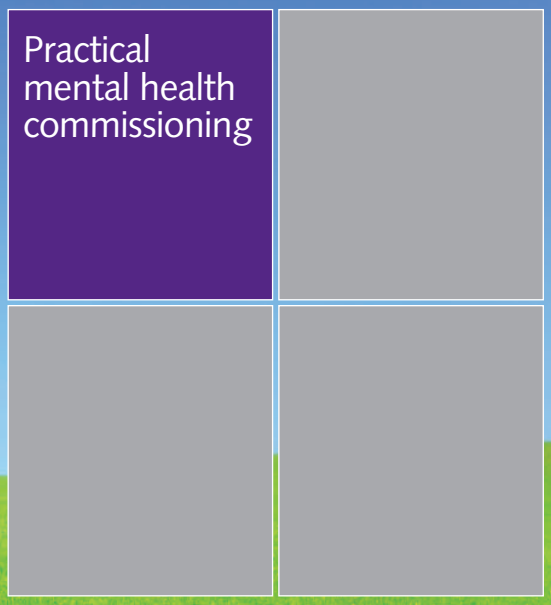
Joint Commissioning Panel for Mental Health

www.jcpmh.info

Guidance for commissioners of

forensic mental health services



Joint Commissioning Panel for Mental Health

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Co-chaired by:

Royal College of General Practitioners

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Membership:

mind For better mental health

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MENTAL HEALTH PROVIDERS FORUM Voluntary Agencies Working Together to Improve Mental Health

Mental Health Network NHS CONFEDERATION

Royal College of Nursing

THE AFIYA TRUST

directors of adass adult social services

National involvement Partnership

The New Savoy Partnership

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1 **Forensic mental health services are provided for (a) individuals with a mental disorder (including neurodevelopmental disorders) who (b) pose, or have posed, risks to others and (c) where that risk is usually related to their mental disorder.**

They may be placed in:

- hospitals (particularly secure hospitals)
- the community
- or prison.

Forensic mental health services work collaboratively with:

- other mental health professionals, General Practitioners (GPs) and social care staff
- agencies working in the criminal justice system.

Forensic services are able to demonstrate effectiveness in reducing serious reoffending in individuals discharged from secure inpatient services[1].

2 **Patients must be at the centre of the care provided by forensic mental health services.** There should be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

Critically, these are not mutually exclusive aims or outcomes, because high quality care will result in improved protection of the public.

3 **Forensic mental health services are 'low volume and high cost' services** (i.e. they work with a smaller number of individuals with typically more complex needs and consequently higher related care costs). **It is essential therefore that they are commissioned in a way which ensures that:**

- patients should make progress through the care pathway according to their risk to others and the stability of their mental health
- forensic services are flexible enough to meet the complex needs of all individuals within the service, regardless of whether this is a secure hospital, in the community, or a prison
- administrative barriers which could block an individual's progress along the care pathway, and also any interfaces between one commissioning body and another, are kept to an absolute minimum
- mental health care in prisons is equivalent to the care provided to individuals in the community.

4 **Commissioners should ensure that security measures promote a safe environment which enables therapeutic work to be undertaken to meet an individual's needs.** Commissioners should be aware that safe care is provided through a combination of physical, relational and procedural elements. It is well recognised that an over reliance on physical security can have a negative impact on the therapeutic environment of secure hospitals.

5 **Commissioners should commission integrated pathways of care rather than individual packages of care – doing otherwise will create administrative delays at each interface.**

A significant challenge to the development of the integrated forensic mental health pathway is the:

- number of service interfaces (which often cross different health, social care and criminal justice agency boundaries)
- different commissioning streams operating within the health and social care sectors
- need for a range of government departments to work collaboratively (this includes the Department of Health and the Ministry of Justice, which commissions the National Offender Management Services – NOMS).

6 The future commissioning of an integrated forensic mental health care pathway will be the responsibility of several different departments of NHS England and Clinical Commissioning Groups (CCGs).

It is therefore essential that the various commissioning streams are coordinated to ensure that there are no gaps or administrative delays because of the different commissioning streams responsible for the components of an integrated pathway.

Ten key messages for commissioners (contined)

7 **It is essential to include the commissioning of effective mental health services in prisons, with this being based on the 'equivalence of care' principle.** This will require an equal provision of care between those health services provided in prison, compared to those available in community settings.

In addition, commissioners also should take into account the specific needs of:

- women
- individuals with a learning disability
- young people
- individuals with comorbid substance misuse problems
- individuals with personality disorders.

The mental health of individuals in prison would be improved significantly with the implementation of the Offender Mental Healthcare Pathway, published by the Department of Health in 2005[2].

8 **Commissioners should ensure that all forensic services are part of the Quality Network for Forensic Mental Health Services (QNFMHS).**

The QNFMHS have been successful in improving standards in medium secure services (www.rcpsych.ac.uk/qnfmhs) largely due to the support given by commissioners to this initiative.

It is essential that the same level of support is given to the extension of the QNFMHS to low secure services, and also the new QNFMHS networks for community forensic services and prison in-reach mental health services.

9 **Commissioners should ensure that the forensic mental health care pathway takes account of the recommendations of the 2009 Bradley report[3].**

The Bradley report addressed the need to divert more offenders with severe mental health problems away from prison and into more appropriate facilities. It included recommendations relevant to the design of the offender pathway including:

- early intervention, arrest and prosecution
- the court process
- prison, community sentences and resettlement
- delivering change through partnership.

The most significant recommendation was the development of Criminal Justice Mental Health Teams. Commissioners need to ensure that services operate in an integrated way with these teams.

In its response, the Government committed to the full implementation of the Bradley report recommendations by 2014.

10 **The time of highest risk for individuals is during the transition between different parts of the pathway – it is essential this transition is managed safely and effectively.**

This is particularly the case for the transition from the security and support in the institutional setting to increased independence and responsibility in the community.

It is essential that this transition is managed safely and effectively by clinicians who are familiar with the individual and with whom the individual has already developed and built a positive and trusting therapeutic relationship.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*[4].

The JCP-MH has two primary aims:

- to bring together people with mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*[5], a briefing on the key values and principles for effective mental health commissioning
- has so far published eight other guides on the commissioning of primary mental health care services[6], dementia services[7], liaison mental health services to acute hospitals[8], transition services[9], perinatal mental health services[10], public mental health services[11], rehabilitation services[12], and drug and alcohol services[13].
- provides practical guidance and a developing framework for mental health.

WHAT IS THIS GUIDE ABOUT?

This guide is about the commissioning of high, medium, and low secure forensic mental health services for working-age adults. These services will be commissioned by NHS England, with commissioning decisions being based upon a set of service specifications developed by an appointed Clinical Reference Group.

These service specifications were consulted on in January 2013 can be found at: www.commissioningboard.nhs.uk/ourwork/d-com/spec-serv/

This guide does not aim to repeat these specifications, but instead attempts to achieve three complementary objectives:

1 to take into account these service specifications

2 to make recommendations which 'go beyond' these service specifications in terms of their aspirations for high-quality, recovery-focused and secure care

Introduction (continued)

3 to provide an 'overview introduction' for new and existing commissioners to allow them to understand and start planning an integrated care pathway for forensic mental health care which includes:

- high, medium, and low inpatient forensic mental health services
- community forensic mental health services (as commissioned at a local level by Clinical Commissioning Groups)
- prison health services and probation services (which are respectively commissioned at a national level by NHS England, and also by the National Offender Management Service)
- police and court 'liaison and diversion' services (as commissioned at a national level by NHS England
- providers of all levels of forensic mental health services (including the NHS, independent sector, Local Authorities, social care and voluntary sector).

While it is not possible to provide an exhaustive guide to commissioning all parts of this integrated care pathway, this document provides a starting point for different commissioners and providers to design or redesign such an initiative. Importantly, several members of the Clinical Reference Group appointed by NHS England have also been involved in writing this guide. This has helped ensure that it (a) builds upon the published service specifications (which are intended to cover commissioning decisions in the next 12 months only), and (b) encourages commissioners to start planning the development of high quality forensic services over a longer time period of three to five years.

WHO IS THIS GUIDE FOR?

The guide should be of value to:

- any commissioner wishing to gain an overview of how a high quality and integrated forensic mental health service pathway can be commissioned
- NHS England
- Clinical Commissioning Groups – these will commission both community forensic mental health services, as well as generic mental health, learning disability, and personality disorder services
- providers of all levels of forensic mental health services (including the NHS, Independent Sector, Local Authorities, social care and third sector)
- the National Offender Management Service
- criminal justice system agencies (including the police and courts)
- Public Health England (PHE) due to the increasing recognition that both mental health and offending are important to the improvement of a number of public health outcomes.

What are forensic mental health services?

This section briefly:

1 outlines the 'core purposes' of all forensic mental health services

2 defines what is meant by 'high', 'medium', and 'low' secure forensic mental health services (as these services are the primary focus of this guide)

3. provides an overview of the care pathway that is typically followed by people who either use/have a need for forensic mental health services.

These issues are also considered later in this guide (and in greater detail) in the section 'What do we know about forensic mental health services? (see page 11).

1 FORENSIC SERVICES: WHAT ARE THE CORE PURPOSES?

The core purposes of all forensic mental health services are to:

- treat individuals with mental disorders (including neurodevelopmental disorders) who pose, or who have posed, risks to others and where that risk is usually related to their mental disorder
- provide this treatment in community, hospital (particularly secure hospitals) and prison settings in line with the principles of a recovery-based approach
- provide treatment aimed at managing mental disorder and reducing risk to others and offending behaviour
- advise and work collaboratively with other mental health professionals, GPs and social care staff – providing specialist risk assessment and management advice on community patients who demonstrate a risk of serious harm to others (perceived or actual), with the aim of reducing risk and avoiding the need for admission to secure care
- give expert advice to, and work with, other criminal justice system agencies to manage risk for individuals with (or thought to have) a mental disorder – this is usually via a Multi-Agency Public Protection Arrangement (MAPPA), which includes police officers, prison staff and probation officers
- provide services to the criminal justice system (these are expected to fit with the 'Criminal Justice Mental Health teams' envisaged by the Bradley Report; see page 13)
- provide evidence-based assessment and treatment that will rely on education and training provided by forensic mental health services
- support research and audit within services.

Since 1999 NHS forensic mental health services have also taken on a "gatekeeping" role (on behalf of commissioners). This included undertaking 'access assessments' to determine the most appropriate placement for the patient in terms of mental health need and level of security required (recent guidance has attempted to improve assessment consistency in England).

Individuals in secure care will require a combination of physical, relational, and procedural security to remain safe. Individuals who do not require this combination will not be appropriately placed in secure forensic services.

Consequently, the maintenance of security is crucial to the provision of effective therapeutic interventions in secure services. These interventions are aimed at managing mental disorder and reducing risk to others and offending behaviour.

They typically include sex offender, aggression management, and fire setting programmes (individual and group).

2 FORENSIC SERVICES: WHAT ARE 'HIGH', 'MEDIUM' AND 'LOW' SERVICES?

The forensic mental health care pathway is comprised of numerous service components. These are commissioned by a number of different organisations, which can represent a challenge to ensuring integrated provision.

This guide provides an overview of these components, but primarily focuses on 'high', 'medium', and 'low' forensic mental health services. Each of these levels of service provision reflects the different levels of risk that patients are considered to present to others.

Consequently, each level provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others. However, in practice, the distinction between high, medium and low secure services has evolved and is often consequently 'blurred'.

What are forensic mental health services? (continued)

High secure services

High secure services are provided for people who "require treatment under conditions of high security on account of their dangerous, violent or criminal propensities" (as defined under the NHS Act 2006).

Prisons in England and Wales are categorised as A, B, C, or D settings, where Category A prisons work with prisoners who pose the highest level of risk to the public or national security. High secure services are provided in hospitals that have physical security arrangements no less than a Category B prison but who (through operational and relational security measures) can provide a Category A environment in which to treat individuals who would (in a prison setting) be in such an environment. There are three hospitals providing high secure services for England and Wales (Ashworth, Broadmoor,and Rampton).

Medium and low secure services

Medium secure services have a fixed level of security and standards with which they must comply (see page 15). However, while complying with these standards, these services can provide differing levels of secure care to meet the different and changing needs of patients (ranging from remand patients charged with serious offences, through to patients on increasing unescorted community leave as part of a pre-discharge programme). Patients in medium secure services move from admission, through rehabilitation, and towards leave and moving on.

There are currently around 150 low secure units. While less clarity exists around what constitutes 'low secure' (compared to high or medium secure services) the Department of Health have stated that *"low secure services are for people aged 18 years and over detained under the Mental Health Act who cannot be treated in other mental health settings because of the level of risk or challenge they present. Patients will not require the level of physical security provided by medium secure services"*[14].

Patients in both medium and low secure services will:

- usually have long-standing and complex mental health disorders
- typically require longer-term rehabilitation and support which either cannot be safely or successfully delivered in open mental health units
- be more likely to exhibit behaviour at a level of risk greater than a general mental health service could be expected to safely manage
- receive care, treatment, and interventions based on a recovery approach.

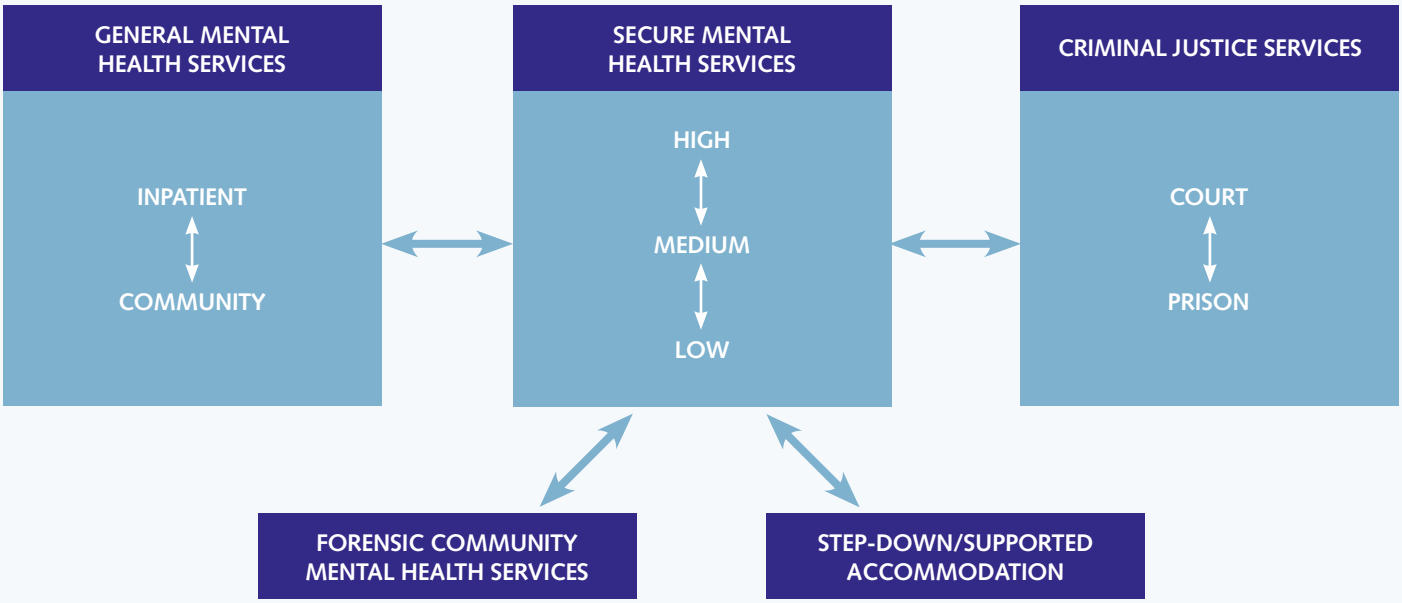
Some low secure services – such as services for people with autistic spectrum disorders – will be highly specialised. Rehabilitation will continue to address the risk behaviours and promote recovery.

3 THE FORENSIC PATHWAY: COMPONENTS AND COMMISSIONERS

As noted above, the fact that the forensic mental health care pathway is comprised of numerous service components, which are commissioned by a number of different organisations (Figure 1), can be a challenge to providing integrated care The forensic care pathway is described in more detail on page 11. However, in general, it can include:

- high, medium and low secure forensic mental health services – as described above (commissioned by NHS England)
- Specialist Forensic Outreach Mental Health Services – this is described in the draft service specifications for medium and low secure services as managing "safely the transition of high risk mentally disordered offenders from secure services into the community and provide advice and act as a consultation service to reduce the need for admission to secure services" (commissioned by NHS England)
- community forensic mental health services – these aim to help individuals who no longer require secure care make the transition back to the community (commissioned at a local level by CCGs)
- step-down services – these include locked rehabilitation units (commissioned by CCGs); supported accommodation in the community, which may vary from 24-hour staffed support to "floating support" at various times during the week (commissioned by health and/or social care services)
- prison health services (commissioned by Offender Health which is part of NHS England) – these include specialist mental health 'in-reach teams' and probation services (commissioned by the NOMS)
- police and court diversion liaison services – these were introduced to ensure that individuals with mental disorder are (a) identified quickly when they come into contact with the police and the courts; (b) where appropriate, diverted to care and support or (c) where the individual is remanded or sentenced to prison, their mental health needs can be communicated to that prison (commissioned by Offender Health, part of NHS England)
- generic mental health services, learning disability services, or personality disorder services (commissioned by CCGs)
- wider physical health and social care services – as provided by the NHS, independent sector, Local Authorities, social care or voluntary sector to help meet the often complex needs of individuals on the forensic care pathway.

Figure 1[21]: Pathways through criminal justice and mental health services



Why are forensic mental health services important to commissioners?

There are six main reasons why forensic services are important to commissioners.

1 PREVALENCE OF MENTAL DISORDER

Mental health problems are more common among men and women in the criminal justice system. For example:

- in 1998, the reported prevalence of mental illness (psychosis, including schizophrenia and bipolar disorder) in male prisoners (over 16 years old) was 20 times that of the general population – the figure for women prisoners was even greater
- there is an increased prevalence of neurodevelopmental disorders among individuals in the criminal justice system and forensic mental health services (including learning disabilities, pervasive developmental disorders on the autism spectrum, and other developmental disorders)[15]
- estimates published in 2011 indicate that almost a quarter (23%) of the prison population have a need for secondary mental health services[16]
- there is an over-representation of people with personality disorders in the criminal justice system – in 1998 it was estimated that two-thirds of all prison inmates would fulfil the criteria of a personality disorder[17].

Despite the relative increase in secure services over the 10 years since some of these studies, it is likely that these figures have not changed substantively, while the prison population over the same period has increased by 66%[18].

2 EQUIVALENCE OF CARE

The principle of 'equivalence of care' established that people in prison should have the same standard of care that is available to the wider (non-imprisoned) population. Established for individuals in prison in 1999[19], the principle was central to the transfer of responsibility for commissioning criminal justice health care in 2006 away from the Prison Medical Service and to the NHS.

3 PATIENT NEED

Patients in forensic mental health services have complex needs. These typically cannot be met by commissioning generic mental health services:

- all will have a mental disorder which at first contact with secure services met the criteria for detention under the Mental Health Act 1983 (amended in 2007)
- all will have shown behaviours which have presented as a risk of harm to others
- all will have complex needs (acute and chronic), and there will be considerable diversity in what these needs are (and also how they are met)
- some patients will also pose a significant threat to themselves (although this should not be the primary reason for admission to a secure service)
- and compared to generic mental health services will have a higher complexity of disorder, a higher incidence of mental illness that is resistant to treatment, and will pose a significant risk to others.

4 EFFECTIVENESS

Forensic mental health services have been shown to be more effective at reducing reoffending (especially for violent offences), than for equivalent offenders released from prison. Ministry of Justice data, for example, shows that the reconviction rate within a two year period for violent and sexual offences for patients conditionally discharged from hospital between 1996-2006 was two percent[1]. An equivalent rate (from a different study) for those released from a prison sentence is around 20%[20].

5 COST

Forensic mental health services are 'high cost, low volume' services'. Generally, this means that the level of security and complexity of patient need means that forensic mental health services are relatively more expensive to provide. However, when commissioning forensic mental health services, there are ways to ensure that the funding is used in the most cost-effective way:

- community forensic mental health services: there is evidence that the absence of a community forensic mental health service can lead to greater delayed discharges from secure forensic mental health services[21]. Such a placement in a secure forensic mental health services can incur a high financial cost, as well as having a significant impact on the individual (who will continue to be detained in a higher level of security than is needed). A greater 'match' between patient need and length of stay could result in a more efficient use of resources

What do we know about current forensic mental health services?

- case managers: where case managers are used in specialist commissioning areas, they will usually have considerable contact with providers (by attending assessment and care planning meetings). This can make a significant contribution to the decision about where the most appropriate placement for a patient will be, which is based on their needs and a detailed knowledge of the local services. This can help reduce costs.
- shorter transfer delays: the funding of forensic mental health services has been linked to the funding of inpatient beds, even where these include community services – the high cost of these beds means that if a patient is delayed for 12 months in moving from high security to medium security, significant amounts of resources will be used.

6 LEGAL OBLIGATIONS ON COMMISSIONERS

The commissioners of forensic mental health services have legal responsibilities which they must be aware of, and comply with:

- individuals transferred to hospital from prison under the Mental Health Act, where the Ministry of Justice has the power to direct them to specific forensic inpatient services
- patients placed on hospital orders by the Courts (see page 14) – there have been a number of instances where commissioners are summoned to appear in court to explain why a bed is not available
- patients who are recalled from conditional discharge back to hospital by the Secretary of State.

WHAT IS THE FORENSIC CARE PATHWAY?

As noted earlier, NHS England commissions high, medium, and low secure services (guidance on what constitutes 'good' provision of these services is given on page 15).

However, there are other types of service which form part of the forensic care pathway, and not all of these will be commissioned by NHS England. As described below, these services include:

- community forensic mental health services
- prison health services and probation services
- police and court diversion liaison services

In addition, most forensic mental health services work closely with Multi-Agency Public Protection Arrangements (MAPPA) to protect the public by managing high-risk offenders living in the community.

Community forensic services

These aim to help individuals who no longer require secure care make the transition back to the community, and are locally commissioned by CCGs.

The majority of forensic patients will be living in the community. Although still relatively rare[21], community forensic mental health services work with these patients, often operating at four different levels according to the needs of the patient:

- **level 1** – by offering a single assessment or consultation undertaken by the community forensic service
- **level 2** – by offering a period of assessment by the community forensic service, for example, to undertake a structured risk assessment, with the referring team retaining responsibility
- **level 3** – by operating an agreed period of shared care with the generic mental health service, which could include completing a more detailed assessment of risk, or guidance on a risk management plan (including an evaluation of its effectiveness)
- **level 4** – with the community forensic service taking full responsibility for care of the patient, including any care coordination functions.

Other operating models exist, but this provides a flexible approach in terms of patients being (a) managed in the least restrictive setting, whilst (b) supporting general psychiatric services to become collaboratively involved in the clinical management of these patients (where clinically appropriate).

Community forensic mental health services also have two additional (and vital) functions:

- to assist the discharge of patients from secure care into the community
- to safely manage the transition from forensic community services to non-forensic community services.

However, it is important to remember that some patients will require longer-term care in a specialist community forensic service. As the National Confidential Inquiry into Suicides and Homicides in their 2010 report[22] recognised, such patients can have (a) complex mental health needs linked to a history of serious violent offending, and (b) can also often have co-morbid substance and non-compliance problems.

Because of their potentially high risk of offending, these patients will need to be managed by community forensic services.

What do we know about current forensic mental health services? (continued)

Prison mental health and probation services

These include specialist mental health 'in-reach teams' (commissioned by NHS England) and services within prisons and the probation service (some of which are co-commissioned by the NOMS with the NHS).

Research studies have shown that there is very high morbidity for mental health disorders in prison and high levels of need especially in female prisons (see page 10). One method of addressing this is through specialist mental health 'in-reach' teams which:

- were set up following the NHS taking over responsibility for Prison Health in 2006
- reflected the model of multi-disciplinary working found in community mental health teams (including nurses, psychiatrists, social workers and, less often, clinical psychologists)[23]
- work with prisoners with severe and enduring mental illnesses.

But issues have arisen since they were first introduced, including:

- reported improvements in mental health care in some (but not all) prisons[23]
- referrals being received for patients with common mental health problems (which should be managed in primary care settings), meaning prisoners with severe mental illnesses are not receiving the care they need
- an absence of implementation guidance for such 'in-reach' teams or for those commissioning them[16].

Other service needs include:

- individuals in prison with a personality disorder – a small number of whom are transferred to a secure hospital during the course of their prison sentence for treatment of their personality disorder, these are then returned to prison when that treatment is completed (or when treatment has not been shown to benefit the patient)
- individuals in prison with a dual diagnosis of mental disorder and substance misuse problems – while it is estimated that 70% of patients cared for by mental health 'in-reach' teams have substance misuse needs, only one in ten of those services have dual diagnosis teams[22].

A particular interface problem arises when inmates with mental health problems are released from prison because the 'offender mental health pathway'[2] has not been universally adopted across all prisons. This means that the Care Programme Approach process has not been consistently used for individuals in prison who are then at risk of having poor, or a total lack of, support following release.

Police and court diversion and liaison services

Commissioned by Offender Health within NHS England, police and court 'diversion and liaison services' have been developed to ensure that individuals with mental disorder are:

- identified quickly when they come into contact with the police and the courts
- where appropriate, diverted to care and support
- or where the individual is remanded or sentenced to prison, their mental health needs can be communicated to that prison.

The most significant driver for the further development of liaison and diversion services came about with the 2009 publication of the Bradley report[3] (box 1).

There is an increasing recognition that 'liaison' is as important as the diversion function. 'Liaison' refers to information and other exchanges between those working in police and court settings and other health professionals, criminal justice agencies, community health providers and the third sector. Throughout, the aim is for services to both meet the needs of offenders, and also address dynamic risk factors.

Offender Health, which currently commissions the police and court diversion and liaison services, has set up a national network of 'pathfinder sites' in England for both adults and young people[24]. This is currently being evaluated with the intention of delivering the requirements of the Bradley report by 2014[25]. The present coverage of these services has been described as variable.

MAPPA

Forensic mental health services overlap with other agencies, especially in the criminal justice system. For example, forensic services operate in prisons, with probation services, and with the courts. Many forensic mental health services work closely with Multi Agency Public Protection Arrangements because (a) their patients fall within MAPPA and (b) these services have expertise in assessing and managing complex high risk individuals in the community (see box 2).

BOX 1: THE BRADLEY REPORT

The review (chaired by Lord Bradley) was set up to address the need to divert more offenders with severe mental health problems away from prison and into more appropriate facilities. Lord Bradley's most significant recommendation was in relation to the development of 'criminal justice mental health teams'. The core elements of these teams are:

- liaison with local community services
- screening and assessment
- coverage of police custody and courts (with links to prison mental health in reach services and resettlement to ensure continuity of care)
- management of information concerning an individual's needs throughout the criminal justice system back into the community
- direct involvement and input into MAPPA
- standardised assessment processes
- joint training for criminal justice and health and social care staff
- active service user involvement
- access to learning disability expertise.

BOX 2: MAPPA

Multi Agency Public Protection Arrangements began in the late 1990s with improved working relationships between criminal justice system agencies. The police, probation and prison services are the key bodies involved in managing risk within MAPPA.

They were introduced with the aim of protecting the public by managing high-risk offenders living in the community and therefore reducing the risk of them committing further sexual and violent offences.

A number of other agencies have a duty to cooperate with MAPPA. These include health service organisations, offenders who commit sexual or violent offences and who receive a hospital order or guardianship will be subject to MAPPA.

MAPPA applies to patients who have been convicted of the relevant violent or sexual offences. Offences are grouped into one of three categories. For each individual subject to MAPPA, one of three levels of risk management can apply:

Level 1: ordinary risk management, when MAPPA management of risk falls primarily under one agency.

Level 2: this is needed when the offender requires active involvement and coordination of interventions from other agencies to manage the presenting risks of harm.

Level 3: this level was intended to cover the 'Critical Few' where there is risk to others of serious harm which is high and imminent. Level 3 MAPPA meetings are expected to include representatives from agencies who are senior enough to make decisions involving allocation of resources.

What do we know about current forensic mental health services? (continued)

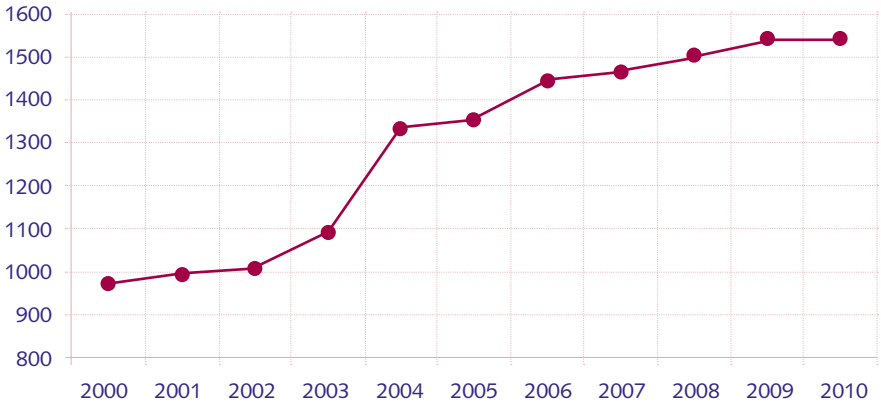
HOW MANY PEOPLE USE SECURE SERVICES?

Currently, there are approximately 6000 individuals in secure mental health services commissioned in England, of which:

- 680 are in high secure
- 2800 are in medium security, and
- 2500 are in low security

Other measures include the admission of patients detained under a 'restriction order' (Part III of the Mental Health Act; Figure 2). Such 'restriction orders' are added by the court or the Ministry of Justice, and are given to control the leave or discharge of an individual deemed to be at increased risk to others in the community. Most of these admissions are (a) from prison and (b) over 95% are to medium secure services[26].

Figure 2[27]: Graph of restricted patient admissions, 2000–2010



Notes: these data omit the admission of patients under unrestricted hospital orders (usually 250-300/year) and patients admitted to secure services under non-forensic sections (Part II) of the Mental Health Act. A non-forensic section involves patients who require secure care, but have not been convicted of any offences.

HOW HAVE SERVICES DEVELOPED?

The Mental Health Act 1959 laid the foundation for forensic mental health services. In introducing the 'hospital order', it allowed a mentally ill person convicted of an offence which would normally lead to imprisonment to be admitted to hospital for treatment.

Further policy milestones included the Butler report in 1975 which contributed towards the development of 'regional secure units' (which would later become known as medium secure services). While the pace of their emergence varied, forensic mental health services were established across England, and (due to historical reasons) have a funding structure almost entirely linked to inpatient beds in secure units.

In the last 10-20 years, an evolutionary change in the provision of secure services has occurred, with a shift away from high to medium secure provision. For example, in 1991 there were more than 1700 beds in high secure services and fewer than 600 beds in medium secure services. However, since then, almost 1000 high secure beds have closed and been replaced by an increase in medium secure provision[26]. Uniquely, the independent sector provides 35% of such forensic mental health service beds in England[21].

Despite the existence of both almost universally accepted 'core purposes' (as described on page 7), and a range of national standards (as summarised on page 16), considerable variation does exist in the types of forensic service that are commissioned (page 18). This variation can both exist within the same specialised commissioning area, and also across different areas. For example, in some areas, the only forensic services may be an inpatient service of medium security (either with or without low secure beds and with a limited community service), while in other areas it could include inpatient secure beds, a parallel community service, prison in-reach teams and criminal justice mental health teams. Often, the reason for such variability is historical.

What would a good forensic mental health service look like?

PRINCIPLES

There are seven principles that should guide the commissioning of any forensic mental health service:

1 Forensic mental health services need to be high quality, patient centred and recovery orientated. Patients should make a significant contribution to commissioning of secure services and to their development and delivery. Services should promote social and clinical recovery and include access to education, employment and peer support.

2 Commissioning of services for a locality needs to ensure there are appropriate care pathways based on patient need, and which also take into account the diversity of their population. They should meet the needs of 'protected groups' as defined in the Equality Act 2010, as well as meeting the needs of groups currently over represented in the forensic patient population (such as people from Black and minority ethnic populations). The ability to meet a specific need should not depend on the geographical location of the patient.

3 Access to forensic mental health services needs to be timely and with clear assessment processes that avoid duplication and unnecessary delays in admission to forensic mental health care.

4 Patients in forensic mental health services typically have complex and multiple needs – forensic mental health services therefore need to be comprehensive and encompass all aspects of mental health care including physical/medical, psychological and social care.

5 Integrated care pathways should be commissioned so that transitions within or between services are seamless. Patients should have clear care plans addressing all their needs including those related to risk, mental and physical health and social care and delivered at the appropriate level of security to meet their needs.

6. Forensic mental health care services are part of a pathway that includes: liaison and diversion with police custody and courts; prison mental health services and mainstream mental health care. Commissioning arrangements need to make sure that these interfaces are reflected in commissioning arrangements.

7. Commissioning plans need to be mindful of the role that the Ministry of Justice frequently has in the placement of patients, their leave and discharge arrangements and their obligation towards the needs of victims.

CARE PATHWAYS

When commissioning forensic mental health services, commissioners should ensure that:

- there is a clear care pathway for each patient from admission to discharge from secure care
- this should be dependent on their identified needs and through whatever levels of security are required
- that there is seamless progress along the pathway, even when this is through different levels of security or different providers of care
- that needs are being regularly reviewed and care plans in place to meet those identified needs
- that there is an expectation that the patient's needs will change as they move along their care pathway

There should not be an expectation that all patients must 'descend' through all levels of security (i.e. high, medium, and low) prior to discharge.

INTEGRATION

Different services will have different processes to manage the pathway of care (with case managers alone or working with clinicians). They should ensure that, even when specific packages of care are commissioned, these are not delivered in isolation. They should be an integrated part of the patient's care pathway.

There are a number points in a patient's pathway where there are potential risks to the managed integrated pathway. These are:

- where there is transition from one service provider to another, and
- where funding arrangements change from one funding authority to another.

It is important that the potential financial disincentives to move a patient along their pathway are not inhibitors or do not delay patients progress.

SECURITY

The forensic/secure pathway for individuals should promote and enable recovery and independence whilst ensuring protection of the public. However, these are not mutually exclusive outcomes because high quality care will result in improved protection of the public.

The forensic/secure pathway should include the provision of appropriate levels of physical, procedural and relational security within a range of environments including high, medium, low secure and transitional step down facilities. Individuals who do not require a combination of procedural, physical and relational security will not be appropriately placed in secure forensic services.

What would a good forensic mental health service look like? (continued)

The application of security measures should aim to promote a safe and therapeutic environment, whilst pro-actively encouraging independence, responsibility and recovery. The application of security should therefore be based on the risk needs of the individual, be as least restrictive as possible, and imposed only when risks have been identified. The balance between procedural, relational and environmental security will depend on the individual's needs and progress along their pathway to discharge/transfer.

Placement within the pathway will be determined by the level of risk of harm to others and the stability of the mental health of the individual concerned. Progress and transition along the pathway will be determined by the reduction in assessed risk to others, and a reduction in the need for care and supervision. Secure care environments should be determined by their ability to meet the needs of the individual and in meeting identified outcomes. Transition between services along the care pathway should be as seamless as possible and kept to a minimum in order to provide effective continuity of care.

OUTCOMES

Current mental health policy advocates the need to place individuals at the heart of their own care as well as an imperative for services to focus on measurable explicit outcomes. For secure services this policy objective will require a shift toward more recovery based approaches, and an emphasis on meeting outcomes for people, rather than focusing on the delivery of interventions.

There are a wide range of outcomes that secure services are required to meet:

- patient outcomes in terms of mental health, risk, quality of life and recovery
- process outcomes and basic data collection
- service outcomes in terms of having good quality and relevant intervention programmes in place
- community safety outcomes (particularly in relation to offenders and those individuals on restriction orders).

One example of such a suite of outcomes is the 'My Shared Pathway' initiative (box 3). This aims to promote a recovery and outcomes based approach to care planning across the secure system.

This programme is currently being implemented across secure services aiming to standardise eight outcome areas, whilst ensuring that good recovery approaches are used that clearly link to the outcome areas.

This approach also attempts to place as much responsibility for delivering outcomes into the hands of patients, and a heavy emphasis is on promoting greater collaboration between patients and staff in identifying and measuring the outcomes required for that individual to move on from secure care. This resonates with other programmes across the NHS which similarly aim to place patients at the centre of monitoring outcomes and the quality of care delivery. Patient Reported Outcome Measures (PROMs) are being developed across NHS services to ensure patients are placed at the centre of their own care through informed choice.

BOX 3: MY SHARED PATHWAY OUTCOMES AREAS

1 My mental health recovery
2 Stopping my problem behaviours
3 Getting insight
4 Recovery from drug and alcohol problems
5 Making feasible plans
6 Staying healthy
7 My life skills
8 My relationships

The aspiration currently therefore is to explore and agree what outcomes secure services are designed to achieve, systematically measure them and then evaluate their effectiveness.

QUALITY IMPROVEMENT

In 2006, the Quality Network for Forensic Mental Health Services (QNFMHS) was launched by the College Centre for Quality Improvement (CCQI).

By 2011, all medium secure units in England, Wales, Northern Ireland and the Republic of Ireland were part of the Quality Network. In England, this was largely because commissioners themselves insisted that membership of the Quality Network was mandatory for services.

The QNFMHS uses an iterative cycle of self and peer reviews using a set of implementation criteria based on Department of Health recommended specifications (box 4). Standards are developed in consultation with the member units of the quality network. Each unit evaluates itself against the standards as a self-review exercise. This is then followed by a peer review visit to validate the data.

The peer review teams include patients as well as a range of multidisciplinary staff from other medium secure units within the quality network. Following the peer review visit, a local report is provided that includes data from both the self and peer reviews. The unit is then expected to develop an action plan to address the areas identified for development.

When all units in the quality network have completed the peer review phase, an annual report of the aggregated findings is produced. Finally, an annual forum is held where good practice between units can be shared.

A second quality network for low secure services has now been established. This uses the same cyclical review process as for the medium secure network. The standards for this network were developed in 2012 and are based on draft commissioning guidance from the Department of Health[14]. The CCQI are also currently developing a Quality Network for community forensic services. The standards for this are being developed through a process of expert consultation workshops.

It has been proposed that a quality network should be developed for mental health in-reach teams in prisons. The continuing support of commissioners of forensic mental health services will be essential to the development of these new quality networks.

BOX 4: IMPLEMENTATION CRITERIA FOR MEDIUM SECURE UNITS

A safety and security
B clinical and cost effectiveness
C governance
D patient focus
E accessible and responsive care
F environment and amenities
G public health

Quality Network for Forensic Mental Health Services (2013)

PUBLIC MENTAL HEALTH

As described in the JCP-MH guide on this issue[38], it is now increasingly recognised that mental health is a public health issue. Mental illness is unique compared to other health conditions in the combined extent of prevalence, persistence and breadth of impact. Added to this is the economic cost, estimated in England to be £105 million each year[28]. As most mental illness begins before adulthood and often continues throughout an individual's life, it is understood that improving mental health early in life will reduce the inequalities that result from chronic mental illness and in turn also improve physical health and increase life expectancy, economic productivity and social functioning.

In addition to the public health issues associated with mental illness, there is recognition that offender mental health is a significant public health issue as well. Forensic mental health services represent the common ground between these two public health issues. As with mental illness, the risk of becoming an offender begins early in an individual's life and increases from childhood onwards. There are strong links between social exclusion and mental disorders. It is suggested that early intervention before those at risk are drawn into the criminal justice system will produce significant health social and financial benefits[29].

If the factors that increase an individual's chance of becoming an offender from childhood onwards are considered, then the overlap with mental health issues becomes clear (Box 5). It could be argued that a good forensic mental health service would at least, take notice of these factors and perhaps try to address them. However, it is only by engaging with public health services that these factors could be prevented from occurring, which would then benefit the individual both in terms of their own mental health and their later involvement with the criminal justice system.

SENSITIVE PERSONAL INFORMATION

Forensic mental health services are party to significant personal and sensitive information about patients under their care. They also need to liaise and communicate with a wide variety of agencies to manage risk and to support recovery. Two significant partners in this process are commissioners and the criminal justice system. When sharing personal and clinical information, forensic psychiatry services need to be vigilant and mindful of confidentiality and work within the 'Caldicott principles'[30]:

BOX 5: CONTRIBUTORY FACTORS THAT INCREASE THE RISK OF AN INDIVIDUAL BECOMING AN OFFENDER, FROM CHILDHOOD ONWARDS

- poor maternal mental health
- poor parenting skills
- abusive home relationships
- family history of involvement in criminal justice system
- learning disability
- truancy and exclusion from school
- poor educational achievement
- being a "looked after" child
- conduct/emotional disorders

1 any information shared by the organisation must be justified and under regular review

2 patient identifiable information must not be used unless it is absolutely necessary and even then only the minimum necessary should be provided and on a need to know basis only

3 it is the duty of staff and services to ensure that every one with access to patient identifiable information is aware of their responsibilities - this is particularly relevant when working with other agencies that may have different rules of confidentiality.

Forensic mental health services and commissioners must always work within the law. The role of commissioners includes supporting the development of appropriate and cost effective services. Aggregated data is most useful for this purpose and forensic services should strive to provide meaningful aggregated data where ever possible. Commissioners are under the same obligation to protect confidential information as required by the Department of Health guidance on Confidentiality[31].

What would a good forensic mental health service look like? (continued)

INNOVATIVE PRACTICE MODELS

Therapeutic community in a high secure LD service[32]

The National High Secure Learning Disability service at Rampton Hospital is developing the evidence base for working with personality disorder concurrent with intellectual disability. The service has adopted a therapeutic community milieu approach on one of the four high secure treatment areas for the last two years, an approach which has not been previously attempted in forensic intellectual disability services. This approach includes democratic decision making in the community, increased permissiveness, and an emphasis on peer feedback and responsibility taking. The model is consistent with the involvement agenda. The milieu approach is combined with small group therapy and traditional skills development and offence focused group work. Early evaluation indicates reduced seclusion hours, reduced internalising behaviour problems such as anxiety, and increased honesty and openness both in general and in relation to offending behaviour. These changes have occurred over time and in relation to a matched comparison group and are encouraging given the complex and high risk nature of the patient group.

Catrin Morrissey, Lead Psychologist, LD Service, Rampton Hospital

Service users assessing their own risks

East London Foundation NHS Trust

One of the key goals of recovery is that of responsibility and hope and the traditional method of risk assessment often creates a passive stance whereby the service user has to adhere to the team's management plans and may feel hopeless about the emphasis on past risks. The low secure service in the East London Foundation Trust developed a 20 week risk assessment group for service users with a history of violence in order to help service users understand what is meant by risk, to learn about the HCR-20 risk assessment and to begin to apply this to themselves and develop management plans. This has enabled service users to discuss their own risk factors openly and be challenged by their peers on certain items such as drug use, their 'insight', or support. The most notable outcome was the opportunity for service users to take responsibility for their own risk, generate hope for their self-efficacy in managing their risk and feeling empowered to change the one thing that keeps them in hospital. There is often a tension between risk and therapy which can create an obstacle within forensic settings. This group is an illustration of how the two can work together towards recovery goals.

Bradley Mann, Consultant Clinical Psychologist

The national psychiatric sex offender advisory service

Northumberland Tyne and Wear NHS Foundation Trust

The national psychiatric sex offender advisory service was set up to facilitate referrals from probation officers and prison psychologists of sex offenders for whom medication might be of benefit in assisting them to manage their sexual drives and behaviour. It was established by Northumberland Tyne and Wear NHS Foundation Trust in 2008, and provides support for psychiatrists in carrying out assessments, with further advice available in respect of prescribing. Referral, assessment and treatment protocols have been developed, as have patient information leaflets. Referrals are reviewed to ensure that consideration for medication is appropriate, following which a local psychiatrist is identified to carry out the assessment and to initiate prescribing if indicated.

Don Grubin, Specialist forensic community personality disorder treatment service

The pathfinder service

Avon and Wiltshire Partnership Trust

The pathfinder team is a specialist service to the West of England cluster of NHS South West. It provides alternatives to inpatient secure care and the provision of community care and treatment of men and women with a diagnosis of personality disorder and a forensic history, including serious harm to others and who pose a current risk. It offers specialised psychological interventions, mainly through group interventions that address both psychological needs and reoffending risk factors. The team works closely with the NOMS to provide assessment, consultation and case management to prisons within the South West. The service also works closely with the inpatient forensic service to support it in the management of inpatients with dual diagnosis who may benefit from the treatment programme on discharge. The service was initially established in July 2007 is a three-year pilot but has been given recurrent funding since October 2010. In April 2012 the service was extended to provide an assertive case management function for out of area placements.

The aims of the service include:

- provide an alternative to hospital admission
- provide a personality disorder gatekeeping service
- facilitate the pathway of personality disordered offenders through the criminal justice system
- reduce the exclusion from services of service users with personality disorder
- work collaboratively with the probation service to identify offenders with personality disorder and provide support to their case management.

Michelle Chauhan, Team Leader and Consultant Clinical Psychologist

Supporting the delivery of the mental health strategy

The Joint Commissioning Panel for Mental Health believes that commissioning which leads to the effective planning and management of forensic mental health services, including the involvement of patients and their carers in the development of these services, will support the delivery of the Mental Health Strategy by contributing to the following shared objectives:

Shared objective 1: More people will have good mental health.

- given the high levels of need in patients in forensic mental health services, staff will need particular expertise to provide high quality care to patients
- treatment will aim to prevent deterioration
- substance misuse is a significant co-morbidity and often causes relapse
- personality disorder is a significant co-morbidity and can delay engagement and progress.

Shared objective 2: More people with mental health problems will recover.

- for most patients the main long term outcome will be discharge to suitable accommodation in the community of their choice, with the maximum amount of comfort, safety and independence
- the numbers of women are small leading to patients with very different needs and at different stages of their pathway being placed together
- it is crucial to incorporate the learning of everyday skills of living within the individual's treatment regime.

Shared objective 3: More people with mental health problems will have good physical health.

- all patients can register with a local GP or the service will provide equivalent access to primary care
- all will have access to skilled and long term follow-up and support.

Shared objective 4: More people will have a positive experience of care and support.

- there will be help to manage money
- there should be meaningful activity (not necessarily employment)
- family support and maintenance and reestablishment of family relationships should occur where possible
- many patients are themselves victims of trauma and abuse.

Shared objective 5: Fewer people will suffer avoidable harm.

- Secure services often require a larger proportion of resources than non-secure services. However, the interfaces with other services are also key for commissioners as the commissioning body changes and interfaces which are not functioning properly will lead to prolonged hospital stays
- services need to be structured to manage need, which will include managing risk
- high quality care will result in improved protection of the public
- there will be a role for:
  - the Ministry of Justice
  - victims' groups
  - multiagency case working.

Shared objective 6: Fewer people will experience stigma and discrimination.

- there will be active work to reduce social exclusion and the stigma of illness and history of offending
- social interventions will work in this difficult area
- the ethnic diversity of the patient population must also be considered
- it is also important to identify and address language and communication issues.

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Development process

This guide has been written by a group of forensic mental health service experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

Resources

MAPPA

www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

My Shared Pathway

www.networks.nhs.uk/nhs-networks/my-shared-pathway

NHS England

www.england.nhs.uk/ourwork/d-com/spec-serv/

Quality Network for Forensic Mental Health Services

www.rcpsych.ac.uk/qnfmhs

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