Review of forensic mental health services: Response to call for evidence

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Scottish
Independent
Advocacy
Alliance

Background

The Scottish Independent Advocacy Alliance (SIAA) is a membership organisation that has the overall aim of ensuring that independent advocacy is available to any vulnerable person in Scotland. Independent advocacy safeguards people who are marginalised and discriminated against or whom services find difficult to serve, empowering people who need a stronger voice by enabling them to express their own needs and make their own decisions.

SIAA welcomes the opportunity to respond to the independent review of forensic mental health services' call for evidence. The review is an area of significant interest for SIAA and our member organisations, many of which deal with users of forensic mental health services on a daily basis.

In December 2019, SIAA hosted a roundtable meeting to address the questions posed by the review team. The meeting was attended by representatives of six of our member organisations, each with specialisms in delivering independent advocacy within forensic mental health services. This response draws on those discussions, as well as the wider experiences of our members and their expertise in supporting users of forensic mental health services to have their voices heard. This provides a clear evidence-base in terms of what currently works and what needs to change in order to create forensic mental health services that are effective and responsive, treating people with dignity and respect.

Questions from the review team

1. Thinking about your experiences of supporting people who are being treated in a secure hospital or hospital unit:

- What did you find helpful?

- Building up good relationships with staff e.g., consultants embracing independent advocacy (IA), because it results in better patient outcomes and makes their jobs easier.
- Opportunities to train staff at inductions and on an ongoing basis.
- Good referral systems - when the person is quickly referred to IA it gives the advocate the chance to explain what IA is and build the person's understanding of IA and their rights early on, leading to better outcomes.
- Opportunities for collective/group IA as well as individual IA.
- Continuing to offer the IA service when someone has initially not engaged – a member provided an example of a person who engaged with IA when they felt ready to do so, after 10 years in hospital.

- What made things more difficult?

- Referral systems to independent advocacy and psychology – even when they work well – tend to be informal and dependent on good relationships rather than the consistent application of policies. There is inconsistency across different services and within a service or ward for referrals to IA.
- There is less access to IA in low secure settings, which is challenging - everyone should have equal access.
- Capacity and funding for IA in hospitals is inconsistent and insufficient.
- It is more difficult for people with learning disabilities to make a self-referral.
- All-women wards which have men staffing them are counterproductive. They should be safe environments to facilitate recovery, but many

people in hospital do not feel safe as other patients can easily come into your room and space.

- People are often placed somewhere that does not fit their needs and which will not aid their recovery, because of the lack of suitable options e.g. including women, older people, young people.

- What would have made the experience better?

- Transparent, consistent, formalised referral systems.
- Staff training on IA primarily happened at a point of crisis when something had gone wrong. Staff training on IA should be better resourced and proactive, but there is no specific funding for advocacy organisations to deliver this sort of training.
- Often it is the victims of homophobic, racist, or sexist abuse from other patients that must move for their safety, rather than the service addressing the underlying issue. There is a clear need for staff training around equalities issues so they can address these issues effectively in the ward.
- Formal collective/group IA happening reliably and consistently in hospital settings across Scotland.

2. Thinking about your experiences of supporting people who have moved between prison and secure hospitals or between hospitals with different levels of security:

- What was the experience like?

- Moving people is not thoroughly planned for, in terms of the services people can access in the new setting.

- There is not always the right level of security available in the right locality, so people must move out of the area. In particular, members noted that the lack of low secure units means people are often moved away from their support networks.
- There is a marked inconsistency of policies around rights in hospitals/wards with different levels of security e.g. medium secure settings often give greater access to phones and laptops than low secure settings. This can impede people's recovery if, when they move to a less secure setting, they suddenly find they are more restricted in terms of what they are allowed to do.

- What worked well?

- One IA organisation has done a lot of work on clarifying with patients how they move through the system, so they know exactly where they are and what is next. This has helped a lot.

- Were there any delays? How did this affect you?

- It can take a long time for people to be moved from higher secure to lower secure settings and this causes understandable frustration and can impede recovery.

- What would have made the experience better?

- Better planning for moves and communication about what will happen and when it will happen
- More consistency across access to services, as well as consistency in terms of rights within the different security settings

3. Thinking of your experiences supporting people who left low or medium secure services and are now in the community:

- What has helped?

- Some people using forensic mental health services get SDS which works well, but not enough people are given this option.
- IA can follow people into the community which is very helpful as it provides ongoing continuity of support. This is helped by IA organisations having good links with one another, so that a person moving out of the area can be put in touch with a local IA organisation.

- Were there any delays? How did this affect you?

- Yes, delays are common because the necessary resources and services are not available.
- Delayed discharge and a slow journey through the system and back into the community does not benefit patients. Often, they require rehabilitation for damage which is caused or exacerbated by their time in hospital.

- What has made it more difficult?

- There is not enough IA to support forensic mental health in the community
- Local statutory services are not planning sufficiently for people coming out of forensic hospital wards
- Members reported of private companies being used to provide the community care and behaving as though they 'owned' the person e.g. going through someone's rubbish as they believed they were drinking alcohol.

- Care workers are on minimum wage and expected to take on more and more responsibility when caring for people in the community. This means that the person's needs are not being met and leads to very high staff turnover.

- What would have made the experience better?

- Much better funding for IA provision to support forensic mental health in the community.
- Packages can be resource intensive but not recovery focused. The focus seems to be on keeping the public safe rather than helping the person recover. There needs to be a shift in emphasis to include, for example, access to psychological services.
- Significantly improved strategic planning by local authorities.
- Formal collective/group IA happening reliably and consistently in community settings across Scotland.

4. Thinking about your experiences supporting people who received support for a mental illness, personality disorder or learning disability while in prison or in police custody:

- What has helped?

- One member reported that they pitch their IA service as helping prisoners with mental wellbeing rather than mental health conditions, as there is still a lot of stigma around mental health.

- What has made it more difficult?

- IA provision in prisons is tokenistic and very poorly funded. For instance, one member reported that they cover two prisons with 900 prisoners –

based on statistics about mental health conditions and learning disabilities in prison populations, this means that potentially 700 prisoners would have the right to access IA. This is covered by one independent advocate, working three days per week across both prisons.

- Many people in prison with mental health conditions could be in forensic mental health hospital setting.
- The majority of IA provision in prison is through self-referral and word of mouth. Very few referrals come through mental health services within the prison.

- What would have made the experience better?

- Formal collective/group IA happening reliably and consistently in prison settings across Scotland.

5. Have the people you supported been able to get the support they need in a place that is close to their support networks?

- As noted throughout this response, often people are not able to get the mental health forensic support they need in a place close to their existing networks. This can be a particular problem for certain groups of people e.g. women, older people, and young people. There is also an issue with poor provision of low secure settings.
- In addition, access to IA for people using forensic mental health services is patchy and inconsistent, requiring a significant increase in resourcing to build capacity. Many people with a right to IA are not able to realise that right.

6. Do you think that the experience of the people you have supported was different from other people because of who they are, for example because of their age, disability, gender reassignment, marriage or civil partnership, pregnancy, race, religion or beliefs, sex, or sexual orientation?

- Human Rights

The theme that ran throughout the whole discussion was that forensic mental health services often infringe the human rights of people who use them.

People who use forensic mental health services have no choice because they are compelled to use the services and once, they lose their liberty they often lose many other rights, without reciprocity.

- Women

There are no forensic services for women in most areas of Scotland including Perth and Kinross and Aberdeen. They are often moved to England away from support networks.

As noted previously, wards for women which have men staffing them seem counterproductive. They should be safe environments to facilitate recovery.

Women's physical health is also often not taken seriously, and they are frequently accused of manipulation. Members reported of women with borderline personality disorder being treated poorly by staff, saying it seems as though the staff are 'bothered' by suicide attempts, so the women get punished for their 'attention seeking' behaviour.

- Black and minority ethnic (BME) people

- A member reported of a BME person who received racist abuse from other patients in a ward which severely impacted on their recovery. Other members reported similar issues, where the BME person was

moved ‘for their own safety’ – so they had their rights reduced, instead of staff dealing with the actual problem.

- LGBTQ+

- Sexuality is something that the forensic estate has previously shied away from, but a member noted there was an ‘Expression of Sexuality’ group in Rohallion. Groups like this are slowly working to improve things, including doing a LGBTI audit of the service as well as looking at rights to private life and expression of identity. The aim is for it to become normal for patients and staff to have open discussions about expression of identity.

- Young people

- There are no low secure settings for young people, so they tend to end up in adult ICPUs or are moved down to England far away from support networks.

- Older people

- There are few resources for older patients needing forensic mental health services.
- For older prisoners with a dementia diagnosis, it is unclear who within the health service has responsibility for them. The aging population in forensic services is an increasing issue, as increasingly people’s access and personal care needs are not being met.

- People with learning disabilities

- It is very common for people providing services for people with learning disabilities to adopt a paternalistic attitude. Members see common

issues around people with learning disabilities asking about their rights and access to their children

- Services seem to work with the view that people with learning disabilities cannot engage in the service or system. IA plays a critical role in these situations.

7. Any other comments

- Some members felt that the word 'forensic' was stigmatising, as it assumes that people who have used or are using forensic services are a danger to others.
- Some members felt that the word 'forensic' is not useful, as there is a low awareness of what it means and what services 'forensic mental health' actually covers.
- Members felt it was helpful to think of forensic mental health services in the context of human rights. A member described people's experiences of these services as 'a series of increasing losses of their human rights…they lose their liberty and then lose rights across the board'.