an approach based on objective evidence which can then be effectively challenged, thereby improving the protection of rights.
- In looking to language, we would look to have consistent terminology across mental health law, so would continue to advocate for defined mental health conditions.
- We would also seek to retain exclusions from certain measures in mental health legislation in certain situations. This would ensure that those who fundamentally need mental health care will get it to the degree of need. Exclusions are particularly in important in the forensic context.
- The implications of changing terminology without addressing the underlying stigma, particularly for those in forensic settings, means that the underlying stigma remains, rather than improving the outcomes for this population. Please see the College's response to the broader question in Chapter 12 of our response to the Review's final report.

6. What are your views on whether or not a SIDMA test (or a similar requirement like ADM) should be added to the criteria for forensic orders? (Section 4.2)

- In considering this, the focus of these orders needs to be borne in mind. This includes the notion of risk to themselves and to wider society, and to engage with them on their condition and the need for treatment. Again, the principle of risk and public protection needs to be considered in this context, and bringing in a civil test of competence may create scenarios where someone who may still be a risk to themselves and others is no longer able to access potentially essential care in a mental health setting due to them now being 'competent'.
- There is a real risk that decoupling detention from treatment would lead to a population of stuck individuals who stay in detention far longer than they should or people coerced into taking treatment in order to clinically progress but without the current safeguards.
- The notion of SIDMA being consistently in place would be beneficial for a small number of patients who have presented in acute distress. Those who do not, however, would have their access to care inhibited by the inclusion of SIDMA or an equivalent test, meaning a denial of their care.

- It is also not justified that a forensic order be kept for longer than necessary, reflecting the circumstances in which that patient is likely to have presented.
- The Northern Irish solution, of a public protection order based on risk rather than capacity, enables the refusing of treatment if you have capacity. This means patients are entrapped in forensic settings and are unable to access appropriate care for their condition.
- We are aware of international examples where an individual is kept in forensic detention for lengthy periods because of them being considered competent to decline medical treatment, as a result of decoupling detention from treatment.
- The notion of transfer for treatment orders, and patients being able to volunteer to seek psychiatric care, could be a space where SIDMA would increase their likelihood of accessing that care and establishing the necessity. This would address a population that can consent to treatment but are not getting appropriate support.
- To deliver an enabling and human rights enriching approach, this is an already marginalised and disadvantaged group so need additional measures to protect their rights.

7. Do you feel that risk to the health, safety or welfare of the offenders ('harm to self') should continue to a criterion for forensic orders? (Section 4.3)

- We believe this criterion should continue, on the basis that the risk to self and others needs to be explicitly acknowledged.
- By explicitly accounting for the person's health and wellbeing, it will help continue to ensure forensic patients are treated in a person-centred way to the greatest degree possible, a principle which has been enshrined in current law and across the Review's proposals.
- The need to clearly define risk and how broadly this definition should be is critical. This includes the risk to self and to others and weighing these up as part of orders. This should also include suicidal ideation.

8. Do you think forensic orders should only be allowed if the offence is punishable by imprisonment? (Section 4.4)

- Often the severity of the actual change is mitigated down because of mental disorder. By only enabling forensic orders for custodial offences, this would have the perverse effect of people with mental disorder not having that pre-trial mitigation in non-custodial cases, or for the court to potentially inflate a charge so that they could access that mitigation.

- While we recognise the point being made around people being denied their liberty and minimising this where possible, the flexibility for orders to apply to non-criminal situations should be retained.
- This includes orders delivered in the community enabling access to support after a court proceeding. Such care would be denied to them if a custodial sentence was set as the bar.
- It would also wrongly suggest that not being given a custodial sentence does not mean the risk to self or others is lower.

9. Do you have any suggestions for updating the criteria for imposing a restriction order? (Section 5)

- If criteria of risk are to be used consistently across settings, a more consistent, simplified criteria would be welcome, establishing a standardised process and assessment of risk.
- It would not be helpful to limit a restriction order's consideration to the High Court. An offence may not meet the threshold for the High Court, but the level of harm may nonetheless require a restriction order.
- The level of assessment for these orders does vary, but it reflects that a patient to which this order is applicable is engaged over a series of months.
- This order enables an interim judgement to be made without imposing lifelong restrictions. We would be therefore cautious in changing the criteria to inhibit this purpose.
- Recovery from mental illness is an additional factor that needs considered in the removal of such an order.
- It was noted there are only ten COROs made per annum, versus eighteen OLRs. An interim compulsion order gives you a 1 in 3 likelihood of being put onto a CORO based on current data and should be borne in mind when considering changes.
- The need for an independent view in the risk report separate to the care team could be of benefits, but there are concerns this would disenfranchise the care team and their knowledge of the patient and would be a significant change to practice. It would require a whole new skills base within teams that does not currently exist and would require additional mental health expertise among restriction teams.
- To ensure consistency in exiting such an order, the entrance and exit criteria for such an order should be aligned where possible.

10. What do you think about the differences between the tests and procedures for imposing an Order of Lifelong Restriction (OLR) and those for a compulsion order and restriction order (CORO)? What should we do about this? (Section 5

- A CORO process implies a level of restriction that means a person can only leave a hospital setting when they no longer require in-patient care to meet their risk. A OLR currently enables engagement and eventually a return to the community for a person, and the distinction between the two in their purpose is critical. When framing discussions around differentiation, this needs to be borne in mind.
- It should be acknowledged there is a deliberate difference. The exit for a compulsion and restriction order is different for a reason, acknowledging the need to avoid lifelong restrictions. Many more people are absolutely discharged and have fewer restrictions with an OLR. The CORO process also brings in a much greater focus on treatment with an appropriate care team, versus a ORL process which focuses around managing risk.
- The CORO process should adapt to the situation and the necessity for a detailed review. This would acknowledge certain reviews do not need to be overly detailed due to a clack of change in circumstance, and settings specific expectations for review would impose an unnecessary criterion of review.
- The danger of additional people having a CORO being imposed versus an OLR is seen as the likely response to streamlining the differences in the two processes. This would be a negative imposition of greater restrictions on patients than may otherwise be necessary.
- A consistent risk assessment process would be useful across the tests, reflecting the similar systems for engaging with this population. In doing so, though, the need should be to reflect the different purposes and potential outcomes for the patient. The approach to an assessment is therefore very different, reflecting different needs for risk assessors, cause of clinical team knowledge, use of mental health specialist etc and a focus on treatment in COROs rather than risk alone with an OLR, in particular risk to the public and 'manageability'.
- The mechanism to identify whether a OLR or a CORO is required needs to be considered.
- The concern could be the usage of COROs increases instead of OLRs, potentially leading to more patients inappropriately falling under its auspices.
- The recidivism rate for those under COROs is felt to be significantly lower than the wider population. Where the concern emerges is whether there are patients who should not have been given a CORO.

- Before proceeding on this issue, we would urge the Review to evaluate the data around these orders, including the number of people who have come off them.

11. What do you think about our proposals for time limiting compulsion orders, with or without restriction orders? (Section 6)

- The recidivism rates among those who leave high-secure settings following a CORO are generally lower than the wider prison population. The system therefore does not need to be rebuilt, but instead focused further on supports available.
- Looking to Mental Welfare Commission reports that people were coming off of compulsion orders too early, timelining these orders could exacerbate this issue.
- Those entrapped in these orders could see their rights upheld through civil proceedings.
- While recognising the need to address delayed discharges for this patient population, without commensurate resource, the person would be provided inappropriate care in the community and would not have their particular needs met.
- If there is a view that people are being inappropriately detained, this needs to be addressed before a decision is made, rather than building in a review mechanism which retrospectively challenges such decisions at an earlier stage.
- The potential for forensic orders in the community to be utilised to support transfer for in-patient settings, though the resource implications would need to be accounted for.
- We would urge the Review to go back to the principle of these orders, and the balance of managing risk to self and others while ensuring access to appropriate care and support is provided.

12. What do you think about our suggestions to either remove or significantly restrict the 'serious harm' test introduced in 1999? (Section 7)

- It is not a psychiatric matter whether a person should be detained regardless of whether or not it is appropriate for them to be receiving care in a psychiatric hospital. Our member's clinical duties are that any detention is in the purposes of treatment, and that no one should be held under this test for any other reason. Retrospective efforts to review any cases where this is currently the case would also be necessary to address this.
- The ethical conflict for the psychiatrist is that they are asked to address a question on the continued compulsory detention of a patient in hospital, under highly restrictive conditions, for a purpose other than the provision of beneficial medical treatment. It is quite unlike any other issue in mental health law that the psychiatrist is required to address.
- It is noted that those who do fall under the stipulations would, if they were discharged, still be offered health care and support.
- It is acknowledged that treatability and people rejecting care is an issue with removing the serious harm test. More widely, issues with the process by which a person goes from receiving care under clear statutory requirements to becoming a general patient with minimal transition support was an issue.
- What is treatable and what is not is a critical fault line in this, including around complex trauma.
- We would also still have other tests under which we could provide care in forensic settings.

13. Do you think the current roles that Scottish Ministers have in the management of restricted patients should be reduced, and to what extent? (Section 8)

- We do not see who is harmed by the Minister holding this duty. It is rare that it would be escalated to the Minister, but it reflects a system of escalation and the seriousness of certain cases.
- Nonetheless, this escalation system should only be for exceptional cases, and proposals in this area should reflect this. The duties of the MHA should also extend to Scottish ministers when it comes to fulfilling this role within mental health law.

14. What do you think about the additional powers we are suggesting for the Mental Health Tribunal around the discharge and recall of restricted patients? (i.e. that they have a role in the recall, a power to vary conditions and a power to discharge to conditions that amount to deprivation of liberty)? (Sections 8, 8.1 and 8.2).

- Many members suggested they had assumed the Tribunal already had many of these powers, including varying conditions at the point of conditional discharge. Regardless of whether these additional proposals are implemented, communication around the Tribunal's role in these matters would be helpful.
- Our members support having greater safeguards for a person's care and believe the proposals for the Tribunal would be welcome in this regard.
- The equity that patients should be able to access judgements from the relevant authority requires a greater tribunal role.
- Restricted patient teams are said to be generally positive sources of engagement with regards to discharge and recall, creating a basis for judgement.
- In contrast, risk management authorities having powers of recall and discharge does not seem feasible. Without additional capacity/scrutiny powers, it's declarations would not have sufficient power.
- The Parole Board's role in recall and discharge for general forensic patients could be replicated by the Tribunal, which would be of benefit to those with mental health conditions.
- Safeguards and protection to uphold a person's human rights must be a critical drive for the Scott Review's proposals, and this should apply here. It would provide for greater independent, expert scrutiny of critical decisions.
- What this should not become is an additional layer of bureaucracy that leads to patients waiting in conditions not of benefit to them. To deliver this, the Tribunal's timelines for delivery needs to change to fit clinical scenarios.
- Patients with a learning disability are said to face particular issues here currently, in particular when they need round the clock specialist care.

15. Are there any issues with respect to cross-border transfers which are relevant for how the law might be changed? (Section 9)

- It is not the legal issues that present issues, but communication difficulties with wider UK teams from the Ministry of Justice that leads to issues. Changing the law will not materially change those difficulties.
- There is a need to address this through logistical and resource means, rather than legal matters.

- The current requirement for orders to be written down and shared with the patient under a cross-border transfer is difficult to make meaningful for that patient, due to the legalistic language required for such forensic orders. The need for patients to be supported and clinicians to be enabled to communicate these orders in an accessible language is critical.
- The transfer of patients from Northern Ireland, who are prejudiced against as they cannot come over based on interim orders and may, as a result of a lack of options for appeal, end up unable to return to their home, needs to be addressed. Doing so would reflect the recommendations accepted by Scottish Government from the Barron Review.

16. Do you agree that there should be an enforceable duty on Scottish Ministers to ensure that prisoners with significant mental health needs are accommodated safely and appropriately? (Section 10)

- The vagueness of the proposal as it stands is a concern for members, who struggled to comment on what this would mean for the services in which they work and the patients who they provide care for.
- On controversial issues like patients in segregation who may not require hospital care but nonetheless are seeing their problems exacerbate, having this lever may be a means of ensuring appropriate care when hospital care is not deemed appropriate for an individual. This would potentially create the space to meaningfully meet that person's care needs.
- It is questioned whether this duty will leverage subsequent resources to meet that patient's needs. To help change this, an additional duty for relevant authorities to record incidents where a lack of resource precludes access to care would be helpful.
- Wider issues around use of funding for mental health care and an unwillingness by IJBs to consider funding for prison mental health are the fundamental blockages. We question whether this provision would address this.
- The description "significant mental health issues" is a broad-brush definition, that is inclusive of a full range of people would not receive mental health care.
- Addressing provision will also require wider resourcing for care and support to ensure that this duty does not create demands on care that cannot currently be met.
- The complexity of transfers from prisons to hospital are complex processes, and this needs to be borne in mind before further interventions are attempted.

- We would also suggest the prison mental health quality standards established by the RCPsych would be worth considering as part of efforts to drive continued improvements in care.

17. Do you agree recorded matters should be allowed for forensic orders? (Section 11)

- Our members would support this proposal. In delivering this, additional procedures to ensure that a recorded matter is meaningfully delivered would be necessary to ensure they had teeth.
- Also critical are the duties around what happens when a recorded matter is not fulfilled, and the need to ensure there is an escalation process in response to address why this has not happened.

18. Do you agree that the current right to appeal against conditions of excessive security (excessive security appeals) should be extended to all people subject to compulsion? (Section 12)

- We recognise the intent of the proposal, and it's focus on ensuring a person is in the least restrictive environment.
- There would need to be thought given, though, to the implications for compulsory care and providing hospital care under this, and whether this becomes an appeal against being in a specific setting. Clarity on the proposals, and whether they would apply to civil orders as well, is necessary before we can offer more detailed comment.
- The notion of appealing against low secure placements is one that our members support, on the basis of driving change to how a person can access the right setting of care.
- We would suggest this should apply to civil orders as well, on the principle of expanding rights and protections.
- There is a need for this appeal to be conducted with risk as a critical principle, recognising this should guide whether it is appropriate for that person to receive care in a lower-security setting in a manner that does not risk harm to themselves or others.

19. What do you think about removing the need for excessive security appeals to be supported by a medical report by an approved medical practitioner? (Section 12)

- We cannot see why, in principle, this would be acceptable. Safeguards and protections need to be in place for this group, and this does provide this through medical expertise informing such decisions.
- In saying this, we do reflect that speculative appeals create a significant resourcing issue, as appeals which have limited to no chance of succeeding nonetheless require a report.
- An alternative mechanism to reducing speculative appeals, such as a duty convenor initially assessing a appeal before it goes to a tribunal, would address the volume of appeals.
- A much clearer criteria on what constitutes grounds for appeal would also help provide clarity to all involved and ensure appeals are taken up on a clear understanding of what would constitute successful grounds.
- Concerns around the lack of criteria for what is an inappropriate placement that is too secure should be considered. This includes explaining that evidence base to patients.
- We cannot simply take the current criteria and make these changes, but to ensure the system is clearer as to what is grounds for appeal.
- The danger of reducing the threshold for appeal resulting in an uptick in appeals unlikely to be successful is a concern.
- This process should revisit the criteria for patients and solicitors as to what constitutes grounds for appeal.
- On who is an approved medical practitioner, the Tribunal has an obligation to assess the clinician who has inputted and the quality of evidence provided.

20. What do you think about giving voting rights to people in the forensic mental health system? (Section 13)

- As part of a system that move towards being least restrictive, we cannot see any legitimate reasons to deny those in forensic settings the vote. This would also ensure that Scotland is compliant with the ECHR's rulings in this regard.

21. Do you have additional proposals for change?

- The review by the RMA with regards to a potential over usage of the OLR and inability to appeal such an order should be considered as part of the wider proposals.
- We believe there is a significant gap in their proposals around transfer for treatment orders. This is a major issue facing mental health settings,

including the disparity in a sentenced patient who is moved to an in-patient setting being unable to call on the law to ensure their consent is explicitly considered.
- The issues identified in Barron around meeting the needs of female prisoners are not addressed in what is proposed by the Review.
- 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.
- Our submission references RCPsych in Scotland's response to the Barron Review. We believe that it is relevant and useful to this consultation and would welcome the opportunity to send over our past response to the Barron Review.

Appendix A: RCPsych in Scotland Forensic Faculty's Response to the Barron Review

RCPsych in Scotland – initial response to the Barron Review of Forensic Mental Health Services (28/05/21)

Overall views

- **Welcome engagement** – the College is grateful to Derek Barron and his team for delivering this report. We appreciated the efforts to ensure clinical voices were heard equally alongside those with lived experience and other key stakeholders. This range of views is reflected in the Review's wide-ranging objectives.

- **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 for these, including:**Equity of provision** for female and child & adolescent offenders.
    - **Mechanisms to avoid patient entrapment and promote patient flow** and ensure people receive the right care in the right setting, with the right level of security whilst maintaining safety.
    - **Promoting human rights-based care**, reflecting the Mental Health Act principles.
    - **Promoting Reed Principles** with an emphasis on least restriction and treatment as near to loved ones as possible.

    - **Multidisciplinary working and patient involvement** across different teams and settings, with real engagement in planning, governance and quality improvement

- **About the how** – the College joins other partners in offering to constructively work to realise these objectives. This includes the how of implementing the recommendations and highlighting the potential barriers that will need to be overcome.

- **Greater depth** – This is a 'short' version of the College's collective response. We would greatly appreciate the opportunity, once initial decisions on implementation have been taken, to discuss further the points raised in this submission.

The National Forensic Board

Our members believe the proposal of a newly established specialist Forensic Health Board to deliver the Barron objectives will present significant challenges. We recognise that this board may facilitate the achievement of some of the above objectives, but the substantial task of establishing the Board needs to be carefully considered.

- **Fully understanding the challenges** – the uniqueness of the structural changes present challenges that have yet to be navigated before, and our members have stated these challenges need to be more greatly considered prior to implementation.

- **Potential alternatives** – In understanding these challenges, it was also suggested by some respondents this model of structural change be assessed alongside other alternatives. This, they suggested, would ensure that all available mechanisms for delivering the Review's objectives are considered prior to implementation.

- **Isolating patients** – one of the concerns that emerged was around the potential impact on patients a separate board could have. This is an already stigmatised group, and the changes could, if not sufficiently integrated with the wider healthcare system, delay or disincentivise transfers from forensic to non-forensic settings. If the challenges of these structural proposals are not addressed prior to implementation, there is felt to be a danger these changes could: harm patients whose care outcomes the Barron Review prioritises; inhibit a person-centred care model by limiting options, and; increase stigma towards forensic patients.

- **Outwith the central belt** – We as a College recognise the communication, recruitment and retention challenges this move seeks to address, but would add 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.

Other key aspects

- **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.

- **Addressing gaps** – we recognise and support the aim to address gaps in service provision. These include the quality of care available in individual areas, people being left to wait in inappropriate settings while they wait for lower security spaces, and others stuck in low security waiting for community placements. This aim could start to be delivered through already-developed, clinically-led plans to address gaps in service provision that exist in many parts of Scotland.

- **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.

- **Secure women's unit** – we as a College 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.

- **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.