FORENSIC
QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

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ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Community Forensic Mental Health Services

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Contents

Method

These standards have been developed by Dr Jeremy Kenney-Herbert, Dr Mark Taylor, Dr Ramneesh Puri and Dr Jaspreet Phull in consultation with Sarah Tucker (Programme Manager, Quality Network for Forensic Mental Health Services). They are based on findings from a guidance paper which was compiled by a working group consisting of forensic psychiatrists working in community forensic mental health services (Appendix 1). The group was formed subsequent to collaboration between the Forensic Faculty Executive (via a member requesting that such a group be formed) and the College Centre for Quality and Improvement (CCQI) of the Royal College of Psychiatrists. Two questionnaires (appendices 2 and 3) were circulated to Forensic Faculty and Quality Network for Forensic Mental Health Services (QNFMHS) members respectively.

A thematic analysis was then undertaken by the CCQI. A literature review was performed in 2010 and updated in 2012 (Appendix 5). Expert discussion and analysis then occurred including as part of workshops at the Faculty of Forensic Psychiatry Annual Conference February 2011 and QNFMHS Annual Forum in May 2011, resulting in the production of draft recommendations. The recommendations were presented for discussion at Forensic Faculty Conference workshop in February 2012 and QNFMHS Annual Forum in May 2012.

An expert working group consulted on a first draft of these standards on 13 November 2013. On the basis of feedback from this event a second draft was prepared and a further consultation event occurred on 19 March 2013 (Appendix 6). Subsequently this initial version of Quality Standards for CFMHS was developed.

The Standards

Number	Standard
A	**Model of Care**
A1	**Core Functions**
A1.1	The Community Forensic Mental Health Service (CFMHS) provides or facilitates case management of a defined caseload of service users in the community who present a significant risk of serious harm to others related to their mental disorder, particularly those leaving secure care, for whom the risk is best managed by specialist forensic mental health services.
A1.2	Service users under the care of the CFMHS include those discharged from secure care from restricted hospital orders (or equivalent) or community treatment orders, and those who have transferred from other community mental health services.
A1.3	Treatment is provided within a recognised framework for delivering multi-disciplinary and multi-agency care.
A1.4	The CFMHS provides liaison, advice, specialist interventions, educational and skills development to mental health services and other agencies; service users, carers and families.
A1.5	The CFMHS is actively involved in care pathway management, into and out of secure settings and prisons, for appropriate individuals. This maybe direct involvement for service users on the team case load or through facilitating and advising those under the care of other teams.
A1.6	Care and case management may need to be long term (i.e. years or even potentially lifelong in some cases) and the CFMHS has the resource to provide this.
A1.7	The CFMHS provides clinical liaison and a resource for Multi Agency Public Protection Arrangements (MAPPA) and associated processes in the area
A1.8	The CFMHS is closely linked to local criminal justice liaison /court diversion services, with written protocols, or the CFMHS may provide court diversion or criminal justice liaison services.
A2	**Forensic Case Management**
A2.1	The CFMHS provides aftercare of appropriate service users discharged from secure care who will often be subject to Conditional Discharges or Community Treatment Orders under Mental Health legislation.
A2.2	Clinicians in the CFMHS have expertise in assessment, treatment and management of individuals with complex mental health and social needs, who have and/or continue to present a significant risk of serious harm to others.
A2.3	Clinicians in the CFMHS have expertise in providing or facilitating care co-ordination within a recognised framework for delivering multi-disciplinary and multi-agency care.
A2.4	The CFMHS provides comprehensive management plans, incorporating clear crisis contingency plans and utilising expertise in risk reducing strategies.

Number	Standard
A2.5	The CFMHS applies risk assessments using structured professional judgment principles (e.g. HCR20, HCR V3).
A2.6	There are agreed mechanisms with local mental health services and crisis services with access to acute psychiatric admission beds.
A2.7	There are agreed mechanisms with local forensic inpatient services (low or medium secure) to enable recall to hospital and admission to a secure setting due to increased risk when appropriate.
A2.8	Managed relationships with other community mental health services to support the care pathway are documented in written agreements based on clinical and risk-related markers, entry and exit criteria allowing service users to move from one service to another in line with their changing needs.
A2.9	The CFMHS works within the principles of the recovery model, using individualized and collaboratively developed with service users care plans which are service user outcome centred, within the context of risk management principles.
A2.10	The CFMHS team has expertise and capacity to provide both health and social needs assessment taking into consideration issues such as leisure, vocational, educational, spiritual and housing needs.
A2.11	The CFMHS team has the capacity and/or relationships with appropriate agencies to provide for leisure, vocational, educational, spiritual and housing needs.
A2.12	There are clear arrangements for 24 hour; 7 days a week, response to crisis or other needs of service users by appropriate clinicians, which are accessible by service users, carers, housing providers and other services.
A2.13	The CFMHS works with carers taking into account their needs.
A2.14	The CFMHS can demonstrate they fulfil their statutory duties in terms of victim liaison.
A2.15	Service users are made aware of the purpose of home visits and other consultations.
A2.16	Sufficient time is available for consultations with service users whether at a CFMHS base or at their residence.
A2.17	Service users are clear as to how to access urgent support at any time including after hours and this is explicit in the care plan.
A2.18	Service users are made aware of the circumstances under which information may be shared with other agencies, the principles that inform this sharing and are given the opportunity, wherever practicable, to discuss the process in advance of the sharing and consent.

Number	Standard
A3	**Referrals, consultative advice and specialist interventions**
A3.1	There are locally agreed procedures for referrals to the service which include a clear joint written agreement containing referral content and specification with non-CFMHS, describing the mechanisms for the provision of consultative advice regarding risk to others and of collaborative working, including governance arrangements. This may involve a tiered approach of advice; joint working in relation to specific treatment needs and case management.
A3.2	Specialist interventions in the CFMHS include a range of interventions related to the management of criminogenic needs in this population emphasising harm reduction such as structured personality disorder assessment and the use of evidenced based structured professional judgment risk assessment tools (such as HCR-20, RSVP, SAM, SARA)
A3.3	The CFMHS team have sufficient resource to meet statutory provision for use of the Mental Health Act such as Approved Mental Health Practitioner or approved social worker provision and doctors with statutory recognition for the use of the Mental Health Act.
A4	**Care pathway management from secure settings**
A4.1	The CFMHS has a function dedicated to the inpatient/specialised management of the care pathway including close working with secure inpatient services to facilitate and provide an oversight of appropriate care pathways for service users to leave secure care.
A4.2	The CFMHS will have provided all relevant secure care services and commissioners with a protocol detailing how to engage CFMHS in community transitions and re-integration.
A4.3	At a service user's initial secure inpatient CPA meeting, the CFMHS will agree with the inpatient service, objectives and outcomes for their secure care pathway.
A4.4	The CFMHS works with the inpatient service to arrange aftercare and engages more intensively in the pre discharge period and respond to requests for information from Tribunals.
A4.5	The CFMHS tracks the progress of their case managed service users when they are transferred to prison or other non-secure care hospitals.
B	**A Safe Working environment**
B1	**Physical Security**
B1.1	There is *a* CFMHS team base for staff members to work in, share practice and develop and maintain a healthy team ethos. The base may stand alone or part of a shared building.
B1.2	Consultations take place in rooms that are suitable and safe for staff members to work in and the environment is that which is appropriate to the Service User's level of risk.
B1.3	Where there is a specific team base/facility which services users and carers attend, there is a reception area where visitors can report on arrival.
B1.4	Where there is a specific team base/facility which services users and carers attend, entrances and exits provide a clear line of sight for staff to be aware of influx and egress from the building.
B1.5	Where there is a specific team base/facility which services users and carers attend, there are clinician only secured areas.

Number	Standard
B1.6	Where there is a specific team base/facility which services users and carers attend, staffs have personal alarms which are tested on a regular basis with a record of testing.
B1.7	Where there is a specific team base/facility which services users and carers attend, there is a mechanism to allow service users to activate an alarm if necessary, for example in the waiting area.
B1.9	Medications management policies and procedures are current and cover all relevant aspects including storage on premises, carriage by community staff (e.g. in cars used to visit service users at their residence) and hazardous products such as blood.
B2	**Procedural Security**
B2.1	There is an Operational Service Policy annually reviewed and updated, in line with over-arching Trust policies and procedures.
B2.2	All procedural policies are reviewed annually or more regularly where necessary (e.g. following *serious incidents*).
B2.3	There is a protocol for the sharing of clinical and risk information, including healthcare and interagency working e.g. MAPPA.
B2.4	Where there is a specific team base/facility which services users and carers attend, there is a policy on prohibited items and a clear statement of these in reception and provided to all visitors
B2.5	There are appropriate testing protocols for monitoring the use of illicit drugs and alcohol in the community.
B2.6	There is a policy on management of violence and aggression (NICE guideline 25).
B2.7	Information Governance policy covers all aspects of storage and communication of sensitive and confidential material both in regards to the service base and when staff are working in the community.
B2.8	There is a lone worker policy that involves regular risk assessment of the appropriateness of single staff visits, communication of staff whereabouts and liaison with police.
B2.9	There are policies for inter-agency working across criminal justice, social care and the third sector.
B3	**Relational Security**
B3.1	There is a multidisciplinary assessment before accepting a service user onto a community forensic caseload.
B3.2	There are clear referral criteria which are based on risk history, complexity of mental disorder and taking account of status in regards to the Mental Health Act.
B3.3	There is a procedure for multidisciplinary meetings for dissemination of up to date risk information and clinical case discussion / formulation which take place at least weekly.
B3.4	CFMHS practitioners have a shared understanding of risk assessment principles within forensic mental health.

Number	Standard
B3.5	There is a training plan to ensure all staff maintain competencies relevant to their role and develop appropriate skills in line with continuing professional development, for example in the provision of written tribunal reports and including social supervisor training.
B3.6	There are sufficient resources to ensure safe and high quality care is provided for the case load of the service.
B3.7	Changes to resource are risk assessed and subject to governance processes.
B3.8	All staff have had enhanced Disclosure (CRB) checks.
B3.9	There is access to appropriate staff support and de-briefing following serious incidents.
B3.10	The multi-disciplinary team consists of or have ready access to staff from a number of different professional backgrounds (e.g. forensic psychiatrists, community psychiatric nurses, forensic and clinical psychologists, social workers, occupational therapists, clinical pharmacy) in order to enable a holistic understanding of the service user group.
B3.11	There are demonstrable and good links with probation, Ministry of Justice, MAPPA, primary healthcare, housing and other secondary health providers.
B3.12	There is a risk management strategy incorporating assessment and management of risk which is annually reviewed and underpinned by structured clinical judgement tools e.g. HCR 20, RSVP.
B3.13	There are regular multi-disciplinary team meetings for clinical formulation, risk analysis and decision making.
B3.14	All staff participate in regular supervision in keeping with local and national guidance, which is audited. Continuing professional development is consistent with professional standards guidance.
B3.15	There are regular business meetings to ensure that the clinical team is consulted on key areas of operational policies / procedures.
B3.16	There are audited standards for continuing professional development, supervision and training, including equality and diversity.
C1	**Governance**
C1.1	The CFMHS clinical governance structure and clinical audit program link to the host organisation clinical governance structure (e.g. Trust) within which the service sits.
C1.2	There is a clear clinical governance structure with regular meetings held specifically for the CFMHS and a planned clinical audit programme.

Number	Standard
C1.3	Key Policies, that specifically address CFMHS working, are up to date and reviewed regularly. These include: • Management of Serious Untoward Incidents • Lone Worker • Medicines Management • Information Governance • Safe Guarding Vulnerable Adults • Safe Guarding Children • Clinical Supervision • Major Incident Planning and Business Continuity • Risk Assessment • Service User involvement • Interagency working • Management of violence and aggression •
C1.5	Service users have opportunities for real involvement in clinical governance and in service development and improvement.
C1.6	Service Users have access to Advocacy services.
C1.7	Service Users are routinely in recruitment of staff at all levels of the organisation.
C1.8	Service Users understand their care plan, relapse prevention plans and risk management plans.
C1.9	Service Users can identify their Care Co-ordinator, Social Supervisor where relevant and Responsible Clinician/Consultant Psychiatrist.

Appendix 1
Developing Quality Standards for Community Forensic Mental Health Services

Introduction
Community forensic mental health services (CFMHS) have developed in an ad-hoc manner throughout the United Kingdom (UK) for over 25 years. They may have different service specifications and operational referral criteria, shaped by clinicians and commissioners based on local needs. There are also prominent similarities of core purpose in many services; that is the safe and timely transitions of mentally disordered offenders from secure care to the community. Drivers for their development have included innovative service re-design, adverse incidents and improved care pathways. There is currently no national guidance or standards that consider the components of such services, their model of care and governance structures. In contrast there have been Quality Network for Forensic Mental Health Services (QNFMHS) standards for medium secure inpatient services since 2006[1] and national guidance and QNFMHS standards[2] for low secure services have recently been published. The significant changes in commissioning arrangements for secure care, including CFMHS, reinforce the need for greater understanding of the role and scope of such services and for the development of a consensus.

Background
This guidance paper was compiled by a working group consisting of forensic psychiatrists working within community forensic mental health services: the group was formed subsequent to collaboration between the Forensic Faculty Executive (via a member requesting that such a group be formed) and the QNFMHS at the College Centre for Quality and Improvement (CCQI) of the Royal College of Psychiatrists.

There were three components of the work completed:

1. Two surveys were completed and presented within a variety of forums
2. A comprehensive literature review was completed[3]
3. Expert discussion and secondary analysis

The above will form the first part of this paper followed by the recommendations section, which provides an overarching vision of community forensic mental health service provision.

Part I: Working group findings
1. Surveys

i. Faculty of Forensic Psychiatry Survey
In total there were 41 responses with good representation across England and Wales, of these, 29 reported that a CFMHS were present. "Patchy" provision was noted including across boroughs in same areas/region

Models of care:
A range of models were described; largely parallel or mixed although examination of responses suggested hybrid also present.

Criminal Justice liaison:
Many respondents reported CFMHS linked in some way to criminal justice liaison work in their area, often a role of Forensic Community Psychiatric Nurses (FCPN's); some viewed this as core business

Interspeciality working:
There were widespread reported difficulties in engaging general adult services for mentally disordered offenders leaving secure care. One respondent reported that a lack of a specified CFMHS in their area was a point of contention between secondary mental health services and Forensic inpatient services. Secondary services were said to disagree with some patients receiving hospital orders rather than prison sentences and there was a lack of CFMHS for learning disabilities observed in many areas.
Care pathway management:

Over half have of community forensic mental health services had some role in out of area placement monitoring. There was varying intensity with some being a major participant in care pathway planning with commissioners.

ii. QNFMHS Survey

There were 27 responses in total; with good representation across England and Wales. Of this number, 65% were from the NHS, and 35% from the Independent sector. There was marked variation across regions and within-some areas the CFMHS was well developed; in some absent. The responses indicated that the CFMHS were valued.

Care pathway management:
Involvement at early stage in pathway is important; helping with the pathway (especially) for out of area patients. Respondents indicated that there was a lack of or poor range of step down facilities; noting that funding problems/issues for aftercare created delays in community transition. When non-forensic teams/care coordinators were involved, it was often late in pathway particularly if out of area. This was a particular issue for independent sector providers who may have service users from a variety of regions, some at considerable distance away. Close integration and working between secure impatient care and CFMHS was noted to be helpful and important.

Team composition:
Forensic Psychiatrists, Social Workers and FCPN's were the major staff groups as were Psychologists. Multi-disciplinary teams were seen as vital but a full team was not always available in all areas.

Interspeciality working:
There was a reluctance of local non-forensic teams to engage; stigma, fear, different approach and emphasis on risk were seen as core issues.

Models of care:
It was reported here needs to be an equal emphasis on recovery and risk management. Respondents felt that CFMHS can manage this potential tension. Issues of capacity and throughput can cause stagnation in services.

Criminal justice liaison:
A liaison role with other services was seen as important; good working relationships and partnership with agencies such Police, housing providers and local MAPPA structures were also seen as very useful.

ii. Key themes From Annual Forums and Forensic Psychiatry Annual Meetings:

Model:
A new definition of the hybrid model was supported; the Best Guidance Practice (DoH 2007) definition does not describe actual practice and process so requires re-defining. Clinicians appear to mean slightly different things when using terms such as "parallel" and "integrated" when describing the services they provide.

There was a need to lay equal emphasis on recovery and risk management and that the CFMHS were well placed to manage this potential tension. A lack of addressing of capacity: sometimes referred to as 'caseload capping' and throughput were noted to create 'stagnation' in services.

Care pathway management:
CFMHS expertise should lie in facilitating transition and sustainable settlement in the community of service users from secure care; particularly those with high risk profile, typically conditionally discharged, with multiple agencies (e.g. NOMS, MoJ, MAPPA etc) involved, often with a high degree of co-morbidity and needing robust and sophisticated risk assessment and management processes including potential rapid access to an appropriate level of secure care.

Standards or core principles of CFMHS were welcomed. Close integration/working between secure impatient care and CFMHS was seen as helpful and important. When non-forensic teams/care coordinators become involved it was often late in pathway particularly if out of area. It was a particular issue for independent sector providers who may have service users from a variety of regions, some at considerable distance away.

Where possible, continuity of care from inpatient care to community is seen to be of particular value, for example having the same responsible clinician and social supervisor who provided inpatient care.

A CFMHS for personality disorder would support facilitating discharge for this particularly complex group, who may find particular difficulty moving into the community without such a team.

Interspeciality working:
Good links to general adult services seen as critical to allow care pathway progression for patients. There was a reported reluctance of local non-forensic teams to engage; with stigma, fear, different approach and emphasis around risk seen as core issues. Learning Disability CFMHS was neglected in some areas, developed in others.

Liaison with non-forensic services is important and can be an integral part of CFMHS. However in some areas there are specific Forensic Liaison Schemes operate that do not provide community follow up for discharged mentally

disordered offenders but do provide advice and support.

CFMHS patients:
It was stated that some patients needed long term CFMHS follow up due to gravity of offences, high profile, ongoing risk profile, need for rapid access to secure care in relapse. These patients were typically restricted/conditionally discharged but not necessarily.

Patients subject to conditional discharge were seen as core business at least for some period, often an extended, of time after discharge. Crown Courts have recognised these individuals as presenting as significant potential ongoing risk of serious harm to others in various forms.

Length of stay:
It was observed that there was a clear reduction in Length of Stay when a CFMHS was introduced in 2 areas of London. A reduction in the number of secure beds/length of stay with a re-investment in CFMHS and step down increasing the efficiency of pathway was suggested.

Liaison:
A liaison role with other services is important; good working relationships and partnership with agencies such Police, housing providers and local MAPPA structures are seen as very useful. Interface with general adult services and "buy in" from all parties are important to develop effectiveness and efficiency.

Liaison with non-forensic services is critical and can be an integral part of CFMHS. However in some areas there are specific Forensic Liaison Schemes operate that do not provide community follow up for discharged mentally disordered offenders but do provide advice and support.

Service innovation and evaluation:

It was suggested that services needed to be able to demonstrate differences CFMHS make and that whilst needing clarity of purpose and of whom the service is for, we should not lose space for innovation.

2. Literature review (full text in Appendix 5)

- The number of FCMHTs has progressively grown (37 identified by Judge et al in 2004). Majority of those (80%) were parallel teams.
- FCMHS tend to have relatively higher proportions of patients subject to a restricted hospital order (one third in the aforementioned survey)

- Professionals have debated whether resources should remain focused on "specialist teams" or spent on more generic teams. (Szmukler, Vaughan, Fahy, Mohan & Turner etc). Despite this debate services have continue to develop.

- Authors like Coid and Sahota have previously compared outcomes between forensic follow-up and general adult follow up. The results have been equivocal but these oft quoted studies have been criticised for

methodological limitations (including choice of outcome measures like reconviction and rehospitalisation). Sahota argued that to determine whether one service is more effective than another, a randomised controlled trial would be required, which in ethical terms would be unrealistic.

- Humber et al (2011) compared clinical characteristics, risk and need profiles of forensic and general adult patients treated within parallel and integrated models of care in London and the Northwest of UK. They found that forensic patients in integrated teams had comparably higher historical and total risk scores on HCR-20 and more unmet needs. These were most frequently reported as needs in relation to social life, daytime activities, intimate relationships and physical health. Clinically they noted that the majority of forensic patients had a diagnosis of Schizophrenia which was different to Personality disorder(s) that Coid et al had reported in their study as the majority diagnosis.

- Evidence from overseas (Australia and USA) is relatively more favourable for the community Forensic teams, and in UK Dalton observed low rates of reconviction and rearrest on evaluating the first three years of the Barnet and Enfield CFMHT in 2005.

- Anecdotal evidence is similarly supportive of the efficacy of such teams (as noted in the National Confidential Enquiry into Homicides and Suicides document of 2010). NCISH in its report "Independent investigations after homicides by people receiving mental health care report" (2010) concluded that despite the Coid 2007 study … "*However, it is clear from the reports we have examined that in the care of certain individuals, general adult services alone cannot provide the necessary forensic mental health experience."* It recommended that Mental health trusts should ensure the provision of comprehensive community forensic mental health services for the management of service users who present a risk of violence in the community

- Patients value accessibility in small FCMHTs but are less satisfied with issues such as housing, lack of "back up services" including daytime activities and sheltered work. They criticise the treatment programmes for not being individual enough. Some feel that weekly appointments are just a way of "checking on them" and find them to be too intrusive.

- Most recently Clarke et al 2013 examined readmission of 550 patients discharged from medium secure care over 20 years. They found the mixed gender cohort were at risk of reconviction, premature death (particularly from suicide), and readmission to secure mental health services. The risk f the above was highest in the first year of discharge but remained over many years. They concluded: *"Those treated in medium security remain at risk of recurrence of their mental disorder and risk events for many years and require careful long-term follow up, retaining a detailed knowledge of their conditions and risks - a difficult task in modern services with multiple teams and transitions in care."*

- To our knowledge there are no direct cost comparison studies that have been done in the United Kingdom that relate to the provision of aftercare for forensic patients in the wider community, something which might be suggested is curious in the face of how potentially expensive such services can be. There is some evidence of cost reduction in USA (Project Link).

3. Feedback from a key stakeholder
Ministry of Justice (MoJ) Mental Health Case Work Section response:

The MoJ was asked to compare the MoJ its experience of CFMHS versus non-forensic supervisors. The following observations were made about medical and social supervisors involved in CFMHS versus other non-forensic areas, there was:

- An enhanced knowledge of secure care provision and access to it
- Timelier reporting of changes in risk behaviour and status and timely responding to these changes
- Enhanced understanding of the "restricted patient system"

"Overall, we have a strong preference for conditionally discharged patients to be managed by forensic teams, and greater confidence in the quality of risk assessments by such teams, compared with general community teams".

Part II: Recommendations

The first key recommendation of our paper is as follows:

Community Forensic Mental Health Services should be operating in each area/region with the main functions of ensuring the safe and sustainable transition of service users to the community from secure care. The exact configuration will reflect demand and local factors but there should be common principles underlying the purpose and delivery of services. These common principles should lead to quality standards.

This section intends to provide a more detailed analysis of this statement.

1. Functions of Community Forensic Mental Health Services (CFMHS)
Consultation with the psychiatric literature[45]below) and governmental guidance[6] reveals the following:

1. Consultation and liaison with local mental health teams and other agencies to provide specialist advice
2. Management of a defined caseload of high-risk individuals in the community and patients on restriction orders with complex needs
3. Providing a resource to multi agency public protection arrangements (MAPPA) in the area.
4. Education and training to other services
5. Some court liaison and diversion arrangements
6. Oversight of patients' in secure hospitals

There are different structural models for the delivery of community forensic mental health services:

- Integrated model– expertise distributed within other mental health teams
- Parallel model – separate specialised teams
- The DH best practice guidance for medium secure units also refers to a 'hybrid' model

Most services within the UK fit within the definition of a 'parallel' or 'hybrid' model. The critical components of this include:

- Defined and managed case load ("Caseload capping")
- Specialist assessments and interventions
- Multidisciplinary working
- Close links with external agencies

A service delivery model of working within community forensic mental health services has been delineated, and subsequently replicated by others:
Level 1 - a single assessment/consultation with the CFMHS;
Level 2 - a period of assessment by the CFMHS with the referring team retaining responsibility;
Level 3 - agreed period of shared responsibility - (a) to assess risk, (b) to evaluate interplay/operation of known risk factors, and (c) to assess efficacy of risk reducing strategies;
Level 4 - CFMHS taking full responsibility for duration of need;
The essential principle of this tiered model is that it allows flexibility in terms of patients being managed in the least restrictive setting, whilst empowering general psychiatric services to become collaboratively involved in the clinical management of this patient group (as clinically appropriate).

The core functions of community forensic mental health services can be described further:

Forensic case management:
Patients adjudged to represent the **'critical few' in terms of risks to others** require to be managed in an appropriate setting on discharge from hospital, with **robust aftercare** from a service with relevant competencies to fulfil this role. This forensically-informed approach balances the clinicians' duties to the patient and the wider public, whilst embracing the principles of recovery, therapeutic intervention and multi-disciplinary working. Clearly for some patients this **role may be transitional** with a view to transferring their care to a general psychiatric service when clinically appropriate. Likewise, there will be some, particularly patients subject to conditional discharge under section 37/41, where they **may require longer-term management** by a community forensic mental health service. This is illustrated further in case studies 1-3 as well as in figure 1 (see later in this paper).

There are likely to be defined caseloads required given the principles of **relational knowledge** of patients and their associated risk behaviours, collaborative working with other agencies and the capacity to respond to crises. Patients would be managed under Care Programme Approach (CPA) Pathway, using structured professional judgement **risk assessment** tools (such as HCR-20 / RSVP).
In order to function safely, there must be good local links with general psychiatric services in terms of **crisis resolution** and support (unless these are

parallel forensic services) and regarding the use of acute psychiatric admission beds. **Established links to forensic inpatient services**, whether low or medium secure, are vital in terms of recall to hospital or where risks require admission to a secure setting.

Assessment, liaison and defined intervention functions:
Referral sources differ depending on local circumstances and the configuration of services. These may include primary care, other secondary psychiatric services, offender health services and other criminal justice agencies (such as the National Probation Service). The purpose of referrals would be for the clinical assessment of mental disorder, its association with risk behaviours and the making of recommendations regarding appropriate treatment interventions.

A tiered model is described which could lead to innovative working relationships and **efficient use of clinical resources**. Providing an educative role to others in the use of forensic principles to inform clinical practice may also be appropriate. These approaches require clarity in terms of clinical responsibility, a shared understanding with referrers of the model and designated time-investment from clinicians.

There are anecdotal descriptions throughout the UK of liaison schemes or clinics which have been developed to provide advice to referrers. It may be that this could better target expensive full clinical assessments (which may take many hours of case file analysis by Forensic practitioners in addition to assessment of the individual); **share the principles of forensic practice** and address commonly described 'interface' issues between general and forensic services.

Defined interventions are where CPA responsibility continues to remain with the referrer whilst specific specialist interventions are provided by the community forensic mental health service, usually over a time-limited period and with identified outcomes. This allows for aspects of integrated working to be adopted, rather than an exclusively parallel interface with forensic services. The relationships fostered may also facilitate timely and appropriate transition of case managed patients in forensic mental health services back to general psychiatric services.

Specialist interventions may include structured personality disorder assessment; use of structured professional judgement risk assessment tools (such as HCR-20, RSVP, SAM, SARA) and psychological therapy interventions (CAT, DBT). The implications of the national Offender Personality Disorder Strategy[7] for community forensic mental health services, in terms of clinical need and models of care, requires further understanding.

It is important for community forensic mental health services that provide specialist advice to educate referrers on aspects of risk management. Training programmes and written protocols could be developed for primary and secondary healthcare together with other key agencies.

Staff training includes:

- Developing skills in utilizing risk assessments, with associated interventions, as listed above.

- Developing a team ethos, team working and peer support.
- Principles of the service including gender, culture and religious awareness training

Through care / pathway management from secure care:
Community forensic mental health services have enhanced knowledge of the provision of safe and sustainable6 clinical management in community settings. They are likely to adhere to similar principles of forensic practice as clinicians in secure care. In comparison, non-forensic community psychiatric teams are unlikely to have the same understanding of and experience in managing mental disorder and its association with risk behaviour. This can lead to blockages, miscommunication, failed discharges and delays in intervening when risk or clinical markers require urgent intervention.

Community forensic mental health services, in collaboration with secure care providers and specialised commissioners[8], can ensure **appropriate oversight of care pathways**. This is in-keeping with pathway-based commissioning. The extent to which this currently occurs though may be limited where specialised commissioning is applied specifically to the provision of secure care placements. The extent to which this role can be delivered by CFMHS throughout the admission period is likely also to depend on resources.

The model of service delivery may include community forensic clinicians contribute to the agreed initial objectives of the secure care placement (at the first CPA meeting) and then re-engage when appropriate care pathway markers have been achieved. There is little consistency throughout the UK in terms of this role[9], and in some areas commissioners may perform this. Their primary purpose is that of ensuring that placements deliver against defined clinical objectives in a manner that represents quality and value for money. This sort of contribution to the setting of **and appraising of clinical objectives** could instead be fulfilled by CFMHS clinicians, with explicit funding and resources available to perform this role.

In a fully operational model it could be envisaged that the needs of a defined geographical area could be mapped against future accommodation options and anticipated discharge timescales. Relational knowledge of patients is accumulated pre-discharge such that a **smooth transition can occur to an appropriate step-down placement in a community setting.** Clinicians will also then later take on care co-ordination responsibilities having developed an understanding of the patient's mental disorder, risk assessment and future treatment interventions.

3. Patient characteristics and care pathways
Work has been undertaken to identify the characteristics of patients requiring secure care (Dundrum group)[10], and this is likely to continue as data is collected within current secure Payment by Results (PbR) clustering models (CQUIN for 2012/3). These concepts can also be applied to community forensic populations[11]. 'The critical few' are likely to be identified based on:

- Risk history: gravity / notoriety of index offence, risk of relapse or disengagement and associated consequences, supervision concerns
- Complexity: co-morbidity, multiple agency involvement
- Typically restricted patients – first discharge particularly (given

transitional issues when moving into community settings)

Managed relationships with non-forensic psychiatric services will be important in ensuring an **influx and efflux of patients, based on clinical markers.** Despite the transitional nature of community forensic mental health services, there will nonetheless remain a significant sub-group of patients who will require long-term case management by such a service.

Performance indicators and outcome measures for community forensic mental health services are not readily identifiable. They could include re-hospitalisation rates, throughput of patients and quality of life measures. Readmission may of course be an essential and positive outcome in terms of reducing potential risk to others

Case study 1: Transitional community forensic patient

- 24 year old convicted of assault / battery whilst acutely psychotic
- First episode of psychotic illness
- No previous violence offences or co-morbid personality disorder / substance misuse
- Good treatment response to psychotropic medication and other psychological interventions

Pathway:
Ensure safe transition to a community setting
Dependent on risk assessment to be referred at a clinically appropriate time to a general psychiatric community service for ongoing rehabilitation

Case study 2: Longer-term community forensic patient

- 35 year old convicted for attempted murder with a kitchen knife whilst acutely psychotic having used amphetamines – received hospital order with restrictions (under section 41)

- Multiple previous convictions for violence
- Co-morbid emotionally unstable and paranoid personality disorder types
- Regular illicit drug screening and involvement of substance misuse services
- Multiple recalls to hospital and informal admissions

Pathway:
Requires high degree of relational knowledge; supervision and collaborative working to ensure safe and sustainable discharge. The clinical team is sometimes required to intervene and liaise regularly with MoJ. After a period of stability (perhaps 1-3 years) in the community and with appropriate liaison, transfer to an appropriate local mental health team will occur. Post transfer close liaison is likely to be required.

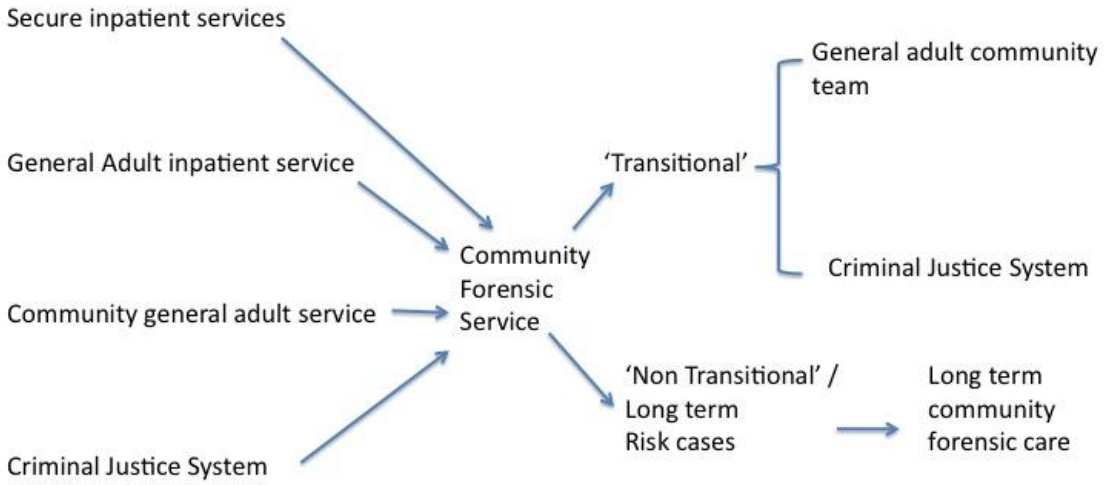
Case Study 3: High profile homicide case-diminished responsibility

- Long term community forensic patient
- 40 year old male who committed a high profile homicide.
- The case attracted local and national attention. There is occasional ongoing media reference to his index offence.

- Found not guilty of murder on the grounds of diminished responsibility
- Progressed through secure care over four years to be ready for discharge into the community.
- Mental disorder is now well controlled but the risk of relapse is associated with high risk of parallel offending behaviour.
- There are MAPPA restrictions and local interest from police and media.
- Has come to trust the forensic mental health team and his previous offence occurred whilst under the care of a local adult mental health team.
- Requires support and risk monitoring whilst recovery is also being promoted. Unlikely to be safe or practicable in the foreseeable future for him to be returned to a local mental health team and neither is this likely to be desired by MAPPA or the Ministry of Justice. The thought of moving away from the team causes him and his family anxiety.

Pathway:
Requires longer term community forensic care with a high degree of relational knowledge with an awareness of offence paralleling behaviours through effective monitoring arrangements; supervision, robust contingency planning, risk reducing interventions and collaborative working with external agencies and victim liaison to manage his risks. The Clinical team are sometimes required to intervene and liaise regularly with MoJ.

Figure 1: Transitional vs. Non – Transitional cases



4. Clinical approach in community forensic mental health services
Underpinning robust risk management in forensic inpatient care are the core principles of relational, physical and procedural security. These principles can be

extrapolated to community settings, though the capacity to restrict some external risk factors is clearly limited.

Within the community, the **main focus is on relational risk awareness** and management. Relational security is based upon staff developing constructive and professional working relationships with colleagues and agencies together with successful therapeutic relationships with the patients, and awareness of early risk indicators.

Community forensic mental health services consist of clinical expertise in terms of: psychiatrists; community psychiatric nurses; psychologists; and social workers. A multi-disciplinary team consisting of different professional backgrounds enables a holistic understanding of the patient group.

Anecdotal experience is that **'forensic clinicians'** are clinicians from different professional backgrounds who have a shared understanding of risk assessment principles within this patient population, and thus practice in a clinically consistent manner. This requires **consistency in terms of competencies** across professional groups. Examples might be that forensic community psychiatric nurses (FCPNs) have forensic inpatient backgrounds, or that consultant psychiatrists have a certificate of completion of training (CCT) in forensic psychiatry or relevant experience in forensic psychiatry. Of importance is the ability to balance the serious risk history and knowledge of the individual as an offender with identifying the strengths and vulnerabilities to ensure both risk management and recovery objectives are held in parallel. The skill set to do this is most likely to develop through working and training in forensic mental health settings.

The mental health policy implementation guide (2001)[12] refers to case load sizes for assertive outreach teams stating that each team should have a caseload of approximately 90 service users and that the Service user to care coordinator ratio maximum 12:1 (ideally 10 to 1). The authors are unaware of any similar suggestions regarding a **defined community forensic caseload sizes**. If however, the complexity and risk profile associated with a forensic caseload is considered, then it is suggested that the number would be similar.

Notably, there is no such caseload-capping recommendation for consultant psychiatrists. Current medium secure best practice guidance refers to consultants' caseload size (of 13-16 acute assessment and up to 20 longer stay patients[6]), as being inherent to the relational security of this tier of secure care. Typically, it is hypothesized that it may be appropriate for a community forensic consultant (working wholly in this domain) would have a caseload of up to 40 patients, including patients who have been conditionally discharged, subject to supervised community treatment order (SCTO) or Guardianship orders and informal patients. Where there are other components to posts, such as inpatient care or prison psychiatry, a formula could be applied to assess clinical workload. Professional guidance (E.G. Royal College of Psychiatrists Job Planning Guidance) for individual professions should be referred to as appropriate in considering job planning and workload issues.

Section 325(3) of the Criminal Justice Act 2003 specifies that health agencies have a duty to '*cooperate in the establishment by the responsible authority*' of

MAPPA. Frequently there is a requirement for clinicians within the forensic team to provide expertise and work collaboratively with MAPPA.

Forensic clinicians frequently have **close links with probation and other agencies through the referral process**; provision of advice or providing treatment and supervision as part of license condition or a mental health treatment requirement.

The consultant forensic psychiatrist and social supervisor have the duty to manage those individuals who are conditionally discharged in the community. This task involves regular liaison with the Ministry of Justice, with regard to the individual's risk and mental disorder. The Ministry of Justice's feedback[13] is supportive of this role being more suited to forensic specialist clinicians rather than other clinicians.

Collaborative working with other mental health teams is critical and the provision of assessment and collaborative working is important to reduce stigma and help develop wider expertise within forensic practice. There is a special relevance in the relationship between forensic and other mental health teams: including referral, treatment and care pathways –enabling the development of service level agreements regarding transitions between services. A concern is that often those patients within forensic services can have difficulty moving into general adult and other mental health services for a variety of reasons. This was highlighted in both the questionnaire exercises.
Furthermore, a critical link should be established between community forensic mental health services and both secure and non-secure beds, to allow for appropriate 'step-up' when inpatient admission is indicated either through the process of recall (of a restricted or community treatment order patient) to secure care, informal admission to an acute psychiatric bed and detention under the Mental Health Act 1983.

Community forensic mental health services are concerned with managing those individuals who have a mental disorder, with an offending history that pose a risk to others.

Effective risk management is based on expertise acknowledged as being a key strength of a community forensic team. The use of a structured tool for care planning and delivery such as the Care Programme Approach, appropriate legal frameworks, effective risk assessment tools, shared expertise and responsibility, the provision of specific interventions and a multidisciplinary approach are critical.

Successful risk management plans are based upon:

- Expertise of the criminal justice system and Part III of the Mental Health Act
- Collaborative multidisciplinary working with effective communication and documentation
- Providing education to other agencies
- Expertise in assessing risk to others in the context of mental disorder using specialised assessment tools and interventions.

5. Discussion regarding the funding implications for community forensic mental health services

Secure placements are to be funded through specialised commissioning arrangements (National Commissioning Board now NHS England). Definition No. 22; Specialised Mental health services[14] notes that the following areas should be covered by specialised commissioning:

"Secure and forensic mental health services include high, medium and low secure in-patient care as well as community and out-patient services.
These services may be provided by specialised mental health services to former patients of high or medium secure care units who are now in low secure units or in the community including patients on Restriction Orders. Follow-up may be provided on a shared care basis with local services".

The Medium and Low Secure Mental Health Service Specification NHS Commissioning Board[15] makes reference to both Community Forensic Mental Health services and Specialist Forensic Outreach services; the latter being commissioned by the NCB, the former by Clinical Commissioning Groups. The distinction between the two services is unclear beyond commissioning arrangements. The splitting in some way of such services does not seem to match the evidence gathered in this paper in regards to good practice and meeting the needs of mentally disorder offenders leaving secure care.

Court or prison diversion, prison in-reach services, psychiatric intensive care and locked rehabilitation services are specifically cited as not being within the remit of specialised commissioning.

Having invested significantly in comparatively small numbers of patients (total patient population in secure hospitals as compared with other areas of specialised commissioning) it would seem imperative that, where appropriate, care is taken to ensure safe and sustainable discharge. Such patients have often been adjudged by the Courts as presenting 'significant risk', thus placing important responsibilities on health services accordingly. Ensuring that specialist clinicians facilitate this, rather than non-forensic community psychiatric teams, would seem to represent a worthwhile investment.

Although local circumstances will dictate the deployment of resources, given the funding and risk-related drivers it would appear reasonable for community forensic mental health services to dedicate a relatively larger proportion of their clinical resources to 'core' forensic functions. The preferred structure of services may differ regionally, whilst the functions should be consistent. This is essential to ensuring clarity in terms of service delivery.

6. A proposed framework for future quality standards in community forensic mental health services:

<u>i) Core functions</u>

Core functions of community forensic mental health services are of forensic case management of a caseload of patients; offering advice / specialist interventions and education to other referral sources; and care pathway management from secure settings.

Limited clinical resources would need to be deployed in a manner which allows

these roles to be performed efficaciously. A tiered service delivery model within a hybrid model, and incorporating the features described earlier in this paper, could be deployed in order to achieve this.

Whilst Court liaison and diversion services are recognised as important in terms of the assessment of mentally disordered offenders, these are not 'core' to community forensic mental health services. In this sense, such services could be considered to be 'secondary' or 'non-core' services. This is consistent with the current specialised services definitions set, and the stratification of resources based on risk and need. The bulk of such work involves screening and sign-posting low risk offenders, usually to general psychiatric and related non-statutory services. The configuration, skill-set and clinical approach is by nature inconsistent with community forensic mental health services. It is also widely accepted that all mental health teams should have some expertise in assessing offenders and that this role is not solely the remit of community forensic mental health services.

Clinical approach

i) Principles

Links to forensic inpatient services, whether low or medium secure, are vital in terms of recall to hospital or whether risks require admission to a secure setting. In order to function safely, there must also be good local links with general psychiatric services in terms of crisis resolution and support (unless there are parallel forensic services) and regarding the use of acute admission beds.

The following are considered critical to the operation of a safe and clinically effective working environment. This is shaped by clinical experience and reference to secure care QNFMHS standards[16]:

- A team base for team members to work, share practice, develop a successful team ethos, provide clinical supervision and access patients within a safe environment

- Environmental security measures such as Closed Circuit Television (CCTV), alarmed rooms, specific patient interview rooms and restricted access to entrances and non-clinical areas.

- Procedural security measures including the dissemination of risk information, 'hot' case clinical discussion forums, supervision meetings, lone worker policies, links with other criminal justice agencies and strong links with inpatient and 'out of hours' psychiatric services.

- Relational security measures (as described below), including multi-disciplinary working

ii) Structure

Patient eligibility characteristics could be delineated, based on factors described earlier in this paper. Clinical criteria could more clearly determine care pathways between community forensic and non-forensic mental health services.

Caseload management and a robust multi-disciplinary approach are critical

aspects of community forensic care. If there are no mechanisms in place to manage caseloads there are risks of care pathway blockages or else that the relational principle of the service is significantly undermined.

Multi or inter agency working is a core feature of community forensic mental health team working. This includes working with the police, probation, MAPPA and other mental health (such as dual diagnosis and others) and housing teams.

Whilst risk management is a generic skill, community forensic services are recognised as having an expertise in assessing risk to others in the context of mental disorder.

Education and supporting other teams to develop their own expertise within risk management is an important part of successful clinical practice.

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2. Department of Health (2002) Mental Health Policy Implementation Guide. National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Department of Health (2012) Consultation on low secure services and psychiatric intensive care http://www.dh.gov.uk/health/2012/01/consultation-on-low-secure-services-and-psychiatric-intensive-care

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12. Ministry of Justice communication to this working group

13. Definition No. 22: Specialised mental health services (all ages). 3rd Edition. Downloaded 26th March 2012

14. NHS Commissioning board, Area C2b: Medium and Low secure, McCann, Broughton and Holloway, 2013

15. Clarke M, Duggan C, Hollin C, Huband N, McCarthy L, Davies S: Readmission after discharge from a medium secure unit. The Psychiatrist (2013) 37, pages 124-129.

16. National Confidential Inquiry into Suicide and Homicide by people with mental Illness July 2010. http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/annual_report_2010.pdf (last accessed 22 April 2013)

Appendix 2
Questions in Faculty of Forensic Psychiatry Survey
Re Establishment of a forum / working group considering the development of standards for community forensic services

Dear colleagues
This email circular is directed at consultants working in community forensic settings.

It is known that there are no national standards or service specification guidance for community forensic psychiatric services such as are available for secure services or other specialist community based psychiatric services (assertive outreach or early intervention). Indeed, models proposed within mental health clustering payment by results (PbR) do not appear particularly applicable to community forensic psychiatric care either.

Given this background, as consultants working in this setting, Vicky Burt and Mark Taylor would like to consult with colleagues to develop national guidance in order to provide clarity to patients, clinicians and commissioners alike in terms of 'proposed models of the role, treatment approach and configuration of community forensic services'. We have been assisted by Jeremy Kenney-Herbert in aligning this group with the Quality Network within the College.
In order to begin this process we wanted to establish some basic demographic details regarding the configuration of services, but also to canvas interested clinicians to assist in the formation of such a group. It is also intended that service lines are considered within the sub-specialty.

1. Which organisation/trust do you work for?
2. Is there a community forensic service in your organisation/trust?
YES NO
3. How is this service structured?
    a) Parallel (separate service working alongside general adult/other teams)
    b) Integrated (forensic practitioners work within general adult/other teams)
    c) Outreach from secure unit
    d) Other, please describe
    More information:
4. Does your service provide?
    a) Forensic case management – is the caseload capped? Restricted cases versus others
    b) Joint working – what specific interventions are provided?
    c) Liaison / discussion clinics or formal referral assessment process with general psychiatric services?
    d) Is criminal justice liaison offered by your service? Is it considered 'core business'?
    e) OATs management / monitoring patients in NHS and independent sector providers re development of pathways from secure services?
    More information:
5. Would you be interested in joining a community forensic forum / working group, and if so in what capacity?
YES NO

Appendix 3
Questions in Quality Network for Forensic Mental Health Survey

Region, NHS or independent provider, level of security

1. How do community follow-up arrangements work in your area?
2. Composition of community forensic service, inclusion / exclusion criteria and policies?
3. Challenges / blocks in community services?
4. Examples of what works well in community services or how the services can be improved?
5. How would you design the processes for admitting people to secure services?
6. Additional comments?

Appendix 4
Questions submitted to Ministry of Justice

1. What do you feel are the features that you look for, and what you do not like, in terms of community services working with you?
2. Has the MHU noticed a qualitative difference in approach between specialist community forensic services compared to other services? If so, can you describe further? (Perhaps in areas such as perceptions re supervisors' knowledge of section 41 provisions, communication)
3. Are you aware of whether there are quantitative differences in terms of achieving targets in producing timely CD reports, numbers of recalls and of recidivism?
4. Are there any other comments that you would like to make?

Appendix 5
Literature review (June 2010 updated March 2012)

By Dr R Puri and Dr J Kenney-Herbert

Provision of forensic psychiatry aftercare in the community is well established in the UK. The vast majority of outreach services affiliated to secure units have evolved over time, into designated Community Forensic Mental Health Teams (CFMHTs), to provide such care. There is, nonetheless, marked variance in the structure and remit of services concerned with the provision of this care due to the differences in commissioning and presumed local requirements.

Legislative context

The Legislative focus on the provision of adequate care in the community has its origins in the National Health Service and Community Care Act 1990, which supported these developments. Following the introduction of the Care Program Approach in 1991, Health Authorities and Social Service departments had a statutory requirement to implement packages of care for all patients in specialist mental health services. This coincided with the Reed Report (1992) which hastened the development of specialist Community Forensic Services[1]. Further legislation followed, to support the implementation of CPA including the Mental Health Act 1995 that introduced the idea of 'supervised discharge' to improve compliance with aftercare[2]. The National Service Frameworks (DH 1999) re-emphasised the focus on provision of care in the community. Subsequent policy review and change has taken place in accordance with the 2007 Amendments to The Mental Health Act 1983, with the introduction of Community Treatment Orders, and, the updated MAPPA Guidance of 2009, produced by the National MAPPA organization. Version 3.0 Section 1.2 of the guidance defined the purpose of MAPPA as "...to help to reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm" and identified Health service as a "Duty to Cooperate" (DTC) agency. It is not unusual for the community forensic teams to provide Single Point of Contact (SPOC) for MAPPA.

Integrated and Parallel Models

The terms 'integrated' and 'parallel' that essentially are now used to define models of forensic aftercare in the community were coined by John Gunn in 1977 and later developed by Snowden et al in 1999[3]. The integrated approach refers to patient care passing from forensic services to generic community teams at the point of discharge, or soon after, with appropriate planning and support. In contrast the parallel model involves forensic services retaining responsibility

[1] *British Medical Journal* 1992;**305**:1448-1449 doi:10.1136/bmj.305.6867.1448 (Published 12 December 1992)

[2] Last accessed 16 January 2011

[3] Gunn J Management of the Mentally Disordered Offender. *Proceedings of the Royal Society of Medicine*, 1997;**70**: 877-80, Snowden P, McKenna J. & Jasper A. (1999) Management of conditionally discharged patients and others who present similar risks in the community: integrated or parallel? *Journal of Forensic Psychiatry*, **10**, 583 -596.

for outpatient follow up and community care. The so called "hybrid" model includes a combination of the two with some patients being returned to the care of more general services and others remaining with forensic services sometimes depending upon historical factors including the nature and severity of any offending behaviour, in some cases the individual's legal status, or the perceived or actual form of inpatient service required when the patient is unwell to include secure provision or not. Patient choice may also play a part.

Using a Modified Delphi consultation, an expert opinion and consensus method, Mohan et al identified thirteen characteristics they considered differentiated between forensic teams working to the parallel or integrated models of care[4]. Parallel teams had their own team base, separate referral meetings, specialist lines of management and clinical supervision, as well as protected funding, forensic psychology, relatively good links with the criminal justice system and capped case loads. In contrast, integrated teams had close links with community mental health services and accepted more referrals from primary care.

Judge et al surveyed 37 services across England and Wales with a 70% response rate. They reported that 80% of their sample operated parallel to the generic community mental health teams[5]. Caseloads varied from 50-150 patients per team and for individual team members anywhere between six and 24. A third of these patients were subject to a restricted hospital order. The majority of staff was forensic community nurses with a mean of four per team. All teams offered clinical case management necessarily under CPA due to the complexity of need and risk assessment using structured but locally developed assessments. Some teams offered anger management programmes and Cognitive Behavioural interventions in specific cases, but very few provided treatment for service users with a personality disorder, sex offenders or those with substance misuse problems.

Whittle and Scally described the CFMHT at the Maudsley hospital which provided care based on the integrated model[6]. They suggested that this had the advantage of minimising stigma, provided support and education to staff and enabled forensic expenditure to be available for a wider group of patients, and staff, than would otherwise have been possible. In contrast, Mohan and Fahy argued that higher caseloads and the mixing of specialist and non-specialist workers may lead to an attenuation or loss of specialist skills[7]. In practice it is likely that the parallel and integrated models are on a continuum and most

[4] Mohan R, Slade M, Fahy TA. Clinical characteristics of community forensic mental health services. *Psychiatr Serv.* 2004 Nov; **55(11):**1294-8.

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[7] Mohan R and Fahy T. Is there a need for community forensic mental health services?. *Journal of Forensic Psychiatry and Psychology* 2006;**17**:pp. 365-371.

existing services combine features of both as outlined by Tighe, Henderson and Thornicroft[8].

In a more recent study, Humber et al compared clinical characteristics, risk and need profiles of forensic and general adult patients treated within parallel and integrated models of care in London and the Northwest of UK[9]. They examined case notes and interviewed the Care Programme Approach care-coordinators to assess risk and need of a total of 639 patients in the two regions. They found that forensic patients in integrated teams had comparably higher historical and total risk scores on HCR-20 and more unmet needs. These were most frequently reported as needs in relation to social life, daytime activities, intimate relationships and physical health. Clinically they noted that the majority of forensic patients had a diagnosis of Schizophrenia which was different to Personality disorder(s) that Coid et al had reported in their study[10].
Roles and functions of CFMHTs

Community-based forensic clinicians carry out a number of specialised tasks. These include the management of forensic cases, carrying out assessments and providing advice as well as liaison with Criminal Justice agencies and delivering specialist interventions e.g. psychological therapies such as anger management, CBT for psychosis and interventions for substance misuse, in context of an identified association with the increased risk of violence[11]. This places demands on the limited resources as majority of those leaving regional secure services will meet criteria for referrals.

Members of CFMHTs often attend MAPPA meetings and maintain close links with the Public Protection Units in their areas. They are also well placed to staff court liaison /diversion schemes[12].

The teams necessarily work within the CPA framework due to the complexity of cases and need they are dealing with and have relatively small case loads that allows for more intense and assertive management, frequent follow up, and continuing concentrated risk assessment and management. In certain circumstances forensic teams will "co-work" with generic teams managing cases jointly either for a particular purpose or a specific period of time. Referrals may

[8] Tighe J, Henderson C & Thornicroft G. Mentally disordered offenders and models of community care provision. 2002; In A. Buchanan (Ed.), Care *of the mentally disordered offender in the community*. Oxford, UK: Oxford University press

[9] Naomi Humber, Adrian Hayes, Steve Wright, Thomas Fahy & Jenny Shaw.A comparative study of forensic and general community psychiatric patients with integrated and parallel models of care in the UK. *Journal of Forensic Psychiatry & Psychology*.2011;**22**:2, 183-202

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[12] James DV, Harlow P. Increasing the power of psychiatric court diversion: a new model of supra-district diversion centre. *Med Sci Law.* 2000 Jan; **40**(1):52-60.

be from a variety of sources and the transfer of care might depend on factors such as the perceived risk of violence, the nature or severity of any offence or offences and legal status. The uptake of referrals has been noted to be less than 15%. Most forensic clinical team members will be well versed in the use of structured risk assessments such as the HCR-20 and are likely to be involved in training others in the use of these instruments[13].

An example of this area of work is Dowsett who evaluated the predictive validity of HCR-20 for the case load of inner city catchment area of Lambeth CFMHT[14]. The HCR-20 risk assessment, which consists of five Historical (H), five Clinical (C) and ten Risk (R) related factors; was completed for all of the 47 patients managed by the team over a 3 month period, as was the revised Psychopathy Check List (PCL-R), on two thirds of them. Subjects were followed up for a 30 month period and data on reoffending were collected from case files and at the time of review meetings. Eight patients were convicted of a new offence during the study period, all involving violence. Those who had reoffended had HCR-20 scores significantly higher than the mean for the total sample of 21. They had high H scores (16+) and high total scores (28+) which matched their clinical histories of "instrumental" violence i.e. violence unrelated to their mental illness. The author argued that this group represented a subset of patients for whom, risk is mostly independent of mental Illness, and, that it is important for Forensic Services to demonstrate expertise in managing these individuals. He added that emphasised the need for supervised placements and specific psychological approaches targeting their criminality, substance misuse and poor anger management.

Outcomes of Community Follow up

There is relatively little literature regarding the effectiveness of CFMHTs. Research has tended to be limited by the use of yet unvalidated outcome measures such as recidivism, imprisonment, hospital readmission and the length of time to reoffending. In the only randomised trial available, Solomon and Draine attempted to test the relationship between receipt of desired community mental health services by homeless mentally ill forensic patients, and return to jail within six months[15]. Those leaving jail were randomly assigned to three different forms of service: intensive case management provided by an assertive community outreach team, intensive case supervision provided by individual case managers, and referral to a community mental health centre. Data were analyzed using discriminant function and chi square analyses.

Thirty-two percent of the 105 patients interviewed at six months had been returned to jail during that study period. Recidivism was related to receipt of fewer services that patients reported they needed, specifically those to do with

[13] Webster, C.D., Douglas K.S., Eaves, D., & Hart, S.D. HCR-20: Assessing risk for violence (version 2). Burnaby, BC: Mental Health Law and Policy Institute, Simon Fraser University 1997.

[14] Dowsett,J. Measurement of risk by Community Forensic Mental Health team, *Psychiatric Bulletin*, 2005;**29**:9-12.

[15] Solomon P, Draine J, Meyerson, A. Jail recidivism and receipt of community mental health services. *Hosp Community Psychiatry.* 1994 Aug; **45**(8):793-7.

the development of independent living skills. The type of service provided was not particularly related to a return to jail. The authors concluded that case management, a flexible community-based service that does not lend itself to clearly prescribed procedures, may easily deteriorate to become a monitoring rather than being an active rehabilitation service for forensic patients and that this might be linked to re-offending.

Coid et al compared outcomes following community after-care from either forensic or general adult psychiatry services. Of the 2085 patients admitted to seven Regional Health Authority Medium Secure Units (MSUs) over a five year period, they studied 1061 in relation to clinical and offending outcomes including hospital readmissions, death rates and rates of criminal convictions[16]. Of these 409 patients had been followed up by Forensic Services and 652 by general services. The authors reported that those managed by the forensic services were older, fewer had been married and more were born outside the UK. In terms of clinical and criminological characteristics, forensic patients were more likely to have a primary diagnosis of personality disorder, to have previously been admitted to a high-security psychiatric hospital and to have committed a serious index offence and previous offences, such as homicide, violence or arson. Forensic patients were more likely to be discharged on a restriction order under the Mental Health Act (1983). They were more likely to be rated as adhering to both medication and supervision during the initial stage in the community. The two groups did not differ on gender, ethnicity, a co-morbid diagnosis of substance dependence or abuse and previous convictions.

At the end of the study period, both groups had a similar rate of readmissions but with the forensic group going to secure hospitals and the other group to general psychiatric hospitals. There was no observed difference between the two groups in the number of criminal convictions during follow-up but the Forensic group had a shorter time to the first reconviction for a violent offence. Both groups had an equal number of suicides but service users in the general group had more deaths from natural or "any other" causes. Based on their finding of a lack of any difference in rates of rehospitalisation and reoffending, the authors concluded that there were no added benefits to Forensic follow up and therefore did not support further development of a "parallel" model. Sahota argued that to determine whether one service is more effective than another, a randomised controlled trial would be required, which in ethical terms would be unrealistic[17].
Sahota et al compared the reconviction rates of patients discharged from an MSU either to a specialised community forensic service or generic service[18]. This was a part of the Trent wide ALACRITy study (Arnold Lodge Admissions Cohort: Reconviction and Intervening Treatment). Seventy patients were

[16] Coid J W, Hickey N. & Yang M. A comparison of outcomes following after-care from forensic and general adult psychiatric services. *British Journal of Psychiatry*, 2007;**190**: 509 -514.

[17] Sahota SS. Specialist community forensic teams: Costly or cost effective? [Response Letter]. *British Journal of Psychiatry*. 2007;Retrieved from http://pb.rcpsych.org/cgi/eletters/29/9/352-a.

[18] Sahota S, Davies S , Duggan C. and Clarke M. The fate of medium secure patients discharged to generic or specialised services , *Journal of Forensic Psychiatry & Psychology*, 2009; **20**: 1, 74 — 84

followed up by a forensic service as opposed to 93 patients followed up by General Adult, Substance Misuse or Rehabilitation services. Results showed relatively poor outcomes for forensic service patients in terms of time to reconviction which was five years as opposed to 14 Years for the other group. The time to a serious offence was also shorter being four years rather than 11 years. The authors attributed these results to "appropriate selection bias" and a longer stay within community forensic services which increases exposure to offending situations as previous offending behaviours are re-established. They supported an integrated model of care as they argued it afforded staff more options to refer patients on and thought that there was less likelihood of staff burnout. An additional although perhaps expected observation was that a previous criminal history was strongly associated with the likelihood of reconviction.

Ong et al looked at community outcomes of mentally disordered offenders who had committed homicide in Australia who were followed-up by a specialist community team from the Victoria Institute of Forensic Mental Health[19]. Only one service user reoffended a minor matter which was dealt with by the Magistrate's Court but 12 (48%) needed readmission to secure care at some point in the 3 year period post-discharge. These results are consistent with other studies that have shown a substantial reduction in recidivism, with well designed and implemented specialist community forensic programmes.

Cuddeback et al analysed 5.5 years of linked data from a large urban community in Western USA to track the use of outpatient mental health services in state as well as local hospitals and jails[20]. They quoted previous landmark studies, for example Lamberti et al, which demonstrated that Assertive Community teams (ACT) were better at reducing rehospitalisation, whilst specialist Forensic Assertive Community teams (FACTS) were effective in reducing re-incarcerations and, defined patient eligibility criteria for Forensic Assertive Community Teams as those with severe mental illness who experience 3 or more psychiatric hospitalisations or jail detentions in a calendar year[21]. They demonstrated that there was an unmet need and that more FACT teams were required. FACTs differed from ACTs in terms of team structure for example having increased multidisciplinary staffing including probation officers as well as in their aims and philosophy for instance with their emphasis on preventing jail recidivism, and the type of housing and services provided

Dalton evaluated the first three years of the Barnet and Enfield CFMHT[22]. Patients were described demographically and a small number were interviewed

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[19] Ong K, Carroll A, Reid S, Deacon A. Community outcomes of mentally disordered homicide offenders in Victoria. *Aust N Z J Psychiatry*. 2009 Aug; **43**(8):775-80.

[20] Cuddeback G S, Morrissey J P, Cusack K J. How Many Forensic Assertive Community Treatment Teams Do We Need? *Psychiatr Serv* 2008; **59**: 205-208

[21] Lamberti J S, Weisman R, Faden D I. Forensic Assertive Community Treatment: Preventing Incarceration of Adults With Severe Mental Illness. *Psychiatr Serv* 2004; **55**: 1285-1293

[22] Dalton, R. Client progress in a community team for mentally disordered offenders. *The British Journal of Forensic Practice* 2005 **7**(1):18-22

to seek their views on progress. Clinicians' perception of their progress was also assessed using serial HONOS (Health of Nation Outcome Scale) which is an instrument developed by the Royal College of Psychiatrists and the Department of Health in UK and comprises of 12 items measuring behaviour, impairment, symptoms and social functioning. Reconviction, rearrest and re-admission to hospital figures were analysed. Low rates of reconviction and rearrest were found and results showed that both the patients and the team perceived benefits of working with the CFMHT and noted improvements in mental state. Patients valued accessibility but remained unsatisfied with issues such as housing, lack of "back up services" including daytime activities and sheltered work. They also criticised the treatment programmes for not being individual enough. Some also felt that weekly appointments were just a way of "checking on them" and found them to be too intrusive. Riordan et al reported similar findings in their qualitative study of inpatients at an MSU in West midlands in UK[23].

Arguments against the need of CFMHTs

Vaughan et al proposed that mentally disordered offenders (MDO), contrary to general belief, should not be the sole concern of specialist and secure services on the basis that their numbers are far greater in the community[24]. They conducted a survey of community teams in Wessex to determine their capacity to support mentally disordered offenders. These included social and probation service teams. Project workers initially met and interviewed the team leaders or mangers using a semi-structured interview schedule and he/she then distributed a set of questionnaires to each team member who was acting as a key worker. The questions related to proficiency, the size and mix of the case load, especially in relation to Mentally Disordered Offenders with what they describes as "challenging behaviours", and the demographic and offence details of those who "challenged" their service. Anonymous returns were collated by team leaders and forwarded to the investigators. Results highlighted a perceived lack of adequate skills among staff, a lack of support from what respondents describes as "experts", the compartmentalised nature of services, difficulties in managing comorbid substance misuse issues, the need for more training amongst probation officers and most importantly the need for specialist community forensic teams due to acknowledged "neglect and remoteness" between secure and non secure services.

Turner and Salter argued for a reintegration of services and that high risk patients are not really the preserve of forensic psychiatry. They debated the disbanding of the specialist forensic psychiatry services with the reallocation of funds to the CMHTs[25]. They stated that in particular patients subject to a Conditional Discharge from a restricted hospital order can as easily be managed in generic teams because the very nature of the order itself and the history of

[23] Riordan S, Wix S and Humphreys M. Forensic community mental health nurses' perceptions of statutory community aftercare: *Implications for practice Journal of Forensic Nursing* Winter 2005; **Vol 1**(4).

[24] Vaughan P J , Pullen N and Kelly M. Services for mentally disordered offenders in community psychiatry teams', *Journal of Forensic Psychiatry & Psychology*, 2001;**11**: 3, 571 — 586

[25] Turner T, Salter M. Forensic psychiatry and general psychiatry: re-examining the relationship. *Psychiatr Bull*; 2008; **32**: 2 -6

institutionalisation generate therapeutic and social control[26]. They found no role for FCMHTs in managing those with "historically established criminality" as there are no proven effective interventions. Lastly the authors believed that using the HCR-20 for risk assessment is not a special skill and that resources could therefore be redirected to generic teams.

Szmulker argued that general services have become increasingly "forensic like" as more patients are seen to be regarded as risky; but these services rarely possess the adequate resources to provide assessment and treatment at a level that is required, in accordance with standards based on inquiries following serious violent incidents[27]. Szmulker referred to the models of care proposed by Tighe et al, based on "risk" as a criterion to determine the service that takes ownership, whilst at the same time highlighting the limitations of risk assessment in events with a low base rate. The authors suggested that adapting prison offender management programmes for mentally ill offenders may be appropriate; citing metanalysis by Bonta in 1998, which highlighted that non-clinical factors such as criminal history, personal demographic characteristics and deviant lifestyle were the strongest predictors of recidivism for both mentally ill and non-mentally ill offenders[28].

Are they worth the money?

To our knowledge there are no direct cost comparison studies that have been done in the United Kingdom that relate to the provision of aftercare for forensic patients in the wider community, something which might be suggested is curious in the face of how potentially expensive such services can be. One possible explanation is the wide variation in the structure of services and lack of standardised operational criteria. A preliminary cost analysis was conducted to examine changes in direct service costs and residential costs resulting from treatment in Project Link[29]. This was a University of Rochester Department of Psychiatry initiative in collaboration with five local community agencies, designed to prevent involvement of individuals with severe mental illness from entering the criminal justice system. Using audited year-end financial statements, all direct service costs during Project Link enrolment including inpatient, outpatient, emergency room, and CDT were calculated. Residential costs were calculated by assigning a monthly charge of $1974.35 to all Project Link patients after enrolment, minus days spent in jail or the hospital. Residential costs were not assigned to patients prior to enrolment in Project Link. Jail costs were calculated at a local rate of $77 per day, and inpatient hospital costs as a local rate of $578 per day. Multiplying all costs by service frequencies, the average yearly service cost per patient decreased from $73,878 during the year prior to enrolment to

[26] Turner, T, Salter, M. What is the role of a community forensic mental health team? *Psychiatric Bulletin*, 2005; **29**, 352

[27] Szmukler G, Interface between forensic and general psychiatry in the community. *Criminal Behaviour and Mental Health* 2002;**12** (1); S73–S79

[28] Bonta M, Law M, Hanson K. The Prediction of Criminal and Violent Recidivism among Mentally Disordered Offenders: A Meta-Analysis. *Psychological Bulletin* .1998; **123** (2); 123-142

[29] Weisman, R L., Lamberti, J S., and Price, N. Integrating Criminal Justice, Community Healthcare, and Support Services for Adults with Severe Mental Disorders. *Psychiatric Quarterly,* Spring 2004;Vol. **75**: No. 1,

$34,360 during the first year in Project Link. This amounts to a significant reduction.

Future of CFMHTs

The Quality Network for Forensic Mental Health Services (QNFMHS) has set up a standards development committee which is tasked with defining current practice and developing future guidance. From the literature review, results of two national surveys done by this group and consultation with key stakeholders including Ministry of Justice, regional commissioners and peers at the Royal College of Psychiatrists' Faculty of Forensic Psychiatry there is clear consensus that offender health pathway is incomplete without adequate care in the community. Secure care is resource-intensive, transition to community is difficult and potentially risky, stigmatisation of forensic cases remains an issue and lack of community psychiatric resources can delay discharge.

The group accepts that any guidance should take into account the limited evidence base for specialist teams both in terms of clinical and cost effectiveness, lack of current definition of forensic community services, existing variability and heterogeneity in the roles and structures of teams and the debate about which patients should be cared for and for how long?

Appendix 6 Delegates Consultation Workshop 19 March 2013

First Name	Surname	Role	Organisation
Godfried	Attafua	Head of Clinical Pathway (Forensic)	South London and Maudsley NHS Foundation Trust
Jeya	Balakrishna	Consultant Forensic Psychiatrist	Hertfordshire Partnership Foundation Trust
Dan	Beales	Service Director & Consultant Forensic Psychiatrist	Greater Manchester West NHS Foundation Trust
Janet	Bell	Service Manager - Secure and Forensic Community	Sussex Partnership NHS Foundation Trust
Paul	Bell	Service Manager	CFT Cornwall
Sue	Browning	Team Manager	CNWL NHS Foundation Trust
Richard	Bunn	Consultant Forensic Psychiatrist	Belfast Trust
Vicky	Burt	Consultant Forensic Psychiatrist	South London and Maudsley NHS Foundation Trust
Chris	Clinch	Clinical Psychologist	Somerset Partnership NHS Foundation Trust
Richard	Comerford	Director - Offender Care Service Line	CNWL NHS Foundation Trust
Andy	Crowther	Team Manager - Westminster FoCUS	CNWL NHS Foundation Trust
Steffan	Davies	Consultant Forensic Psychiatrist	Northamptonshire Healthcare NHS Foundation Trust
Dominic	de Souza	Consultant Forensic Psychiatrist & College Tutor	Kensington & Chelsea Forensic Community Service Central & North West London NHS Foundation Trust
Christine	Kennedy	Consultant Forensic Psychiatrist	Northern Trust Community Forensic Mental Health and Learning Disability Team, Belfast
Patrick	Duggan	General Manager	South West Yorkshire Partnership NHS Foundation Trust
Melanie	Evens	Service Director - forensic psychosis common mental health service lines	Barnet, Enfield, Haringey Mental Health Foundation Trust
Jane	Ewbank	Consultant Forensic Psychiatrist	Dorset HealthCare University NHS Foundation Trust
Lindsay	Foy	Forensic Integrated Resource Team Manager	Merseycare NHS
Shaun	Gallagher	Team Manager, CPN Dept	Oxleas NHS Foundation Trust
Andy	Harris	Service Manager	Norfolk & Suffolk NHS Trust
Abdi	Hussein	Service User Expert	RCPsych
Amina	Jappie	Senior Forensic Social Work	South Essex Partnership Trust
Steve	Jenkins		Birmingham and Solihull
Ann	Kenwright	SaFE Partnerships CBU Service Director	Merseycare NHS
Des	Kerins	Criminal Justice & Forensic Mental Health Service Manager	Hertfordshire Partnership Foundation Trust

First Name	Surname	Role	Organisation
Nusrat	Khan	Consultant Forensic Psychiatrist	Hertfordshire Partnership Foundation Trust
Paula	King	Head of Forensic Community Services, Specialist and Forensic Services.	West London Mental Health Trust
Mark	Landy	community forensic service manager	Barnet, Enfield and Haringey Mental Health Trust
Fiona	Langford	Senior Social Worker	Birmingham and Solihull
Helen	Lycett	Professional Lead for Occupational Therapy	Oxford Health
Paul	Macallister		Nottinghamshire Healthcare
Pily	Maden	Community Offender Mental Health Team Leader	Northamptonshire Healthcare NHS Foundation Trust
Lystra	Madho	Matron	Sussex Partnership NHS Foundation Trust
Terry	Mc Cabe	Community Forensic Mental Health & Learning Disability Team Manager	Northern Health and Social Care Trust
John	Buckle		NOMS
John	Morgan		CFT Cornwall
Jackie	Newell	Community Occupational Therapist	Oxford Health NHS Foundation Trust
Amit	Nigam	Consultant Forensic Psychiatrist - Westminster FoCUS	CNWL NHS Foundation Trust
Claire	Oaten	Community & Prison Services Manager	Oxleas NHS Foundation Trust
Jim	Ormsby	Consultant Forensic Psychiatrist	Southern Health NHS Foundation Trust
Ian	Pachner	Head of Forensic Social Work	South Staffordshire & Shropshire Healthcare NHS Foundation Trust.
Sandra	Parsons	Senior Social Worker	Partnerships in Care
David	Porter	Matron Forensic Services	Dorset HealthCare University NHS Foundation Trust
Seb	Pringle	Service User Expert	RCPsych
Richard	Pyatt	Consultant Psychiatrists	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST
Jeremy	Resnick	Consultant Forensic Psychiatrist	Nottinghamshire Healthcare
Lisa	Reynolds	Divisional Lead Health Services Research and Management	City University
Sachitra	Sabarigirivasan	Consultant Forensic Psychiatrist	Cardiff and Vale UBH - Forensic Low Secure
Martin	Saberi	Service User Expert	RCPsych
Lavinya	Sebastian	consultant forensic psychiatrist	South Staffordshire and Shropshire Healthcare Foundation NHS Trust
Jenny	Shaw	Clinical Director Adult Community & Specialist	Lancashire Care NHS Foundation Trust

First Name	Surname	Role	Organisation
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Ann	Stanley	Consultant Forensic Psychiatrist/Lead Appraiser	Norfolk and Suffolk NHS Foundation Trust
Huw	Stone	Consultant Forensic Psychiatrist	Surrey Community Forensic Service
Michelle	Taylor		Merseycare NHS
David	Taylor	Team Manager	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST
Ian	Tearle	Deputy Line Lead Forensic and LD Services	Hertfordshire Partnership Foundation Trust
Joseph	Vella	Consultant Forensic Psychiatrist	Black Country Partnership NHS Foundation Trust
Mike	Wheeler	Interim Forensic Social Work Manager and Community Forensic Services Manager,	South West London and St Georges Foundation Trust
Steve	Moody		Northumberland, Tyne and Wear NHS Foundation Trust
Gurpreet	Kaler		Northumberland, Tyne and Wear NHS Foundation Trust
Rajesh	Nadkarni		Northumberland, Tyne and Wear NHS Foundation Trust

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