

**CARE PATHWAY AND MODEL FOR
COMMUNITY FORENSIC
TEAMS IN
N. IRELAND**

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SECTION 1: INTRODUCTION & BACKGROUND

Introduction

The main purpose of this paper is to provide a composite regional care pathway for community forensic mental health and learning disability services. It outlines the links needed with probation, prison and police services as an integral element to provide streamlined access to community forensic services. In addition this paper provides an overview of current arrangements and processes within forensic mental health and learning disability services in place across Northern Ireland.

The paper makes reference to Community Forensic Teams (CFT's) as defined in Bamford 2006, for ease of reading. CFT's covers both Community Forensic Mental Health Teams (CFMHT) and Community Forensic Learning Disability Teams (CFLDT), with each service, where available, working within their own specialisms. In Trusts where there is no CFLDT established, the CFMHT will provide advice on such issues as offending behaviour and risk management where appropriate. It is recognised that this arrangement is not endorsed in every Trust area; however a Forensic Learning Disability proposal is being taken forward to address this deficit.

Background

The Public Health Agency and Health & Social Care Board established the Mental Health and Learning Disability Taskforce in 2010 to take forward the implementation of the Bamford Action Plan 2009-11 which was the DHSSPSNI response to the Bamford Review of Mental Health and Learning Disability Services (2007).

The Mental Health & Learning Disability Commissioning Team is responsible for planning and commissioning services through the Board and Agency, and for supporting and assisting the overall constituent elements of the service team structure i.e. Project Board/Commissioning Board and the range of sub groups. Membership of the sub groups includes a wide range of stakeholders, including the voluntary and community sector, service users and carers (appendix 1).

The Bamford Specialist High Support Services Sub-Group forms one of the work streams that are responsible for taking forward specific work packages within a number of workstreams, of which the Bamford Forensic Sub Group is one. Members of the Bamford Forensic Sub Group identified the need to

review the community forensic services care pathway document that was produced in 2006 to more accurately reflect and inform on current community forensic health care provision.

Definition of a Care Pathway

An integrated care pathway is a multi-disciplinary outline of anticipated care, placed in an appropriate timeframe to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes (www.evidence-based-medicine.co.uk, 2001)

The purpose of a forensic health care pathway is to ensure that service users are receiving a quality service that is accessible and appropriate to their needs.

The formation of a care pathway allows for better monitoring and streamlining of the care process, this is of particular relevance where there are a range of professionals/agencies involved in the management of the client. This in turn helps to ensure a high degree of efficiency and consistently delivered care regionally, thus reducing unnecessary variations in treatment and outcomes. The care pathway also supports the development of care partnerships, a vital component of interagency collaborative working, whilst at the same time empowering clients and their carers to participate and contribute to their specific care needs.

The development and implementation of a care pathway informs outcome measures and is an integral part of both Quality and Modernisation agendas across health communities. *“They are key to reducing variations in healthcare... are crucial to ensuring the delivery of care that is safe, effective, patient centred, timely, efficient and equitable.”* (Davis 2004).

Strategic Context

There are a number of significant strategic drivers that underpin the need for a co-ordinated and streamlined care pathway for community forensic mental health and learning disability services. Further detail can be found at Appendix 2.

SECTION 2: CURRENT SERVICE PROVISION

Mental Health

High Secure Services

Currently in Northern Ireland there is no provision for high secure services; this service is provided by the State Hospital Carstairs in Scotland (male) and Rampton in England (female). In exceptional circumstances male patients may also be located in any of the 3 High Secure Hospitals in England.

Medium Secure Services

Shannon Clinic, on the Knockbracken site in Belfast, provides regional medium secure inpatient services. The Unit is made up of 34 beds spread across 3 wards:

- Ward 1: Admission/Assessment and Intensive Care
- Ward 2: Continuing Care Services
- Ward 3: Rehabilitation

Ward two has five beds that can be made available for female patients, although this is not a dedicated provision. The Unit is supported by the four Community Forensic Mental Health Teams across the region who each deliver services to their respective Trust population.

Low Secure Services

There is currently no dedicated low secure provision for forensic mental health patients in Northern Ireland.

Community Forensic Mental Health Services / Teams

There is a Community Forensic Mental Health Team (CFMHT) in each of the Trusts across the region, with the exception of the South Eastern Trust which is covered by the Belfast Trust's CFMHT.

Learning Disability

High secure Services

Within Northern Ireland there is currently no high secure service provision for forensic learning disability clients. Currently forensic learning disability services for male clients are accessed through The State Hospital, Scotland, with services for female clients again being provided by Rampton Hospital.

Medium Secure

There is currently no dedicated medium secure provision for this client group, causing individuals to remain in high secure settings for longer than necessary or to be inappropriately placed in a low secure setting.

Low Secure

Learning Disability in-patient forensic services are provided by the Sixmile Low Secure Unit on the Muckamore site. This unit caters solely for male clients and there is currently no low secure provision for females, although they may be admitted to Cranfield Unit, Muckamore. The Sixmile Unit is comprised of two elements, a 4 bed assessment unit and a 15 bed treatment unit. The Unit is predominantly supported by generic learning disability community teams which include senior social work practitioners who act as designated risk managers as defined by PPANI, and where available Community Forensic Learning Disability practitioners and Community Forensic Learning Disability psychologists.

Community Forensic Learning Disability Services / Teams

Three out of the five Trusts, Northern, Southern and Belfast, currently provide dedicated community forensic services for their respective learning disability populations. These services are delivered via two service models. The Northern Trust CFLDS is integrated within the CFMHS infrastructure working to the same protocols and operational policies, and availing of the same training and supervision as their forensic mental health colleagues. The alternative existing approach is a stand alone model, as is the case in the Southern Trust (the senior Forensic Practitioners in the mental health team however have dedicated time devoted to the Community Learning Disability Team to promote an integrated model) and more recently the Belfast Trust. In January 2011, the Belfast Trust commissioned a community forensic learning disability post (Forensic Psychologist) with the intention of developing a comprehensive service. Current arrangements mitigate against delivery of services at level 4 although clients requiring complex and specialist assessments and interventions can be facilitated.

For both CFMHS and CFLDS the underpinning rationale for service delivery is the need to support the smooth transition from secure provision towards community integration. In addition their role is to support adult mental health and learning disability services in the risk assessment and safe management of those clients who meet the defined criteria as laid out in Section 3. Collaborative working with the Criminal Justice Service is paramount in the contribution to the assessment, treatment and management of Mentally Disordered Offenders whilst promoting recovery and being mindful of public safety (appendices 6 & 7).

This care pathway recommends that community forensic teams should work within the four level model outlined below:

Level 1 - A specialist consultation, education and training role which may include, for example, CFT attendance at case reviews to offer advice and support to generic teams, and a service co-ordination role or liaison between health and criminal justice. This will also include initial assessments following referral to determine immediate needs and decrease response time to referring agent.

Level 2 - An in-depth assessment (which may include a standardised risk assessment and management plan) prepared by the CFT with the referring team retaining responsibility.

Level 3 - An agreed period of shared responsibility for any or all of a variety of reasons including to assess risk; to evaluate the interplay/operation of known risk factors; to offer a specialist piece of therapeutic work; and to assess the efficacy of risk reducing strategies.

Level 4 – CFT taking full responsibility for the duration of need with referral back to the appropriate services when deemed appropriate. This will be particularly evident for clients being discharged from secure environments into the community (MSU, NIPS).

It would be assumed that the majority of the CFT's work would be at level 1 with only a small minority at level 4. (Bamford 2006).

Forensic mental health and learning disability services aim to uphold the underlying philosophy of recovery focused services in line with the Departmental Guidelines on Promoting Quality Care (2010) and the service development standards as defined in Bamford (2006). The Bamford High Support Services Sub Group supports the implementation of the Bamford standards in principle considering the current resource limitations.

Team structure and Multi-disciplinary working

The multi-disciplinary team (MDT) across the scope of forensic services consists of a range of professionals including Forensic Psychiatry, Forensic/Clinical Psychology, Nursing, Social Work and Occupational Therapy. These professionals work in support of each other to ensure best outcomes for the clients, being mindful of their own accountability and the way in which they practice.

The MDT approach to care delivery is best evidenced and supported through the implementation of the Department of Health's New Ways of Working for

Everyone, (NWW) (2007). This document gives clear indicators of effective multi-disciplinary team working, and should be evidenced in the delivery of forensic healthcare regardless of the setting (appendix 3).

In order to ensure a regionally consistent evidence based approach to care delivery, training needs analysis and subsequent commissioning should be undertaken at a regional level on an annual basis. This will ensure that all forensic practitioners have equal access to training, thus minimising the potential for inequalities in service delivery.

Quality and safety:

Key priorities for CFTs are to ensure a focus on safety and continuous improvement in the quality of services. CFTs will foster a culture of openness and learning where staff will feel supported and concerns about safety and care can be openly discussed. Training, personal development and supervision for all staff will be the cornerstone of the strategy to deliver safe, high quality care.

CFTs will provide care and treatment that is evidence based. Regular audit and evaluation processes will enable CFTs to assess their performance using a range of audit measures to evaluate clinical outcomes, service level outcomes, patient reported outcomes and patient reported experiences.

As national standards for community forensic services are developed it is anticipated that CFTs will aspire to benchmark their service against these standards.

Where disputes arise between agencies relating to their respective roles and responsibilities resolution should be sought through local senior management structures in the first instance.

SECTION 3: DEFINITION OF CLIENT GROUP

Patients suitable for referral to a CFT are usually (but not exclusively) between the ages of eighteen and sixty-five, currently suffering from a mental disorder (as defined in the 1986 Northern Ireland Mental Health Order) and who require a forensic service on the basis of either (i) risk, (ii) specialist need or (iii) continuity of care. The service will also provide advice/guidance to referring agents where the level of risk is not clearly defined but there are ongoing concerns. The categories are further explored below:

Risk: The patients will have behaviour that may bring them into contact with the Criminal Justice system and are a cause for concern, either because of the seriousness of their offending or their significant risk (that which is sufficiently serious to warrant a response) of causing serious harm to others.

Serious offending would include serious violence (such as murder, manslaughter, attempted murder, threats to kill or malicious wounding with intent, arson, kidnapping and any offence against a vulnerable adult) or a history of serious sexual offence against an adult or any sexual offence against a child.

Serious harm is defined in the Public Protection Arrangements for Northern Ireland Manual of Practice as “Harm (physical or psychological) which is life threatening and/or traumatic and from which recovery is usually difficult or incomplete”.

Specialist need: The patients should have forensic needs, which cannot be met by other available Mental Health or Learning Disability Services.

For example as personality disorder services continue to develop at primary, secondary and tertiary levels, the CFT, in line with NICE guidance, may offer for people with complex needs and challenging behaviours a structured assessment of personality functioning, and where appropriate specialist risk assessment to inform the delivery of treatment interventions (see Section 5).

Continuity of care: It is expected that all conditionally discharged restricted patients and those patients who have been discharged from high or medium secure mental health services will require advice to be sought from forensic services regarding the prospective management of the case.

Exit criteria conversely should apply as risk diminishes or is reasonably reduced/managed to an acceptable level. This will be after an agreed period

of observed stability and may coincide for example with the absolute discharge of a restriction order or the reduction in risk category by Public Protection Arrangements for Northern Ireland to category 1.

SECTION 4: REFERRAL PROCESS

Community Forensic Team's (CFT's) ideally function as a tertiary level service within the spectrum of both mental health and learning disability services. It is therefore important to ensure that the referral process is compatible with the current structures already in place across services.

Mental health services have /are in the process of implementing the regionally agreed 'stepped care model'. The implementation of this model follows the strategic vision of a system that ensures the most effective, yet least resource intensive, treatment is delivered to the patient (CSIP 2006). In essence, this means, having the right service in the right place, at the right time delivered by the right person.

A number of principles underpin the delivery of an effective and efficient stepped care model of service delivery, see appendix 4 for further detail.

Appendix 5 sets out the diagrammatic version of the Care Pathway.

Referrals from generic mental health and learning disability services:

The aim of CFT's is to provide an inclusive and equitable service that is underpinned by the multi-disciplinary team making decisions which are based on client need and the teams' expertise to address those needs.

Each service will have an operational policy that clearly outlines the systems and processes in operation to facilitate robust governance in the management of referrals into the service. These governance arrangements must take cognisance of the Health and Social Care Boards (HSCB) 2010 Mental Health Services Integrated Elective Access Protocol Addendum (IEAP). The key principles underpinning the referral process are:

- All referrals should be on the prescribed proforma i.e. a Community Services Referral Form including an up to date Comprehensive Risk Assessment (in line with Promoting Quality Care guidelines) and a case summary review letter from the referring agent (Team Leader / Consultant).
- All referrals are made to the Multi-disciplinary team and not individuals within the team.
- Referrals will be accepted from both community based services and inpatient services.

- On receipt all referrals are screened by a member of the forensic team to determine urgency, this should be done by the end of the next working day.
- All referrals are discussed at the Multi-disciplinary forensic team meeting, no more than seven working days from receipt, where consensus is reached on the appropriateness of the referral.
- If the referral is deemed appropriate, the referral will be allocated to a team member at that meeting.
- The Multi-disciplinary forensic team will communicate the outcome of their discussions to the referring agent and the GP as soon as practical following the close of the meeting but no later than three working days.
- Patients who require interventions will be seen within 15 working days from the date of acceptance by the team.
- For cases accepted at level 2 the appointed practitioner will contact the referral agent to update on initial findings within fifteen working days.
- The decision to intervene at level 3 & 4 will be decided by CFS following consultation with the referral agent.

Forensic Patients moving across Trust Boundaries:

- Where a patient, who is known to CFT, moves to/plans to move to another Trust area, it is the responsibility of the originating Trust to convene a transfer of care meeting with the receiving Trust within 15 working days prior to relocation.
- If the move is unplanned, the originating Trust should coordinate a transfer of care meeting with the receiving Trust within 7 working days of move becoming known.
- The originating Trust will provide a minimum data set which will include the case summary report, referral form and up to date comprehensive risk assessment in line with Promoting Quality Care Guidelines, as part of the transfer process.
- The responsibility for care resides with the Trust coordinating the transfer until such time as the transfer is complete.

Forensic Patients released from prison to non-originating Trust locality:

- When released from prison a forensic patient may through choice relocate to another Trust catchment area so that their care will be the responsibility of the receiving Trust. Where these arrangements are temporary (e.g. as part of Bail conditions) care will be temporarily coordinated by the receiving Trust CFT, with support and input from the originating Trusts CFT in line with Promoting Quality Care Guidelines.

- The Prison Healthcare Discharge Liaison Team (DLT) will coordinate with the originating Trust to ensure that Promoting Quality Care Guidelines are implemented in relation to this patient group.

Patients returning to N. Ireland following a period of care and treatment in the UK (Extra Contractual Referrals).

- Where forensic health services are involved in the repatriation of ECR patients, the role of the Care Coordinator remains with the originating Trust, regardless of where the patient is relocating to.
- This duty of care remains in force for a period not exceeding 6 months by which time the duty of care rests with the receiving Trust.
- The originating Trust will ensure that the Promoting Quality Care Guidelines are adhered to through the transfer process, facilitating and coordinating an appropriate number of meetings to ensure smooth transition of care.
- The originating Trust care co-ordinator will liaise with the receiving Trust to identify appropriate services prior to repatriation and will work collaboratively during the six month transition period.

Interface with Secure Units (Shannon Clinic/Sixmile Unit):

- The CFT will allocate a named professional to each patient from their Trust residing in these secure units.
- The named professional will attend secure unit review meetings regularly and report back to the CFT multi-disciplinary team.
- The named professional will endeavour to establish a therapeutic relationship with the patient prior to discharge.
- The named professional will actively participate in the discharge process for patients who will be returning to their respective Trust area.

Referrals from the Criminal Justice Services:

All referrals into forensic services are predicated by the need to adhere to each respective Trust's single point of access and the referral criteria as defined earlier in this document. To facilitate this process the CFT will act as a conduit/facilitator to ensure that the referred client, if required, has access/is known to core services.

Probation Board NI:

- Community forensic health services will accept referrals for initial assessment from Probation Services via the Probation Psychology Dept.

- Community Forensic Learning Disability Teams can only accept referrals via tier two services at this time i.e. PBNI need to refer to generic LD services in the first instance.
- Should the client require input from secondary mental health services and is not currently known/open to them the CFT will work in collaboration with the referring agent to ensure safe seamless engagement.
- All referrals from PBNI will be discussed at pre-arranged multi-agency/multi-disciplinary meetings. These discussions will be informed by the appropriate documentation to include referral form and a written risk formulation report.
- If at initial assessment it is evident that CFT or core mental health/learning disability services have no input to deliver, the case will be returned to the referring agent.
- A client who is currently open to CFT and who has a Probation Order in place will be managed via a joint agreement between the respective agencies, being mindful of PBNI statutory functions and responsibilities.
- The PBNI psychologist should, following agreement, attend the CFT team meetings on a regular basis (approx 8-12 weekly) to discuss currently opened cases and where appropriate new cases for consideration by the team. This timeline is by nature flexible and will be dictated by level of need and urgency.
- Reaching consensus/agreement on case management responsibilities will be facilitated through a multi-agency meeting coordinated by the CFT, being mindful of the PBNI statutory function and responsibilities.

Prison Services: (pathway out)

Forensic Needs:

- The CFT will work closely with the Discharge Liaison Team (DLT) to facilitate the smooth transition from prison into the community of those prisoners deemed to be suffering from a mental disorder who fall under the remit of "Promoting Quality Care". This is because of the risk to others, with identified forensic needs and in need of on-going secondary level mental health/learning disability care.
- Prior to discharge the DLT will make contact with the relevant CFT to coordinate a pre-discharge meeting to facilitate the transfer of care from prison health care to community services for those individuals who fall under the PQC Guidelines.
- All such meetings should be compliant with the PQC Guidelines and referrals to CFT should be on the prescribed proforma.

Non Forensic Needs:

- Where the prisoner requires secondary mental health/learning disability services CFS will liaise with the appropriate Community Team to facilitate discharge from the prison to the appropriate service.
- This transition process will be informed by the client's response to treatment and evidence of ongoing manageable levels of risk.

Prison Services: (pathway in)

- The CFT will inform the DLT when a forensic patient (managed at level 3/4) is committed to prison. They will provide a minimum data set comprising of case summary report in line with PQC Guidance and a up to date comprehensive risk assessment within two working days.
- The CFT will, if required, act as a contact point to support effective communication between the DLT and core mental health/learning disability services. The DLT will link with appropriate NIPS mental health services.

Police Service of N. Ireland:

The development of a composite regional care pathway, and supporting protocols, is required to manage the day to day interface with the PSNI in particular for the effective and timely management of vulnerable adults and offenders with mental health and learning disability needs who fall outside of the CFT criteria. CFT's are primarily concerned with those patients subject to PPANI, and as such the PSNI do not have a direct referral route into CFT's. This does not preclude the PSNI referring into each Trusts respective single point of access.

- Where a mental health/learning disability patient is managed though PPANI the CFT may act as care providers where appropriate.
- The Trust representative in PPANI will liaise with the CFT where the patient is open to mental health/learning disability services.
- There is an expectation that all mental health/learning disability patients under PPANI should be allocated to a forensic practitioner. This will be facilitated through regular communication between the CFT and the respective Trust's representative on the Local Area Public Protection Panel.

SECTION 5: Risk Assessment/Management & Therapeutic Interventions.

CFT's provide care and treatment for individuals who have a major mental disorder and demonstrate serious offending behaviours or present a significant risk to others. The CFT offers assessment, consultation, care and treatment, which is proportionate to the situation and underpinned by risk assessment/management and treatment of offending behaviours. Where deemed appropriate and to assist in the formulation of treatment needs, psychological assessments are also undertaken, for example, personality assessments (IPDE), Psychopathy Checklist (R) (PCLR) etc .

Interventions by the CFT are preceded by the timely, comprehensive and professional completion of evidenced based assessments of risk. CFT's use a varying range of evidence based risk assessment tools for this purpose.

The completion of informed detailed risk assessments facilitates the formulation of robust multi-disciplinary risk management strategies, which in turn inform the therapeutic process whilst promoting public safety and emphasising a strong recovery based ethos to service delivery.

Interventions are predominantly based on the cognitive behavioural model, and delivered at both an individual and group level. Group interventions use a Cognitive Behaviour Therapy (CBT) approach and include psychosocial and life skills training such as Motivational Enhancement, Good Thinking Skills and Anger Management. Depending on the assessed needs, group interventions can be delivered on a one to one basis, if it is not appropriate for the client to participate in group work, or as booster sessions following group participation.

Although these groups predominantly target community clients, in-patients can also attend following assessment. Alternatively the CFT may in-reach into acute facilities to deliver one to one interventions.

Other treatment approaches include.

- Pharmacotherapy
- Use of positive behavioural management approaches
- Offence and offending type related work
- Sex offending related work
- Substance misuse work
- Medication concordance therapy
- Relapse prevention therapy
- Psychosocial interventions with families
- Developing contingency plans for crises and relapses.

SECTION 6: Evaluation measures.

Having identified the objectives of CFS as outlined in appendix 6, CFS recognises the need to ensure robust systems and processes are in place against which the service delivery can be measured and held accountable. This is a key component in ensuring a safe and effective service given that CFS is delivered across a range of interfaces and agencies.

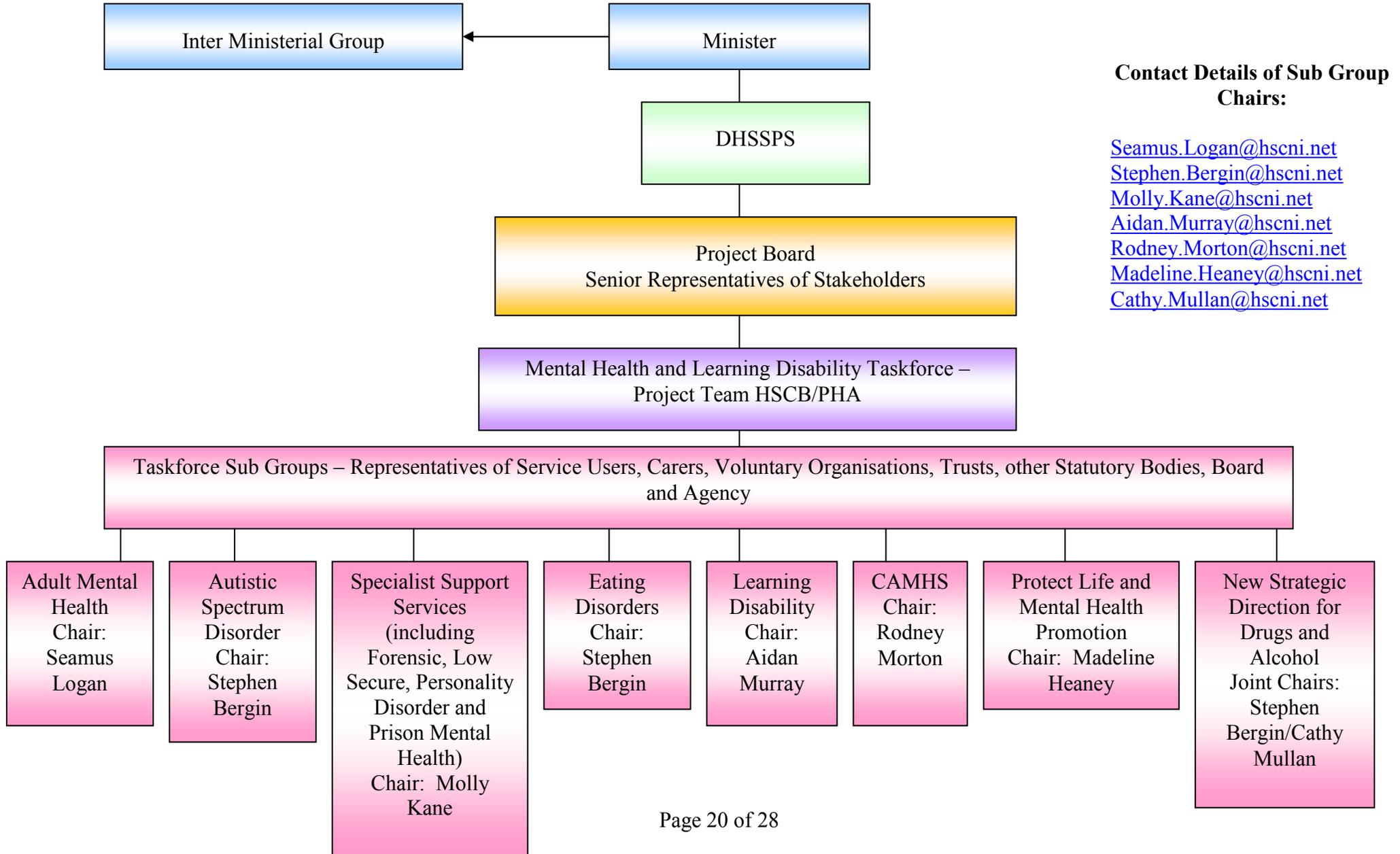
CFS will by March 2013 developed a range of standards and performance indicators encompassing Lord Darzi's 2008 'High Quality Care for All' definition of quality. Lord Darzi's review sets out a vision of high quality care, in which quality is defined as: clinically effective, personal and safe. The main themes of the standards will focus on:

- Primary focus on delivery of high quality care for patients
- Reducing variation in quality of care delivered
- Empowering patients to make their own choices
- Safe care - getting the basics right
- Preventative care, measures to improve health and well being

Glossary

CFT	Community Forensic Team
CFMHT	Community Forensic Mental Health Team
CFLDT	Community Forensic Learning Disability Team
CFMHS	Community Forensic Mental Health Services
CFLDS	Community Forensic Learning Disability Services
PPANI	Public Protection Arrangements Northern Ireland
BHSCT	Belfast Health & Social Care Trust
NHSCT	Northern Health & Social Care Trust
SHSCT	Southern Health & Social Care Trust
WHSCT	Western Health & Social Care Trust
MDT	Multidisciplinary Team
NWW	New Ways of Working
RcPsych	Royal College of Psychiatrists
CSIP	Care Services Improvement Partnership
IEAP	Integrated Elective Access Protocol
DLT	Discharge Liaison Team
ECR	Extra Contractual Referral
PBNI	Probation Board Northern Ireland
LD	Learning Disability
PQC	Promoting Quality Care
PSNI	Police Service Northern Ireland
IPDE	International Personality Disorder Examination
PCLR	Psychopathy Check List-Revised
STAR	Salford Tool for Assessment of Risk
HCR20	Historical Clinical Risk 20
RSVP	Risk of Sexual Violence Protocol
ARMADILO	Assessment of Risk and manageability of Intellectually Disabled individuals who Offend
RAMAS	Risk Assessment Management and Audit Systems
CBT	Cognitive Behaviour Therapy
DRAMS	Dynamic Risk Assessment & Management System
START	Short Term Assessment of Risk

APPENDIX 1 - Mental Health/Learning Disability Bamford Taskforce – Project Structure



Appendix 2 – Literature Review

- **The Reed Principles (1991)** as aspired to in the Bamford Review (2005), stated that patients, including Mentally Disordered Offenders should be cared for ‘as far as possible in the community rather than institutional settings’.
- **The Bamford Forensic Services Report (2006)** http://www.dhsspsni.gov.uk/forensic_services_report.pdf makes a total of 169 recommendations relating to the care and treatment of Mentally Disordered Offenders with several recommendations to the on-going development and operational capacity of community forensic services.
- **Bamford Action Plan (2009)** http://www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf recommends the establishment of a N. Ireland Forensic Mental health and Learning Disability Steering Group, to ensure better joined up services for people who need forensic services.
- **Priorities for Action (2010/11)** http://www.dhsspsni.gov.uk/microsoft_word_-_priorities_for_action_2010-11.pdf require Commissioners and Trusts to maintain the staged developments of specialist services, including forensic mental health and learning disability services.
- **Health and Social Care (Reform) (N. Ireland) Act 2009** <http://www.legislation.gov.uk/ukpga/2009/21>, Sections 19 and 20 place a statutory duty on HSC organisations to ensure that there are structures in place where individuals and local communities are actively engaged in their own health and wellbeing and in improving and shaping local services, thus ensuring services are person centred, responsive and meet the individuals assessed needs appropriately.
- **Not a Marginal Issue, Criminal Justice Inspectorate Report (2010)** <http://www.cjini.org/CJNI/files/24/24d6cd45-20bb-4f81-9e34-81ea59594650.pdf>, findings point to the need for a more coordinated and focused approach to the delivery of mental health services that concentrates on the need to divert people away from custody where appropriate and provide the right care in the right setting. Furthermore, the need to improve the interface between justice and health, whilst strengthening linkages with care in the community.
- **Promoting Quality Care (2010)** <http://www.dhsspsni.gov.uk/good-practice-guidance-and-risk-assessment.pdf>. Departmental guidelines describing the principles of best practice in making decisions about managing risk and potential risks that service users may cause harm to themselves or others. The broad principles of this guidance are to be

applied to any individual receiving care and treatment from learning disability and specialist mental health services, including forensic services.

Appendix 3

The following excerpts are drawn from the NNW document as indicators of effective MDT working:

Leadership: should be based primarily on competence rather than profession, with the focus on the team rather than the individual professions. The teams' ethos will be of developing the competence of all its members rather than one or two professions dominating the proceedings, this in turn makes the team more effective and stronger.

Team working and attitude: The team culture is one where by each individual takes personal responsibility for the governance of their work in an atmosphere of openness. Those with the most experience and clinical skills will deal with people with the most complex needs whilst supporting and developing the less experienced team members, thus building their competence, which in turn impacts positively on the overall teams' capabilities.

User and carer focus: Care is delivered through the sharing of capabilities within the team and blending them to the needs of the individual service user. Care is also delivered on a clear service pathway by the most competent practitioner to provide it, regardless of profession. Users and carers believe that their individuality is being responded to and therefore can engage more effectively with the service.

Innovation and efficiency: Services are underpinned by a system of care coordination, in which interventions are organised and delivered when required, this leads to more effective and efficient service delivery. This approach frees up practitioners, allows for even distribution of the workload, facilitating the timely management of increasing demands that can be placed on the service.

The intelligent use of information: Service structures and processes facilitate transparent and open caseload management. Through the processes of supervision and dynamic team meetings, everybody is challenged to consider what progress is occurring. Adopting this approach allows team members to know the bigger picture and see beyond the clinical work they are engaged in. This in turn creates a service that is dynamic and there is clear evidence of clinical movement, benefiting not only the team but also service users and carers.

The fundamental principle underpinning the decision making processes within the multi-disciplinary team is the concept of Recovery and Strengths based practice. This approach recognises that clients often feel powerless and disenfranchised, that these feelings can interfere with initiation and maintenance of mental health care, and that the best results come when the client feels that treatment decisions are made in ways that suit their cultural, spiritual, and personal ideals. The Recovery approach focuses on wellness and resilience and encourages clients to participate actively in their care.

Appendix 4

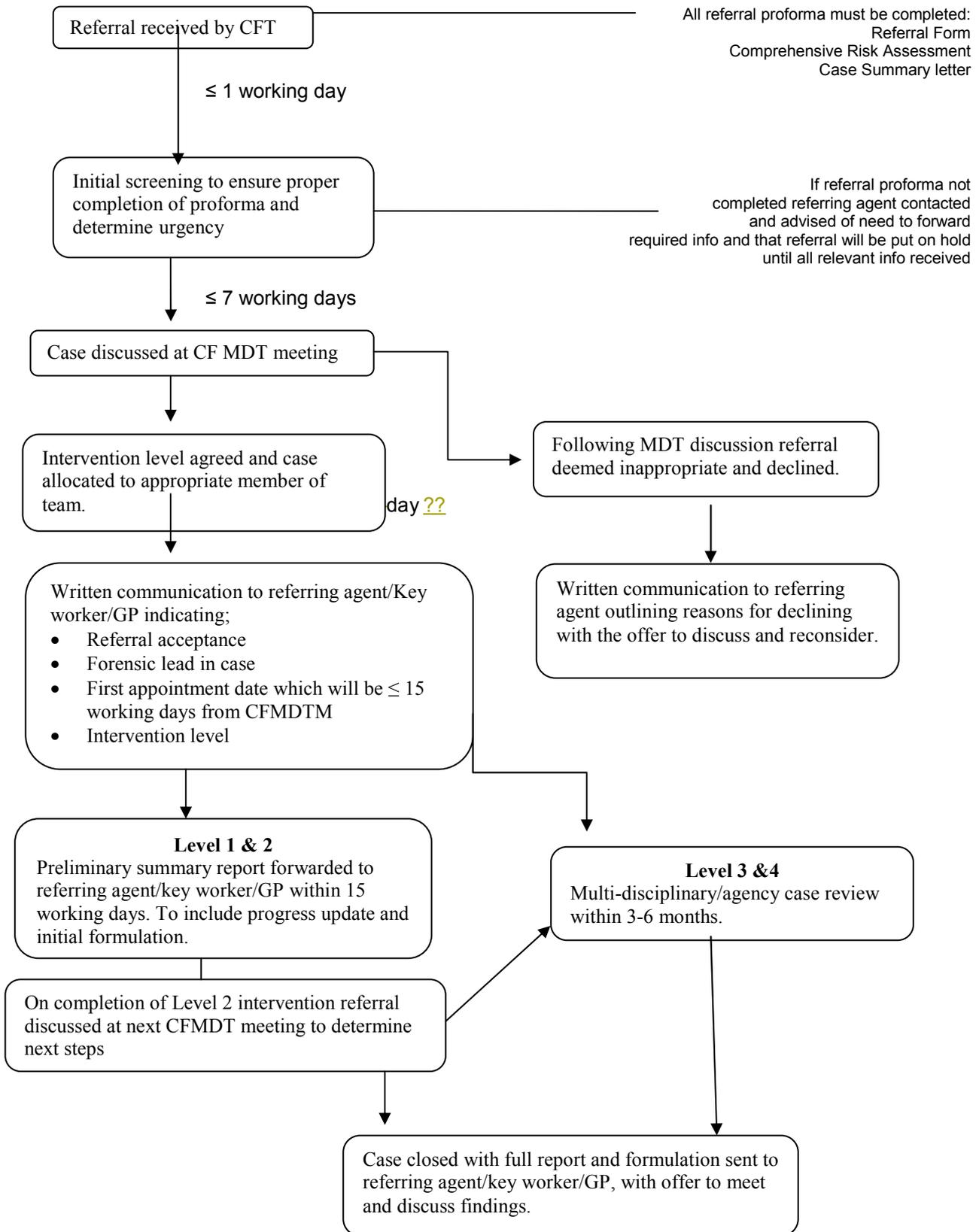
A number of principles underpin the delivery of an effective and efficient stepped care model of service delivery:

- Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
- A system of scheduled review is in place that detects and acts on non-improvement to enable stepping up to more intensive treatments or stepping down where a less intensive treatment becomes appropriate.
- The establishment of a single point of access in association with robust screening, triage and assessment function.
- A focus on early intervention and signposting people to the most appropriate care and services which are provided by the Trust and/or voluntary/community/independent sector organisations.

The stepped care model creates structures that facilitate a single point of access to all mental health and learning disability services, offering pre-referral advice, screening assessment and treatment or onward referral. The model provides a clear pathway which sets out how people will move through the service, ensuring they get the most appropriate care by the right part of the service.

APPENDIX 5 – Care Pathway Diagram

Referral pathway into Community Forensic Teams:



Appendix 6 – Objectives of Forensic Mental Health and Learning Disability Services

- To develop a service which is safe, secure and supportive, with skilled, confident staff who aim to manage risk effectively, within a framework of organisational managerial support.
- To promote patient, carer and whole family approaches in the development of treatment plans, through choice, negotiation and person centred approaches.
- To integrate closely with existing services.
- To facilitate the integration and maintenance of the individual into society, as far as is possible.
- To work in partnership with other relevant agencies for the benefit of patients, facilitating, establishing and maintaining a team knowledgeable of local, statutory and independent services.
- To monitor the changing needs of the forensic caseload (by developing a case register and routinely assessing need) and bring unmet need to the attention of the mental health and learning disability senior management team and commissioners.
- To regularly evaluate service and facilitate ongoing improvements - from patient, carer, referrer and staff perspectives.
- To promote awareness of forensic mental health and learning disability issues, including the valuable work of other agencies involved in the delivery of services to this complex population.
- To provide a training resource for other professionals.
- To contribute to the Bamford Action Plan for Forensic services.

Appendix 7 – Forensic Team composition (as of April 2011)

Team composition		
Trust	Post	WTE
Belfast Trust* and South Eastern Trust	Band 7 Nurse	3.0
	Band 7 Social Worker	3.0
	Band 8A Social Work Locality Manager	1.0
	Band 6 OT (not funded)	1.0
	Consultant	1.0
	Consultant Psychotherapist	0.25
	Band 8c Psychologist	0.5
	Band 4 Admin	1.0
	Band 3 Admin	1.0
	Band 2 Admin (not funded)	1.0
Southern Trust	Band 7 Practitioners	3.0
	Band 6 (vacant)	2.0
	Band 3 Admin	1.0
	Forensic Consultant	0.5
	Forensic Psychologist	0.8
Western Trust	Consultant	0.5
	Junior Doctor	0.5
	Band 8A	1.5
	Band 7 Practitioners	1.0
	Band 6	4.0
	Band 4	1.0
	Band 3	1.50
Northern Trust	Nurse Practitioners	4.0 (2 vacant)
	OT	1.0
	Forensic Team Leader	1.0
	Clinical Psychologist	0.75
	Forensic Psychiatrist	0.5
	Personal Secretary	1.0
Forensic Learning Disability Team Composition		
Trust	Post	WTE
Belfast Trust	Band 8B	1.0
Southern Trust	Forensic Psychiatrist	0.2
	Forensic Psychologist	0.2
	Band 7 Practitioners	2.0
Western Trust	No Forensic Learning Disability Service	
Northern Trust	Learning Disability Nurse Practitioner	1.0
	Learning Disability Social Work Practitioner	1.0
South Eastern Trust	No Forensic Learning Disability Service	

*** Belfast Trust was commissioned by the legacy Eastern Health & Social Services Board to provide Community Forensic Services to both Belfast and South Eastern Trust areas.**