Community Forensic Psychiatry: An Ugly sister or Cinderella service?

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Pathways and Outcomes

• Patients move through services in all sorts of different directions: Up tiers of security, down tiers of security, from side to side (e.g. from one medium secure unit to another), between NHS and independent sector services, between secure services and general psychiatric services, and between secure services and prison.

There is a renewed focus on-

• Measurable Outcomes
• Facilitating discharge
• Efficiency/ QIPP
• Models of Commissioning
The issue

Offender Health Pathway is not complete without adequate /appropriate care in the community

- It is argued that many patients stay in medium secure for long periods, partly because of a lack of suitable provision at lower levels of security /step down and community services.
- “A better balance of investment is needed to enable step-down and community provision”.

(Pathways to Unlocking Secure Mental Health Care. National Mental Health Development Unit. Apr 2011)
What is Community Forensic Psychiatry?


- The outreach teams in most secure units evolved over time to designated Community Forensic Mental Health Teams.

- By 2004, Judge et al identified 37 community forensic services based in regional secure units and covering a mix of urban and rural areas.

- Some predated NSF by more than a decade.
Literature review

- 1x Randomised Trial
- 6x Follow up studies (case controlled, observational, retrospective and prospective)
- 6x Surveys (cross sectional, postal surveys)
- 3x Evaluations (programme or service evaluations)
- 6x Opinions (editorials, correspondence)
- 2x Qualitative Studies (including a modified Delphi consultation)
- 1x Published Audit
80% teams identify themselves as parallel (Judge et al 2004) as opposed to integrated although its likely most are on a continuum (a.k.a “hybrid”)

Main roles: forensic case management, risk assessment and management, consultation liaison, co-working, court diversion and court liaison, MAPPA, PPUs, and more recently CTOs (Malik et al 2007)

Patients value easy accessibility and few named contacts. Dislike frequent appointments (“surveillance”) and lack of “back up services” (day hospital, sheltered employment, appropriate accommodation etc.)... (Riordan et al 2005)
...contd

• Mixed results about effectiveness using outcome measures like jail recidivism, hospital admissions and mean survival times to reoffending in publications-
  Solomon et al 1994,
  Lamberti et al 2004,
  Dalton 2005,
  Coid et al 2007,
  Sahota et al 2009,
  Ong et al 2009,
  NCISH 2010

• One USA study(Weisman et al 2004) demonstrates cost effectiveness.
Limitations of Evidence....

• Evidence is from lower down the established hierarchy of evidence (no RCTs, more surveys)
• “Landmark studies” methodologically limited (e.g. sampling bias, use of unvalidated outcome measures, short follow-ups etc)
• No UK studies on health economics /cost effectiveness of community forensic teams.
Who should follow these patients?


• General Psychiatric services believe they deal with “equally or even more” risky patients but without the matching resources.

• Forensic teams express anxieties about lack of adequate skills/experience/competencies in generic teams.

• Often highlight diffused focus on relational aspects, patients often being lost to follow up, stigmatisation of perceived “difficult” patients and even rejection by overstretched members of generic teams.
Are the conclusions of the NCISH 2010 valid?

• NCISH 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.”

• “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.”
The West Midlands Experience
AWA and Forensic: Partners in Care

• Reaside Clinic has provided community follow up services for mentally disordered male offenders for over 23 years.
• Despite regular discharges from MSU, the community caseload has remained fairly constant, indicating an existent informal pathway out of secure care.
• Birmingham now has a FLATT (Forensic Liaison Assessment and Treatment Teams) joint working group comprised of forensic, AWA, social care, service users and carers and other relevant stakeholders which meets every month; and aims to formalise the existing liaison links and define a safe, optimum and consistent care pathway for mentally ill offenders leaving secure care.
Alternate view of Liaison from Wolves and Shropshire

• Circumscribed areas
• Referrals to a Single Point of Contact
• Purely consultation model
• Does not get involved in follow-up
• Special funding
What standards can Quality Network set around this issue?

- **National Standards in Community Forensic Psychiatric Services project (joint collaboration with forensic exec)**
  - Aim: To put together a draft paper of core elements of community forensic services which would be worked upon by a small core group and then circulated for comment within a web-forum.

- Rationale: Research review completed by JKH/RP. In the absence of robust primary evidence a consensus opinion would be appropriate, the group having collated this from expert clinicians in the field (electronic survey).

- Themes: An outline of service lines within community forensic psychiatry, core elements of forensic case management (such as relational security / knowledge), capturing the essence of the ‘model of care / approach’. Nonetheless, the paper could not be too prescriptive, as services will have developed due to localised factors / circumstances.
In Summary

• It difficult to conclude, based on published literature alone, whether Forensic or other community services are better in following up ‘forensic’ patients.

• CFMHTs are prevalent and developing but without clarity as what basic principles or standards are needed.

• What standards should we set?

• Can we afford to ignore CFP in current economic climate esp. in view of large numbers in secure care?

• Opportunities for improved quality and efficiency
Thanks