



Baseline Audit of Forensic Mental Health and Learning Disability Services – Adult Services

August 2018

www.rqia.org.uk

Content	Page
Introduction	
• Background	3
• Aims and Objectives	5
• Audit Standards	7
• Methodology	8
Findings	10
Evidence Referral Pathways Utilised by Forensic Mental Health Services	11
Evidence of Comprehensive Risk Assessment and Management Tool	20
Evidence of Patient Centred Care	23
Patient Questionnaire	27
Discussion	29
Recommendations	35
Project Team	36
References	37
Appendices: 1 to 24	
Appendix 1: Tables: Referral Pathway for Forensic Mental Health Services	39
Appendix 2: Tables: Comprehensive Risk Assessment and Management Tool for FMHS	43
Appendix 3: Tables - CFMHTs Treatment and Care Plan	44
Appendix 4: Tables - FMHS patient responses	46
Appendix 5: Graphs - CFMHTs Patient survey Responses	48
Appendix 6: FMHS - Comment from Service Users	50
Appendix 7: Shannon Clinic RSU - Referral Pathway	51
Appendix 8: NIPS - Mental Health Teams Referral Allocation & Assessment Pathway	52
Appendix 9: CFMHTs - Care Pathway Diagram into CFMHTs	56
Appendix 10: Regional Joint Protocol	57
Appendix 11: FMHS - References to Audit Standards	60
Appendix 12: Shannon Clinic RSU & Six Mile Unit Manager Questionnaire	62
Appendix 13: Shannon Clinic RSU - Patient Note Proforma	64
Appendix 14: Six Mile Unit - Patient Note Proforma	67
Appendix 15: NIPS - Managers Questionnaire	69
Appendix 16: NIPS - Patient Note Proforma	71
Appendix 17: CFMHTs - Managers Questionnaire	74
Appendix 18: CFMHTs - Patient Note Proforma	76
Appendix 19: Shannon Clinic RSU & Six mile Unit - Patient Questionnaire	80
Appendix 20: NIPS - Patient Questionnaire	81
Appendix 21: CFMHTs - Patient Questionnaire	82
Appendix 22: Description of Risk assessment and Management Tools	83
Appendix 23: Description of Psychological Therapies	85
Appendix 24: Description of Audited Adult FMHS in Northern Ireland	86

INTRODUCTION

Background to Forensic Services

Forensic mental health services assess and treat mentally disordered offenders and patients with major behavioural, mental health problems and learning difficulties, in a range of secure health facilities and the community, in police stations, courts and prisons.

Forensic Network, as cited in Ridley et al. 2014.¹

There is a much higher prevalence of mental disorder, substance misuse, self-harm and suicide among people in the criminal justice system, compared to the general population and such individuals have complex needs that require specialist assessment and management.²

Equally, many people with learning disability who come into contact with the criminal justice system can have additional mental health problems, other developmental disabilities, and substance use disorders, as well as mental illnesses such as psychosis.³

Northern Ireland Forensic Services

The Bamford review of mental health and learning disability services in Northern Ireland recommended the need to provide appropriate assessment, treatment and rehabilitation, for those with a mental illness who are subject to the criminal justice system and pose a significant risk of serious harm to others.²

Forensic mental health services (FMHS) should therefore take into account the needs of the service user, their carers, the wider public and other health service providers.

McCann (1999)⁴ described the needs of the forensic patient as being complex which involve a number of agencies, requiring a collaborative and coordinated approach across service and professional boundaries. FMHS work collaboratively with trust services such as generic mental health teams, learning disability teams, substance misuse teams, primary care, and social care; as well as the independent sector and criminal justice agencies such as courts, police, prison, probation and public prosecution services. There is a need for close working relationships between these groups in order to promote positive outcomes, with the overall aim of forensic services being to reduce offending behaviour and minimise risk to others.

Service Development within Northern Ireland

Over the last decade, FMHS in Northern Ireland have expanded from having almost no service provision to having a dedicated service. In 2000 a proposal was developed by a Regional Project Board set up by the Department of Health to consider inpatient and community forensic mental health services. Shannon Clinic, a Regional Secure Unit (RSU) opened in April 2005 when funding was released, and it is Northern Ireland's only medium mental health secure unit. In parallel with this Community Forensic Teams were developed across the region.

Prior to the opening of Shannon Clinic RSU in 2005, there was no specialist inpatient FMHS in Northern Ireland. Forensic patients were treated in psychiatric intensive care units, in prison and in the high secure facility Carstairs State Hospital, Scotland. Community patients were managed by generic community mental health services.

In 2006 the Six Mile Unit at Muckamore Abbey Hospital, Antrim (Northern Ireland's only low secure forensic unit) provided a service for adult males with learning disability who are in contact with the criminal justice system and who require a level of secure care.

Another development was the responsibility for provision of healthcare within all prison establishments transferring to a local health Trust (currently South Eastern Trust) in 2008.

More recently, further regional investment has occurred in services targeting community learning disability and child and adolescent client groups.

Rationale

The need to provide high quality services that are co-ordinated and consistent across the region is essential; therefore:

- Services must be patient focussed in order to improve their experience and importantly their engagement.
- Care delivered in forensic services must adopt recovery approaches.
- The use of evidenced based tools is crucial in providing the appropriate care that is specific to the varying complex needs of the forensic patient.
- Appropriate formulation and management of risk as well as the need for extensive psychological input are key to reducing the likelihood of re-offending.

This baseline audit focused on adult FMHS in:

- Shannon Clinic Regional Secure Unit (RSU)
- Six Mile Unit, Muckamore Abbey Hospital
- Maghaberry and Hydebank Wood Prisons - Northern Ireland Prison Service (NIPS)
- Community Forensic Mental Health Teams (CFMHTs)

Appendix 24 provides further descriptions of the individual adult FMHS

Aim

This audit will inform service improvement in:

- Effectiveness of services' own individual referral pathways.
- Regional 'Care Pathway and Model for Community Forensic Teams in Northern Ireland'.⁵
- Patient Centred Care.

It will focus on:

- The promotion of patient involvement.
- Measuring the recovery approach across services.
- Benchmarking against national standards.
- Facilitating patient feedback on their experiences.

The information gathered will be used to promote improvements that benefit patients, carers and the public. The audit forms part of the work plan of the Bamford Regional Forensic Sub Group.

Objectives

To assess the quality of services currently provided by HSC Trusts and FMHS across in-patient, community and prison settings, including the in-patient forensic learning disability service by auditing practice in relation to:

- Evidence of utilising referral protocols.
 - Evidence of assessment and management of risk tools.
 - Evidence of patient centred care.
- and to:

- Benchmark practice across all HSC Trusts against national standards, identifying areas for improvement.
- Focus on patient experience and involvement.
- Develop an action plan to be submitted to the Forensic Managed Care Network for implementation.

Audit Standards

The standards for this baseline compliance audit were derived from a combination of sources as outlined below. Where agreed standards were not available, best practice guidelines were agreed and utilised after discussion within the project team.

Referral and Pathway standards utilised by individual FMHS
Evidence within patient notes that 'Regional Guidance on Admission/Discharge' is being utilised in accordance with guidance by Shannon Clinic RSU . (Appendix 7)
Six Mile Unit – No referral process was available at time of audit.
Evidence within patient notes that the 'Referral Allocation and Assessment Pathway' is being utilised in accordance with guidance by NIPS . (Appendix 8)
Evidence within patient notes that the Regional 'Care Pathway and Model for Community Forensic Teams in Northern Ireland' ⁵ is being utilised in accordance with guidance by CFMHTs (Appendix 9).
Evidence within patient notes of CFMHTs and NIPS that the Regional Joint Protocol implemented in 2015-16 (developed between NHSCF CFMHT and NIPS) is being utilised in accordance with guidance by both services. (Appendix 10)
Comprehensive Assessment and Management of Risk Tool (CRA)
Evidence within the patient notes of all FMHS that CRA's are being utilised and discussed with patients. (Appendix 11: References for standard)
Patient Centred Care
Evidence within all FMHS patient notes of the review of treatment and care plan/recovery plans and discussion of these with patients. (Appendix 11: References for standard)
Evidence of psychological assessment/treatment and or group/individual therapeutic intervention utilised within all FMHS . (Appendix 11: References for standard)

The standards covering the three key areas reviewed within audit and have been colour coded and this is also reflected within the report findings and within appendix 1, 2, 3, & 4.

Methodology

This was the first audit of forensic mental health services in Northern Ireland and used both quantitative and qualitative methods to provide a baseline picture of Forensic Mental Health and Learning Disability Services (Adult services).

Whilst we are aware that some areas across the Northern Ireland Health and Social Care Community use the term “intellectual disability”, for the purpose of this audit the term Learning Disability will cover both Learning and Intellectual Disabilities.

This retrospective audit (January - March 2017) used a random sample of 25% (125) of patient notes across Shannon Clinic RSU, Six Mile Unit, NIPS (Maghaberry and Hydebank Wood Prisons), and Trusts’ CFMHTs. Within NIPS patient notes were divided into 5 categories: urgent, routine, pre assessment, CRA’s and key worked. Eight sets of patient notes were audited from each category. A breakdown of patients’ notes audited is outlined in Table 1.

Table 1: Number of patient notes audit for each service

Services audited	Number of patient notes
Shannon Clinic RSU	N= 8
Six Mile Unit	N= 5
NIPS: Maghaberry Prison	N= 35
Hydebank Wood Prison	N= 5
Community Forensic Mental Health Teams (CFMHTs); NHSCT n=20, WHSCT n= 20, BHSCT n=20, SHSCT n=12	N= 72
Total	N=125

Quantitative Data

To assist in the development of data collection tools, audit meetings were held with relevant teams and managers within Shannon Clinic RSU, Six Mile Unit, NIPS (Maghaberry and Hydebank Wood prison) and CFMHTs.

The draft data collection tools were forwarded to all relevant team managers for their feedback. The project lead ensured that follow-up discussions took place between relevant team managers before the tool was finalised. The tool was piloted within one of the CFMHTs and one in-patient service (Shannon Clinic RSU).

Qualitative Data

Consultations took place with patient and carer advocacy services as well as the Recovery College.⁶ Advice was also sought from other organisations such as the Forensic Network Scotland⁷ and the Carstairs State Hospital (a psychiatric hospital providing care and treatment in conditions of high security for patients from Scotland and Northern Ireland) as a means of quality assurance due to their expertise in the development of patient questionnaires.

Managers and patients from all audited services were given the opportunity to contribute to the design for their own individual service questionnaire. Patients from Shannon Clinic RSU were able to provide comment on both the CFMHTs and the Shannon Clinic RSU as they had experience of both services.

Focus groups were held with service users from the Six Mile Unit, Maghaberry and Hydebank Wood prisons. This was to ensure that the overall format and content of the questionnaire allowed all service users including those with a learning disability to complete it.

The questionnaire was posted to patients within the CFMHT and within the NIPS; the questionnaire was presented to patients who had been allocated with a key worker. Patients who did not have continued/regular contact and input from a key worker (i.e. key worked) were not included in the sample.

Distribution of patient questionnaires

A total of 294 patient questionnaires were distributed (Appendices 19, 20 and 21).

Questionnaires were offered in all services: Shannon Clinic RSU (n=33), Six Mile Unit (n=18). Within CFMHTs surveys were offered to 179 patients managed at Level 3 and Level 4 as there was continued input and responsibility maintained by the CFMHTs for this cohort of patients.

To enable distribution of patient questionnaires within Maghaberry and Hydebank Wood Prisons (n=64) the Project Lead was accompanied to the various landings by a Healthcare Support Worker from the prison Mental Health Team.

Within the forensic mental health and learning disability services a cohort of patients had literacy difficulties and required the support of the Project Lead to complete the patient questionnaire.

A total of 117 (40%) patient questionnaires were returned from the combined services. (Table 2)

Table 2: Number of questionnaires returned from each service

	%	Number
Shannon Clinic RSU	94%	29 of 33
Six Mile Unit	78%	14 of 18
Maghaberry & Hydebank Wood Prison	52%	33 of 64
Community Forensic Mental Health Teams (Intervention Level 3 and 4)	23%	41 of 179
Response	40%	117 of 294

Findings

A random sample of 25% of patient notes from the four adult FMHS audited was selected and within each of these key areas the findings for all services will be incorporated as applicable (Table 1).

The report will present the findings of the patient note audit for the four Forensic Mental Health Services within three key areas:

- | |
|---|
| • Evidence of Referral Pathway(s) |
| • Evidence of Comprehensive Risk Assessment and Management Tool (CRA) |
| • Evidence of Patient Centred Care |

A service manager's questionnaire was distributed to all services (seven in total) - four to CFMHTs (one for each Trust) and one to each other service audited. Completion of the manager's questionnaire provided information relating to referral pathways utilised, and identified the risk assessment and management tools utilised and the psychological interventions available and utilised.

Evidence of Referral Pathway(s)

Managers from Forensic Mental Health Services (Shannon Clinic RSU, Six Mile Unit, CFMHTs, NIPS (Maghaberry Prison, Hydebank Wood Prison) were asked if their service utilised a referral pathway(s) that informed the standards used within the patient note proforma for these individual services.

Three of the four services indicated that they used a referral pathway as the Six Mile Unit did not have a referral pathway in place at the time of audit. (Table 3)

Shannon Clinic RSU and Six Mile Unit Referral Pathways

Managers from within the regional inpatient services (Shannon Clinic RSU & Six Mile Unit) completed a questionnaire and were asked if their service had a referral pathway (Appendix 12). Shannon Clinic RSU had developed its own service referral pathway 'Regional Guidance on Admission/Discharge'. (Appendix 7)

The Six Mile Unit did not have a referral pathway at time of the audit and had no accessible recorded information in relation to the source of their referrals. (Table 3)

Table 3: Compliance with Service Referral Pathway

Referral Pathway	Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)
Does your service utilise a referral pathway?	Yes	No*
	Compliance	
Was appropriate referral form fully completed?	100% (8)	-
Was the pre-admission assessment completed within 2 weeks of receipt of the referral form?	100% (8)	-
Did the referring agent receive a response within 2 weeks that the referral was accepted?	100% (8)	-
If accepted was a bed offered within 5 weeks?	100% (8)	-

Admissions to Shannon Clinic RSU are relatively low and a seven year period (1 January 2010 - 31 December 2016) was used to identify the source of referrals.

Admissions from the NIPS over the 7 year period came from different locations within the prison as outlined in Table 4. It should be noted that due to the closure of the residential healthcare facility ('healthcare wing') within Maghaberry Prison, the last referral from there was accepted in March 2013 and subsequently a proportion of patients were then accepted from the Care and Supervision Unit (CSU).

The residential healthcare facility 'healthcare wing' was a high support landing which was used to manage acutely mentally unwell prisoners. It had 24 hour coverage by general health and mental health staff.

A Care and Supervision Unit (CSU) within a prison is a separate residential landing where the prisoners held have restricted association with other prisoners and limited access to the generally available facilities within the prison. Prisoners may therefore spend more time alone and in their cells than would otherwise be the case. A prisoner may be placed by the prison authorities in the CSU if they break prison rules, commit an offence, or in response to their behaviour, which in some cases can be due to an underlying mental health problem.

From 2014-2016 10 referrals were accepted from CSU to the Shannon Clinic RSU compared to no referrals from CSU between 2010 and 2013 when the 'healthcare wing' was still available.

Table 4: Number of referrals accepted to Shannon Clinic RSU from locations within NIPS.

	Normal location	Segregation-Care and Supervision Unit (CSU)	Residential Healthcare facility (Healthcare Wing)	Total
2010	2	0	8	10
2011	1	0	7	8
2012	2	0	17	19
2013	11	0	2	13
2014	9	2	0	11
2015	5	4	0	9
2016	7	4	0	11

Information taken from Shannon Clinic RSU referral database between 1 January 2010 and 31 December 2016

During the period 2014-2016 there were 31 referrals accepted from the NIPS, originating from normal locations within the prison (e.g. Landings) and the Care and Supervision Unit (CSU), an increase of 15 referrals from 2010-2013.

The need for collaborative working between teams⁵ in relation to promoting quality care reviews was evident in Shannon Clinic RSU’s contact/invite to the relevant CFMHTs to attend a pre-discharge planning meeting. Of the eight patient notes audited all had evidence that this contact had been made. (Table 5)

A random sample from the regional CFMHTs patient notes (N=20) also evidenced that the pre-discharge meeting between Shannon Clinic RSU and relevant CFMHTs had taken place. (Table 5)

Table 5: Evidence of contact by Shannon Clinic RSU with the CFMHTs in relation to Pre Discharge Meeting.

Shannon Clinic RSU	
Did Shannon Clinic RSU make contact with the relevant CFMHT to attend the pre-discharge meeting?	100% (8 of 8)
Pre-discharge meeting with CFMHTs (random selection of patient notes across Level 4 intervention N=20)	
Did a pre-discharge meeting take place prior to the patient being discharged?	100% (20 of 20)

Northern Ireland Prison Service (NIPS)- (Maghaberry Prison and Hydebank Wood Prison) - Referral pathway

Through the manager questionnaire (Appendix 15) it was identified that the NIPS mental health service utilised the ‘NIPS Mental Health Team Referral Allocation and Assessment Pathway’ (Appendix 8).This pathway identified the standards NIPS was audited against.

Table 6 shows the overall compliance with use of this pathway in relation to urgent and routine referrals. The compliance in relation to its use for urgent referrals across all areas was 100%. Similarly, compliance in relation to routine referrals was 100%. The lowest area of compliance within the pathway was routine patients being seen within the prescribed timeframe (≤ nine weeks) from receipt of referral where compliance was 63% (5 of 8). Further tabular breakdown is available within Appendix 1: Tables 1.1 to 1.3 in relation to this pathway.

Table 6: Northern Ireland Prison Service Referral Pathway

	Compliance
Urgent Referral (N=8) and Routine referral (N=8)	100% (16 of 16)
Was the Urgent referral patient (N=8) seen within prescribed time frame of 10 days of receipt of referral	100% (8 of 8)
Was the Routine patient (N=8) seen within prescribed time frame of within nine weeks of receipt of referral	63% (5 of 8)
Did the mental health practitioner complete the Initial Mental health Assessment form (PH/MH/F02) (N=16)	94% (15 of 16)
Was a regional risk screening tool completed or a CRA updated for urgent and routine referral? (N=16)	94% (15 of 16)
Is there evidence to support the outcome of the urgent referral form? (N=8) (e.g. Allocated key worker, Refer to psychiatry, Allocated to group work, Onward referral and discharge from services). NB - Patients notes could have received more than one of these onward referrals (Appendix 1: Table 1.2 for more detail)	100% (8 of 8)
Did the mental health practitioner record a summary of the assessment and management plan for urgent and routine referral? (N=16)	100% (16 of 16)
Did the Mental Health Practitioner complete a summary of the assessment and management plan? (N=16)	100% (16 of 16)

Compliance within the pre-assessment contact timeframe (≤ 3 weeks) was 88% (7 of 8). Within this contact the mental health practitioner completed a summary of the assessment and management plan in all cases (100%). (Table 7)

Table 7: Pre-assessment contact

	Compliance
Was the pre-assessment contact completed within three weeks of referral (N=8)	88% (7 of 8)
Is there evidence to support the outcome of the pre-assessment was one of the following <i>N=8</i> (e.g. allocated for full assessment, group work, onward referral and discharged from services) NB - Patients could have received more than one of these onward referrals. (Appendix 1: Table 1.3)	100% (8 of 8)
Did the Mental Health Practitioner complete a summary of the assessment and management plan?	100% (8 of 8)

Community Forensic Mental Health Teams (CFMHTs) Referral Pathway

CFMHT managers through their questionnaire (Appendix 17) confirmed that their services were using the community forensic referral pathway (Regional ‘Care Pathway and Model for Community Forensic Teams in Northern Ireland’) and these are the standards set out within the CFMHTs patient note proforma. (Appendix 9)

Within this model, four levels of intervention are identified with levels 1 through to 4 to be used by all CFMHTs (Table 2). CFMHTs within WHSCT, NHSCT and SHSCT utilise all levels and demonstrated 100% compliance. The patient note audit for the BHSCT CFMHTs showed limited evidence to indicate that they were operating in line with the four level interventions model so they achieved a compliance rate of 25%. The regional compliance level was therefore 75%. (Table 8)

Table 8: Compliance: Intervention Levels 1 to 4 and utilisation by Trust CFMHTs and Regionally (N=72)

CFMHT	Compliance	Level 1	Level 2	Level 3	Level 4	Total
WHSCT	100%	5	5	5	5	20
NHSCT	100%	5	5	5	5	20
BHSCT	25%	0	0	0	20	20
SHSCT*	100%	4	2	2	4	12
Regional	75%					

Table 9 reflects the referral process within the CFMHTs care pathway model and the timeframes for actions. The entire sample of 72 patient notes was not included in this pathway at all stages. The reason provided for this was that a referral letter was not always required as some patients were already known and under the care of the CFMHTs and therefore some of the pathway did not apply to these patients.

Within Table 9 the sample or subsample that the question relates to is included. Individual Trust CFMHT findings are available where applicable.

Further tabular breakdown for individual Trust CFMHTs is available within Appendix 1: Table 2.1 to Table 2.10.

Table 9: Regional Compliance to CFMHTs Referral Pathway

Regional Compliance Subsample(N=50)	
Referral received by CFMHT screened within one working day (N=50)	94% (47 of 50)
If all information is not available on the referral proforma the referring agent should be asked to forward on the required information. (N=15)	80% (12 of 50)
If all information not available on referral proforma, was referring agent informed it would be put on hold until it was received? (N=15)	80% (12 of 50)
At initial screening was urgency determined (N=50)	96% (48 of 50)
Was written communication provided to referring agent/keyworker/GP indicating;(N=50) <ul style="list-style-type: none"> • Referral acceptance, • Forensic lead in case, • First appointment date • Intervention level 	96% (48 of 50) 100% (50) 84% (42 of 50) 88% (44 of 50)
Regional Compliance Subsample (N=72)	
Case being allocated to an appropriate team member (N=72)	100% (72)
First appointment ≤ 15 working days from the CFMDTM	76% (55 of 72)
3 x Trust Compliance Subsample (N=26) (excludes BHSCT)	
Preliminary summary report forwarded to referring agent/key worker/GP within 15 working days – Refers to Level 1 and 2 (N=26) (* All 22 patient notes where the preliminary summary report was forwarded had included a progress update and initial information). <i>Please note compliance relates to WHSCT, NHSCT and SHSCT only as BHSCT did not utilise these levels.</i>	85% (22*)
On completion of Level 2 intervention, was the referral discussed at the next CFMDTM meeting to determine the next steps? (N=12) <i>Please note compliance relates to WHSCT, NHSCT and SHSCT only as BHSCT did not utilise this level.</i>	100% (12)
Compliance Subsample (N=46)	
Was there a multi-disciplinary/agency case review carried out within three to six months? Relates to level 3 & 4 only (N=46) (Refers to All Trusts)	100% (Levels 3 & 4) WHSCT, NHSCT, SHSCT
BHSCT evidence of level 4 intervention only.	100% (Level 4 only) BHSCT

Breakdown by Trust Community Forensic Mental health Teams (CFMHTs)

Regional compliance for referral screening within one working day was 94% (47 of 50). NHSCT, BHSCT and SHSCT compliance was above the regional average at 100% with WHSCT below the regional average at 81%.

If information was not available on the referral proforma, the referring agent should be asked to then forward on the required information. This happened in 12 out of 15 cases, a regional compliance rate of 80%. Within the remaining 3 patients' notes (20%) no evidence was available that the referring agent was asked to forward on the required information. The NHSCT (100%) and WHSCT (86%) demonstrated compliance higher than the regional average (80%). The BHSCT attained 60% compliance whilst the SHSCT had no cases relevant to this question.

Of the 15 applicable patient notes audited, in 12 cases, the referring agent was informed that the referral would be put on hold until the required information was received, a regional compliance of 80% and in three cases (20%) the referral agent was not informed. The NHSCT had 100% compliance and the WHSCT 86% compliance which was higher than the regional average of 80%. The BHSCT had 60% compliance. The SHSCT had no cases relevant to this question

The regional average for compliance with the standard of written communication relating to referral acceptance was 96% (48 of 50). The NHSCT, BHSCT and SHSCT achieved 100% compliance and the WHSCT achieved 88%

The regional figure for compliance with written communication relating to the forensic lead was 100% compliance (50 of 50).

In 42 out of 50 cases written communication relating to first appointment date was present, a compliance rate of 84%. Compliance across trusts ranged from 100% in the SHSCT to 58% in the BHSCT.

In relation to cases being allocated to the appropriate team member, regional and individual Trust compliance was 100%.

In 55 of 72 cases, a compliance rate of 76% first appointments were sent on or within the 15 working days from a Community forensic multi-disciplinary team meeting (CFMDTM) with 24% falling outside this timeframe. Compliance within Trusts ranged from 100% in the SHSCT to 45% in the BHSCT.

In relation to a preliminary summary report being forwarded within 15 working days, of the 26 cases relating to this question, compliance within the applicable 3 Trusts was 85% (22 of 26). Compliance within the NHSCT and SHSCT was 100% and the WHSCT had 60% compliance.

All of the preliminary summary reports (n=22) forwarded included a progress update and initial information.

Results indicated that on completion of Level 2 intervention, the applicable referrals (n=12) were discussed at the next CFMDTM meeting to determine the next steps.

Forty-six patient notes identified level 3 or level 4 interventions, and within this group of patients all multi-disciplinary/agency case reviews had been carried out within three to six months.

Regional Joint Protocol between CFMHTs and NIPS Mental Health Team

Within the NHSCT CFMHT a joint protocol has been developed with NIPS mental health team in relation to the admission and discharge of patients from the NIPS. This has now been adopted as a regional joint protocol which to date has been adopted by the WHSCT and BHSCT CFMHTs (Appendix 10). The SHSCT at the time of audit had not adopted this protocol.

This joint protocol is the agreed standard for the admission and discharge of patients to and from the NIPS. (Table 10 & Table 11)

Table 10: Pathway into Prison: Regional Joint Protocol between NIPS and CFMHTs

Prison Pathway into Prison (NIPS Proforma)	Yes
Did the Community Forensic Mental Health Team inform the NIPS mental health team when a patient managed at Level 3 or Level 4 is committed to prison? (N=8) sample is from the prison service case note.	100% (8 of 8)

Table 11: Pre-discharge meetings/ unexpectedly released from NIPS

(CFMHTs Proforma) Prison Compliance	Prison Compliance
Evidence that the discharge NIPS (liaison team within the prison(s)) make contact with the applicable CFMHTs Team to arrange a pre-discharge meeting when an individual was due for release (N=8).	63% (5 of 8)
Evidence of a pre-discharge meeting taking place with NIPS (liaison team within the prison(s)) and CFMHT(s) prior to the individual being released? (N=8).	63% (5 of 8)
Evidence that if a patient was unexpectedly released from prison, that the prison contacted /notified the CFMHTs (N=2)	50% (1 of 2)

Evidence of the NIPS discharge liaison team making contact to arrange a pre-discharge meeting with the CFMHT was present in 5 of the 8 cases (63%).

Evidence of Comprehensive Risk Assessment and Management Tool (CRA) within Forensic Mental Health Services (FMHS)

The Promoting Quality Care Guidelines: Good Practice Guidelines on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010⁸ standards were used for the development of the FMHS proformas. The FMHS proforma included questions in relation to the CRA and also sought evidence of other risk assessment and management tools being used within these services.

The main risk assessment and management tool used by all FMHS was the Comprehensive Risk Assessment and Management Tool (CRA). However, other risk assessment tools were identified by these services.

CRA: Shannon Clinic RSU & Six Mile Unit (in-patient services)

Within Shannon Clinic, of the 8 patient notes audited, 88% (7 of 8) CRAs had been reviewed within an appropriate timeframe (3 months). Fifty percent (4 of 8) patients' notes provided evidence that the CRA had been discussed with and explained to the patient. (Table 12)

Within the Six Mile Unit 80% (4 out of 5) CRAs had been reviewed within an appropriate timeframe (6 months). Forty percent (2 of 5) patient notes provided evidence that the CRA had been discussed with and explained to the patient. (Table 12)

CRA: Northern Ireland Prison Service (NIPS) - (Maghaberry Prison and Hydebank Wood Prison)

All NIPS CRAs N=8 had been reviewed within an appropriate timeframe (3 months) and 38% (3 of 8) provided evidence that the CRA had been discussed with and explained to the patient. (Table 12)

CRA: Community Forensic Mental Health Teams (CFMHT)

Of the 72 patients' notes audited, in 65 cases (90%) CRAs had been reviewed regularly – a minimum of every three months and 7 (10%) had not been reviewed within the appropriate timeframe. (Table 12)

The WHSCT and BHSCT achieved 100% compliance, with the NHSCT achieving 80% and the SHSCT 75% for CRA being reviewed regularly - a minimum of every three months.

Of the 46 cases (Level 3 & 4); in 33 cases (72%) there was evidence of the CRA being discussed with and explained to the patient, whilst 13 (28%) of cases had no supporting evidence. (Table 12)

Evidence that the CRA had been discussed with and explained to the patient varied within trusts. The WHSCT achieved 90% which was higher than the regional average of 72%. The NHSCT achieved a result of 70%, the BHSCT achieved 65% and the SHSCT achieved 67%.

Further tabular breakdown for individual Trust CFMHTs is available within Appendix 2: Tables 3.1 to 3.3.

Table 12 shows the overall compliance in all audited services and the numbers that varied by service and question asked.

Table 12: Regional compliance with Comprehensive Risk Assessment and Management Tool (CRA) by Forensic Mental Health Services

Compliance: Is there evidence of CRA?			
Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)	NIPS (N=8)	CFMHT (N=72)
100% (8 of 8)	100% (5 of 5)	100% (8 of 8)	100% (72 of 72)
Compliance: Is the CRA reviewed regularly, a minimum of every 3 months /(6 months in Six Mile Unit)			
Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)	NIPS N=8)	CFMHT (N=72)
88% (7 of 8)	80% (4 of 5)	100% (8 of 8)	90% (65 of 72)
Compliance: Is there evidence to support that the CFA has been discussed and explained to the patient?			
Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)	NIPS (N=8)	CFMHT subsample of level 3 & 4 only (N=46)
50% (4 of 8)	40% (2 of 5)	38% (3 of 8)	72% (33 of 46)

Other Forensic Risk Assessment and Management Tools

Of note: Compliance was not required within this area. All FMHS audited identified and used other forensic specific risk assessment and management tools in conjunction with the CRA.

Of the 72 CFMHTs' patient notes reviewed, 14 were not applicable to this question as other appropriate risk assessments may be completed at Levels 2, 3 and 4; therefore, a sample of 58 patient notes was used. Thirty two (55%) of CFMHTs' patient notes had evidence of using other risk assessment and management tools. Thirty cases identified 'Historical Clinical Risk Management-20 Version 3' and two cases identified 'Risk for Sexual Violence Protocol'. (Table 13)

Appendix 22 provides a list and brief description of other risk assessment and management tools. Individual CFMHTs' findings are available in Appendix 2: Table 3.3.

Table 13: Utilisation of Other Risk Assessment and Management Tool by Forensic Mental Health Services

Is there evidence of other risk assessment and management tools?			
Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)	NIPS (N=8)	CFMHT (N=58)
88% (7 of 8)	40% (2 of 5)	13% (1 of 8)	55% (32 of 58)
'Historical Clinical Risk Management-20 Version 3'	'ARMIDILO-S'	'Historical Clinical Risk Management-20 Version 3'	'Historical Clinical Risk Management-20 Version 3' and 'Risk for Sexual Violence Protocol'

Evidence of Patient Centred Care within all FMHS

Within the FMHS manager's questionnaire (Appendices: 12, 15 &17) information was sought in relation to the therapeutic interventions and psychological assessments and recovery tools utilised within services. The service proformas developed for the case note audit included questions related to patient centred care. The proformas were developed in line with the Regional Care Pathway for Mental Health 'You in Mind Care Pathway'⁹ which recognises that all treatment and care needs to be highly personalised and recovery orientated. Treatment and care plans/nursing care plans/recovery plans were reviewed where applicable to find evidence of specific care plans and review of these by services. Other standards that were included in the development of the patient note proforma were Standards for Low and Medium Secure Care as well as Standards of Care for the Prison Service.

Table 14a shows the overall compliance within FMHS in relation these specific care plans.

Shannon Clinic RSU & Six Mile Unit

Both Shannon Clinic RSU and the Six Mile Unit achieved 100% compliance for review of treatment and care plans. The Six Mile Unit achieved 100% compliance through having clearly identified timescales on the treatment and care plans and Shannon Clinic RSU achieved 75% compliance (6 out of 8).

Both Shannon Clinic RSU and the Six Mile Unit achieved 100% in relation to evidence of patient views being considered, contents of the treatment and care plan being discussed with the patients, patients receiving education in relation to their illness/symptoms and liaison with carer(s)/family members.

Wellness Recovery Action Plan (WRAP) was being provided to 80% of patients within Shannon Clinic RSU; however the Six Mile Unit showed no evidence of WRAP's being utilised.

Northern Ireland Prison Service (NIPS) - (Maghaberry Prison and Hydebank Wood Prison)

NIPS only achieved 25% compliance (2 of 8) in relation to the reviewing of patient's recovery plans. A similar level of compliance (25%) was achieved in relation to clearly identified timescales for reviewing recovery plans. In relation to evidence of patient views being considered and contents of the recovery plan being discussed with the patients NIPS achieved 88% compliance (7 of 8). Compliance of 100% was achieved for both patients receiving education about their illness/symptoms and receiving education about their medication. Evidence of liaison with carer(s)/family members by NIPS was noted in 50% of the patient notes (4 of 8).

There was no evidence of WRAP being utilised in NIPS.

Community Forensic Mental Health Teams (CFMHT)

Of the 72 patient notes audited, 46 (Levels 3 & 4) treatment and care plans were reviewed. Of these, 35 (76%) had clearly defined timescales for review of the treatment care plan and 11 (24%) did not.

Of the 46 patient notes audited, 43 (93%) had evidence of review of the treatment care plan and three (7%) did not. Regional compliance was 93%. The WHSCT, NHSCT and BHSCT achieved 100% compliance whilst the SHSCT achieved 50% compliance against the regional average.

Of the 72 patient notes audited, patient views were noted in 64 (89%) cases, patient refusal was noted in 6 (8%) and in two cases there was no evidence of patients' views.

Of the relevant patient notes (N=46) (Level 3 & 4), there was evidence that the content of the treatment and care plan had been discussed with the patient in 39 (85%) cases. Five (11%) of patients refused to discuss the content of their treatment and care plan (no recorded reason for refusal) and in 2 (4%) cases no evidence of discussion was documented.

As the NHSCT does not currently utilise WRAP, the figure changes from N=46 to N=36.

In 16 patient notes (44%), across all other Trusts evidence of the relapse plan (WRAP) was documented. In 7 (19%) cases, patient refusal was documented. In 13 (36%) cases no evidence of WRAP was documented.

The Regional average for evidence of recorded 'patients' views' on their treatment and care plan in patient notes was 89%. Within trusts, evidence of recording ranged from 100% in the SHSCT to 80% in the WHSCT.

In relation to evidence that the contents of the treatment and care plan had been discussed with the patient, the SHSCT achieved 100%, the NHSCT achieved 90% which was higher than the regional average of 85%. The BHSCT achieved 85% whereas the WHSCT fell below the regional average, achieving a result of 70%.

Evidence of a relapse plan (WRAP) being recorded was present in 60% of records in the WHSCT and 50% in the BHSCT. The NHSCT did not utilise WRAP at the time of the audit and the SHSCT evidence showed that all patients refused.

Further tabular breakdowns for Individual CFMHTs are available in Appendix 3: Tables 4.1 to 4.4.

Table 14a: Evidence of Patient Centred Care Note: Calculation of services compliance included the sub groups of 'Yes' or 'No' responses only (patient or carer refusal were not incorporated into the calculation).

Compliance	Shannon Clinic RSU (N=8) treatment and care plan	Six Mile Unit (N=5) treatment and care plan	NIPS (N=8) Recovery plan	CFMHT subgroup varied
Are there clearly identified timescales for review of the treatment and care plan/Recovery Plan?	75% (6 of 8)	100%	Recovery plan 25% (2 of 8)	76% (35 of 46)
Is there evidence of review of the treatment and care plan?	100%	100%	25% (2 of 8)	93% (43 of 46)
Compliance - Within the treatment and care plan/recovery plan is there evidence of the following:				
Patients' views	100%	100%	88% (7 of 8)	97% (64 of 66)
Evidence that the contents have been discussed with the patient	100%	100%	88% (7 of 8)	95% (39 of 41)

Wellness Recovery Action Plan (WRAP)	80% (4 of 5)	0%	0%	55% (16 of 29)
Is the nursing care plan signed (written or electronic evidence) by the patient?	86% (7 of 8)	100% (electronically recorded).	N./A	N/A
Compliance	Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)	NIPS (N=8)	CFMHTs subgroup varied
The patient has received education about his/her illness/symptoms	100% (8 of 8)	100% (5 of 5)	100% (8 of 8)	95% (61 of 64)
The patient has received education about his/her medication	100% (8 of 8)	80% (4 of 5)	100% (8 of 8)	98% (63 of 64)
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)	100% (8 of 8)	100% (5 of 5)	50% (4 of 8)	100% (62 of 62)

Table 14b provides information in relation to psychological assessments /treatment and therapeutic intervention tools used within in-patient forensic services (Shannon Clinic RSU & Six Mile Unit).

Table 14b: Utilisation of Psychological assessments /treatment and therapeutic intervention tools within FMHS

	Shannon Clinic RSU (N=8)	Six Mile Unit (N=5)
Psychological assessment	63% (5 of 8)	80% (4 of 5)
Psychological treatment	50% (4 of 8)	80% (4 of 5)
Group therapeutic intervention	83% (5 of 6)	38% (3 of 5)
Individual therapeutic intervention	86% (7 of 8)	80% (4 of 5)

Patient Questionnaire

Patient questionnaires were distributed within all services to provide an opportunity for service users to comment on their individual service provider. (Appendix 19, 20 & 21)

A total of 294 questionnaires were distributed to patients within all forensic mental health services audited and a response rate of 40% (117) was achieved. Table 15 shows a breakdown of the distribution of questionnaires to each service.

Table 15: Patient questionnaires distribution:

Service	HSC Trust Services are located	Distributed	Response
Shannon Clinic RSU	BHSCT	33	29 (87%)
Six Mile Unit	BHSCT	18	14 (78%)
Maghaberry and Hydebank Wood Prison	SEHSCT	64	33 (56%)
CFMHTs	NHSCT, WHSCT, BHSCT & SHSCT	179	41 (33%)
Total		294	117 (40%)

Table 16 provides the breakdown across individual Trust CFMHTs.

Table 16: CFMHTs patient questionnaires distributed across the Trusts

Trust	Distributed	Returned
WHSCT	59 (32%)	9 (15%)
NHSCT	28 (15%)	8 (29%)
BHSCT	76(42%)	12 (16%)
SHSCT	16 (9%)	12 (75%)
Total	179 (100%)	41(23%)

The purpose of the patient questionnaire was to provide patients with an opportunity to comment on aspects relating to their care and their involvement in that care. The patient questionnaire contained the same seven questions but within the two inpatient services (Shannon Clinic RSU and Six Mile Unit) a question relating to the nursing plan was also incorporated.

A breakdown of all the forensic mental health services' findings with all the response categories recorded is available in Appendix 4: Tables 5.1 to 5.6.

Table 17 only relates to the first two response categories in each question and provides combined forensic mental health figures as well as individual services overall figures.

Table 17: ‘Always/Often’, ‘Very /Mostly involved’ and ‘Yes’ responses only from patients’ questionnaire by all services

Patient responses are applicable to all services excluding the *Nursing plan	All services (n=117)	Shannon Clinic RSU (n=29)	Six Mile Unit (n=14)	Maghaberry and Hydebank wood (n=33)	CFMHTs (n=41)
Patient response;					
‘Always/ often’ feel supported by the caring staff caring for you	84%	79% (23)	100% (14)	33% (11)	98% (40)
‘Always/often’ feel they are treated with respect	59%	79% (23)	79% (11)	76% (25)	100% (41)
‘Always/often’ feel they are listened to	53%	76% (22)	100% (14)	58% (19)	90% (37)
‘Always/often’ feel their views are taken into account	41%	66% (19)	71% (10)	42% (14)	85% (35)
‘Very /mostly involved’ in their care	32%	62% (22)	79% (11)	36% (12)	85% (35)
‘Yes’ Have seen their treatment and care plan	34%	79% (23)	100% (14)	64% (21)	70% (29)
‘Yes’ Have seen their risk assessment	42%	34% (10)	79% (11)	21% (7)	51% (21)
*Shannon Clinic RSU & Six Mile Unit only ‘Yes’ Have seen their nursing plan	58%	48% (14)	79% (11)	-	-

Appendix 5: Graph 1 to Graph 6 illustrates specific responses to the questions for CFMHTs in relation to in Table 17. Appendix 6: Provides a list of additional comments from the services users from within the four FMHS audited.

Discussion

Over the last decade Northern Ireland has experienced major developments in the provision of forensic mental health and learning disability services. In-patient forensic mental health services (Shannon Clinic RSU) and learning disability (Six Mile Unit) have become well established. The development of Community Forensic Mental Health Teams underpins the need to support the smooth transition from secure provision towards community integration.

Not only are FMHS responsible for healthcare needs of patients but they also manage risk whilst working alongside and liaising with criminal justice agencies such as the NIPS, Police Service Northern Ireland (PSNI), Public Prosecution Service (PPS), probation service and the courts.

Through discussions with service managers, all services audited recognised the importance of effective interagency and multidisciplinary team working, for the delivery of safe and effective care, that is specific to the varying forensic healthcare needs of their patients.

NIPS mental health staff discussed how they deliver care to a very large, ever changing and challenging patient base. The Donard Centre 'Hub Centre' within Maghaberry prison is focused on therapeutic interventions and patients told the project lead about how much they valued this facility.

Areas of good practice

Psychological Therapies

Within Northern Ireland, the regional in-patient FMHS (Shannon Clinic RSU & Six Mile Unit) and CFMHTs deliver well recognised psychological treatments, both in the form of one to one and group sessions, dependent on patient need. NICE guidelines¹⁰ recommend the need to provide psychological interventions to adults with mental health problems who come into contact with the criminal justice system. These services have a forensic psychologist as part of their multidisciplinary team. The information received from the FMHS managers' questionnaires (Appendix: 12, 15 & 17) as a background to this audit highlighted a varied range of psychological treatment and or therapies being delivered across FMHS (Appendix: 23) Examples of these include:

- Dialectical Behaviour Therapy (DBT)
- Cognitive Behaviour Therapy (CBT)
- Motivational Enhancement Therapy New Beginnings (MET)
- Good Thinking Skills (GTS)

- Substance Misuse Therapy/Drug & Alcohol Therapy
- Psychology led specific index offence related work
- Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories.

Risk assessment and management tools

All of the FMHS audited showed 100% compliance with evidence of Comprehensive Risk Assessment and Management tools being utilised within their service.

In-patient forensic services (Shannon Clinic RSU & Six Mile Unit) and the CFMHTs utilise more specific evidence based risk assessment and management tools (Appendix 22). Examples of these include:

- Historical Clinical Risk Management-20 Version 3 (HCR20v3)
- Risk for Sexual Violence Protocol (RSVP)
- The Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend (ARMIDILO-S)
- Risk Matrix 2000
- Spousal Assault Risk Assessment (SARA)
- Stalking Assessment and Management (SAM)
- Short-Term Assessment of Risk and Treatability (START)
- DRAMS (Dynamic Risk Assessment and Management System)

The use of these risk assessment and management tools is dependent on the specific needs of the service (mental health or learning disability) and the specific needs of the patient.

Patient Centred Care

A position statement 'Recovery is for All' 2010¹¹ stated that one of the criticisms of recovery orientated care or practice is the capacity to be sometimes 'woolly' or 'vague'. It is important then that forensic services within Northern Ireland continue to ensure that care is completely individualised and specific to a person's needs.

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effect of mental illness.¹²

The importance and emphasis that FMHS in Northern Ireland place on involving patients in their care was apparent and this was evidenced by the results achieved in relation to 'evidence of the contents of the treatment and care plans being discussed with the patient' which ranged from 95% within CFMHTs to 100% within the other services audited.

Other evidence of positive collaborative care that was identified by the audit was in relation to patients who had received education about their illness or symptoms where the percentages ranged from 95% (regional result for CFMHT) to 100% for the inpatient services (Shannon Clinic RSU & Six Mile Unit) as well as the NIPS.

Patients receiving education in relation to their medication also showed good results ranging from 80% in the Six Mile Unit and 98% from regional CFMHTs to 100% in the other two other services (Shannon Clinic RSU & NIPS).

A large part of recovery orientated care and processes in FMHS involve working collaboratively with patients with a drive towards shared decision making and responsibility. Evidence of patient views being recorded within patient notes and or treatment and care plans achieved results of 88% in the NIPS, 97% for the CFMHTs with inpatient facilities (Shannon Clinic RSU & Six Mile Unit) achieving 100%. This audit reflects the current situation within FMHS and demonstrates how these services have developed over the past decade.

There was a clear emphasis on the need for family and carer involvement within all of the services audited. Within CFMHTs 86% (62 out of 72) of patient notes contained evidence of liaison/involvement with family/carer(s). In relation to in-patient services, Shannon Clinic RSU had had evidence of involvement in 86% (7 out of eight patients) and the Six Mile Unit achieved 100% (5 out of 5). Within NIPS, 50% (4 out of 8) had evidence of liaison/involvement with family/carer(s) members.

Services had also shown evidence of consideration being given to a patient's wish to not have their family/carer(s) involved as well as consideration being given to a family/carer(s) wish to not be involved in care.

All written feedback received through the patient questionnaires are provided within the report which also reflects the verbal comments received by the project lead. Feedback came from all service areas-refer to Appendix 6 examples of which are:

- *"Thanks for the care and treatment I receive."*
- *"I feel very supported here."*

- *“I would like some more time with my doctor.”*
- *“We need the mental health wing back people are suffering on landings and then harming themselves.”*
- *“The mental health team have been very good to me but the problem is there is no mental health wing anymore for people to go when they are really ill.”*

Areas for improvement

Shannon Clinic RSU

The audit showed that four out of the eight cases demonstrated supporting evidence that the CRA has been discussed and explained to the patient (Table 12). However; evidence of identified timescales for review of the treatment and care plan were only available in six of the eight patient notes (Table 14a).

Six Mile Unit

Qualitative discussions with staff as well as the returned manager’s questionnaire identified the lack of a specific formalised referral pathway into the Six Mile Unit.

Maghaberry Prison

Information collected regarding the location within the NIPS from which patients were accepted for admission to Shannon Clinic RSU, over the 7 year period from 2010 to 2016, showed a significant proportion coming from the Care and Supervision Unit (CSU), following closure of the residential healthcare facility in 2013 (Table 4). The residential healthcare facility, ‘healthcare wing’, was a high support landing where acutely mentally unwell prisoners could be located and it had 24 hour coverage by general and mental health staff. From 2014-2016, of the total of 31 patients accepted from the NIPS there were 10 referrals accepted from CSU to Shannon Clinic RSU compared to none of the 50 referrals accepted from the NIPS between 2010 and 2013.

The placement of mentally ill people within conditions of segregation such as within the CSU can be detrimental to their mental wellbeing and is not in keeping with the principle of equivalence of care between prison and the wider community. It has also been shown by forensic services in Dublin that the use of seclusion can be reduced by providing a high support unit within a prison.¹³

With an increasing focus on improving the quality of mental health service provision within prisons, the Royal College of Psychiatrists¹⁴ has published Standards for 24 Hour Mental Healthcare in Prisons, to promote quality improvement where such units are put in place.

Within the NIPS patient questionnaire, service users within the prison service have stated their support for the previous benefits of a residential healthcare facility 'healthcare wing' within the prison. Some patients also documented this on the questionnaire:

"We need the mental health wing back. People are suffering on landings and then harming themselves"

"The mental health team have been very good to me but the problem is there is no mental health wing anymore for people to go when they are really ill"

Community Forensic Mental health Teams (CFMHTs)

The findings of this audit showed that only three out of the four CFMHTs were working within the 4 level model of care as identified in the standard 'Care Pathway and Model for Community Forensic Teams in Northern Ireland'. The agreed standard is that all 4 levels of care are adhered to.

During qualitative discussions with the relevant CFMHT managers we were told that the Northern CFMHT has developed a joint protocol with the NIPS which was approved for regional implementation in 2015-16. However only two of the CFMHTs have adopted this protocol. In discussions with the project lead, team managers from both the NIPS and CFMHTs identified that the protocol has been extremely beneficial during patient discharge as well as for patients who enter the NIPS.

Patient feedback in relation to their involvement

For patients within Shannon Clinic RSU, 34% (10 of 29) had reported seeing their treatment and care plans and 79% (11 out of 15) within Six Mile Unit had seen theirs. Within CFMHTs, 51% (21 out of 41) reported to have seen their treatment and care plans. (Table 17)

Psychological Therapies

Three of the four CFMHTs had a psychologist as part of their team whilst within the WHSCT they did not. It is important that CFMHTs mirror and benchmark practice with one another. There is also a need for forensic patients to access higher intensity complex psychological therapies.

The audit showed a deficit of psychological assessments being delivered to patients within in-patient services (in Shannon Clinic RSU). Five out of the eight cases within Shannon Clinic RSU had evidence of psychological assessments.

Risk Assessment and Management Tools

Risk assessment and management is integral to providing safe and effective care and making decisions on transition between services (Royal College of Psychiatry 2016).¹⁵ Regionally, CFMHTs showed that 55% (32 of 58) of patients' notes had evidence of other forensic specific risk assessment and

management tools being used, namely HCR20v3 (n=30) and RSVP's (n=2). Within the Six Mile Unit, evidence of the use of the Armadillo tool was documented within two out of the five patient notes audited. Within Shannon Clinic RSU the overall percentage of HCR20v3's completed was 88% (seven out of eight patients audited). (Tables 13)

Wellness Recovery Action Plan (WRAP)

The findings in this audit reflect that WRAP plans are not consistently used across all FMHS.

Recommendations

1. The Six Mile Unit should develop and implement a specific referral pathway.
2. All CFMHTs should implement the regional joint protocol for admission and discharge of patients to prison.
3. All CFMHTs should implement the four level model of care.
4. FMHS should promote and utilise forensic specific risk assessment and management tools; examples include the HCR20v3 and the RSVP.
5. Forensic Mental Health Services (FMHS) should involve and collaborate with patients in their risk assessment and management in line with Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010 <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mhld-good-practice-guidance-2010.pdf>
6. The Prison Health Commissioning Team should in partnership with NIPS/ SEHSCT re-assess the need for a residential healthcare facility within Maghaberry prison.
7. All CFMHTs should have a psychologist as part of their team.
8. FMHS should promote and utilise psychological therapies and treatment within group and individual intervention.
9. All relevant Forensic Mental Health staff should be trained in the delivery of WRAP. Service Managers should review and promote its delivery by trained staff.
10. FMHS should include appropriate timescales for review of treatment and care plans for all patients.

Project Team

Name	Job title/Specialty	Trust Area	Role within project
Martina Coyle	Forensic Nurse Therapist	WHST	Project lead
Brian Simpson	Forensic Team Manager	WHST	Project lead manager
Adrian East	Consultant Forensic Psychiatrist	SHST	Advisory
Barry Mills	Senior Manager, Learning Disability Services	BHST	Advisory
Noel Mc Donald	Forensic Services Operations Manager	BHST	Advisory
Hugo Kelly	Forensic Team Manager	SHST	Advisory
Ian McMaster	DoH Medical Policy Advice	DoH	Advisory
Terry Mc Cabe	Forensic Team Manager	NHST	Advisory
Leanne Armitage	Consultant Forensic Psychiatrist	WHST	Advisory
Mary Donaghy	Social Care Commissioning and Think Family NI Lead	HSCB	Advisory
Christine Freeburn	Social Worker	WHST	Advisory
Paul McMonigle	Independent Advocate	BHST	Advisory
Jane Reynolds	Occupational Therapist	NHST	Advisory
Siobhan Crilly	Regional Clinical Audit Facilitator	RQIA	Advisory

Acknowledgements

The project team would like to offer a special thanks to the Quality Improvement and audit Department in the WHST, in particular Deirdre Kelly for facilitating the project as well as her continued support during the project.

References

- 1 Ridley, J., McKeown, M., Machin, K., Rosengard, A., Little, S., Briggs, S., Jones, F. and Deypurkaystha (2014). Exploring Family Carer Involvement in Forensic Mental Health Services. Edinburgh: Support in Mind. pp 8. Available at: <https://www.supportinmindscotland.org.uk/exploring-family-carer-involvement-in-forensic-mental-health-services>
- 2 Department of Health and Social Services and Public Safety (2006) Bamford Review of Mental Health and Learning Disability (Northern Ireland) Forensic Services DHSSPS; Belfast.
- 3 *Centre for Mental Health (2011) Mental health care and the criminal justice system; London: Centre for Mental Health. Available online at:* <https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=59e8d013-dad3-48af-842d-a509de7723c1>
- 4 McCann, G. (1999) Care of the mentally disordered offenders, *Mental Health Care*, 3(2), 65-67.
- 5 Kelly, H, Mc Cabe, T, Devine, P, Simpson, B (2011) Care Pathway and Model for Community Forensic Teams, Northern Ireland; Public Health Agency; Health and Social Care Board; Belfast. Available at: http://www.publichealth.hscni.net/sites/default/files/Care%20Pathway%20and%20Model%20for%20Community%20Forensic%20Teams%20in%20NI%20October%202011_0.pdf
- 6 The 'Recovery College' <http://www.mentalhealthrecoverystories.hscni.net/recovery-college/>
- 7 'Forensic Network' Scotland <http://www.forensicnetwork.scot.nhs.uk>
- 8 Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010 <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mhld-good-practice-guidance-2010.pdf>
- 9 Rooney, R, Watts, V 2014 Regional Care Pathway for Mental Health, Northern Ireland; Public Health Agency; Health and Social Care Board; Belfast. Available at: http://www.northerntrust.hscni.net/pdf/Care_pathway_for_people_who_require_mental_health_care_and_support.pdf
- 10 NICE (National Institute for Health and Care Excellence) (2017) Mental health of adults in contact with the criminal justice system. <https://www.nice.org.uk/guidance/NG66/chapter/Recommendations#psychological-interventions>

- 11 Royal College of Psychiatrists (2010) Recovery is for All. Available at: <http://www.rcpsych.ac.uk/pdf/Recovery%20is%20for%20all.pdf>
- 12 Repper, J. & Perkins, R. (2003) Social Inclusion and Recovery: A model for mental health practice. London: Bailliere Tindall.
- 13 Reducing the use of seclusion for mental disorder in a prison: implementing a high support unit in a prison using participant action research (2012) <https://www.ncbi.nlm.nih.gov/pubmed/22487212>
- 14 Royal College of Psychiatrists (2017) Standards for 24 Hour Mental Healthcare in Prisons *Quality Network for Prison Mental Health Services 24 hour provision within prison service* https://www.rcpsych.ac.uk/pdf/24_Hour_Mental_Healthcare_in_Prison_Standards.pdf
- 15 Royal College of Psychiatrists (2016) Rethinking Risk to Others in Mental Health Services (*Council Report 201*). Royal College of Psychiatrists.

APPENDIX 1: Referral Pathways for Forensic Mental Health Services

NIPS (Maghaberry and Hyde Bank Prisons) Referral Pathway Tables (N=40)

Standard(s): NIPS mental health team's referral allocation and assessment pathway (n=40) (Maghaberry (n=35), Hydebank (n=5)).

Eight patient notes were reviewed within the five categories listed in Table 1.

Question numbers refers to NIPS (Maghaberry and Hydebank Wood Prisons) patient note proforma. (Appendix 15)

Table 1.1: Breakdown of Referrals

Category	Number of patients	Relevant Questions
Urgent referral	8	1 to 6
Routine referral	8	1 to 4 and 6
Pre-assessment contact	8	7 to 9
Patients with a Comprehensive Risk Assessment and Management Plan	8	10 to 12
Key worked patients	8	13 to 17

Table 1.2: Referral allocations (Urgent referral only) (n=8)

	Yes
Q5. Is there evidence to support the outcome of the urgent referral form? NB - Patients notes could have received more than one of these onward referrals:	8
Types of onward referrals	
Allocated key worker	2
Refer to psychiatry	3
Allocated to group work	3
Onward referral	6

Table 1.3: Pre-Assessment Contact (n=8)

	Yes	No
Q7: Was the pre-assessment contact completed within three weeks of referral	7	1
Q8: Is there evidence to support the outcome of the pre-assessment was one of the following NB - Patients could have received more than one of these onward referrals.	Yes	No
Allocated for full assessment	4	0
Allocated to group work	1	0
Onward referral	4	0
Discharged from the service	1	0

Community Forensic Mental Health Teams (CFMHTs) Referral Pathway Tables (N=72 - subgroups can vary within table)

Standard(s): Regional 'Care Pathway and Model for Community Forensic Teams in Northern Ireland'

Question numbers refers to Community Forensic Mental Health Teams (CFMHTs) patient note proforma. (Appendix 18)

Table 2.1: Referral received by CFMHT screened within one working day

Q1	Regional N=50	WHST N=16	NHST N=15	BHST N=12	SHST N=7
Yes	47 (94%)	13 (81%)	15 (100%)	12 (100%)	7 (100%)
No	3 (6%)	3 (19%)	0 (0%)	0 (0%)	0 (0%)

Table 2.2: If all information is not available on the referral proforma the referring agent should be asked to forward on the required information. (N=15)

Q2	Regional N=15	WHST N=20	NHST N=20	BHST N=20	SHST N=12
Yes	12 (80%)	6 (86%)	3 (100%)	3 (60%)	N/A
No	3 (20%)	1 (14%)	0 (0%)	2 (40%)	N/A

Table 2.3: If all information not available on referral form, was referring agent informed it would be put on hold until it was received? (N=15)

Q3	Regional N=15	WHST N=20	NHST N=20	BHST N=20	SHST N=12
Yes	12 (80%)	6 (86%)	3 (100%)	3 (60%)	N/A
No	3 (20%)	1 (14%)	0 (0%)	2 (40%)	N/A

Table 2.4: At initial screening was urgency determined (N=50)

Q4	Regional N=50	WHST N=16	NHST N=15	BHST N=12	SHST N=7
Yes	48 (96%)	14 (88%)	15 (100%)	12 (100%)	7 (100%)
No	2 (4%)	2 (12%)	0 (0%)	0 (0%)	0 (0%)

Table 2.5: Was written communication provided to referring agent/keyworker/GP indicating referral acceptance, forensic lead in case, first appointment date and intervention level?

Q8	Regional N=50	WH SCT N=16	NH SCT N=15	BH SCT N=12	SH SCT N=7
Referral acceptance					
Yes	48 (96%)	14 (88%)	15 (100%)	12 (100%)	7 (100%)
No	2 (4%)	2 (12%)	0 (0%)	0 (0%)	0 (0%)
Forensic lead in case					
Yes	50 (100%)	16 (100%)	15 (100%)	12 (100%)	7 (100%)
No	0 (0%)	0 (0%)	0 (0%)	0(0%)	0 (0%)
First appointment date					
Yes	42 (84%)	14 (88%)	14 (93%)	7 (58%)	7 (100%)
No	8 (16%)	2 (12%)	1(7%)	5 (42%)	0 (0%)
Intervention level					
Yes	44 (88%)	14 (88%)	15 (100%)	8 (67%)	7(100%)
No	6 (12%)	2 (12%)	0 (0%)	4 (33%)	0 (0%)

Table 2.6: Was the case allocated to the appropriate team member?

Q7	CFMHTs compliance N=72	WH SCT N=20	NH SCT N=20	BH SCT N=20	SH SCT N=12
Yes	100%	100%	100%	100%	100%

Table 2.7: First appointment ≤ 15 working days from the CFMDTM

Q9	Regional N=72	WH SCT N=20	NH SCT N=20	BH SCT N=20	SH SCT N=12
Yes	55 (76%)	17 (85%)	17 (85%)	9 (45%)	12 (100%)
No	17 (24%)	3 (15%)	3 (15%)	11(55%)	0 (0%)

Table 2.8: Preliminary summary report forwarded to referring agent/key worker/GP within 15 working days?

Q10	Regional N=26	WH SCT N=10	NH SCT N=10	*BH SCT	SH SCT N=6
Yes	22 (85%)	6 (60%)	10 100%)	N/A	6 100%)
No	4 (15%)	4 (40%)	0 (0%)	N/A	0 (0%)

*BH SCT had only Level 4 interventions

Table 2.9: On completion of Level 2 intervention, was the referral discussed at the next CFMDTM meeting to determine the next steps?

	Three Trust CFMHTs compliance N=12	WHSCT N=5	NHSCT N=5	*BHSCT N=0	SHSCT N=2
Q11					
Yes	100%	100%	100%	N/A	100%

**BHSCT had no Level 1-3 interventions*

Table 2.10: Evidence that (Level 3 and/or 4) interventions had a multi-disciplinary/agency case review carried out within three to six months.

	CFMHTs compliance N=46	WHSCT N=10 Level 3 & 4	NHSCT N=10 Level 3 & 4	BHSCT N=20 Level 4 only	SHSCT N=6 Level 3 & 4
Q12					
Yes	100%	100%	100%	50%	100%

APPENDIX 2:

Comprehensive Risk assessment and Management Tool (CRA): breakdown for individual Trust CFMHTs.

Standard(s): Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010.

All (100%) of Trust CFMHTs patients notes audited (n=72) had evidence of a CRA.

Question numbers refers to Community Forensic Mental Health Teams (CFMHTs) patient note proforma. (Appendix 18)

Table 3.1: CRA's had been reviewed regularly – a minimum of every three months

Q14.	Regional N=72	WHSCT N=20	NHSCT N=20	BHSCT N=20	SHSCT N=12
Yes	90% (65)	100% (20)	80% (16)	100% (20)	75% (9)
No	10% (7)	-	20% (4)	-	25% (3)

Table 3.2: Evidence to support that the CRA has been discussed and explained to the patient (Level 3 and 4)

Q15:	Regional N=46	WHSCT N=10	NHSCT N=10	BHSCT N=20	SHSCT N=6
Yes	33 (72%)	9 (90%)	7 (70%)	13 (65%)	4 (67%)
No	13 (28%)	1(10%)	3 (30%)	7 (35%)	2 (33%)

Table 3.3: Evidence of other risk assessment and management tools

Q16.	Regional N=58	WHSCT N=15	NHSCT N=15	BHSCT N=20	SHSCT N=8
Yes	32* (55%)	8 (53%)	9 (60%)	10 (50%)	5 (63%)
No	26 (45%)	7 (47%)	6(40%)	10 (50%)	3 (37%)

Of the 72 cases reviewed, 14 were not applicable to this question as other appropriate risk assessments may be completed at Levels 2, 3 and 4.

*Thirty cases identified 'Historical Clinical Risk Management-20 Version 3' and two cases identified 'Risk for Sexual Violence Protocol'.

APPENDIX 3:

Breakdown for individual Trusts Community Forensic Mental Health Teams (CFMHTs) Treatment and care plan Tables (Level 3 & 4 only)

Table 4.1: Clearly identified timescales for review of the treatment and care plan? (n=46)

	Regional n=46	WHSCCT N=10	NHSCCT N=10	BHSCCT N=20	SHSCCT N=6
Yes	35 (76%)	9 (90%)	10 (100%)	15 (75%)	1(17%)
No	11(24%)	1(10%)	0 (0%)	5 (25%)	5 (83%)

Table 4.2: Evidence of review of the treatment and care plan?

	Regional n=46	WHSCCT N=10	NHSCCT N=10	BHSCCT N=20	SHSCCT N=6
Yes	43 (93%)	10 (100%)	10 (100%)	20 (100%)	3 (50%)
No	3 (7%)	0 (0%)	0 (0%)	0 (0%)	3 (50%)

Table 4.3: Within the treatment and care plan or patient notes is there evidence of the following:

	Regional N=(72)	WHSCCT N=20	NHSCCT N=20	BHSCCT N=20	SHSCCT N=12
Patients' views (n=72)					
Yes	64 (89%)	16 (80%)	17 (85%)	19 (95%)	12 (100%)
No	2 (3%)	0 (0%)	1(5%)	1 (5%)	0 (0%)
Patient refused	6 (8%)	4 (20%)	2 (10%)	0(0%)	0 (0%)
Evidence that the contents of the treatment and care plan have been discussed with the patient (n=46)					
Yes	39 (85%)	7 (70%)	9 (90%)	17 (85%)	6 (100%)
No	2 (4%)	0 (0%)	0 (0%)	2 (10%)	0 (0%)
Patient Refused	5 (11%)	3 (30%)	1 (10%)	1(5%)	0 (0%)
Relapse plan (Wellness Recovery Action Plan (WRAP)) (n=36)					
Yes	16 (44%)	6 (60%)	0 (0%)	10 (50%)	0 (0%)
No	13 (36%)	1(10%)	0 (0%)	6 (30%)	0 (0%)
Patient refused	7 (19%)	3 (30%)	0 (0%)	4 (20%)	6(100%)

Table 4.4: Evidence by Trust that patients had received education about illness, medication and liaison with family/carer.

	Regional (N=72)	WHSCCT (N=20)	NHSCT N=20	BHSCT N=20	SHSCT N=12
The patient has received education about his/her illness					
Yes	61(85%)	14(70%)	15 (75%)	20 (100%)	12 (100%)
No	2 (3%)	1(5%)	1(5%)	0 (0%)	0 (0%)
Patient refused	9 (13%)	5 (25%)	4 (20%)	0 (0%)	0 (0%)
The patient has received education about his/her medication					
Yes	63 (88%)	15 (75%)	16 (80%)	20 (100%)	12 (100%)
No	1 (1%)	0 (0%)	1(5%)	0 (0%)	0 (0%)
Patient refused	8 (11%)	5 (25%)	3 (15%)	0 (0%)	0 (0%)
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)					
Yes	62 (86%)	16 (80%)	16(80%)	18(90%)	12 (100%)
No	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Patient refused	3 (4%)	1 (5%)	2 (10%)	0 (0%)	0 (0%)
Carer(s)/family members refused /none identified	7 (10%)	3(15%)	2 (10%)	2 (10%)	0 (0%)

APPENDIX 4:

Breakdown of patient responses from all Forensic services across the region. (Patient questionnaires Appendix 19, 20 & 21)

Table 5.1 Do you feel supported by the staff caring for you?

	Always	Often	Sometimes	Rarely	Never
Shannon Clinic RSU (N=29)	13 (45%)	10 (34%)	6 (21%)	-	-
Six Mile Unit (N=14)	9 (64%)	5 (36%)	-	-	-
Maghaberry and Hydebank Wood (N=33)	10 (30%)	11(33%)	6 (18%)	6 (18%)	-
CFMHTs (N=41) Regional Result	34 (83%)	6 (15%)	1 (2%)	-	-

Table 5.2: Do you feel you are treated with respect?

	Always	Often	Sometimes	Rarely	Never
Shannon Clinic RSU (N=29)	13 (45%)	10 (35%)	5 (17%)	1 (4%)	-
Six Mile Unit (N=14)	10 (71%)	1 (7%)	3 (21%)	-	-
Maghaberry and Hydebank Wood (N=33)	11(33%)	14 (42%)	4(12%)	2 (6%)	2 (6%)
CFMHTs (N=41) Regional Result	35 (85%)	6(15%)	-	-	-

Table 5.3: Do you feel listened to?

	Always	Often	Sometimes	Rarely	Never
Shannon Clinic RSU (N=29)	12 (41%)	10 (35%)	6 (21%)	1(3%)	-
Six Mile Unit (N=14)	10 (71%)	4 (29%)	-	-	-
Maghaberry and Hydebank Wood (N=33)	9 (27%)	10 (30%)	6 (18%)	4(12%)	4(12%)
CFMHTs (N=41) Regional Result	31 (76%)	6 (15%)	4 (10%)	-	-

Table 5.4: Do you feel your views are taken into account?

	Always	Often	Sometimes	Rarely	Never
Shannon Clinic RSU (N=29)	9 (31%)	10 (34%)	6 (21%)	4 (4%)	-
Six Mile Unit (N=14)	9 (64%)	1(7%)	2 (14%)	1 (7%)	1(7%)
Maghaberry and Hydebank Wood (N=33)	6 (18%)	8 (24%)	10 (30%)	4 (12%)	5 (15%)
CFMHTs (N=41) Regional Result	24 (59%)	11(27%)	6 (15%)	-	-

Table 5.5: How involved do you feel in your care?

	Very involved	Mostly involved	Sometimes involved	Rarely involved	Never involved
Shannon Clinic RSU (N=29)	6 (21%)	16 (55%)	5 (17%)	2 (7%)	-
Six Mile Unit (N=14)	7 (50%)	4(29%)	2 (14%)	1(7%)	-
Maghaberry and Hydebank Wood (N=33)	5 (15%)	7 (21%)	13(39%)	4 (12%)	4 (12%)
CFMHTs (N=41) Regional Result	20 (49%)	15 (37%)	6(15%)	-	-

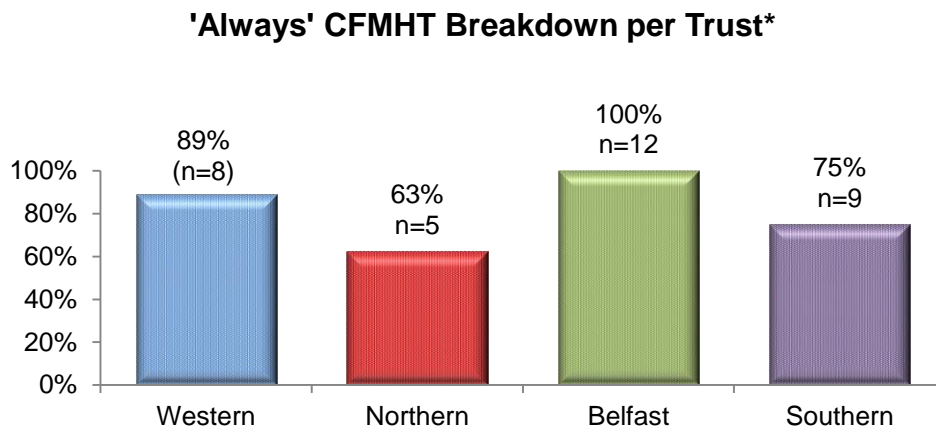
Table 5.6: Have you seen your....?

	Treatment & Care Plan			Risk Assessment				Nursing Care Plan		
	Yes	No	Not sure	Yes	No	Not sure	No reply	Yes	No	Not sure
Shannon Clinic RSU (N=29)	11 (38%)	12 (41%)	6 (21%)	10 (34%)	10 (34%)	9 (31%)	-	14 (48%)	9 (31%)	6 (21%)
Six Mile Unit (N=14)	11 (79%)	3 (21%)	-	11 (79%)	3 (21%)	-	-	11 (79%)	3 (21%)	-
Maghaberry and Hydebank Wood (N=33)	1 (3%)	20 (61%)	12 (36%)	7 (21%)	16 (49%)	10 (30%)	-	-	-	-
CFMHTs (N=41) Regional Result	17 (41%)	12 (29%)	12 (29%)	21 (51%)	9 (22%)	9 (22%)	2 (5%)	-	-	-

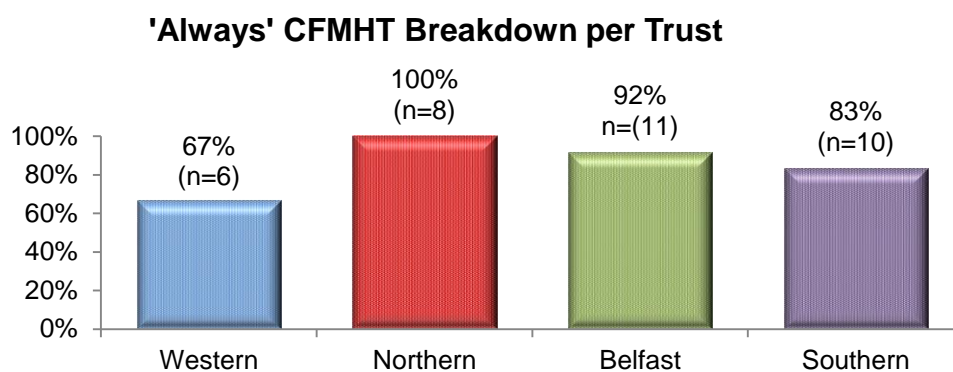
APPENDIX 5:

Breakdown of individual Trusts' CFMHTs patient questionnaire responses: CTMHTs patient questionnaire (Appendix 20)

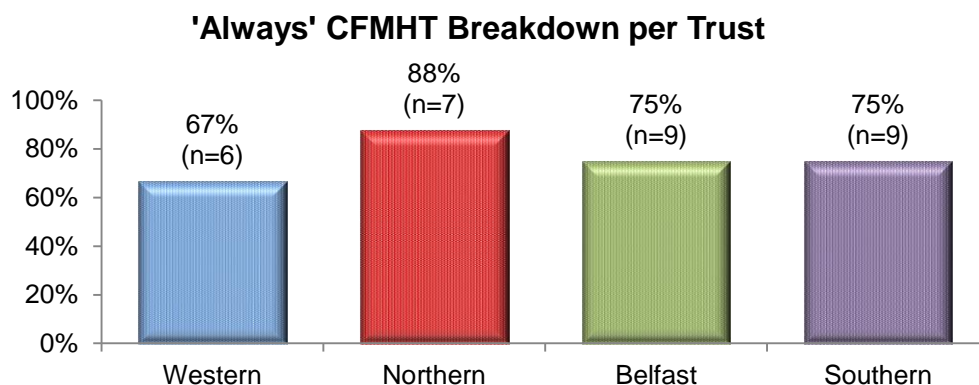
Graph 1: Do you feel supported by the staff caring for you?
CFMHT breakdown of patients feeling supported (always responses)



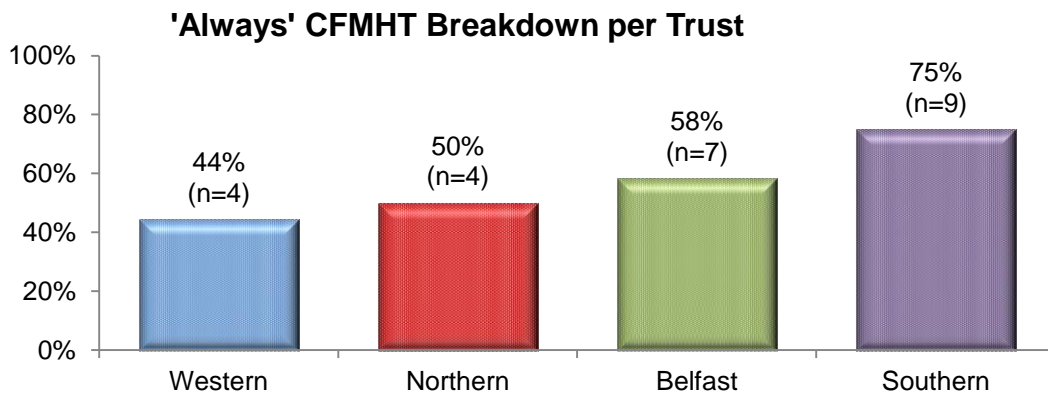
Graph 2 - Do you feel you are treated with respect by CFMHS-Trust breakdown?



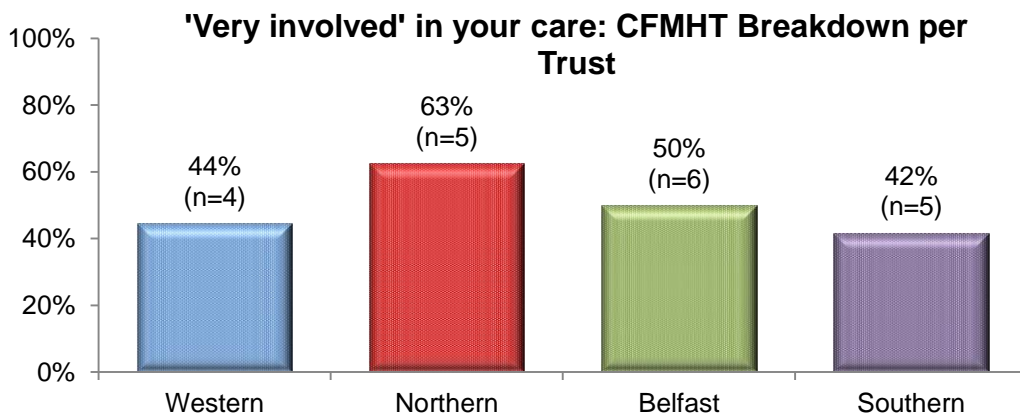
Graph 3 - Do you feel listened to by CFMHS-Trust breakdown?



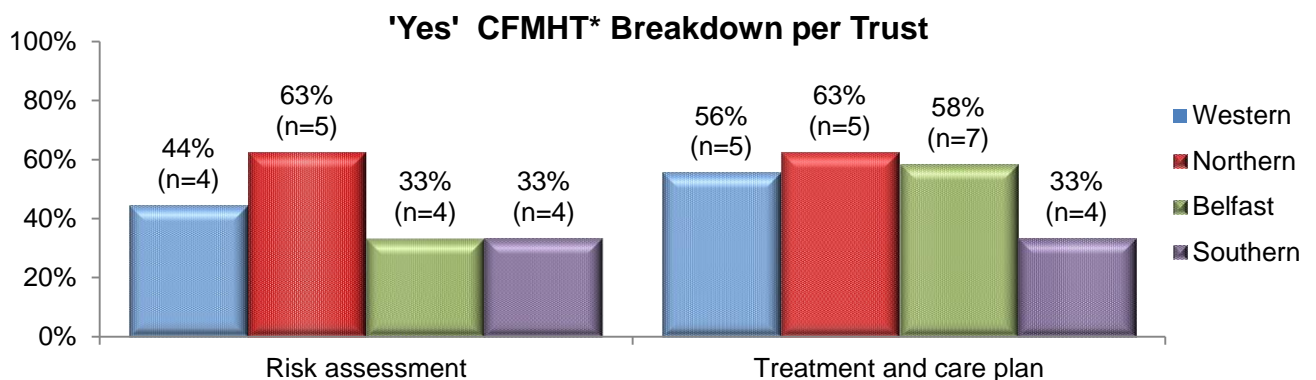
Graph 4: Do you feel your views are taken into account by CFMHT-Trust breakdown?



Graph 5- How involved do you feel in your care by CFMHT-Trust breakdown



Graph 6: Seen documents by CFMHT-Trust breakdown



APPENDIX 6: Comments received from patients across services.

All comments provided by patients from within each service

Community Forensic Mental Health Service (CFMHS)
"Seeing my risk assessment and care plan would be helpful for everyone."
"I am happy with the care I receive."
"I have chosen not to see my risk assessment or care plan."
Six Mile Unit
"I feel very supported here."
"I feel well looked after."
Maghaberry and Hydebank Wood
"I am happy with the mental health team."
"The mental health team have been good to me."
"We need the mental health wing back people are suffering on landings and then harming themselves."
"The mental health team have been very good to me but the problem is there is no mental health wing anymore for people to go when they are really ill."
Shannon Clinic Regional Secure Unit
"Thanks for the care and treatment I receive."
"Thanks for all your help."
"I would like some more time with my doctor."

APPENDIX 7:

Shannon Clinic RSU Referral Pathway.

Shannon Clinic

Regional Guidance on Admission/ Discharge

The admission/ Discharge guidance protocol highlights the recommended maximum timescales from referral to admission is 9 weeks. This 9 week period consists of:

- Two weeks from referral to a response from Shannon to the referring agent whether they accept or refuse the referral.
- Two weeks to carry out preadmission assessment.
- One week to offer advice if refused admission or 5 weeks to accept the referral and offer a bed.

APPENDIX 8:

Prison service mental health team's referral allocation and assessment pathway



SOUTH EASTERN TRUST

Title:	Referral Allocation and Assessment Procedure
Author(s)	Mental Health Team (Prison Healthcare)

The outcome of the referral allocation meeting can be:

- Urgent full assessment
- Routine full assessment
- Pre-assessment contact
- Therapeutic Group i.e. Step Care Model
- Inappropriate Referral

(A) Urgent Full Assessment

All urgent referrals will have a full Mental Health Assessment completed within 10 days of receipt of referral.

1. Mental Health Team Lead co-ordinates room and staffing for clinics and liaises with Admin.
2. The Admin Team will book an appointment for the client and forward a letter (PH/MH/L03).
3. A full Mental Health Assessment is completed by the allocated Mental Health Practitioner, using the Initial Mental Health Assessment Form (PH/MH/F02).

4. In the case of a re-referral within 12 months a Re-Assessment / Update Form is completed (PH/MH/F03).
5. Regional Risk Screening Tool is completed or Comprehensive Risk Assessment is updated.
6. The outcome of the urgent assessment will be one of the following:
 - Allocated Key Worker
 - Refer to Psychiatry
 - Allocated to group work
 - Onward referral
 - Discharged from service
7. Client documentation is returned to Admin Team to update the spread sheet and the Mental Health Practitioner enters a summary of assessment and management plan on EMIS.

(B) Routine Referral

All routine referrals are seen within 9 weeks.

1. Mental Health Team Lead co-ordinates room and staffing for clinics and liaises with Admin.
2. The Admin Team will book an appointment for the client and forward a letter (PH/MH/L03).
3. A full Mental Health Assessment is completed by the allocated Mental Health Practitioner allocated, using the Initial Mental Health Assessment Form (PH/MH/F02).
4. In the case of a re-referral within 12 months a Re-Assessment / Update Form is completed (PH/MH/F03).
5. Regional Risk Screening Tool is completed or Comprehensive Risk Assessment is updated.

6. The outcome of the assessment will be one of the following:
 - Allocated Key Worker
 - Refer to Psychiatry
 - Allocated to group work
 - Onward referral
 - Discharged from service
7. Client documentation is returned to Admin Team to update the spread sheet and the Mental Health Practitioner enters a summary of assessment and management plan on EMIS.

(C) Pre-Assessment Contact

All pre-assessment contacts are normally completed within 3 weeks of referral.

1. Mental Health Team Lead co-ordinates room and staffing for clinics and liaises with Admin.
2. The Admin Team will book an appointment for the client and forward a letter (PH/MH/L03).
3. The Mental Health Practitioner will complete the Pre-Assessment Contact Form (PH/MH/F04).
4. The outcome of the pre-assessment will be one of the following:
 - Allocated for full assessment
 - Allocated to group work
 - Onward referral
 - Discharged from service
5. Client documentation is returned to Admin Team to update the spread sheet and the Mental Health Practitioner enters a summary of assessment and management plan on EMIS.

(D) Therapeutic Group

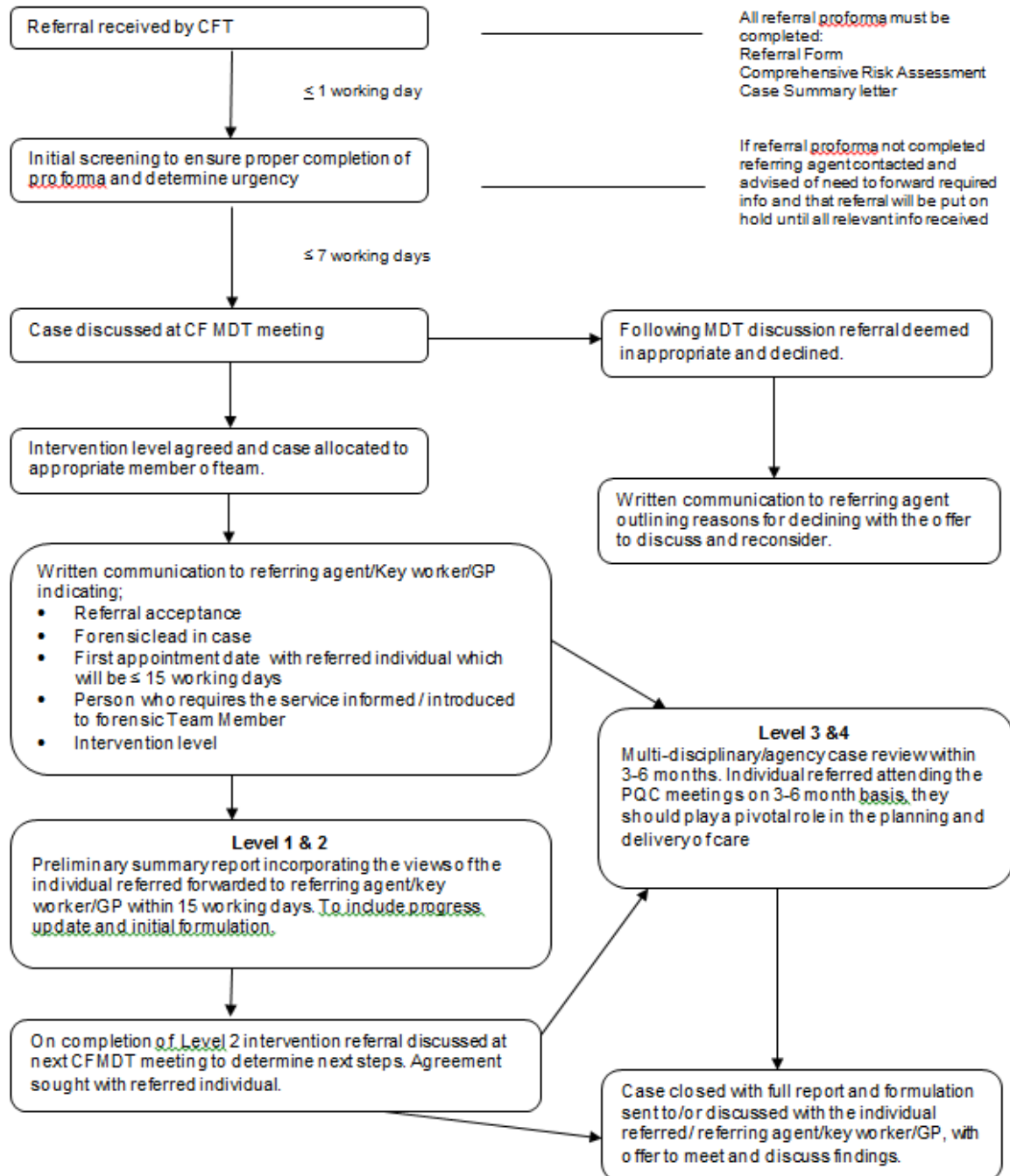
1. The client will be placed on a waiting list for appropriate group by the Admin Team.
2. The Admin Team will book an appointment for the client and forward a letter (PH/MH/L03).
3. The Practitioner documents progress and attendance on EMIS records.

(E) Inappropriate Referral

1. Where a referral is not meeting the referral criteria, it will be returned to the referring agent and EMIS will be updated with the clinical rationale. The Admin Team will remove the referral entry from the spread sheet.
2. In the case of Safer Custody / PSST. They will be informed with the decision via letter (PH/MH/L04).

APPENDIX 9:

REFERRAL PATHWAY INTO COMMUNITY FORENSIC TEAMS:



APPENDIX 10:

Regional Joint Protocol Community Forensic Mental Health Team and Prison Healthcare Interface Procedures

Overview:

The Northern Trust and South Eastern Trust Prison Healthcare Service piloted a Prison Healthcare Liaison Service in 2013. Both services agreed that the pilot was a success at improving communication between both organisations. As a result of this working group, the following procedures have been adopted to facilitate information sharing between both parties.

1. A liaison officer will be identified from within each organisation, to facilitate communication between each of the services and attend meetings as planned.
2. Both organisations will commit to meet 4 weekly. Any cancellations should ideally be given within 3 working days and an alternative date agreed at the time of cancellation where possible.
3. An updated list of patients will be provided by the prison mental healthcare staff the week prior to each meeting via a password protected email.
4. Minutes of each meeting should be recorded and a file of these minutes kept in a registered file within each relevant mental healthcare dept.
5. Attendees should include liaison leads from each service, representative of committal healthcare staff and representatives of the mental health teams working within the prison. Other members of the CFMHT may also attend as appropriate. Where appropriate prison staff from Resettlement Service, Prison Probation Service and the Offender Management Unit may also be invited to discuss specific cases.
6. All Northern Trust sector patients known to Prison Mental Health Services will be discussed at each meeting. This update will include a summary of contact with prison mental health services, potential release dates, review of appropriateness of management under 2010 Promoting Quality Care process and identification of dates for Comprehensive Risk Assessment review where necessary.
7. The meeting will also provide an opportunity to discuss issues relating to victims and carers.
8. Any prisoners who may require transfer direction orders or are likely to be committed or returned to prison following a period of time in hospital or the community will also be identified and discussed.
9. The Community Forensic Mental Health Service and Community Forensic Learning Disability Service liaison interface will act as a conduit for information between prison healthcare and generic mental health services.
10. Any potential committals known to the Community Forensic Mental Health Service and Community Forensic Learning Disability Service will be identified

and information shared as per the protection of personal information legislation. The Community Forensic Mental Health Service and Community Forensic Learning Disability Service 'transfer of information' form will be used to facilitate this process. Where possible, best practice dictates seeking and gaining the service user's consent to share this information. Where risk is imminent and specific the information can be considered for sharing with prison healthcare services without consent.

Planning for release from Prison – Multidisciplinary checklist

This document has been devised as an aide memoire/prompt to support health care staff when planning for a client's release from prison, in particular when arranging PQC meetings. It is not exhaustive so please feel free to add/amend as required. It is intended to support and facilitate better multi-agency/disciplinary working as part of best practice.

Client details	Key personnel details	
Name:	Healthcare key worker:	Tel:
DOB:	OMU sentence Manager:	Tel:
Prisoner Number:	Prisoner Probation Officer:	Tel:
Release date/expected date:	Prison Housing Officer:	Tel:

PQC Meeting Planning

Date/time/venue of PQC meeting:

Agencies/personnel invited to PQC meeting:

Date Comprehensive Risk Assessment (CRA) last updated:

Resettlement needs	Consider	Details/update on progress
Housing	Private/NIHA/Supported Accommodation	
Probation	<ul style="list-style-type: none"> • Frequency of community follow-up • Licence conditions 	
Healthcare	<ul style="list-style-type: none"> • Is the client registered with a GP? • Will there be CMHT/CFMHT follow up? • If yes, which team? 	

Finances/Benefits	DLA ESA IS HB Leaving Grant	
Additional Agencies	<ul style="list-style-type: none"> • Any additional agencies involved? • If yes, who and what is their role? 	
ID		

Discharge planning checklist

Task	Completed Y/N	Details
Has a PQC meeting been held?		
Has CRA been updated and circulated to relevant personnel?		
Has discharge letter been sent to GP?		
If CMHT/CFMHT involvement, has a key worker been identified?		
Liaise with Pharmacy re discharge medications		
Date of last Depot (if applicable)		
Any outstanding issues (to include risk alerts)?		

APPENDIX 11: Standards - References

FMHS Referral Standards - Pathways & Procedures

- Shannon Clinic RSU admission/discharge guidance protocol (Appendix 7).
- Six Mile Unit – No referral pathway available at time of audit.
- NIPS mental health team’s referral allocation and assessment pathway (Appendix 8).
- Care Pathway and Model for Community Forensic Teams in Northern Ireland. (Appendix 9)
http://www.publichealth.hscni.net/sites/default/files/Care%20Pathway%20and%20Model%20for%20Community%20Forensic%20Teams%20in%20NI%20October%202011_0.pdf
- Regional protocol 2015-16 (Initially developed between the Northern CFMHT and the Prison service (Appendix 10).

Standard for the Assessment and Management of risk in FMHS – CRA

Standard for the Assessment and Management of risk in FMHS – CRA

- Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services 2010
<https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mhld-good-practice-guidance-2010.pdf>

Standards for Patient Centred Care

- Regional Care Pathway ‘You in Mind’
<http://www.northerntrust.hscni.net/pdf/CarepathwayForPeopleWhoRequireMentalHealthCareandSupport.pdf>
- NICE Quality Standards CG136
[NICE Quality standards for service user experience in Adult Mental Health Services CG136](https://www.nice.org.uk/guidance/qs136)
- Standards for Medium Secure Units Quality Network for Medium Secure Units

<http://www.rcpsych.ac.uk/pdf/Final%20Standards%20for%20Medium%20Secure%20Units%20PDF.pdf>

- Standards for Low Secure Services
<http://www.rcpsych.ac.uk/pdf/Final%20Standards%20for%20Low%20Secure%20Units%20PDF.pdf>
- Standards for Prison Mental Health Services – Third Edition
<http://www.rcpsych.ac.uk/pdf/QNPMHS%203rd%20Edition%20Standards%20for%20Prison%20Mental%20Health%20Services%20PublicationFC.pdf>
- NICE (National Institute for Health and Care Excellence) (2017) Mental health of adults in contact with the criminal justice system.
<https://www.nice.org.uk/guidance/NG66/chapter/Recommendations#psychological-interventions>
- Standards for 24 hour healthcare in prisons
<https://www.rcpsych.ac.uk/pdf/24HourMentalHealthcareinPrisonStandards.pdf>

Appendix 12: Shannon Clinic RSU & Six Mile Unit Manager Questionnaire

1. Number of referrals received from 01 January 2010 to 31 December 2016:

2. Number of referrals received from the prison service from 01 January 2010 to 31 December 2016: _____

3. Number of available beds: _____

4. Number of beds currently occupied: _____

5. Does the service utilise a referral pathway? Yes No

If no please specify reasons
why

6. Which risk assessment and management tool does the service utilise?

- Comprehensive Risk Assessment and Management Tool (CRA)
- HCR20 v 3 SARA RSVP
- Risk Matrix 2000 SAM
- Other, please specify _____

7. Are psychological assessments undertaken in order to assist in the formulation of treatment needs?

- Yes No

8. Are psychological treatments available?

- Yes No

If yes specify treatments

9. Are there group therapeutic interventions available for patients?

Yes No

If yes, which of the following group therapeutic interventions are available?

Good Thinking Skills Relapse Prevention Therapy

Other, please specify _____

10. Are there opportunities for a patient to avail of individual therapeutic interventions?

Yes No

If available which individual interventions are utilised?

Anger Management Medication Management

Other, please specify _____

11. Which recovery tools are utilised within the service?

WRAP Recovery Star

No specific tool used

Other, please specify _____

APPENDIX 13: Shannon Clinic RSU Patient Notes Proforma

1. Was the appropriate referral form fully completed? Yes No

If no, what areas were missing? _____

2. Was the pre-admission assessment completed within 2 weeks of receipt of the referral form?

Yes No

3. Did the referring agent receive a response that the referral was accepted?

Yes No

4. Was a bed offered within 5 weeks? Yes No

Comprehensive Risk Assessment and Management Tool (CRA)

5. Is there evidence of a CRA?

Yes No

6. Is the CRA reviewed regularly, a minimum of every 3 months?

Yes No

7. Is there evidence to support that the CRA has been discussed and explained to the patient?

Yes No

8. Is there evidence of other risk assessments and management tools?

Yes No

If yes, identify which one:

HCR20 v 3 SARA RSVP

Risk Matrix 2000 SAM

Other, please specify

Evidence of patient centred care.

9. Are there clearly identified timescales for review of the treatment and care plan?

Yes No

10. Is there evidence of review of the treatment and care plan?

Yes No

11. Within the treatment and care plan is there evidence of the following:

	Yes	No	Patient refused
Patient's views			
Evidence that the contents have been discussed with the patient			
Relapse plan (WRAP)			

12. Is the nursing care plan signed by the patient?

Yes No Refused to sign

13. Where an individual has refused to sign is there evidence to support that the nursing care plan has been discussed and explained to the patient?

Yes No

14. Did the patient have:

	Yes	No	Patient refused
Psychological assessment			
Psychological treatment			
Group therapeutic intervention			
Individual therapeutic intervention			

15. Is there evidence that:

	Yes	No	Patient refused	Carer(s)/family members refused
The patient has received education about his/her illness				
The patient has received education about his/her medication				
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)				

General comments:

APPENDIX 14: Six Mile Unit Patient Notes Proforma

Comprehensive Risk Assessment and Management Tool (CRA)

1. Is there evidence of a CRA?

Yes No

2. Is the CRA reviewed regularly, a minimum of every 6 months?

Yes No

3. Is there evidence to support that the CRA has been discussed and explained to the patient?

Yes No

4. Is there evidence of other risk assessments and management tools?

Yes No

If yes, identify which one:

HCR20 v 3 SARA RSVP

Risk Matrix 2000 SAM

Other, please specify

Evidence of patient centred care.

5. Are there clearly identified timescales for review of the treatment and care plan?

Yes No

6. Is there evidence of review of the treatment and care plan?

Yes No

7. Within the treatment and care plan or patient notes is there evidence of the following:

	Yes	No	Patient refused
Patient's views			
Evidence that the contents have been discussed with the patient			
Relapse plan (WRAP)			

8. Did the patient have:

	Yes	No	Patient refused
Psychological assessment			
Psychological treatment			
Group therapeutic intervention			
Individual therapeutic intervention			

9. Is there evidence that:

	Yes	No	Patient refused	Carer(s)/family members refused or none identified
The patient has received education about his/her illness				
The patient has received education about his/her medication				
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)				

General comments: _____

APPENDIX 15: Prison Service Manager Questionnaire

1. Number of patients currently in receipt of care from the mental health team:

2. Does the service utilise a referral pathway?

Yes

No

If no, why not: _____

3. Which risk assessment and management tool does the service utilise?

Comprehensive Risk Assessment and Management Tool (CRA)

HCR20 v 3

SARA

RSVP

Risk Matrix 2000

SAM

Other, please specify:

4. Are psychological assessments undertaken in order to assist in the formulation of treatment needs?

Yes

No

5. Are psychological treatments available?

Yes

No

If yes specify treatments: _____

6. Are there group therapeutic interventions available for patients?

Yes

No

7. Which of the following group therapeutic interventions are available?

- Good Thinking Skills
- Relapse Prevention Therapy
- Other, please specify:

8. Are there opportunities for patients to avail of individual therapeutic interventions?

- Yes No

If available which individual interventions are utilised?

- Anger Management
- Medication Management
- Other, please specify:

9. Which recovery tools are utilised within the service?

- WRAP No specific tool used
- Recovery Star
- Other, please specify:

APPENDIX 16: Prison Patient Notes Proforma

1. Following the referral allocation meeting was the referral allocated to the appropriate level of service?

Yes

No

2. Was the patient seen within the prescribed time limits?

Yes

No

Urgent referral (within 10 days of receipt of referral)

Routine referral (within 9 weeks of receipt of referral)

3. Did the mental health practitioner complete the Initial Mental Health Assessment Form (PH/MH/F02)?

Yes

No

4. Was a Regional Risk Screening Tool completed or Comprehensive Risk Assessment and Management Plan (CRA) updated?

Yes

No

Urgent referrals

5. Is there evidence to support the outcome of the urgent assessment from:

	Yes	No
Allocated key worker		
Refer to psychiatry		
Allocated to group work		
Intervention level		
Onward referral		
Discharged from the service		

6. Did the Mental Health Practitioner enter a summary of the assessment and management plan on EMIS?

Yes

No

Pre-Assessment Contact

7. Was the pre-assessment contact completed within 3 weeks of referral?

Yes

No

8. Is there evidence to support the outcome of the pre-assessment was one of the following:

	Yes	No
Allocated for full assessment		
Allocated to group work		
Onward referral		
Discharged from the service		

9. Did the Mental Health Practitioner enter a summary of the assessment and management plan on EMIS?

Yes

No

Comprehensive Risk Assessment and Management Tool (CRA)

10. Is the CRA reviewed regularly, a minimum of every 3 months?

Yes

No

11. Is there evidence to support that the CRA has been discussed and explained to the patient?

Yes

No

12. Is there evidence of other risk assessments and management tools?

Yes

No

If yes, identify which one:

HCR20 v 3

SARA

RSVP

Risk Matrix 2000

SAM

Other, please specify

Evidence of patient centred care.

13. Are there clearly identified timescales for review of the recovery plan?

Yes No

14. Is there evidence of review of the recovery plan?

Yes No

15. Within the recovery plan or patient notes is there evidence of the following:

	Yes	No	Patient refused
Patient's views			
Evidence that the contents have been discussed with the patient			
Relapse plan (WRAP)			

16. Is there evidence that:

	Yes	No	Patient refused	Carer(s)/family members refused
The patient has received education about his/her illness				
The patient has received education about his/her medication				
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)				

Pathway into prison

17. Did the community forensic mental health team inform the discharge liaison team when a patient managed at Level 3 or 4 is committed to prison?

Yes No Not applicable

General comments:

APPENDIX 17: CFMHT Team Manager Questionnaire

1. Number of patients currently in receipt of care: _____

2. Number of patients managed at 4 Level model:

Level 1: _____

Level 2: _____

Level 3: _____

Level 4: _____

3. Does the service utilise the community forensic referral pathway?

Yes

No

If no, why
not?

4. Which risk assessment and management tool does the service utilise?

Comprehensive Risk Assessment and Management Tool (CRA)

HCR20 v 3 SARA RSVP

Risk Matrix 2000 SAM

Other, please specify

5. Are there group therapeutic interventions available for patients?

Yes

No

6. Which of the following group therapeutic interventions are available?

Good Thinking Skills

Relapse Prevention Therapy

Other, please specify

7. Are there opportunities for a patient to avail of individual therapeutic interventions?

Yes No

If available which individual interventions are utilised?

Anger Management

Medication Management

Other, please specify

8. Are psychological assessments undertaken in order to assist in the formulation of treatment needs?

Yes No

9. Are psychological treatments available?

Yes No

If yes specify treatments

10. Which recovery tools utilised within the service?

WRAP

Recovery Star No specific tool used

Other, please specify

APPENDIX 18: Community Forensic Mental Health Team Patient Notes Proforma

1. Was the proforma screened within 1 working day?

Yes No

2. If all information is not available on the referral form, was referring agent informed to forward on required information?

Yes No Not applicable

3. If all information is not available on the referral form, was referring agent informed it would be put on hold until they do so?

Yes No Not applicable

4. At initial screening was urgency determined?

Yes No

5. Was it allocated to appropriate team member?

Yes No

6. Was there written communication to referring agent / keyworker / GP indicating:

	Yes	No
Referral acceptance		
Forensic lead in case		
First appointment date		
Intervention level		

7. Was the first appointment ≤ 15 working days from CFMDTM?

Yes No

For Level 1 & 2 Intervention, please answer questions 11 and 12. For Level 3 & 4 Intervention, please answer question 13.

8. Was there a preliminary summary report forwarded to referring agent / key worker / GP within 15 working days?

Yes

No

If yes, did this include progress update and initial information?

Yes

No

9. On completion of Level 2 intervention, was the referral discussed at the next CFMDT meeting to determine the next steps?

Yes

No

10. Was there a Multi-disciplinary / agency case review carried out within 3 – 6 months?

Yes

No

Comprehensive Risk Assessment and Management Tool (CRA)

11. Is there evidence of a CRA?

Yes

No

12. Is the CRA reviewed regularly, a minimum of every 3 months?

Yes

No

13. Is there evidence to support that the CRA has been discussed and explained to the patient?

Yes

No

14. Is there evidence of other risk assessments and management tools?

Yes

No

If yes, select which one:

HCR20 v 3

SARA

RSVP

Risk Matrix 2000

SAM

Other, please specify

Evidence of patient centred care.

15. Are there clearly identified timescales for review of the treatment and care plan?

Yes

No

16. Is there evidence of review of the treatment and care plan?

Yes

No

17. Within the treatment and care plan or patient notes is there evidence of the following:

	Yes	No	Patient refused
Patient's views			
Evidence that the contents have been discussed with the patient			
Relapse plan (WRAP)			

18. Is there evidence that:

	Yes	No	Patient refused	Carer(s)/family members refused
The patient has received education about his/her illness				
The patient has received education about his/her medication				
There was liaison with carer(s)/family members (either in treatment and care plan or patient notes)				

APPENDIX 19: Shannon Clinic RSU & Six Mile Unit Patient Questionnaire

We need to know what you think about your experience because it helps us understand what is really important to you, what we do well and what we could do better.

The questions are about your care and treatment. This questionnaire is **anonymous**. **There is no need to put your name on it.**

1) Do you feel supported by the staff caring for you?

Always Often Sometimes Rarely Never

2) Do you feel you are treated with respect?

Always Often Sometimes Rarely Never

3) Do you feel listened to?

Always Often Sometimes Rarely Never

4) Do you feel your views are taken into account?

Always Often Sometimes Rarely Never

5) Have you seen your Risk Assessment?

Yes No Not sure

6) Have you seen your Nursing Care Plan?

Yes No Not sure

7) Have you seen your Treatment Care Plan?

Yes No Not sure

8) How involved do you feel in your care?

Very involved Mostly involved Sometimes involved Rarely involved Never involved

Please feel free to use the additional comments section below as another way to express your view. Please tell us about anything we could do to improve your experience.

Additional Comments: _____

APPENDIX 20: NIPS Patient Questionnaire

We need to know what you think about your experience because it helps us understand what is really important to you, what we do well and what we could do better.

The questions are about your care and treatment. This questionnaire is **anonymous**. **There is no need to put your name on it.**

1) Do you feel supported by the staff caring for you?

Always Often Sometimes Rarely Never

2) Do you feel you are treated with respect?

Always Often Sometimes Rarely Never

3) Do you feel listened to?

Always Often Sometimes Rarely Never

4) Do you feel your views are taken into account?

Always Often Sometimes Rarely Never

5) Have you seen your Risk Assessment?

Yes No Not sure

6) Have you seen your Treatment Care Plan?

Yes No Not sure

7) How involved do you feel in your care?

Very involved Mostly involved Sometimes involved Rarely involved Never involved

Please feel free to use the additional comments section below as another way to express your view. Please tell us about anything we could do to improve your experience.

Additional Comments: _____

APPENDIX 21: Community Forensic Mental Health Team Patient Questionnaire

We need to know what you think about your experience because it helps us understand what is really important to you, what we do well and what we could do better.

The questions are about your care and treatment. This questionnaire is **anonymous**. **There is no need to put your name on it.**

1) Do you feel supported by the staff caring for you?

Always Often Sometimes Rarely Never

2) Do you feel you are treated with respect?

Always Often Sometimes Rarely Never

3) Do you feel listened to?

Always Often Sometimes Rarely Never

4) Do you feel your views are taken into account?

Always Often Sometimes Rarely Never

5) Have you seen your Risk Assessment?

Yes No Not sure

6) Have you seen your Treatment Care Plan?

Yes No Not sure

7) How involved do you feel in your care?

Very involved Mostly involved Sometimes involved Rarely involved Never involved

Please feel free to use the additional comments section below as another way to express your view. Please tell us about anything we could do to improve your experience.

Additional Comments: _____

APPENDIX 22: Description of Risk Assessments and Management Tools

- Historical Clinical Risk Management-20 Version 3 (HCR20v3) contains extensive guidelines for the evaluation of not only the presence of 20 key violence risk factors, but also their relevance to the evaluatee at hand. It also contains information to help evaluators construct meaningful formulations of violence risk, future risk scenarios, appropriate risk management plans, and informative communication of risk. HCR-20 V3, or simply V3, is a comprehensive set of professional guidelines for the assessment and management of violence risk.
- The Risk for Sexual Violence Protocol (RSVP) is a Structured Professional Judgement (SPJ) instrument for the assessment and management of individuals considered to pose a risk of sexual violence.
- The Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations who Offend (ARMIDILO-S) is a risk assessment and management tool specifically designed to take into account issues of particular relevance to individuals with developmental and intellectual limitations who offend. The assessment tool is designed to assess risk in both the offender and challenging behaviour groups and covers a broad range of offending and challenging behaviours.
- Risk Matrix 2000 is a statistically-derived risk classification process intended for males aged at least 18 who have been convicted of sex offence.
- The Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence. With 20 items, the SARA assessment screens for risk factors in individuals suspected of or being treated for spousal or family-related assault.
- Stalking Assessment and Management (SAM) is a set of comprehensive structured professional judgment (SPJ) guidelines for assessing and managing risk for stalking. The SAM incorporates the latest advances in the SPJ approach to risk assessment, including methods for violence risk formulation and scenario planning.

- Short-term Assessment of Risk and Treatability (START) is a concise clinical guide for the dynamic assessment of short-term (i.e. weeks to months) risk for violence (to self and others) and treatability. It guides clinicians toward an integrated, balanced opinion to evaluate the patient's risk across seven domains:
 - violence to others
 - suicide
 - self-harm
 - self-neglect
 - unauthorised absence
 - substance use
 - risk of being victimised
- The Dynamic Risk Assessment and Management System (DRAMS) is an assessment for dynamic/proximal risk factors in people with intellectual disabilities

APPENDIX 23: Description of Psychological Therapies

- Dialectical behavior therapy (DBT) treatment is a cognitive-behavioral approach that emphasizes the psychosocial aspects of treatment. The treatment in itself is largely in behaviorist theory with some cognitive therapy elements as well. The explicit aim is to create a practical way of helping people who are otherwise very difficult to treat by increasing their interpersonal skills, emotional regulation skills, distress tolerance skills and core mindfulness skills.
- Cognitive Behaviour Therapy (CBT) is a talking therapy. It can help people who are experiencing a wide range of mental health difficulties. What people think can affect how they feel and how they behave. This is the basis of CBT.
- Motivational Enhancement Therapy (MET) is a counselling approach which helps individuals resolve their ambivalence to engaging in their treatment. Use of motivational enhancing techniques are associated with increased participation in treatment and positive treatment outcomes such as reductions in targeted behaviour, higher abstinence rates in substance misuse, better social adjustment, successful referrals to treatment, increasing participation and involvement in treatment, retaining people in treatment, improving treatment outcomes and a quicker return to treatment should relapse occur.
- Good Thinking Skills (GTS) is a psycho-educational group comprising approximately 23 sessions, divided into 5 modules. The group incorporates motivational enhancement strategies, social skills training, emotional recognition, problem solving and skills building. The final module encourages participants to apply the learning to current or anticipated future problems. The Good Lives Model underpins the group philosophy.
- Substance Misuse Therapy/Drug & Alcohol Therapy is designed to assist individuals to understand issues related to drugs and alcohol and to discourage misuse. This therapy examines the close relationship between substance misuse, mental health problems and offending. The therapy predominantly focuses on staying free from drugs or alcohol and learning associated skills to help achieve this. Relapse prevention strategies are also included as part of this.
- Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories.

APPENDIX 24: Description of Audited Adult Forensic Mental Health Services in Northern Ireland

Shannon Clinic RSU is a purpose built 34 bedded regional medium secure unit, linking mental health services throughout Northern Ireland. Its established multidisciplinary team provides in-patient services for people with mental illness, who require intensive psychiatric treatment and rehabilitation in a structured, secure and therapeutic environment. The unit is comprised of three wards: Ward 1 is the acute admissions/psychiatric intensive care ward; Ward 2 is the continuing care ward containing both male and female patients; and Ward 3 is the rehabilitation ward.

Referrals are primarily from high secure hospitals; courts, prisons, psychiatric intensive care units and CFMHTs. The multidisciplinary team includes consultant forensic psychiatrists, forensic psychologists, mental health social workers, occupational therapists, mental health nurses and mental health healthcare support workers.

Consultant forensic psychiatrists maintain responsibility for patients from within their retrospective trusts in both Shannon Clinic RSU and their CFMHT. This means that patients within Shannon Clinic RSU are already known to CFMHTs and under the care of the appropriate consultant forensic psychiatrist.

Six Mile Unit - Muckamore Abbey Hospital is a regional low secure forensic learning disability inpatient unit. The ward consists of a four bed assessment unit and a 15 bed treatment unit. It provides multidisciplinary assessment, care and treatment to male patients with a learning disability who have mental health difficulties and have had previous contact with forensic services. Some of these men have been referred by the criminal justice system and assessed as likely to benefit from treatment and therapeutic services in a healthcare environment. The multidisciplinary team includes a consultant psychiatrist, specialty registrar, consultant forensic psychologist, nursing staff and a social worker.

Maghaberry Prison is a high security prison housing adult male long term sentenced and remand prisoners in both separated and integrated conditions. Responsibility for mental healthcare in prisons was transferred to the South Eastern Health and Social Care Trust (SEHSCT) in April 2008. The prison site aims to provide a healthcare service that is equivalent to that experienced by the wider population/community.

The emotional wellbeing hub 'Hub Centre' resides in the main prison. It is a purpose-built unit, developed in partnership with the Northern Ireland Prison Service (NIPS) and the SEHSCT. The mental health team is based in the 'Hub Centre' and provides a range of therapeutic, evidence based programs that are

designed to assist clients to develop a tool kit of skills that support their wellness and recovery. The mental health teams within both Maghaberry and Hydebank Wood prisons deliver a similar treatment format to that of a community based model of care and work across the entire prison.

Hydebank Wood, otherwise referred to as Hydebank Secure College, has a focus on education, learning and employment. It accommodates young people between the ages of 18 and 24. It can accommodate up to 200 young offenders. Ash House is the women's prison located within Hydebank Wood. Female remand and sentenced prisoners are accommodated in Ash House, a house block within the complex.

Community Forensic Mental Health Teams (CFMHT) are located in four of the five trusts across the region, with the SEHSCT being covered by the Belfast Health and Social Health Trust's (BHSCT) CFMHT.⁵

While the CFMHTs are similar in their multidisciplinary composition there are some variations due to local priorities and available resourcing e.g. in relation to provision for forensic service users with a learning disability.

- The Northern Health and Social Care Trust (NHSCT) Community Forensic Learning Disability Service is integrated within the community forensic mental health infrastructure.
- The Southern Health and Social Care Trust (SHSCT) has a stand-alone model meaning that senior forensic practitioners in the Mental Health Team have dedicated time devoted to the Community Learning Disability Team to promote an integrated model.
- The Belfast Health and Social Care Trust (BHSCT) in January 2011 commissioned a community forensic learning disability post (forensic psychologist) with the intention of developing a comprehensive service. Current available resources mitigate against delivery of services at Level 4 although patients requiring complex and specialist assessments and interventions can be facilitated (See CFMHT Care Pathway and Model Level 1 to level 4 below).
- The Western Health and Social Care Trust (WHSCT) has a learning disability practitioner based within the CFMHT.

Community Forensic Mental Health Teams Care Pathway and Model

The regional 'Care Pathway and Model for Forensic Mental Health Teams in Northern Ireland'⁵ provides a composite regional care pathway for community forensic mental health and learning disability services. It outlines the links needed between probation, prison and police services as integral elements to

provide streamlined access to community forensic services, and recommends that CFMHTs work within the four level model.

Level 1

A specialist consultation, education and training role, which may include CFMHTs attending case reviews to offer advice and guidance to generic community mental health teams. CFMHTs may have a service co-ordination or liaison role between health and criminal justice. This will include initial assessments following referral, to determine immediate needs and decrease response time to the referring agent.

Level 2

An in-depth assessment which may include a standardised risk assessment and management plan prepared by the CFMHT 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, evaluate the known risk factors, offer a specialist piece of therapeutic work and to assess the efficacy of risk reducing strategies.

Level 4

CFMHT takes full responsibility for the duration of need with a referral back to the relevant services when deemed appropriate. This will be particularly evident for those being discharged from secure environments, NIPS or Shannon Clinic RSU, back into the community.

The decision to intervene at Levels 3 and 4 will be decided by the CFMHT following consultation with the referral agent. Within Level 4 of the model, the CFMHT takes full responsibility for the duration of need, with a referral back to the relevant services when deemed appropriate.



The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9536 1111

Email info@rqia.org.uk

Web www.rqia.org.uk

 [@RQIANews](https://twitter.com/RQIANews)