Mental Health Commission

Position Paper

Forensic Mental Health Services For Adults in Ireland

February 2011

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1. INTRODUCTION

The Forensic Mental Health Services committee was established in 2004 by the Mental Health Commission with the following terms of reference

- To review models of best practice in forensic mental health services
- To review and clarify definitions within the area of forensic mental health
- To review current provision of secure care and forensic mental health services in Ireland for adults and children /adolescents
- To review mental health services within prisons
- To prepare a discussion paper including recommendations on forensic mental health services for the Commission with a view to wider circulation as a discussion paper issued by the Commission.

In February 2006 the Discussion Paper "Forensic Mental Health Services for Adults in Ireland" (Mental Health Commission 2006) was published and disseminated widely. Responses were invited from all stakeholders in the mental health community and any other interested parties. The Discussion Paper put forward a range of recommendations for the development of a modern comprehensive forensic adult mental health service. The paper stimulated a good deal of discussion and debate about the development of our forensic adult mental health services and a number of written submissions were received by the Committee.

Subsequent to the publication of the discussion paper, "A Vision for Change" (Department of Health & Children 2006), governmental policy on mental health was published. The policy includes specific recommendations in relation to forensic mental health services. These have been taken into account in preparing this position paper.

The position paper addresses forensic mental health services for adults. It does not address the specialised forensic mental health services required for some children and some people with an intellectual disability.

2. WHAT DO WE MEAN BY FORENSIC MENTAL HEALTH SERVICES?

The literature on defining the province of forensic mental health services indicates variations and debate on what constitutes forensic mental health services. By its very name it implies a connection with courts of law. The Faculty of Forensic Psychiatry of the Royal College of Psychiatry defines forensic psychiatry as a "speciality in psychiatry concerned with helping people who have mental disorder and who present a significant risk to the public. It covers areas such as the assessment and treatment of mentally disordered offenders; investigation of the complex relationships between mental disorder and criminal behaviour; working with criminal justice agencies to support patients and protection of the public".

Writers who favour a broader definition refer to the criminal and civil sphere. For example McFadyen (1999) states that forensic mental health services "deal with those mentally ill people whose presentation has been assessed as requiring a more focused level of expertise and/ or increased levels of physical security. Some of these people will have exhibited behaviours which present major challenges, with or without associated violent conduct, beyond the capabilities of general psychiatric services. Others will be mentally disordered offenders who have broken the law or who have the propensity to do so. Some patients will have been identified at the level of general psychiatry and some via the criminal justice system. Of the latter some will be on remand........... others however will be convicted prisoners who are subsequently transferred from prison during the course of their penal sentence."

Gordon and Lindqvist (2007) in their overview of forensic psychiatry in Europe opt for the broader perspective, "Definitions of forensic psychiatry vary but its essence relates to the assessment and treatment of people with mental disorder who show antisocial or violent behaviour. Key elements include the interface between mental health and the law, affording expert evidence in civil and criminal courts, and the assessment and treatment

of mentally disordered offenders and similar patients who have not committed any offences. Forensic psychiatry is a sub-specialty of general psychiatry, which itself is a sub-specialty of medicine. Concurrently forensic psychiatry overlaps with law, criminal justice and clinical psychology and occurs in an evolving social and political context."

Acceptance of the wider definition of forensic mental health services facilitates access and movement between different levels of therapeutic security and services without undue obstacles and delays for the individual service user, and ensures that the multiple and complex social and health needs of service users are met within a forensic setting.

The Mental Health Commission in this position paper adopts the wider definition of forensic mental health services in line with the definition quoted from Gordon and Lindqvist (2007).

3. FORENSIC MENTAL HEALTH SERVICES: PRINCIPLES AND ETHICAL GUIDELINES

The Mental Health Commission holds firmly the view that the promotion and protection of the human rights of people availing of mental health services must be a core principle underpinning all practice in the mental health services. This fundamental principle is even of greater significance within forensic mental health services. Forensic mental health care practitioners must be familiar with and honour the protections expressed in the European Convention for the Protection of Human Rights and Fundamental Freedoms, in particular Articles 3 and 5. (See Appendix 1). The UN Convention on the Rights of People with Disabilities, especially Articles 14 and 25 is also germane to the rights of service users. (See appendix 1).

The principle of equivalence of care as enunciated in the UN Principles regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) must underpin the provision of forensic mental health services. Principles 7.1 and 7.2 concerning the right to be treated and cared for in one's own community as far as possible and Principle 9.1 in relation to the right to be treated in the least restrictive environment appropriate to one's needs are key concepts in planning the development of forensic mental health services. (See Appendix 2).

The development and application of an ethical framework for forensic mental health services has been identified as one of the key challenges for practitioners. Dr Paul Appelbaum and Dr Alan Stone have taken the lead in this debate since 1984 joined by others in particular Dr Jose Taborda, Dr Erza Griffith and the American Academy of Psychiatry and the Law. In 1997 Dr Appelbaum put forward a theory of ethics for forensic psychiatry which has become known as the "Standard Position". Dr Appelbaum emphasised that the "Standard Position" was in addition to the ethical obligations that flow from us as human beings and as members of particular professions and that it is derived from the functional roles performed by those in forensic mental health services. He outlined two broad principles: truth-telling and respect for the persons. In relation to

truth telling he outlined a two fold obligation i.e. testify to what one believes is true and secondly that the testimony should accurately reflect the scientific data on the subject. But truth telling must be guided by respect for the person, “respect for the humanity of the evaluee. Hence, we do not engage in deception, exploitation, or needless invasion of privacy of the people whom we examine or about whom we testify”.

In 2005 the American Academy of Psychiatry and the Law adopted ethics guidelines for the practice of forensic psychiatry (see Appendix 3). These guidelines refer specifically to

- Confidentiality
- Consent
- Honesty and Striving for Objectivity
- Qualifications
- Procedures for Handling complaints of Unethical Conduct

The development, organisation and delivery of forensic mental health services in Ireland should be underpinned by these international human rights principles and ethical guidelines. Forensic mental health services should incorporate:-

- Active, informed, partnership with service users in the individual assessment process, the individual care plan process, and all therapeutic interventions of care and support;

- Active, informed partnership with users and carers in the development, evaluation and monitoring of services;

- Delivery of high quality, effective therapeutic interventions, care and support, consistent with the ethical principles governing the service user-service provider relationship;

- Equal treatment as to access and provision of services, including the needs of people from minority cultures, people with a disability, people subject to the criminal justice system;

- Provision of services which are readily accessible, including prompt and adequate mental health support and treatment;

- Delivery of continuity of care and support as long as is needed;

- Provision of a comprehensive and co-ordinated range of services and accommodation based on individual needs;

- Taking account of the needs and views of carers, where appropriate, in relation to assessment, therapeutic interventions, care and support;

- Provision of comprehensive, professional and peer advocacy, where required or requested;

- Promotion of independence, self-respect, self-esteem, social interaction and social inclusion through choice of services, facilitation of personal responsibility, self-management, opportunities for employment and social activities;

- Promotion of safety for service users, carers, providers and members of the public;

- Provision to multidisciplinary teams of the necessary education, training and support;

- Services subject to evaluation and review, informed by best practice;

- Treatment, care and support that is as far as possible in the community, rather than in inpatient settings; under conditions of security and restriction no greater than is justified by the degree of danger of service users present to themselves and others; and is open accountable and subject to external review.

4. FORENSIC MENTAL HEALTH SERVICES: NEEDS ASSESSMENT AND PROVISION

A comprehensive needs assessment must be undertaken as an initial and immediate action to inform the future development of forensic mental health services in Ireland. Specific areas to be addressed as part of this assessment of need include a review of the unmet mental health needs of the generic population and specifically of the prison population. **Recommendation 1**

Existing studies on the prevalence of mental illness among prisoners provide valuable information. A survey undertaken by Linehan et al (2005) of the extent of mental illness in prisoners revealed that 2.6% of sentenced prisoners had a severe or enduring mental illness, rising to 7.6% among remand prisoners. This is double the rate of mental illness found in remand prisoners internationally.

Other studies have shown that:

- Of those committed annually to prison, 2.1% of prisoners will be currently psychotic, 3.9% will have a six month prevalence of psychosis and 4.6% will have a major depressive disorder on committal. Among male prisoners, 15% of those committed to prison in 2003, 25% of remand prisoners and 22% of sentenced prisoners had a mental illness of some kind.

- Ireland commits over 300 people to prison each year who have a six month prevalence of severe and enduring mental illness.

- Among female prisoners, the rates are higher: 37% of sentenced women and 23% of women committed to prison in 2003 had a psychiatric illness.

- Of those committed to prison in Ireland and who are mentally ill, 80% will already be known to community mental health services. 91% of those with a major depressive disorder and 66% of those with a psychosis will already have had contact with community mental health services.

This assessment of needs should also address the specialised mental health care of the female prison population and the significant prevalence of substance misuse by people with mental health problems who offend.

This assessment will determine the inpatient provision required at each level of secure provision, the range and model of community forensic mental health services and the service requirements to meet the mental health needs of the prison population.

Further and separate reviews on the needs of children and people with intellectual disability who may require access to forensic mental health services will also be required.

Inpatient Facilities

In general inpatient forensic mental health facilities are stratified according to levels of security. Crichton (2004) who chaired the working group in Scotland on defining security levels in psychiatric inpatient facilities adopted the following definition of the purpose of security "The purpose of security in psychiatric care is to provide a safe and secure environment for patients, staff and visitors which facilitates appropriate treatment for patients and appropriately protects the wider community". Kennedy (2006) refers to the environmental, relational and procedural security characteristics of a service. Relational security is of the utmost importance and cannot be minimised or reduced. The differences in these characteristics of security within the high secure, medium secure and low secure unit are outlined in Appendix 4.

There is general agreement, based on the size of our population that high and medium secure care can be provided centrally in one location in the Dublin area. All other forensic mental health services including low secure units should be provided on a regionalized basis. The needs of service users are not well served by the provision of forensic mental health services from one central complex. Regionalised services are a very necessary development in moving towards a modern and comprehensive service.

Recommendation 2

Inpatient forensic mental health services must only be provided in centres which are registered as approved centres in accordance with the Mental Health Act 2001 and subject to annual inspection (minimum requirement) by the Inspector of Mental Health Services. All such facilities should also meet the legislative requirements arising from the Criminal Law (Insanity) Act 2006 and the Criminal Law (Insanity) Act 2010.

Community Forensic Mental Health Service

Although service developments until the last decade have mostly focused on secure inpatient facilities, more recently, in line with the general trend within mental health services, there has been an increased focus on the development of community forensic mental health teams (CFMHTs). (See Appendix 5)

Community forensic mental health teams are viewed as part of the overall development of more specialized mental health community services, such as early detection and intervention of first episode psychosis and assertive outreach teams. The role of community forensic mental health teams has been described by Malik at al (2007) as:

(a) Consultation and advice: Advising on the assessment and management of patients with forensic mental health needs.

(b) Risk assessment and advice on risk management: A comprehensive risk assessment is an essential element of an appropriate care and treatment plan,

(c) Case management; Multidisciplinary teams work with individual service users with an emphasis on assertive engagement and persistent follow up.

(d) Co working: This may involve a consultation role with other services including probation and prison services, secure inpatient facilities, and other relevant services,

(e) Court diversion and court liaison.

A key challenge in the development of community forensic mental health services is planning the most appropriate and effective delivery model taking into account geographical and resource factors. In general, other jurisdictions have favoured either the integrated or parallel model of care. In the integrated model, specialists work within the general community mental health team; in the parallel model, the services are provided by a separate multidisciplinary specialist team. Snowden et al compares these two models of care, as follows:-

Comparison of integrated and parallel models of community forensic mental health teams

	Integrated	Parallel
Description	CFWs work in the community health team	CFWs work in a separate team Separate referrals meeting
Advantages	Continuity of care and good communication More access to community resources Readmission easier if required Level of care can be reviewed	Specialist interventions available Specialist trained staff Links with CJS and secure hospitals Smaller caseload sizes
Disadvantages	Lack of specialist skills Lack of resources to manage difficult patients Larger caseload sizes	Isolated from other services Stigmatisation of patients Focus on high risk patients

CFW: community forensic worker, CJS: criminal justice system

Research in the UK indicates that initially the parallel model was adopted but that now a combination of both is more likely. Studies in Australia show that a hybrid system operates "consistent with the notion that parallel and integrated services are not mutually exclusive, but rather two ends of a continuum".

Clear protocols between forensic and general mental health teams, including seamless referral and treatment pathways are essential in ensuring optimal care for service users. Models of care which promote collaboration and the removal of barriers to a continuum of mental health care such as joint responsibility for low secure regional units, co-case management, formalised liaison schemes, should be developed through the use of service level agreements and individual service user care and treatment contracts.

Recommendation 3

Inpatient and community mental health services should:

- Provide access to the full range of therapeutic interventions and programmes. These will generally involve multiple components to address the alleviation of psychiatric symptoms and psychological disturbances, the preservation and

enhancement of personal, social and occupational skills required for positive community living and the reduction or elimination of inappropriate or destructive behaviours.

- Adopt and integrate a recovery focused approach to care and treatment.
- Provide access by the service user to multidisciplinary teams, which will include in its core membership consultant psychiatrists, mental health nurses, clinical psychologists, mental health social workers, occupational therapists and addiction counsellors. Other personnel in the fields of vocational training, speech and language therapy, education may also be required.

Governance of Forensic Mental Health Services

The system of governance (defined as "the use of institutions, structures of authority and even collaboration to allocate resources and coordinate or control activity in society or the economy" (Bell, Stephen, 2002)) is crucial in determining the effective provision of forensic mental health services and ensuring that service users can access services based on need. There is extensive reference in the literature to the challenge of providing a seamless service, offering a continuum of care and ensuring that forensic mental health services are utilized most optimally.

To support the robust governance of forensic mental health services the HSE should establish a national oversight group to oversee the utilisation of high and medium secure inpatient forensic beds. This group also should have a policy development function within the forensic mental health services including the monitoring of relevant legislation. The membership of the national group should include management and clinical representation from the four regional areas, and service user and carer representation. This group should also prepare a template for local protocols and referral procedures. **Recommendation 4**

Protocols in relation to the sharing of information which balance the confidentiality of the clinical relationship with concerns about public safety and risk reduction are required both internally within the forensic mental health services and the interface with general mental health services and externally with agencies working within the criminal justice system. The procedures underpinning information sharing must:

- Be compliant with relevant legislation (e.g. Data Protection Acts)
- Ensure that information is shared on a need to know basis
- Protect the dignity of the persons involved
- Ensure that information is shared in a safe and secure manner

The evidence base in relation to models of care within forensic mental health services, in particular in the area of community services to date is limited. Ongoing monitoring and evaluation of forensic mental health services is essential to define what is working and why and what needs to change. International research linkages are also important.

The development of a comprehensive forensic mental health service will require much larger numbers of staff with forensic mental health training than are currently available. Career opportunities and defined career paths need to be available to attract and retain a motivated and skilled workforce. In order to develop a sufficient pool of staff in the initial stages of the development of the service it will be necessary to develop and resource specific training initiatives for each of the disciplines required.

Legislation

Greater priority should be given to the reform of the legal framework governing mental disorder as this provides the basis for many essential aspects of forensic service provision.

Recommendation 5

The amendments of Sections 4 & 13 of the Criminal Law (Insanity) Act 2006 through the enactment of the Criminal Law (Insanity) Act 2010 are welcomed by the Mental Health Commission. (See Appendix 6).

Mental health professionals, Gardaí, lawyers and the courts in all regions should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings. Services should be based on a nationally established policy of diversion towards treatment and recovery options, in keeping with the principles of "A Vision for Change" (DOHC 2006) and the proposal by the National Crime Council to introduce Community Courts in Ireland.

Recommendation 6

The enactment of a new mental capacity law in line with the recommendations of the Law Reform Commission (2005) is an urgent priority and an essential protection for the human rights of people availing of forensic mental health services.

Recommendation 7

It is also important that in any new legislation in the mental health sphere, Ireland should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients between England, Wales, Scotland, Northern Ireland and the Republic of Ireland. This will reduce the current level of frustration and confusion for practitioners and families who become involved in inter-country transfers and make best use of referral to specialist services.

Recommendation 8

5. MENTAL HEALTH SERVICES WITHIN THE PRISON SERVICE

The importance of appropriate and comprehensive health care for prisoners has been recognised now for sometime. There is an increasing emphasis on the development of multidisciplinary and multi-agency models of health care within the prison systems. Mental health care must be a key component of the overall prison health care system.

The initial health assessment, including a mental health assessment is a critical component in ensuring appropriate mental health care for prisoners. Agreed protocols between prison health care service and forensic mental health services facilitate the provision of comprehensive mental health services.

Mental health services to each prison population should be provided by the forensic mental health service for the region the prison is situated in as a secondary in-reach service. (Appendix 7).
Recommendation 9

Regional Forensic Mental Health services providing services to the prison population should work very closely with prison medical, psychology, social work (probation and welfare), addiction counselling and vocational services to maximise the effectiveness of their input into the individual prisoner's care and formal liaison with each of these services is strongly recommended. "A Vision for Change" (DOHC 2006) recommends *"prison health services should be integrated and coordinated with social work, psychology and addiction services to ensure provision of integrated and effective care. Efforts should be made to improve relationships and liaison between forensic mental health services and other specialist community mental health services."*

In addition, these prison health care services, which form the primary care level of service for the prison population, should be resourced appropriately to allow them to deal with issues within their remit thus reducing inappropriate referrals to the secondary mental health services.

Mental health services in prisons should be guided by the Recommendations on European Prison Rules (Council of Europe, Committee of Ministers to member states on the European Prison Rules).

Recommendation 10

6. COURT ASSESSMENT AND DIVERSION

Concern has been expressed about the high representation of people with mental health problems who are in prison and the unsuitability of the prison environment for many such mentally disordered offenders. "While public protection remains the priority, there is a growing consensus that prison may not always be an appropriate environment for those with severe mental illness and that custody can exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide". Increasingly court assessment and diversion schemes are being advocated as a more effective intervention, and government policy in a number of other jurisdictions is to divert people with a mental illness from the criminal justice system when public interest and protection does not require prosecution and with the consent of the person to this option.

"A Vision for Change"(2006), national government policy on mental health recommended the introduction of court diversion schemes and that legislation should be introduced to allow this to take place. The National Crime Council in a report published in 2007 advocated the introduction of community courts.

Brooker and Ullmann (2009) suggest that there are three reasons for providing appropriate treatment for offenders who generally have poorer mental health than the general population .These are the moral case, the public health case and the economic case. "The moral case, based on equivalence ...... is that mentally disordered offenders should receive the same quality of care as the general population. The public health case is argued by those who see the criminal justice system as an opportunity for early mental health intervention. The economic case (perhaps the least well developed o f the three) is that investment in mental health care for offenders will ultimately lead to a reduction in crime."

There is no universally agreed definition or model of diversion. Existing criminal justice legislative framework and system have shaped the development of diversion schemes.

Some focus on diversion at the time of a court appearance whereas other schemes allow for intervention at different stages. Bradley favours the broader definition of diversion: "'Diversion' is a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence." The Sainsbury Centre for Mental Health support the broader definition which allows for diversion at any stage in the route through the criminal justice system and has developed an all stages model or framework for diversion (See Appendix 8).

Court diversion arrangements must always rely on consent and cannot override the right to due process, that is the right to have one's case heard before the courts under the criminal law if that is the person's informed preference. Ireland should have a legislative basis to allow court diversion schemes to operate.

The establishment of Appropriate Person, Police and Court Diversion Schemes must be a priority.

Recommendation 11

7. RECOMMENDATIONS

1. A comprehensive needs assessment must be undertaken as an initial and immediate action to inform the future development of forensic mental health services in Ireland. Specific areas to be addressed as part of this assessment of need include a review of the unmet mental health needs of the generic population and specifically of the prison population.

2. There is general agreement, based on the size of our population that high and medium secure care can be provided centrally in one location in the Dublin area. All other forensic mental health services including low secure units should be provided on a regionalized basis. The needs of service users are not well served by the provision of forensic mental health services from one central complex. Regionalised services are a very necessary development in moving towards a modern and comprehensive service.

3. Clear protocols between forensic and general mental health teams, including seamless referral and treatment pathways are essential in ensuring optimal care for service users. Models of care which promote collaboration and the removal of barriers to a continuum of mental health care such as joint responsibility for low secure regional units, co-case management, formalised liaison schemes, should be developed through the use of service level agreements and individual service user care and treatment contracts.

4. To support the robust governance of forensic mental health services the HSE should establish a national oversight group to oversee the utilisation of high and medium secure inpatient forensic beds. This group also should have a policy development function within the forensic mental health services including the monitoring of relevant legislation. The membership of the national group should include management and clinical representation from the four regional areas, and

service user and carer representation. This group should also prepare a template for local protocols and referral procedures.

5. Greater priority should be given to the reform of the legal framework governing mental disorder as this provides the basis for many essential aspects of forensic service provision.

6. Mental health professionals, Gardaí, lawyers and the courts in all regions should have a comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings. Services should be based on a nationally established policy of diversion towards treatment and recovery options, in keeping with the principles of "A Vision for Change" (DOHC 2006) and the proposal by the National Crime Council to introduce Community Courts in Ireland.

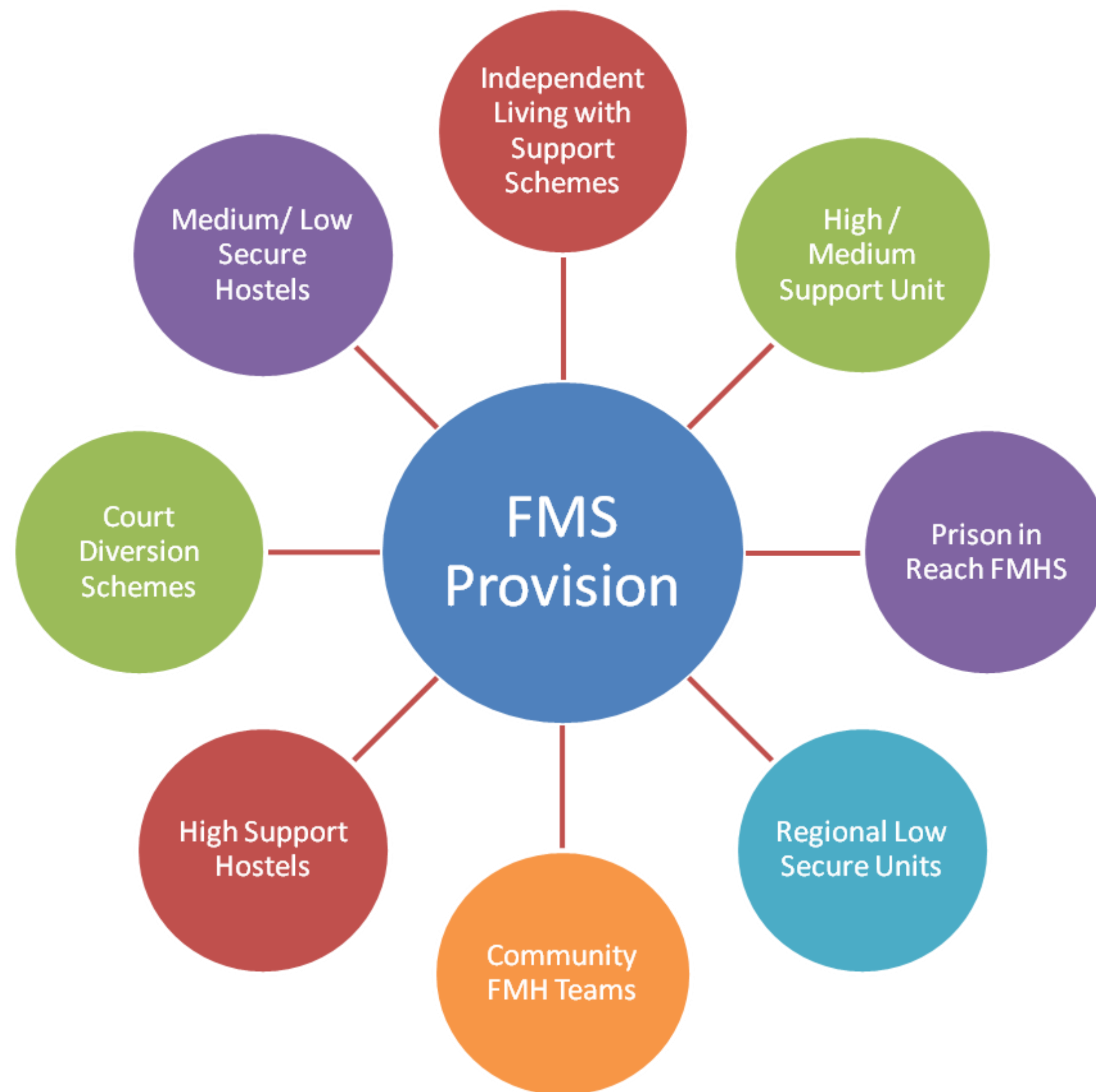
7. The enactment of a new mental capacity law in line with the recommendations of the Law Reform Commission (2005) is an urgent priority and an essential protection for the human rights of people availing of forensic mental health services.

8. It is also important that in any new legislation in the mental health sphere, Ireland should seek to have reciprocal arrangements that allow for the transfer of detained mentally disordered patients between England, Wales, Scotland, Northern Ireland and the Republic of Ireland. This will reduce the current level of frustration and confusion for practitioners and families who become involved in inter-country transfers and make best use of referral to specialist services.

9. Mental health services to each prison population should be provided by the forensic mental health service for the region the prison is situated in as a secondary in-reach service. (Appendix 7).

10. Mental health services in prisons should be guided by the Recommendations on European Prison Rules (Council of Europe, Committee of Ministers to member states on the European Prison Rules).

11. The establishment of Appropriate Person, Police and Court Diversion Schemes must be a priority.


Independent Living with Support Schemes
Medium/ Low Secure Hostels
High / Medium Support Unit
Court Diversion Schemes
FMS Provision
Prison in Reach FMHS
High Support Hostels
Regional Low Secure Units
Community FMH Teams

APPENDICES

APPENDIX 1

(A) European Convention on Human Rights and Fundamental Freedoms Articles 3 & 5

Article 3

No one shall be subjected to torture or to inhuman or degrading treatment or punishment

Article 5

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

   a the lawful detention of a person after conviction by a competent court;

   b the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

   c the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;

   d the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;

   e the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;

   f the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3. Everyone arrested or detained in accordance with the provisions of paragraph 1.c of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation

(B) United Nations Convention on the Rights of People with Disabilities Articles 14 & 25

Article 14 - Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

   a. Enjoy the right to liberty and security of person;
   b. Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

Article 25 - Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
c. Provide these health services as close as possible to people's own communities, including in rural areas;
d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
e. Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
f. Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

APPENDIX 2

United Nations General Assembly's 1991 resolution *'Principles Regarding the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'*. In particular the following principles have, it is considered, special relevance to forensic mental health services.

Principle 1.1	All persons have the right to the best available mental health care, which shall be part of the health and social care system.
Principle 7.1	Every person shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
Principle 7.2	Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
Principle 8.1	Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
Principle 9.1	Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patients health needs and the need to protect the physical safety of others.
Principle 9.2	The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularily, revised as necessary and provided by professionally qualified staff.
Principle 11.11	Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.
Principle 13.2	The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age.
Principle 14	A mental health facility shall have access to the same level of resources as any other health establishment and in particular (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy (b) Diagnostic and therapeutic equipment for the patient (c) Appropriate professional care (d) Adequate, regular and comprehensive treatment, including supplies of medication.

Principle 20 This principle deals specifically with ‘criminal offenders’ and reiterates that all of the U.N. Principles apply to this group ‘*to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances’*.

APPENDIX 3

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY

Adopted May 2005

I. Preamble

The American Academy of Psychiatry and the Law (AAPL) is dedicated to the highest standards of practice in forensic psychiatry. Recognizing the unique aspects of this practice, which is at the interface of the professions of psychiatry and the law, the Academy presents these guidelines for the ethical practice of forensic psychiatry.

Commentary

Forensic Psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. These guidelines apply to psychiatrists practicing in a forensic role.

These guidelines supplement the Annotations Especially Applicable to Psychiatry of the American Psychiatric Association to the Principles of Medical Ethics of the American Medical Association.

Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings and abuses.

Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility. However, when a treatment relationship exists, such as in correctional settings, the usual physician-patient duties apply.

II. Confidentiality

Respect for the individual's right of privacy and the maintenance of confidentiality should be major concerns when performing forensic evaluations. Psychiatrists should maintain confidentiality to the extent possible, given the legal context. Special attention should be paid to the evaluee’s understanding of medical confidentiality. A forensic evaluation requires notice to the evaluee and to collateral sources of reasonably anticipated limitations on confidentiality. Information or reports derived from a forensic evaluation are subject to the rules of confidentiality that apply to the particular evaluation, and any disclosure should be restricted accordingly.

Commentary

The practice of forensic psychiatry often presents significant problems regarding confidentiality. Psychiatrists should be aware of and alert to those issues of privacy and confidentiality presented by the particular forensic situation. Notice of reasonably anticipated limitations to confidentiality should be given to evaluees, third parties, and

other appropriate individuals. Psychiatrists should indicate for whom they are conducting the examination and what they will do with the information AAPL Ethics Guidelines 2 Obtained. At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluee that the psychiatrist is not the evaluee's "doctor." Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluee may develop the belief that there is a treatment relationship. Psychiatrists should take precautions to ensure that they do not release confidential information to unauthorized persons.

When a patient is involved in parole, probation, conditional release, or in other custodial or mandatory settings, psychiatrists should be clear about limitations on confidentiality in the treatment relationship and ensure that these limitations are communicated to the patient. Psychiatrists should be familiar with the institutional policies regarding confidentiality. When no policy exists, psychiatrists should attempt to clarify these matters with the institutional authorities and develop working guidelines.

III. Consent

At the outset of a face-to-face evaluation, notice should be given to the evaluee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the forensic evaluation should be obtained when necessary and feasible. If the evaluee is not competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction.

Commentary

Informed consent is one of the core values of the ethical practice of medicine and psychiatry. It reflects respect for the person, a fundamental principle in the practices of psychiatry and forensic psychiatry.

It is important to appreciate that in particular situations, such as court-ordered evaluations for competency to stand trial or involuntary commitment, neither assent nor informed consent is required. In such cases, psychiatrists should inform the evaluee that if the evaluee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony.

Absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons are: known to be charged with criminal acts; under investigation for criminal or quasi-criminal conduct; held in government custody or detention; or being interrogated for criminal or quasi-criminal conduct, hostile acts against a government, or immigration violations. Examinations related to rendering medical care or treatment, such as evaluations for civil commitment or risk assessments for management or discharge planning, are not precluded by these restrictions. As is true for any physician, psychiatrists practicing in a forensic role should not participate in torture.

Consent to treatment in a jail or prison or in other criminal justice settings is different from consent for a forensic evaluation. Psychiatrists providing treatment in such settings should be familiar with the jurisdiction’s regulations governing patients’ rights regarding treatment.

IV. Honesty and Striving for Objectivity AAPL Ethics Guidelines 3

When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.

Commentary
The adversarial nature of most legal processes presents special hazards for the practice of forensic psychiatry. Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.

Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data. They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical "facts," "inferences," and "impressions."

Psychiatrists should not distort their opinion in the service of the retaining party. Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination. For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions, clearly state that there was no personal examination and note any resulting limitations to their opinions.

In custody cases, honesty and objectivity require that all parties be interviewed, if possible, before an opinion is rendered. When this is not possible, or is not done for any reason, this should be clearly indicated in the forensic psychiatrist's report and testimony. If one parent has not been interviewed, even after deliberate effort, it may be inappropriate to comment on that parent's fitness as a parent. Any comments on the fitness of a parent who has not been interviewed should be qualified and the data for the opinion clearly indicated.

Contingency fees undermine honesty and efforts to attain objectivity and should not be accepted. Retainer fees, however, do not create the same problems in regard to honesty and efforts to attain objectivity and, therefore, may be accepted.

Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes. AAPL Ethics Guidelines 4 Treating psychiatrists appearing as "fact" witnesses should be sensitive to the unnecessary disclosure of private information or the possible misinterpretation of testimony as "expert" opinion. In situations when the dual role is required or unavoidable (such as Workers' Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important. When requirements of geography or related constraints dictate the conduct of a forensic evaluation by the treating psychiatrist, the dual role may also be unavoidable; otherwise, referral to another evaluator is preferable.

V. Qualifications

Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience.

Commentary

When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely. As a correlate of the principle that expertise may be appropriately claimed only in areas of actual knowledge, skill, training and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise.

VI. Procedures for Handling Complaints of Unethical Conduct

The American Academy of Psychiatry and the Law does not adjudicate complaints that allege unethical conduct by its members or nonmembers. If received, such complaints will be returned to the complainant for referral to the local district branch of the American Psychiatric Association (APA), the state licensing board, and/or the appropriate national psychiatric organization of foreign members. If the APA or the psychiatric association of another country expels or suspends a member, AAPL will also expel or suspend that member upon notification of such action. AAPL will not necessarily follow the APA or other organizations in other sanctions.

Commentary

General questions regarding ethical practice in forensic psychiatry are welcomed by the Academy and should be submitted to the Ethics Committee.

The Committee may issue opinions on general or hypothetical questions but will not issue opinions on the ethical conduct of specific forensic psychiatrists or about actual cases. The Academy, through its Ethics Committee, or in any other way suitable, is available to the local or national committees on ethics of the American Psychiatric Association, to state licensing boards or to ethics committees of psychiatric organizations in other countries to aid them in their adjudication of complaints of unethical conduct or the development of guidelines of ethical conduct as they relate to forensic psychiatric issues.

APPENDIX 4

Characteristics of Secure Inpatient Settings within Forensic Mental Health

Introduction

> *'Patients should be detained at no greater level of security than is necessary. This principle can be seen in the organization of secure psychiatric services according to stratified risk'*
>
> Kennedy (2002, p. 438)

Forensic mental healthcare is provided in a range of residential settings in particular conditions of security. Security refers to the security conferred by secure buildings and secure external spaces and facilities including monitoring systems but also to 'relational security' where it is the provision of high staff to patient ratios of well-trained staff allowing not only appropriate supervision and monitoring but also the opportunity for building good therapeutic relationships with patients which in a large part confers security. The different levels of secure care provision are described below.

The philosophy of care for all secure units should incorporate the following:

- The unit should promote the dignity, privacy and safety of all patients, balanced with the safety and security of the wider community.
- Each patient should have an individualized treatment plan addressing his/her psychiatric, psychological, psychosocial and spiritual needs.
- Patients should be involved in the care planning process so that care plans take account of individual circumstances, choices and expectations.
- A structured system of advocacy should be available to patients and service user involvement in service development should be encouraged.
- It should be possible to map out care pathways for individuals allowing people to move through the rehabilitation process with an absence of artificial barriers.
- The unit should provide a support system for the families and carers of patients and facilitate involvement with peer support networks.

In terms of the day to day service delivery each person in the care of the forensic mental health services should

- Undergo a period of assessment, which will identify the individual's strengths and needs and facilitate a thorough risk assessment.
- Be allocated a key worker who will co-ordinate the patients care during their stay and ensure a co-ordinated approach to discharge/transfer back to his/her own area and other service where appropriate.

- Participate in regular multi disciplinary reviews of their care and be given every opportunity to contribute to their own care plan including their ongoing risk assessment.

(a) Low Secure Forensic Units

Low secure units deliver intensive, comprehensive, multidisciplinary treatment, care and rehabilitation for patients who present with a level of behavioural disturbance in the context of a serious mental disorder. Treatment and rehabilitation is provided, usually over a lengthy period, with ongoing risk assessment and review. Patients in low secure units will be admitted under mental health legislation and the Criminal Law (Insanity) Act 2006 and will present a less serious physical danger to others than persons requiring a medium or high secure treatment setting. Security arrangements provided are designed to impede rather than completely prevent those who wish to escape or abscond. Low secure provision should have a greater reliance on staff observation and support rather than physical security arrangements. Low secure units have an ethos of active rehabilitation and therefore emphasise patient access to acute and community services and promote a philosophy of community integration. Low secure units should be distinguished from Psychiatric Intensive Care Units (PICU) described below which are designed for the short-term care of persons with disturbed behaviour in the context of acute illness.

Typical Service User Characteristics

- Admitted following a risk assessment that determines the admission criteria are met
- Admitted under Mental Health Act (2001) or Criminal Law (Insanity) Act 2006
- Risk assessment indicates that this level of security is required
- Mix of offending and non-offending behaviours such as challenging behaviour, self neglect and deliberate self harm
- Persons who offend who may or may not be charged
- Risk predominantly to others
- Persons in generic mental health services

Typical Security Characteristics

- Perimeter security that impedes rather than prevents a determined escape attempt
- Secure external exercise area
- Locked entrance doors
- High dependency areas
- Seclusion facilities
- Good levels of observation and support
- Alarm systems
- Appropriate environmental design including use of space to provide a restful environment with low levels of stimulation.

Entry to low secure care will usually be from a full range of mental health services following a risk assessment, from court services where an inpatient assessment is

required or from prison where a period of inpatient treatment is required and this level of security is indicated. Low secure care is therefore available as a resource to the generic mental health services for the management of persons requiring assessment and treatment in conditions of greater security than can be provided in the generic mental health services and teams working in low secure care services should have close working relationships with generic mental health teams so that there is ease of movement in both directions for persons requiring care and treatment.

Low secure units should provide a full range of treatment options i.e. pharmacotherapy, psychological therapies, psychosocial programmes and vocational training opportunities. Each low secure unit must have a clear link to community based residential facilities, whether these are dedicated facilities or shared with mental health rehabilitation services, in addition to having a pathway to transfer patients back to the generic mental health services in the person's local area.

Within our current service provision this level of secure care tends to be provided, in an unsatisfactory way in very many cases, by a number of 'locked units' throughout the services. To provide a modern low secure forensic service these units require substantial re-organisation in terms of physical layout, staffing levels and staff training, admission criteria and the provision of therapeutic facilities.

Good environmental design in forensic mental healthcare, in addition to producing environment layouts which enhance security, tends to make use of natural light, high ceilings, good sound-proofing, neutral colours, soft furnishings and other design elements to promote a restful environment with low levels of stimulation and to maximize the feeling of space and freedom of movement within units.

(b) Medium Secure Forensic Units

Medium secure units provide a treatment environment for patients who present a serious but less immediate danger to others. Physical security protocols and procedures, supported by high levels of staff, should be sufficient to deter all but the most determined to escape or abscond. Patients accepted into medium secure services will present with a serious risk to others and the potential to escape or abscond.

Within the perimeter of the medium secure service a good range of therapeutic and recreational facilities and activities should be available. These facilities and activities should be comprehensive in order to meet the needs of patients who are not ready for leave into the community, but with an emphasis on graduated use of ordinary community facilities when possible.

Typical Service User Characteristics

- Admitted under Mental Health Act (2001) or Criminal Law (Insanity) Act 2006
- Risk assessment indicates that level of security is required
- Offending behaviour
- Risk predominantly to others

- Significant capacity or risk to attempt to escape or abscond
- Serious but less immediate risk to the public if at large
- Non-Offenders with a history of violent behaviour whose needs cannot be appropriately met by local services

Typical Security Characteristics

- Perimeter fencing to a height of 3-4 metres with close-welded steel mesh, with bars at 12 mm centres in one direction
- Controlled access lobby to secure area, with outer and inner doors controlled by reception staff to form an airlock arrangement
- Where the fabric of the building acts as part of the secure perimeter of the unit the specification should be commensurate with preventing external access to the unit, and to ensure that contraband items cannot be passed to patients
- Provisions of exercise space internal to the building stock and exercise space with access to fresh air within the secure perimeter
- Provision of alarm systems
- Procedural security checks
- Locked doors to regulate access and movement of patients and visitors within the secure perimeter
- Appropriate environmental design including use of space to provide an environment with low levels of stimulation.
- Visiting facilities specifically separate areas for children.

The medium secure unit should be purpose built to provide up to date therapeutic facilities for patients. A modern medium secure unit will provide a high level of environmental security so as to allow maximum freedom of movement for individuals within the unit. Medium secure units must be staffed and managed by specialist forensic mental health staff and must have access to facilities at a lower level of security e.g. a staffed 24 hour hostel and/or easy transfer to a low secure unit in order to provide proper rehabilitation pathways for patients. Patients may also be transferred to high secure care if their risk status is changed. These units should be models of best practice providing a full range of treatment interventions i.e. pharmacotherapy, psychological therapies, psychosocial interventions and vocational training opportunities.

In some countries these units have often been sited on the campuses of generic mental health services rather than as stand alone units.

(c) High Secure Forensic Units

High secure units provide a treatment and rehabilitation environment for those patients who would pose a grave and immediate danger to others if at large. Security arrangements should be capable of preventing even the most determined escape attempt or absconder.

Within the high secure perimeter a full range of therapeutic and recreational facilities and activities should be available. The comprehensive range of services, both recreational and

clinical, acknowledges the severe limitations for patient access to community services and facilities.

Typical Service User Characteristics

- Admitted under Mental Health Act (2001) or Criminal Law (Insanity) Act 2006
- Charged or convicted of a grave offence
- Assessed as being an immediate danger to others in the community
- Significant capacity for co-ordination of outside help to perpetrate an escape attempt or absconding
- Patients may have a high public profile
- Risk predominantly to others
- Non-Offenders with a history of violent behaviour whose needs cannot be met in medium secure services

Typical Security Characteristics

- Perimeter fencing or escape proof wall to a height of 6 metres
- Access and egress to the secure area via regulated airlock arrangements for staff, visitors, patients and vehicles
- Regular monitoring and inspection of perimeter
- Regulation of items into the secure perimeter
- Security checks of staff
- Security checks of all visitors
- Provision of exercise space internal to the building and exercise space with access to fresh air within the secure perimeter
- Educational, rehabilitation, therapy and recreational facilities for patients sited within the secure perimeter
- Appropriate environmental design including use of space to provide some areas with low levels of stimulation
- Provision of alarm systems
- Procedural security checks
- Locked doors to regulate movement of patients and visitors
- Specific visiting arrangements especially for children
- Regulated access by patients to outside communication
- Monitoring of mail

Entry to the high secure service will usually be from the prison service where this level of security is required, from the courts under particular circumstances and from medium secure units. There needs to be clear protocols for transfer of persons from medium secure services to high secure care and conversely back to medium secure care when treatment in a high secure service is no longer indicated.
A national medium and high secure service will inevitably be geographically distant from family for a high proportion of patients and special care needs to be taken to preserve contact with families.

Forensic Rehabilitation Facilities

Forensic rehabilitation focuses on preparing individuals for transfer to lower levels of security and gradual re-integration into community settings with appropriate support. The service works with the service user, their carers and their support networks to address both mental health issues and issues of risk management allowing the person to move gradually towards living safely and independently in the wider community. In each area forensic rehabilitation services need to have access to community based facilities including residential facilities, whether these are dedicated facilities or shared with mental health rehabilitation services. The community residences may be part of the forensic service.

Psychiatric Intensive Care Units

There has been much debate about the need to develop psychiatric intensive care units (PICU) as part of our mental health services and confusion has arisen about how psychiatric intensive care units relate to forensic mental health care.

PICU's are designed for patients, usually compulsorily detained, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward. Care and treatment offered is patient-centred, multidisciplinary, and collaborative and will allow an immediacy of response to critical situations. Length of stay will be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks in duration - recommended maximum of 12 weeks (Department of Health UK 2002).

In the Northern Ireland Mental Health Services, Psychiatric Intensive Care Units - along with Challenging Behaviour Units - may commonly function as the 'first rung' on the forensic mental health service 'ladder' and low secure units are less commonly available. There are, however, serious difficulties in requiring psychiatric intensive care units to act as treatment centres for patients who are not acutely disturbed but rather in need of low secure care on a medium or long term basis. Brown and Bass (2004) highlight the difficulties of allowing PICU beds to be utilised by longer term patients because of a lack of longer term low secure provision. They point out that the typical PICU Unit is small and lacks longer term rehabilitation facilities. **Psychiatric Intensive Care Units are a resource for the generic mental health services and are not suitable for forensic mental health treatment beyond the period of acute disturbance.**

APPENDIX 5

Regional Forensic Mental Health Teams Working in the Community

Regional Forensic Mental Health Teams are specialist multidisciplinary teams with specialist forensic training offering services to all those with forensic mental healthcare needs within a specified geographical area. In addition to the provision of secure in-hospital care within the region these teams provide a community assessment and treatment service and a continuing care and monitoring service to several groups of people within their catchment area. Their client group in the community are mainly comprised of

- firstly those who have been discharged from secure care and who continue to require a specialist forensic service to manage their continuing care
- Other clients whose forensic mental health history is such that they require specialist monitoring and continuing care services. Some clients with forensic mental health needs may be managed by the specialist forensic team for a period and will then be transferred back to their own catchment area community mental health services when their level of risk and need for specialist care has decreased
- Some clients may be managed jointly with the catchment area mental health teams where the catchment area mental health team requests assistance and specialist advice regarding management.

In addition

- the Regional Forensic Mental Health Teams provide an in-reach assessment and consultancy service to generic inpatient facilities
- regional forensic teams can also provide a service to prisons and places of detention
- Regional forensic teams can provide back up specialist assessments to court diversion schemes where a specialist assessment is required.

In their work in the community the ethos of the regional forensic mental health team is an assertive multidisciplinary approach towards the mental health and psychosocial needs of persons with forensic mental health needs in the community. The overall objectives of work in the community are:-

1. To complete an assessment of any individual referred in order to determine the mental health and risk issues.
2. To provide advice to other professionals and partners within the criminal justice system on mental health issues or on the management of individual patients.
3. To provide liaison with other mental health services to ensure that patients are being linked into the most appropriate services for their care.
4. To provide treatment and monitoring to patients with long term forensic mental health needs.

5. To take a co-ordinated approach to care planning and delivery.
6. To provide a comprehensive risk assessment risk management package.
7. To support patients, carers and their families to develop plans of care, support networks and ongoing case management.
8. To explore relapse prevention techniques and to promote mental health and non-offending behaviour.
9. To provide a range of treatment packages to promote insight into offending behaviours, significantly reducing risk and recidivism.
10. To promote insight into and maintain stability of mental, physical, social, intellectual and spiritual health.
11. To promote good working relationships with appropriate agencies in the criminal justice system, housing, social services, government agencies and the voluntary sector.

APPENDIX 6

Legislation

Background

The 2001 Mental Health Act (the 2001 Act) was partially commenced in 2002 with the remaining sections commenced on the 1st November 2006. Up to November 2006 the legal framework for involuntary admission in Ireland was provided by the Mental Treatment Act 1945. Mental disorder is defined in the 2001 Act and for an involuntary admission to occur under the 2001 Act the criteria for mental disorder, under section 3, must be met. A diagnosis of personality disorder on its own is not sufficient grounds for involuntary admission under the 2001 Act. There are similar restrictions in relation to social deviancy and addiction to drugs or intoxicants. Relevant mental health legislation in England and Wales has taken a different position in relation to personality disorders but this has drawn criticism for being overly restrictive, particularly from a human rights perspective. Personality disorder is one of the most common co-morbid forensic mental health disorders, Specific therapeutic interventions for people with co-morbid personality disorder must be part of comprehensive therapeutic programmes at all levels of mental health care including forensic mental health care.

The Criminal Law (Insanity) Bill 2002 was introduced to address the fact that some aspects of Irish legislation concerning mentally disordered people involved in criminal proceeding were outdated and based on legislation introduced in the 19th century. As a result the Criminal Law (Insanity) Act, 2006, (the 2006 Act) was commenced with effect from 1 June, 2006. The 2006 Act introduces the concept of diminished responsibility into Irish law. It is only applied in the case of murder, which carries a mandatory sentence of life imprisonment. The provisions in the 2006 Act allow courts to refer persons with mental illness for appropriate care or treatment in designated psychiatric centres or an in-patient or out-patient basis as appropriate, rather than to prison. In line with the provisions of the European Convention on Human Rights, which has been given further effect in Irish law since the end of 2003, an independent Mental Health (Criminal Law) Review Board was also established in 2006. The main function of the Board is the regular review of all cases of detention in designated centres of persons found not guilty by reason of insanity or unfit to be tried, including persons detained under military law. The Board is also responsible for reviewing the detention of patients who have been transferred to the Central Mental Hospital from within the prison populace and reviewing the detention of military prisoners suffering from mental disorders, who have been transferred to the hospital from prison and military personnel referred by tribunals under the relevant Defence Acts. The Board has the power to discharge persons under its charge unconditionally or subject to conditions as it sees fit having regard to all the circumstances involved, including medical evidence. The 2006 Act also provides for new administrative procedures governing the transfer of prisoners who are mentally ill between prisons and designated centres for appropriate care or treatment.

At the present time the absence of suitable secure mental health regional facilities prevents the detention of patients committed under the 2006 Act in any centre other than in the Central Mental Hospital. In practice this has resulted in long waiting times, for patients in prison or in centres approved under the 2001 Act, for places in the Central Mental Hospital. There is also a need to provide separate facilities for those aged under18 who could be committed under the provisions of the 2006 Act. The placement of those under 18 in centres for adults is at variance with best practice.

The Commission provided a comprehensive response to the 2002 Bill in the consultation phase (Mental Health Commission 2004). The alignment of the civil and criminal law provisions in regard to mental disorder, implicit in the Bill, was in general welcomed by the Commission. However, it was the view of the Commission that a number of significant amendments were required to the Bill to ensure that it was fully compliant with international principles on human rights and with the provisions of the Mental Health Act 2001.

The 2001 Act (Sections 62-64) defines an approved centre as a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. The Commission has the statutory responsibility for the establishment and maintenance of a list of approved centres that must meet the criteria for registration as specified by the Commission. An amendment to the Criminal Law (Insanity) Bill 2002 providing for consultation by the Minister with the Mental Health Commission in relation to the designation of psychiatric centres (other than the Central Mental Hospital) as designated centres has been welcomed by the Commission. A designated centre, under the 2006 Act should, in the Commission's view, be registered as an approved centre and therefore come within the remit of the Inspectorate for Mental Health Services. The Commission is conscious that the majority of approved centres at present are acute units within general acute hospitals and would be unsuitable for designation under the 2006 Act. These acute units tend to be relatively small, open units and the staffing would not generally include personnel with expertise in forensic mental health services. They are not designed to provide the conditions of security which would be required in a designated centre.

A Modern Legislative Framework

Most comparable jurisdictions have mental health policies and legislation which provide a modern integrated framework for civil confinements and/or the detention of mentally disordered people who become involved in criminal proceedings. Such frameworks place the responsibility for providing care and treatment to patients with a mental disorder, involved in criminal proceedings within a forensic mental health service. In general mental health services have moved from institutionally based services to community based services and forensic mental health services in other jurisdictions have moved in this direction. "A Vision for Change" (2006) a report of the government appointed Expert Group on Mental Health Policy, recommends the creation of four additional multidisciplinary, community-based forensic mental health teams, one per HSE region, and that priority be given to the care of individuals with severe and enduring mental illness in the least restrictive environment possible. The separation in Ireland of legal

powers for civil and criminal confinements in relation to mental disorder may cause confusion as to the responsibilities of the relevant state agencies. The danger is that this may result in ambiguities concerning strategic service developments and the implementation of modern methods of effective patient care. These are co-ordination issues that should be evaluated in a post implementation review of the operation of the 2001 Mental Health Act and the Criminal Law (Insanity) Act 2006. A further such issue that will also require careful monitoring is how any forthcoming legislation on mental capacity, as proposed by the Law Reform Commission of Ireland (2005), interacts with existing mental health legislation.

The Commission's proposals to amend Section 3 of the Criminal Law (Insanity) Bill 2002 are also of note in relation to diversion schemes. The 2006 Act allows only one option to the judiciary i.e. committal to a designated centre if a question arises about the charged person's fitness to be tried. The Commission proposed that this section be amended to allow the judiciary a wider range of options and to ensure that the most appropriate intervention is offered to the person, as does the legislation for example in Scotland and State of Victoria, Australia. A mechanism is needed for community treatment of mentally disordered offenders. "A Vision for Change" (2006) recommends that forensic mental health services should be expanded and reconfigured so as to provide court diversion services and that legislation should be devised to allow this to take place.

The Commission's proposal remains that the 2006 Act should be amended to facilitate remand of the person on bail (thereby integrating this Act with the Bail Act 1997) with their informed consent to attend for assessment on an outpatient basis. The inclusion of this option is in line with best practice regarding diversion schemes in mental health care and treatment. It would also ensure compliance with United Nations Principle 7.1 and the Third Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons (Henchy Report 1978).

Mentally disordered people who are subject to criminal proceedings have the same right to psychiatric assessment, treatment and care as any other person. Accessibility to legal representation, a feature of both the 2001 and the 2006 Acts, will assist patients in making their case for appropriate treatment. However, Ireland has not embraced the notion of other statutory forms of advocacy services for people with mental illness such as Scotland's where, under the 2003 Mental Health (Care and Treatment) Act, every person with a mental disorder has a right of access to independent advocacy.

APPENDIX 7

Effective Provision of Mental Health Services in the Prison Service

Mental health services to the prison population will best be provided by the Forensic Mental Health Service which covers the locality within which the prison is located.

- Mental health services to prisons should be provided by the Regional Forensic Mental Health Service as a secondary referral service accessed through the prison health care services
- Each prisoner on admission should have a thorough mental health assessment as part of the initial healthcare screening
- Mental illness, significant psychological or psychosocial difficulties or substance abuse identified by the Primary Care physician (or Primary Care Team where this is in place) at the initial assessment or during the period of custody may be managed by the Primary Care physician (or Team) or dealt with by referral of the person to the service most appropriate to his/her needs
- The referral might be to a service within the prison system i.e. the Probation and Welfare Service, the Prison Psychology Service or the Addiction Counselling Service or to the Regional Forensic Mental Health Service where a specialist mental health service is required
- Prison Psychology Services, Addiction Services and Probation and Welfare services should be resourced appropriately to deal with issues within their remit thus reducing inappropriate referral to the secondary mental health services. All of these services should have formal liaison with the mental health services and engage in joint work to meet the needs of particular individuals.

The provision of mental health services to the prisons by the Forensic Mental Health Services has a number of important advantages over the provision of services by local Community Mental Health Teams.

- Forensic Mental Health Services are specialist multidisciplinary services with particular expertise in the assessment, treatment and monitoring of mental health difficulties in people with a forensic history and persons in custody. They have particular expertise in the assessment of risk
- Inpatient treatment of prisoners always involves the added consideration of security requirements and hence local acute psychiatric units are often unsuitable because of their open nature. Forensic Mental Health Services will have access to low secure inpatient beds within their catchment area where a period of inpatient treatment is required
- The current situation where prisoners are transferred to the Central Mental Hospital for inpatient treatment often results in the person being treated in a facility with a higher level of security than he/she requires and does not preserve the person's right to be treated in his/her local area as far as possible. A regionalised forensic mental health service could provide inpatient treatment within the region at an

appropriate level of security for the majority of prisoners requiring a period of inpatient care

- Forensic Mental Health Services will on occasions need to request transfer for inpatient treatment to a higher secure setting where this is required
- Forensic Mental Health Services will have close links with the generic mental health services in the region so the individuals can be gradually transferred to the care of their local mental health service and their local Community Mental Health Team if this is the more appropriate service after their release and re-integration into the community
- Prison populations are often not from the immediate local area and hence provision of mental health services by the local sector Community Mental Health Team throughout the period in custody would not necessarily ensure continuity of care after release
- Some prisoners because of their risk category will continue to need specialist follow up from the Forensic Mental Health Services after release.

APPENDIX 8

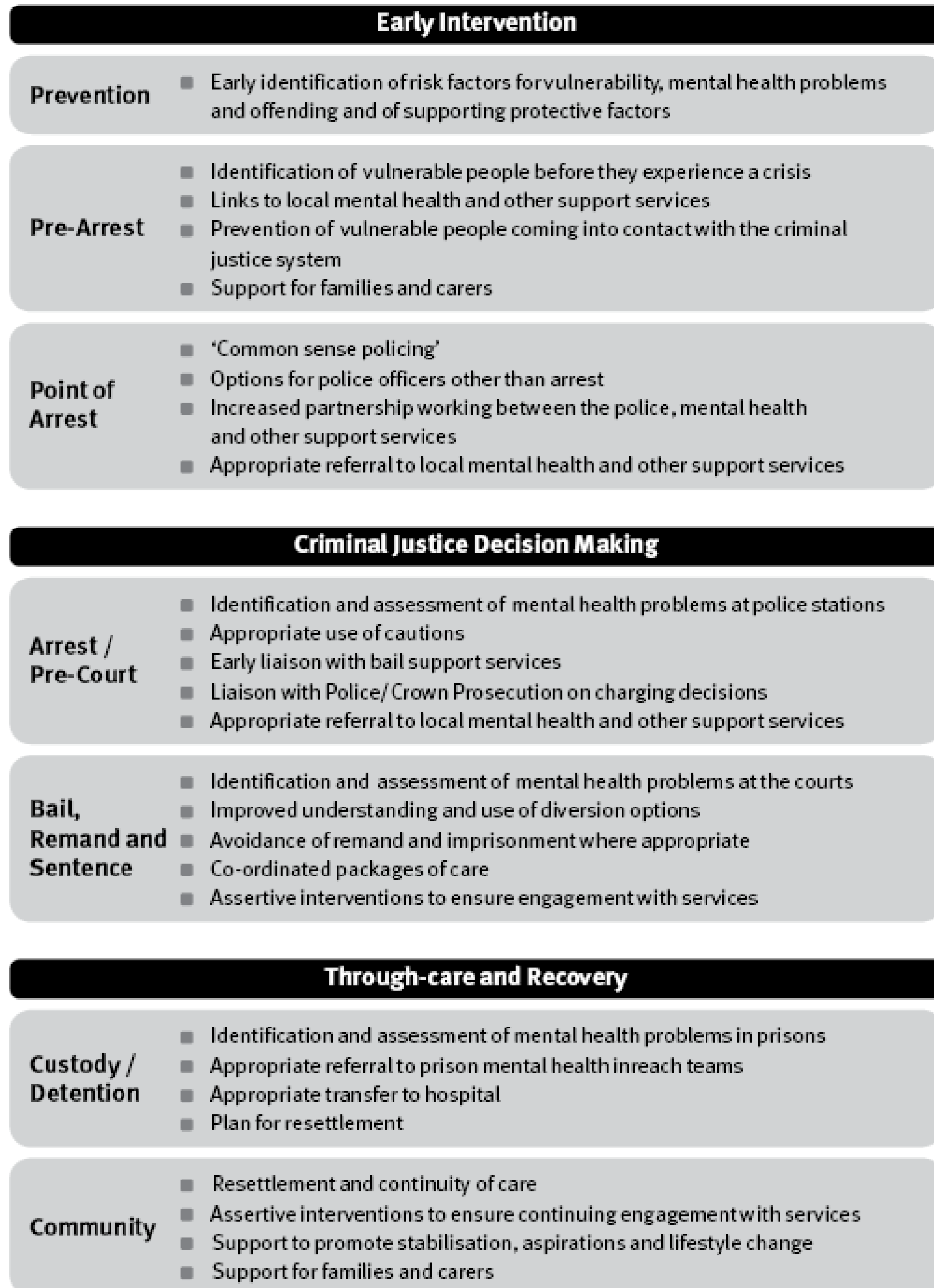

INTRODUCTION

Figure 1: All-stages diversion model (adapted from Sainsbury Centre, 2008a)

Early Intervention

Prevention	■ Early identification of risk factors for vulnerability, mental health problems and offending and of supporting protective factors
Pre-Arrest	■ Identification of vulnerable people before they experience a crisis ■ Links to local mental health and other support services ■ Prevention of vulnerable people coming into contact with the criminal justice system ■ Support for families and carers
Point of Arrest	■ 'Common sense policing' ■ Options for police officers other than arrest ■ Increased partnership working between the police, mental health and other support services ■ Appropriate referral to local mental health and other support services

Criminal Justice Decision Making

Arrest / Pre-Court	■ Identification and assessment of mental health problems at police stations ■ Appropriate use of cautions ■ Early liaison with bail support services ■ Liaison with Police/ Crown Prosecution on charging decisions ■ Appropriate referral to local mental health and other support services
Bail, Remand and Sentence	■ Identification and assessment of mental health problems at the courts ■ Improved understanding and use of diversion options ■ Avoidance of remand and imprisonment where appropriate ■ Co-ordinated packages of care ■ Assertive interventions to ensure engagement with services

Through-care and Recovery

Custody / Detention	■ Identification and assessment of mental health problems in prisons ■ Appropriate referral to prison mental health inreach teams ■ Appropriate transfer to hospital ■ Plan for resettlement
Community	■ Resettlement and continuity of care ■ Assertive interventions to ensure continuing engagement with services ■ Support to promote stabilisation, aspirations and lifestyle change ■ Support for families and carers

Source: Diversion: A Better Way for Criminal Justice & Mental Health – Sainsbury Centre for Mental Health 2009.

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