Standards for community forensic mental health services (April 2013)

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The Standards

A: Model of Care

1: Core Functions
2: Forensic Case Management
3: Referrals, consultative advice and specialist interventions
4: Care pathway management from secure settings

B: A Safe Working Environment

1: Physical Security
2: Relational Security
3: Procedural Security

C: Governance
Did CFMHS need standards?

- Offender Health Pathway is incomplete without adequate care in the community
- Secure care is resource-intensive
- Transition to and living in the community can be difficult and potentially risky
- Stigmatisation of forensic cases
- Lack of community psychiatric resources can delay discharge
Timing?

• Natural next step, having completed quality standards for medium (and low secure) services

• QIPP – efficiency, length of stay, My Shared Pathway....

• New NHS commissioning structures

• PbR Forensic- only looking at secure provision
The journey to get here

2010:
QNFMHS Advisory board discusses the need for standards
The core members of working group identified and agreed
Literature review and a review of key documents
National survey through Forensic Faculty of The Royal College

2011:
Liaison with The Ministry of Justice
National Survey through the Quality Network
Workshops at the Faculty meeting in Berlin and the QN annual forum

2012:
Workshops at the Faculty meeting in Newcastle the QN annual forum
First Draft of standards
First Expert Consultation Group meeting.
2013
Second Expert Consultation Group Meeting
Surveys/Feedback

Survey results:

RCPPsych Forensic Faculty survey had 41 responses and 29 had CFMHS. Key themes included range of models, difficult engaging local services, patchy provision, some out of area monitoring role, criminal justice liaison core business for some.

QNFMHS survey had 27 responses with 2/3 NHS and 1/3 Independent providers. marked variation in provision, CFMHS valued, early involvement aids repatriation, reluctance of non forensic teams to engage, added delays if patient out of area, interagency working seen as important, long term care for some needed some would like caseload capping.

Workshops: ‘hybrid’ model preferred, expertise should be in facilitating transition to non secure care, sophisticated risk assessment skills should be integral to working, close/good links to general adult services essential, Restricted HO/ CD patients should be core business at least for a period of time, should take on PD patients, need for long term care in community for some etc.
Expert Consultation Groups

Welcomed the draft standards, preferred them to remain aspirational, recommended further detail in standards around core functions of the teams,

Some suggested additional care pathway management role for prison in-reach and other nonsecure settings

Others suggested a need for a standard around providing 24h care, teams could have assessment or treatment roles independent of each others, safe therapeutic environment should extend to GP surgeries, A&Es and patients’ homes.

Identified need for bespoke IT/Governance policies for CFMHS
Ministry of Justice perspective
(the head of casework section)

Comparison with non-forensic supervisors:

• Knowledge of secure care provision and access to it

• Timely reporting of changes in risk behaviour and responses to it

• Better understanding of restricted patient population
NCISH in its Independent investigations after homicide 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
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. [i] 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 the Personality disorders that Coid et al had reported in their study. [ii]

• 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 of the above was highest in the first year of discharge but remained over many years. It was greater for those with Mental illness as opposed to psychopathic disorder (PD).

• 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.”

Contentious issues?

• Limited evidence base for specialist teams?

• Lack of definition of forensic community mental health services
  – Associated with variability / heterogeneity across UK (roles as well as structures)

• Which patients should be cared for and for how long?

• Cost effectiveness/ Who should be commissioning what
Specialist forensic outreach services will be required for individuals transferring from secure services into the community who demonstrate:

- An identifiable mental disorder (mental illness, personality disorder, borderline learning disability, alcohol/substance misuse related mental illness, organic brain disorder or a combination of these)
- There is a significant risk of harm to others related to the mental disorder.
- Significant risk suggests that the risk is **real and relatively imminent** in given circumstances and that it cannot be safely managed without the intervention of a specialist forensic service.
- **A repeated demonstration through offence paralleling behaviours** suggesting that the individual continues to pose a significant risk of potential harm even when discharged into the community requiring specialised forensic observation and risk assessment in the long term or even life long
- These outreach services will work with any **locally (CCG) commissioned community forensic service (or equivalent service)** to ensure risks are managed and there is a smooth transfer of care to local services.
- Individuals who no longer present needs which require specialist forensic expertise but who require further care and support will be referred on to local generic mental health or primary care services.
Some issues

• CCQI standards are part of evidence base in the NHS England Service Specifications so can the CCCQI CFMHS now inform the on going development of the Service Specifications?

• What is the difference between Outreach (NHS England) and CFMHS(CCG)...where does one stop and the other begin? Can they be provided by the same teams?

• Are the criteria for Outreach in the current Service Specifications implementable?

• Should the CFMHS standards apply to Outreach and CFMHS?
Next Steps

• Realigning of terminologies within CRG, NCB CCG and CQCI?

• A new Quality Network dedicated to Community Forensic Services?

Thank You