

Commissioning Board

C2b

**2012/13 NHS STANDARD CONTRACT
FOR ACUTE, AMBULANCE, COMMUNITY AND MENTAL HEALTH
AND LEARNING DISABILITY SERVICES
(MULTILATERAL)**

**SECTION B PART 1 –MEDIUM AND LOW SECURE MENTAL HEALTH SERVICE
SPECIFICATION**

Service Specification No.	C2b Medium and Low Secure Mental Health Services
Service	Forensic/Secure CRG
Commissioner Lead	Ged McCann
Provider Lead	Nick Broughton/Josanne Holloway
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

- Individuals with mental disorder or neuro-development disorder who are liable to be detained under the Mental Health Act (1983) and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings, require care and treatment within a secure mental health service.
- Individuals will typically have complex mental disorders, with co-morbid difficulties of substance misuse and/or personality disorder, which are linked to offending or seriously irresponsible behaviour. Consequently most individuals are involved with the criminal justice system, the courts and prison system and many have Ministry of Justice restrictions imposed.

- In order to manage the risks involved the therapeutic environment is carefully managed through the delivery of a range of security measures. A number of levels of security currently exist to manage increasing levels of risk to others. Presently these consist of High, Medium and Low secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others including other patients, staff and the general public. In addition community forensic mental health services provide for the transition back to the community for individuals who no longer require secure care.
- All individuals admitted to either low or medium secure services will be detained under the Mental Health Act (1983 amended in 2007).
- The decision to admit to a secure service will be based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital. Many, but not all of those admitted to secure services, will have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence. Low and medium secure services play a key role in assessing an individual's ability to participate in court proceedings and in providing advice to courts regarding disposal following sentencing.
- This specification relates specifically to medium and low secure mental health services provided for men and women (aged 18 and above) with mental illness, personality disorder and neuro-developmental disorders including learning disabilities. A specification for medium and low secure mental health services for young people under the age of 18 are described in a separate document.

Prevalence

- Commissioners in England currently purchase approximately 6000 inpatient beds in secure mental health services.
 - Approximately 680 in high secure (commissioned for England and Wales)
 - Approximately 2800 in medium security and
 - Approximately 2500 in low security
- This indicates a population prevalence of 1.3, 5.3, and 4.6 respectively per 100,000.

National Policy

A Quality Network for Forensic Mental Health Services led by the Royal College of Psychiatry College Centre for Quality Improvement (CCQI) is established for medium and low secure services. Medium secure services are described in the DH Best Practice Guidance (August 2007) and guidance for low secure services is due to be published by the Department of Health in 2012.

Evidence Base

Evidence for best practice exists within a range of nationally agreed standards, guidance frameworks and legislation, as well as mental health literature associated with mental disorder. Particularly relevant materials include:

- See Think Act (DH 2010)
- DH design guide
- CCQI Standards
- Risk Best Practice
- Mental health strategy and implementation
- Criminal Justice Act
- Mental Health Act (1983 amended in 2007) and Code of Practice
- Mental Capacity Act 2005 and Code of Practice
- NICE guidelines for mental disorders

2. Scope

2.1 Aims and objectives of service

OVERALL AIM:

Low and medium secure services provide a therapeutic psychiatry services for individuals with a mental disorder – mental illness, personality disorder, neuro-developmental disorder, who present a significant risk of harm to others.

OBJECTIVES:

- The core objectives for secure services are to assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery. Secure services provide a comprehensive range of evidence based care and treatment. Care and treatment is provided by practitioners expert in the field of forensic mental health including consultants in forensic psychiatry. A range of specialist offence related treatment programmes delivered either individually or within groups will be available. These will typically include sex offender treatment programmes, aggression management programmes and programmes to address fire setting. The aim is for the individual to safely return to the community or prison or transfer out of secure services.

- The maintenance of security is crucial to the provision of effective therapeutic interventions in secure services. A key principle underpinning the provision of secure services is that individuals should be managed in the least restrictive environment possible in order to facilitate their safe recovery. Least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment.

- These objectives will be met through:
 - Ensuring every patient has an agreed integrated pathway through secure care with clear therapeutic objectives agreed as early on in the admission as possible.
 - Effective assessment of mental health and risk needs prior to admission
 - Further specialist assessment of mental health and risk needs to identify the links between mental disorder and risk.
 - Management of mental disorder and risk using specialist interventions and treatments to stabilise mental state and reduce risk of harm. Delivered in a timely manner.
 - Supporting recovery and rehabilitation through engagement and self management.
 - Timely discharge or transfer along the care pathway.
 - Use of the CPA process and My Shared Pathway outcome measures to monitor progress and minimise length of in-patient stay in secure care.
 - Having appropriately trained staff working in secure services.
 - Having effective clinical governance and external monitoring processes of the secure care pathway.

2.2 Service description and care pathway

- It is expected that individuals will be treated and managed within a whole care pathway approach with services working collaboratively with each other in order to ensure that the admission and any transfer within the secure care pathway is achieved seamlessly and efficiently. The pathway through care should be identified early in admission though may be subject to change depending on changing needs or circumstances.
- Multi-disciplinary working and the Care Programme Approach (CPA) process will underpin service delivery. The multidisciplinary team will include appropriately trained medical staff including forensic psychiatrists, clinical psychologists, mental health nursing staff, occupational therapists and social workers supported by other therapists including for example art therapists.
- It is expected that each individual will be treated and managed in accordance with a 'care pathway'. The Care pathway will be planned in consultation with the individual. The care pathway, whilst not prescriptive, describes the individual's anticipated journey of transition into, through and out of the secure care. In general it can be described in five phases:
 - Referral
 - Assessment and Pre-admission
 - Admission, Care and Treatment
 - Forensic Care Pathway
 - Transition

Components of a secure service

- The fundamental strategic aim for all secure mental disorder services is a model of integrated services incorporating all levels of security. To this end secure services will be commissioned taking account of the wider forensic networks and care pathways.
- The core tasks of these services is to undertake the necessary clinical and risk interventions to enable the individual to either return to prison or to continue treatment in a less secure environment.
- The services will have specialist skills in risk assessment and management of individuals who have mental health problems and present a risk of harm to others. Services would have an in depth knowledge and understanding of the Criminal Justice System and relevant legal issues. Forensic services will work within the appropriate health, criminal and legal systems.

- Medium Secure Services will meet the High Level Performance Indicators described within the Best Practice Guidance: Specification for adult medium secure services and be subject to an annual peer review undertaken by the College Centre for Quality Improvement (RCPsych).
- Low Secure Services will meet the performance indicators described within the Best Practise Guidance for Low Secure Services (in publication) and be subject to an annual peer review undertaken by the College Centre for Quality Improvement (RCPsych).
- The components of a secure service include:

Referral

- To maintain close links with generic mental health services and to provide advice to these services to reduce the need for admission to secure forensic services.

Assessment and Pre-admission

- Assessment of need for admission to secure care/ transfer from another secure care environment and advice where admission is not offered
- Providing information to individual about placement, assessment process, and outcome of assessment
- Introducing individual to key staff

Admission Care and Treatment

- Evidence based specialist assessment, treatment and management of mental disorder - mental illness, personality disorder, neuro-developmental disorder.
- Evidence based assessment, reduction and/or management of risk, specifically the risk of harm to others through the provision of specialist offence related treatment programmes which can be delivered either individually or within groups that address offending and risk behaviours.
- On-going appropriate risk assessment and proactive risk management strategies
- Assessment of fitness to plead/stand trial of in-patients and provision of advice to Courts regarding psychiatric disposal options.
- Individualised care and treatment provided in the least restrictive environment (least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment).

- Development of a Care Plan reflecting an outcome based whole care pathway approach based on the My Shared Pathway and including transition and engagement with the next step provider
- Recovery and outcome focussed multidisciplinary treatment and intervention with the Care Programme Approach (CPA) forming the cornerstone of the delivery of an effective care pathway through secure care. CPA meetings to be held at least six monthly.
- Access to social, educational and occupational opportunities that is meaningful and supports rehabilitation and recovery (minimum 25 hours per week)
- Meeting physical health care needs through a full range of primary health care interventions including health promotion and physical health screening.
- Full cooperation with the First Tier Tribunal system to ensure timely review of authority for detention of patients
- For “restricted” patients, secure services will ensure compliance with the Ministry of Justice requirements.
- Providing effective involvement infrastructures to ensure involvement of all individuals in decision making at all organisational levels
- Providing effective governance arrangements to ensure the service complies with best practice
- Maintaining a programme of internal clinical and security training to support the above objectives.
- Engagement in Research and Development (R&D) that contributes to the developing forensic mental health and learning disabilities evidence base.
- Providing social work services in line with national standards

Forensic Care Pathway and Transition

- Effective and early liaison with local area services and relevant others to facilitate discharge planning reflected through an assertive care pathway management approach to ensure that transition to the community, generic mental health services or prison is carried out in a timely manner.
- Development of a Care Plan reflecting an outcome based whole care pathway approach based on the My Shared Pathway and focusing on transition and engagement with the next step provider
- For individuals supported in the community by forensic mental health teams, development of a community care plan reflecting a whole person approach to recovery and rehabilitation into the community based on risk assessment and proactive risk management strategies
- Effective and early liaison with local area services and relevant others to facilitate timely transfer to local services individuals supported post discharge by community forensic mental health teams.

Risk Management

Secure services shall meet the risk management requirements appropriate for the care and safety of all individuals. This will include (but is not limited to) compliance with the following:

- The risk assessment and management should aim to support self-assessment and management through engaging the individual as much as possible and by providing the individual with information and support about the risk assessment process.
- The risk assessment and management model/s shall incorporate the principles of hazard identification, risk reduction, risk evaluation and a risk management process that includes a recognised risk communication process.
- The services shall have a dynamic risk assessment model/s in place to support clinicians in making day to day decisions about individual care.
- Care plans should reflect risk assessment and reduction over the course of the individual's detention.
- The service shall undertake significant event analysis of all Serious Incidents (SI's) identifying learning points and evidence of shared learning.
- The service shall undertake CPA and risk assessment audits with evidence of completing the audit cycle.

The Secure Pathway

- The forensic/secure pathway should promote and enable recovery and independence of the individual whilst ensuring protection of the public. The pathway will include the provision of appropriate levels of physical, procedural and relational security within a range of environments including high, medium, and low secure facilities. Individuals in medium and low secure care will require a combination of physical, relational, and procedural security to remain safe. Individuals who do not require a combination of procedural, physical and relational security will not be appropriately placed in secure forensic services.
- The application of security measures should aim to promote a safe and therapeutic environment, whilst pro-actively encouraging independence, responsibility and recovery. The application of security should therefore be based on the risk needs of the individual, be as least restrictive as possible, and imposed only when risks have been identified. The balance between procedural, relational and environmental security will depend on the individual's need and progress along their pathway to discharge/transfer.

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

- The indicators and criteria used for assessing progress and transition along the pathway will include:
 - Nature and degree of mental disorder and its relationship to risk
 - Level of risk to others
 - Level of care and supervision required
 - Need for input from specialist services or staff
 - Need for offence/risk behaviour related therapy
 - Level of compliance with treatment/care plan
 - Level of engagement in structured and meaningful activities
 - Level of misuse of drugs or alcohol

- Individual's will move out of High Secure Hospital care when:
 - They no longer need a category B environment
 - They no longer present a grave danger to the public
 - They no longer present a severe risk of escape or absconding from a lower degree of security
 - They no longer require the enhanced levels of physical, relational and procedural security provided in a high secure environment

- Individuals outside high secure care will move along their secure pathway, which may include medium, and/or low secure. Their progress along their pathway of care will be dependent on a reduction in the severity of the risk to others, a reduction in the risk of escape or absconding and or an escape or absconding will not pose an immediate or significant risk of harm to others, evidence of progress towards integration back into the community as evidenced by successful use of escorted and unescorted leave. Not all levels of security may be required for an individuals pathway of care.

- Specialist forensic outreach services will be required for individuals transferring from secure services into the community who demonstrate:
 - An identifiable mental disorder (mental illness, personality disorder, borderline learning disability, alcohol/substance misuse related mental illness, organic brain disorder or a combination of these)
 - There is a significant risk of harm to others related to the mental disorder. Significant risk suggests that the risk is real and relatively imminent in given circumstances and that it cannot be safely managed without the intervention of a specialist forensic service.
 - A repeated demonstration through offence paralleling behaviours suggesting that the individual continues to pose a significant risk of potential harm even when discharged into the community requiring specialised forensic observation and risk assessment in the long term or even life long

- These outreach services will work with any locally (CCG) commissioned community forensic service (or equivalent service) to ensure risks are managed and there is a smooth transfer of care to local services.

- Individuals who no longer present needs which require specialist forensic expertise but who require further care and support will be referred on to local generic mental health or primary care services.

Referrals

- The referral arrangements, assessment process and service user experience will be as outlined within the Access Assessment Commissioning Guidance (May 2012), and implemented using local access assessment procedures and protocols and supported by forensic case managers.

- It is important to note that each referral is unique and the receiving clinical team should determine the urgency of the referral on receipt. Discussions between referrer, assessing clinicians and case managers may be required.

Referral process

- For emergency referrals
 - Initial verbal response regarding appropriateness of referral within 24 hours of receipt
 - Assessment within 24 hours
 - Outcome verbally notified to referrer within 24 hours of the assessment
 - Formal written report to referrer within 48 hours of assessment.

- Bed offered
- For urgent referrals
 - Initial verbal response regarding appropriateness of referral within 24 hours of receipt
 - Inform referrer of who is undertaking assessment and ask that they make individual aware of assessment prior to visit.
 - Assessment within 14 days,(must be multi-disciplinary consultant psychiatrist and psychiatric nurse as a minimum if decision is to admit)
 - Outcome verbally notified to referrer within 24 hours of the assessment
 - Formal written report to referrer within 7 working days.
 - Bed offered
- For routine referrals
 - Initial verbal response regarding appropriateness of referral within 14 working days
 - Inform referrer of who is undertaking assessment and ask that they make individual aware of assessment prior to visit.
 - Multi-disciplinary assessment within 1 month of all necessary information being available to referrer.
 - Formal written report to referrer within 2 weeks
 - Bed offered within 6 weeks

For prisoners requiring transfer to a secure mental hospital, guidance within “Good Practice Procedure Guide the transfer and remission of adult prisoners under s47 and 248 of the Mental Health Act” should be followed. This guidance requires a transfer within 14 days of the first doctors’ assessment.

Assessment

The assessment should

- Identify need for admission to hospital
- Identify level of security (physical, procedural, relational) required
- Identify level of urgency
- Identify needs based on documentation review and examination
- Identify further initial assessment requirements

- Provide advice to referrer on future care and management of the individual should admission not be recommended.

Pre-Admission management

- The provider shall monitor and manage the referral and admission process and inform the co-ordinating commissioner of any delayed admissions
- Should the individual not be admitted within the agreed timescale and the individual continues to require admission to Secure Services, the provider shall inform the Coordinating Commissioner including information regarding reasons for delay and a plan to achieve admission.
- Pre-admission the service should:
 - Provide the referrer with information for the individual about the admitting service
 - Provide the individual with verbal or written feedback about the outcome of the assessment and initial next steps.
 - Have a “buddy” system with contact made with the individual prior to admission if possible and appropriate to do so
 - Identify initial therapeutic targets
 - Ensure that an initial Care Plan will be in place from the day of admission to the secure service. The Care Plan/s will be individualised, gender sensitive and recovery orientated and address health and risk needs. Secure services will ensure care is provided with the purpose of meeting the individual’s goals and outcomes. These outcomes should be structured around the eight outcome areas as outlined in the document My Outcomes, Plans and Progress.¹
 - Identify Payment by Results (PbR) cluster
- The provider shall ensure that for D/deaf individuals (That is individuals who are culturally (D) and or audiologicaly deaf (deaf):
 - The assessment process ascertains the most recent language assessment (including communication barriers) and that this is used to ensure the necessary communication/hearing aids are organised.
 - Preparation will be made to ensure the individual will be admitted to the appropriate ward (D/deaf Services) - Following the initial assessment a decision will be made by the Clinical Team whether admission to D/deaf Services is the most appropriate placement.

- The Provider shall ensure that for individual's with learning disabilities:
 - Evidence is provided by the referrer that the patient has a learning disability based on an assessment by both a suitably qualified specialist psychiatrists and similarly qualified psychologist
 - In addition there must be evidence of both reduced intellectual functioning and problems with adaptive living skills which arose in the developmental period (by convention before age 18)
 - Appropriate needs led communication requirements are obtained from the referrer and other pre admission needs assessed to support successful transition and settlement into high secure services environment.
 - Following the decision to admit, the Care Plan will clearly include the assessment and description of additional or extraordinary requirements for the individual's transition.

- The Provider shall ensure that for women:
 - An appropriate assessment team will be appointed and the appropriate clinical stream within the national women's high secure service will be identified.
 - If assessed as being required, an appropriate 'first 72 hours' safety transitional Care Plan will be agreed.

- Services will undertake a full assessment including the use of the Payment By Results Mental Health Clustering Tool. An initial care plan will be developed based on identified needs and in collaboration with the individual wherever possible.

Admission, Care and Treatment

Multi-disciplinary assessment and care planning involving the individual is a continuous process whose focus changes from assessment to management to self-management as the individual moves through the care pathway.

The first three months will focus mainly on orientating the individual to the service, assessing and meeting initial physical and mental health care needs, assessing and managing risk and commencing the appropriate care and treatment.

Components of the admission assessment will include:

- Physical health needs:
 - Physical examination and routine investigations

- Management of physical health conditions
- Mental health needs:
 - Assessment and management of mental state
 - Psychological assessment
 - Nursing assessment
 - Undertake HoNOS-secure
- Relationship needs
 - Social circumstances assessment (including any safeguarding issues)
- Risk needs:
 - Psychological assessment
 - Nursing assessment
 - Undertake HCR 20
 - Drug and alcohol assessment
- Daily living, educational and occupational needs
 - Occupational therapy assessment
- Introduction to My Shared Pathway including use of A Shared Understanding and initial Outcomes, Plans and Progress document
- Review of the individual Care Plan, developed, where possible, in collaboration with the individual, based on a multidisciplinary assessment of need
- Admission to the appropriate care pathway/ward to best meet individual's needs.
- Ministry of Justice (MoJ) expectations identified and shared with individual as appropriate

CPA review meetings

- The Care Programme Approach (CPA) will be implemented for all individuals. The CPA will form the basis of all person centred care planning and treatment options, dynamically supporting the individuals transition through secure services
- Where services cover a wide geographical area facilities should be in place to enable effective teleconferencing and/or video conferencing for individuals who are unable to attend the CPA meeting in person.

- An initial CPA meeting should be held within 3 months of admission. The aims of the meeting will be to:
 - Review assessments (supported by medical, nursing, psychology, OT and social work reports).
 - Review PbR cluster
 - Confirm Forensic pathway (1-5)
 - Confirm care co-ordination arrangements and responsibilities.
 - Review Outcomes section of My Outcomes, Plans and Progress document
 - Identify further assessment and intervention needs.
 - Identify indicative pathway and timescale including liaison with the next step service

CPA meetings

- The CPA review process shall not take place less frequently than six monthly.
- Local care co-ordinators and NHSCB case managers will be invited to attend. (Local care co-ordinators are expected to attend meeting when discharge or transition is being planned. NHSCB case managers will be informed if they fail to attend.)
- Appropriate reports and documents (e.g. summary outcome plan from My Outcomes, Plans and Progress document) will be available to the individual, invited clinicians and social care staff including NHSCB case managers.
- Individuals will be supported to prepare for the meeting with their advocacy worker if appropriate. The service will ensure that they are compliant with the 'Service User Defined CPA Standards (2009).²
- The Provider shall ensure that individuals who are D/deaf or where English is not their preferred language:
 - Have access to continuing communication assessment and development e.g. appropriate language lessons (British Sign Language BSL).
 - Have access to interpreters and communication support workers.
 - Are cared for in a ward environment (Appropriate Milieu) or has an individual care plan that is conducive to the overall treatment and rehabilitation of an individual who has communication difficulties.

The aims of the meeting will be to:

- Review assessments (supported by medical, nursing, psychology, OT and social work reports)

- Review and evaluate progress with interventions and treatment programmes.
- Review Outcomes section of My Outcomes, Plans and Progress document to.
 - Identify progress that has been made in achieving therapeutic objectives set
 - Identify any barriers to progress and recovery
 - Identify further assessment and intervention needs including rationale.
 - Identify which other agencies need to be engaged (e.g. next service in pathway)
 - Update and agree therapeutic objectives recorded in My Summary Outcome Plan.
 - Review/ update discharge/ transition date
- Support the individual's engagement in their recovery.

The output of the review will be:

- An agreed revised Care Plan – My Summary Outcome Plan based on the 8 My Shared Pathway outcome areas identifying interventions and treatment outcomes anticipated.
- Formal minutes of the review to include consideration of indicative discharge date.

Forensic Pathway

- The PbR Forensic Pathway to which the individual is allocated will assist in identifying the range of interventions required to meet identified needs within an agreed timeframe.
- The Forensic Pathway will vary according to individual needs, but will reflect an individualised recovery and outcome based whole care pathway approach.
- Assessment and management will be multi-disciplinary.
- The principle of recovery will underpin all interventions.

- Components will include:
 - Assessment, Treatment and management (including self-management) of mental disorder. Treatment will be based on NICE and other national guidance and may include medication and other physical treatments, psychological therapy and social interventions .Interventions may include: mental health awareness, emotional regulation, hearing voices groups, relapse prevention.
 - Assessment, treatment and management (including self-management) of risk of harm to others. Treatment will be based on NICE and other national guidance and evidence based practice and may include medication (for example anti-libidinal medication for sex offenders) psychological therapy and social interventions. This will include Specialist offence related treatment programmes delivered either individually or within groups by appropriately qualified and experienced staff trained in their use. Offence analysis and formulation will underpin interventions to address risk and offending behaviour. Types of intervention may include: CBT, DBT, schema therapy, positive behavioural support, mentalisation. Intervention should include:
 - sex offender treatment,
 - fire setting interventions,
 - substance misuse programmes,
 - thinking skills and problem solving,
 - anger management,
 - violent offender management programmes.
 - Use of S17 leave for rehabilitation and assessment.
 - Assessment, Treatment and management (including self-management) of physical disorder and supporting a healthy lifestyle. Treatment will be based on f NICE and other national guidance and may include medication and other physical treatments, psychological therapy and social interventions. These should include access to primary care, access to dietician and healthy food, access to physical activity, smoking cessation
 - Assessment of and enhancing of life skills and social, cultural and spiritual needs, taking into account their age and gender. This will include educational and occupational activities, work experience, social and cultural activities.
- All treatment interventions and programmes should be delivered in a timely manner without un-necessary delay and regularly evaluated with progress reviewed at CPA meetings

- Individuals will have access to their clinical records (when requested) with the exception of third party/restricted information, or information that would result in risk or harm,
- Secure services form part of a mental health care pathway and will therefore need to maintain close links with local services and commissioners. The service will work collaboratively with local services; particularly care co-ordinators, and commissioners so as to expedite the transfer of individuals as soon as it is appropriate. Secure mental health services will be bound by rules of patient confidentiality. There will be a need to share information about the individual with other agencies including the Ministry of Justice. Reasons for sharing information may include: for the purposes of rehabilitation and move on out of secure care, secondary to their detention under the Mental Health Act, for the purposes of managing the care pathway, to manage risk. When sharing the individuals information services will follow Caldicott guidance and where possible inform the individual of the information being shared about them.

Transition

- Transition from secure services (including back to prison) will be considered throughout the pathway and occur in a timely fashion. The decision to discharge or transfer the individual will usually be agreed at formal CPA review meetings except when a patient is discharged by a tribunal against advice. Prior to any First Tier Tribunal when discharge against clinical advice is understood to be a significant possibility, the Clinical Team will hold a Section 117 meeting to consider a contingency discharge plan.
- Transfer and discharge will be managed by the clinical team and where a discharge to local services is to take place, the local care coordinator. Commissioners and representatives such as case managers will be involved in decisions relating to the transfer from the secure service. The service will ensure that all relevant parties (including future clinical teams and the Ministry of Justice if appropriate) are informed and involved as early as possible in the transfer process.
- The key components of forensic/secure outpatient services will include the close management of individuals who are deemed as 'high risk' during the transition to locally commissioned mental health services. For these individuals a period of time in step down specialist forensic units (outside the secure unit perimeter) designed as part of the secure pathway for individuals requiring additional transitional support may be required which will need to be negotiated with the local CCG commissioner.

- Components of transfer arrangements:
 - A S117 meeting will take place prior to discharge/ transfer. . Where transition is a return to a prison environment all discharge arrangements including the Care Programme Approach (CPA) meetings will be undertaken with the appropriate prison mental health team.
 - Information will be shared as appropriate adhering to Information Governance arrangements and Caldicott principles, and will include:
 - Current Outcomes, Plans and Progress documentation
 - Copies of the last CPA review minutes
 - The most recent risk assessment and management plan
 - Record of all current medication
 - Documentation providing a clinical summary.
 - Discharge/ transfer care plan addressing the individuals need for health and social care. Pre-Discharge planning arrangements will ensure appropriate provision is made with the receiving service provider for the individual to have access to appropriate benefits/entitlements where they apply.
 - At discharge/ transfer, the service will ensure the individual's clinical records and belongings [including money] are transferred and that appropriately qualified staff are part of the escorting transfer team when being transferred to another unit.
 - The responsible commissioner will be informed of the transfer/discharge.
 - The service shall ensure the appropriate reports are received by the Ministry of Justice (where applicable) in a timely manner.

Additional Service Components

Specialist Forensic Outreach Mental Health Services

- Forensic outreach mental health services manage safely the transition of high risk Mentally Disordered Offenders from secure services into the community and provide advice and act as a consultation service to reduce the need for admission to secure services. In line with this specification LAT areas will confirm their providers of Specialist Forensic Outreach Mental Health Services and this service will be described within a LAT Protocol.

- Outreach Services are an essential component of the pathway from high security to the high street providing clear and continuous lines of sight of people with mental health problems who present significant risk to others enabling them to safely leave highly expensive secure inpatient services and move back to the community and reducing the need for their admission to those highly expensive secure inpatient care. A small proportion of these patients will continue to require specialist forensic mental health care and supervision when discharged into the community in order to manage risk of harm to others.
- The decision to accept a patient for forensic outreach services will be based on a comprehensive risk assessment and consideration of how the potential risk identified can be managed safely in the community.
- The core objectives of forensic outreach mental health services is to provide ongoing psychiatric assessment, formulation and treatment to manage high risk Mentally Disordered Offenders with recognised mental disorders and related risks to prevent their re-admission. They provide on-going support for high risk individuals in managing any potential identified risks as well as their psychological and social care needs which if these failed would lead to relapse and re-offending.
- Outreach forensic mental health services provide a package of care which is developed with the individual and which: is sensitive to their personal needs; clearly defines responsibilities for services and individuals who use services; is outcome focused.
- These objectives will be met through:
 - Ensuring every patient has an agreed integrated pathway through secure care with clear therapeutic objectives agreed.
 - Clear transitional arrangements for patients who require support by an outreach forensic mental health team.
 - Continued specialist assessment of mental health and risk of harm to others
 - Management of mental disorder and risk using specialist interventions and treatments to maintain stability and to support continued safe recovery and rehabilitation.
 - Timely discharge to local services
 - Use of CPA process and My Shared Pathway outcome measures to monitor progress and facilitate transfer to local services when appropriate.
 - Having appropriately trained staff working in outreach forensic services.
 - Having effective clinical governance and external monitoring processes of the forensic patient pathway.

- These services will have specialist skills in risk assessment and management of individuals who have mental health problems and present a risk of significant harm to others.

- Services would have an in depth knowledge and understanding of the Criminal Justice System and relevant legal issues and expertise in facilitating transition and sustainable settlement in the community of individuals from secure care who require robust and sophisticated risk assessment and management processes including the potential rapid access to appropriate levels of secure care. Outreach forensic mental health services will work within the appropriate health, criminal justice and legal systems.

- The components of a specialist outreach forensic mental health service include:
 - Assessment of need and providing advice to other professionals who manage those with mental health needs who present a risk to others.
 - Consultation and liaison with any CCG community forensic services and local psychiatric services in the assessment and management of risk to avoid where possible admission to secure care.
 - Consultation and liaison for Multi Agency Public Protection Arrangements (MAPPA panels) and other criminal justice agencies.
 - Consultation and liaison to other services (eg NOMS, approved premises, bail hostels) to prevent admission into secure services and where appropriate to provide expert psychiatric advice.
 - On going evidence based specialist treatment and management of mental disorder - mental illness, personality disorder, neuro-developmental disorder and including intensive time limited support to avoid the need for re-admission, working with other agencies when required particularly in relation to social care needs
 - On going evidence based management of risk, specifically the risk of harm to others through the provision of specialist interventions which can be delivered either individually or within groups that address offending and risk behaviours.
 - On-going appropriate risk assessment and proactive risk management strategies
 - Individualised care and treatment
 - Development of Community Care Plan in conjunction with community forensic services (or equivalent) reflecting a whole person approach to recovery and rehabilitation based on risk assessment and proactive risk management building on My Shared Pathway principles, which includes a relapse prevention plan that addresses any problem behaviours and which clearly identifies relapse indicators to risk or deteriorating mental state. It must also include transition and engagement with the next step provider when appropriate.

- Recovery and outcome focussed multidisciplinary treatment and intervention with the Care Programme Approach (CPA) forming the cornerstone of the delivery of an effective care pathway in an appropriate care environment. CPA meetings to be held at least six monthly.
 - Full cooperation with the First Tier Tribunal system to ensure timely review conditionally discharged patients and those on a community treatment order.
 - For “restricted” patients, compliance with the Ministry of Justice requirements. Compliance with statutory and legal requirements associated with Community Treatment Orders, Probation licence and Mental Health Review Tribunal conditions
 - Manage effectively and safely any transfer of care from the forensic/secure service to local community forensic services or mainstream mental health services. This interface must be managed with clearly agreed care pathways and responsibilities.
 - Effective liaison and involvement of the individuals significant others and social networks as determined by the individual. This transition phase will be a challenging time for the individual who will require support while developing life skills and developing or re-establishing relationships.
 - Providing liaison with primary care to support the individual to take care of their physical health care needs and where needed (for example Clozapine use) to provide specific physical health care.
 - Providing effective involvement infrastructures to ensure involvement of all individuals in decision making at all organisational levels
 - Providing effective governance arrangements to ensure the service complies with best practice
 - Maintaining a programme of internal clinical and security training to support the above objectives.
 - Engagement in Research and Development (R&D) that contributes to the developing forensic mental health and learning disabilities evidence base.
 - Providing Social work services in line with national standards
 - Collaborative multidisciplinary working with effective communication and documentation
- The forensic/secure pathway should promote and enable recovery, responsibility and independence of the individual whilst ensuring protection of the public.
 - The indicators and criteria used for assessing progress and transition/ discharge to local services will include:
 - Nature and degree of mental disorder and its relationship to risk
 - Level of risk to others
 - Level of care and supervision required

- Need for input from specialist services or staff
 - Level of compliance with treatment/care plan
 - Level of engagement in structured and meaningful activities
 - Level of misuse of drugs or alcohol
- The need for specialist forensic outreach services will be required for individuals transferring from secure services into the community who demonstrate:
 - An identifiable mental disorder (mental illness, personality disorder, borderline learning disability, alcohol/substance misuse related mental illness, organic brain disorder or a combination of these)
 - There is a significant risk of harm to others related to the mental disorder. Significant risk suggests that the risk is real and relatively imminent in given circumstances and that it cannot be safely managed without the intervention of a specialist forensic service.
 - A repeated demonstration through offence paralleling behaviours suggesting that the individual continues to pose a significant risk of potential harm even when discharged into the community requiring specialised forensic observation and risk assessment in the long term or even lifelong.
- All secure services will describe the transition component of the secure care pathway. The outreach component may be: provided by the provider who provides secure service with no change in RC; provided by the provider who provides secure services with a change in RC, provided by a specialist outreach forensic service from a different provider if the patient is moving to an area where they have not been an inpatient.
- All specialist outreach forensic services will describe the agreed arrangements for regular engagement and collaborative working with their community forensic service or community mental health services, and have in place a protocol for the transition of individuals who no longer require specialist care. This will include the provision of forensic advice, consultation and expertise in the management of individuals to prevent re-admission to secure services.
- Specialist Outreach Forensic services will describe the agreed arrangements for the safe transfer of individuals into community forensic services or equivalent generic mental health services. These arrangements will be based on careful consideration of the following:
 - Nature and degree of mental disorder and its relationship to risk
 - Level of risk to others
 - Level of care and supervision required
 - Need for input from specialist services or staff

- Level of compliance with treatment/care plan
- Level of engagement in structured and meaningful activities
- Level of misuse of drugs or alcohol

Acceptance Criteria

- The person has a complex mental disorder either because of co-morbidity or because of symptom profile and is in the process of transition from secure inpatient care
- The person has a history of significant and serious offending while mentally disordered despite being under the care of general psychiatric services, they have a history of poor compliance and a significant risk of relapse at which time they have acted with violence, their risk is unpredictable in that their mental state may deteriorate suddenly and unpredictably and their current service request an opinion or ongoing advice.
- The person has committed serious offences when unwell and continue to exhibit offence paralleling behaviour when apparently mentally well which suggest the possibility of similar high risk behaviour when unwell.
- The person can be managed safely only through structured supported consistent interventions using the specialist skills within a Forensic outreach service and within a timescale as set out in the local Area Team protocol
- They are individuals who because of the nature of their offending, the nature of their disorder and/or their political profile require complex, multi-agency management with agencies with whom the Forensic outreach service have regular and good working relationships. The responsibility for these patients needs to be confirmed within the Area Team protocol. The expectation is that the responsibility will not remain with NHS CB Area Team commissioned services, as other services (CCG or NOMS) must retain their primary responsibility

Exclusion Criteria

- Individuals who continue to require high levels of physical, procedural and or relational security to manage their risk of harm to others.
- Individuals who are unlikely to pose a risk of significant harm to others should their mental health deteriorate.
- Individuals whose risks are unrelated to their mental health.

Leave of Absence (including Trial Leave)

- Well planned task orientated leave, sensitively executed and has an important part to play in rehabilitation and recovery in secure care. Leave should be considered as an essential part of each individuals care plan and successful

leave can act as a key milestones in the pathway through and out of secure care.

- The purpose of leave will include:
 - To aid assessment and continuing development of social, interpersonal and practical skills
 - As an adjunct to risk assessment and management
 - To enable access to targeted meaningful activity and support therapeutic interventions
 - To support engagement with the multi-disciplinary team
 - To enhance mental and physical wellbeing
 - To support re-integration into the community into which the individual may be discharged
 - To access community resources to aide and support recovery and rehabilitation

- Granting of leave will follow effective risk assessment which must include assessment of risk of absconding, risk of harm to the public while the patient is on leave or should they abscond, and respect the feelings and fears of those who may have been affected by the patient's past actions. Where relevant, leave must be planned taking into account victim support services and MAPPA arrangements. Appropriate risk assessment measures to support leave of absence and trial leave will be developed. The model of risk assessment shall include the provision of evidence to support Leave being granted and a Care Plan to facilitate the Leave. The Care Plan shall indicate the expected provision of staff resources and non-staff resources required to safely and appropriately minimise any risks presented during the period of the Leave and set out clearly a Contingency Management Plan in case of untoward events. The care plan should also include how the planned leave will help with the service user's recovery journey.

- When leave is escorted, the individual will remain in the custody of a staff escort who have the necessary training and competence to convey and restrain the individual if required. For restricted patients the Ministry of Justice may stipulate the use of handcuffs in the escorting of patients and these arrangements will be put in place. Unescorted leave will be considered when an individual is able to respect the conditions of leave, behave safely in the community and abide by the time limits set for return to hospital. Overnight leave may become appropriate close to transition from the secure service. Overnight leave to activity centres or facilities offering "holidays" or whose description gives the impression that it is a holiday centre, must be given particular scrutiny especially with regard to the expected therapeutic benefits of such leave.

- Trial Leave from medium and low secure care will not usually be necessary as the step down and transition services will be engaged early in the individual's pathway unless there are clear clinical or risk reasons for this. Any trial leave must therefore be agreed with the Responsible Commissioner prior to commencing. The secure service will maintain links with the individual whilst on Trial Leave and where it is unsuccessful; will readmit the individual patient onto the appropriate place on the care pathway.

Special Observations and Enhanced Observations

- Special or enhanced observations should only be considered within a framework of support and engagement with patients and staff to minimise the need for prolonged special or enhanced observation. Arrangements must comply with counter fraud guidance.
- This will be assured through:
 - Development and implementation of a policy for Special or Enhanced Observations
 - Policies that support the core values of engagement and collaboration with the individual to minimize risk to self or others.
 - The maintenance of environmental and procedural safety to uphold dignity, respect and care for the individual and reflect their immediate needs and the needs of others.
 - Undertaking regular review of the continuing need for the observation and observations reduced to the minimum level at the earliest opportunity while maintaining safety.
 - Normally the costs of any additional Observations are included within the contract. In exceptional circumstances where additional Observations may require additional funding over and above the current contract the NHSCB must be notified in writing. Such notification will be provided no later than two operational days after the commencement of observations, supported by the relevant clinical justification, and monitoring information.

Emergencies

Secure services will :

- Ensure that sufficient staff with appropriate skills, training and competence are available to maintain safety at all times
- Ensure that appropriate healthcare specialist on-call arrangements are in place
- Ensure that all policies and procedures are readily available and accessible to all staff

- Ensure that a safe environment is maintained for all individuals including visitors to the services premises, employing an appropriate risk management strategy to minimise potential hazards

Medical Emergencies

Secure services will ensure:

- There are appropriate agreements in place with primary and secondary care providers to allow for the treatment of individuals within other facilities
- There are arrangements in place to ensure staff are familiar with the process for emergency transfer of an individual under Ministry of Justice jurisdiction
- That procedures are in place to allow rapid access of emergency services into the unit
- There are adequate easily available emergency medical equipment in keeping with a secure service and that there are measures in place to maintain the equipment
- That all qualified staff as a minimum undertake annual basic life support training

Psychiatric Emergencies

- The management of violence and aggression will follow NICE Guideline 2005, 'Violence: The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments'
- All staff involved in administering or prescribing rapid tranquillisation, or monitoring individuals to whom parenteral rapid tranquillisation has been administered, should receive on-going competency training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) covering airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators. The policy for Rapid Tranquillisation will be easily accessible to all staff.

Primary Healthcare

All individuals will have access to primary healthcare services (including health promotion) as appropriate and in particular shall have access to:

- Information on the primary healthcare services available including access hours and service details
- The provision of primary medical care services e.g. dentist; general practitioner services; optician services; dietician; podiatrist;

physiotherapist. Access should be the same as for the general in keeping with the Department of Health guidelines and Good Clinical Practice

- Smoking cessation advisors and treatments
- Primary care practice staff who hold the appropriate professional or vocational qualification and receive professional support
- Appropriate age and gender specific screening in line with the Department of Health guidance
- Access to a GP of the same gender as the individual.
- A general health assessment and health check on an annual basis
- Access to secondary healthcare for physical health should comply with Department of Health guidelines or Good Clinical Practice

Secondary Care

Where an individual requires secondary care for physical health care needs at the recommendation of the primary care clinical staff the service shall;

- Make the necessary arrangements in accordance with the agreed protocol to meet the appropriate national waiting time for treatment and patient choice targets, within the scope of the individual's legal status and in accordance with good clinical practice.

Patient/Carer Information and Involvement

- In keeping with the recovery model, individuals will be encouraged to take as much responsibility as possible for their own wellbeing and progress. As far as possible services will encourage individuals to be involved in all decisions about themselves. This includes being an equal member and fully involved with multidisciplinary meetings, care programme approach review meetings, and other meetings relating to their care and treatment.
- Secure services will have in place an involvement strategy and system to support individuals to be involved in their care, treatment and pathway plans, and decision-making at all levels of the organisation. This includes representation in governance structures, policy-making and service development. Services will have an involvement action plan to ensure implementation and development of the strategy.
- Secure services will have in place a carer engagement strategy and system to support carers to be involved in the care, treatment and recovery pathway plans subject to agreement with the individual concerned. The strategy will define how the needs of carers will be addressed and supported.

- All information about the service, treatment and care plans will be in a format that individuals can access and understand taking in to account individual communication needs.
- An independent IMHA advocacy service will be commissioned to ensure individual rights are safeguarded. Advocacy services will work towards the self-advocacy model and will support individuals as necessary and specifically in relation to CPA meetings and transition planning.

2.3 Population covered

- The service outlined in this specification is for individuals ordinarily resident in England*; or who are the commissioning responsibility of the NHS in England (as defined in *Who Pays?: Establishing the responsible commissioner* and other Department of Health guidance relating to individuals entitled to NHS care or exempt from charges).

Note: for the purposes of commissioning health services, this EXCLUDES individuals who, whilst resident in England, are registered with a GP Practice in Wales, but includes individuals resident in Wales who are registered with a GP Practice in England.

- Specifically medium and low secure services are for adult individuals with mental disorder who require care and treatment in a secure service because of the risks they present to others. Specific requirements are needed for the following populations:

Individuals who are culturally deaf (D) and audiotologically deaf (deaf)

Secure services shall ensure that for D/deaf individuals:

- The assessment process must ensure that the necessary communication/hearing aids are organised
- At initial assessment a brief communication assessment is undertaken by specialised deaf services staff and following admission, a more formal communication assessment is undertaken by the Speech and Language Therapist and Deaf Support Worker (preferably including video recording of the individual) unless already available
- A detailed audiometry assessment is undertaken unless already available.
- Preparation will be made to ensure the patient will be admitted to the appropriate service for people who are both culturally deaf (D) and have auditory deafness (deaf) (D/deaf Services)

If admission to D/deaf Services is the most appropriate placement for the individual there are two medium secure deaf services in England and the national High Secure Deaf service at Rampton Hospital. If secure services are not warranted there are three non secure deaf inpatient services available nationally.

Individuals with Neurodevelopmental Disorders

- Neurodevelopmental Disorders (NDD) are mental disorders, beginning before adulthood, which lead to impaired social and psychological functioning. The term encompasses learning disabilities, pervasive developmental disorders on the autistic spectrum, acquired brain injuries in childhood, and other developmental communication disorders. NDD's are not defined on the basis of global IQ scores, but on the basis of treatment need. Because of the demands of highly specialised secure forensic pathways, many people with only mild or borderline overall intellectual impairment will be appropriately placed in a secure forensic service for people with NDD. Individuals with more severe intellectual impairment, who are unable to access even highly adapted treatment programmes, or whose risk to others relates primarily to challenging behaviour, will not be appropriately placed in a secure forensic service.
- Neurodevelopmental disorders are common: approximately 2% of the adult population in the UK has a learning disability. Estimates of the number of people with learning disabilities in the criminal justice system varies widely, depending on case finding; it is estimated that between 20-30% of people in criminal justice settings have a learning difficulty or learning disability that significantly impacts their ability to cope. At least 1 in 100 people in the UK has an autism spectrum condition, making autism at least as common as many severe mental disorders, such as schizophrenia. Most studies indicate that most cases of autism are undiagnosed. Rates of autism in secure hospitals are almost certainly higher than the population average. There are about 30 moderate to severe head injuries per 100,000 population per year. About 1 in every 500 people in the UK has an enduring neurological problem due to acquired brain injury. The majority of people in criminal justice settings have a history of acquired brain injury.
- All medium and low secure services will need some competence in the assessment and treatment of people with NDD. Many people with mild NDD, coincidental to other mental disorders, will receive appropriate treatment for their primary mental disorders in mainstream secure mental health services, with only minor adjustments to the care provided. In order to ensure reasonable adjustments can be made, and specialist advice where necessary, all secure forensic services will provide:
 - Routine screening for NDD's
 - A clear pathway for formal diagnosis of NDD, delivered in partnership with specialist neurodevelopmental disorder services.

- Access to independent advocacy and external support networks with experience in the management of people with neurodevelopmental disorders.
- When such adjustments are not sufficient to allow participation in treatment, or when specialist treatment is needed for the NDD itself, then treatment in a specialist NDD service will be needed.
- Care pathways for individuals with NDD might include periods in a secure forensic service for people with NDDs, and periods in a more mainstream forensic service. This is likely to be a particular consideration at points of transfer between levels of security, or out of hospital into community provision. Secure forensic services for people with NDDs will need appropriate staffing numbers and skill mix to meet the whole-person needs of people with NDDs. Where people with NDDs are treated in mainstream forensic services, staff should have sufficient skills to meet the communication and treatment needs of those people. In practice, this will include:
 - An environment designed to meet the needs of people with NDD, including adapted signage, decoration, lighting, and access to sensory areas.
 - Access to adapted information, taking account of the sensory and communication needs of individuals.
 - Access to a specialist clinical team, including access to psychiatrists and psychologists with skills and competence in working with people with NDD, specialist speech and language therapists, dysphagia specialists, sensory integration trained therapists, and an appropriate mixture of registered learning disability and mental health nurses.
 - An adapted care pathway, including specialist access assessment, routine sensory integration, communication, intellectual and adaptive function assessments, and routine diagnostic assessment for autism spectrum conditions.
 - Adapted outcome measures, including the use of person-centred planning, and health action plans, that are personalised to allow maximum participation of the individual in their own care pathway.
 - Access to adapted treatment programmes, including group and individual psychological therapies and programmes designed to address problem behaviours, and aid rehabilitation. Access to teaching professionals providing specialist education within the service.
 - Access to skilled independent advocacy services with expertise in working with people with NDD.

The principles of Valuing People (Department of Health, March 2001), *Valuing People Now* (Department of Health, Jan 2009) , and *Fulfilling and Rewarding Lives* (Department of Health, March 2010) will be applied in all services.

Forensic Child and Adolescent Mental Health services

Medium and Low Secure Forensic Child and Adolescent Mental Health (FCAMH) services are described in separate specifications.

Women's Services

All secure services should be gender sensitive and underpinned by principles of empowerment, respect and dignity. Women's secure services should reflect the essential differences in women's social and offending profiles; their mental distress and complex patterns of behaviour; and their care and treatment needs.

Services for women will:

- Have a single sex living environment.
- Have access to a range of single sex therapeutic opportunities.
- Ensure that their policies and procedures meet the specific needs of women.

2.4 Acceptance and Exclusions

Acceptance Criteria

- Suffering from a mental disorder (including mental illness, neuro-developmental disorder, learning disability and personality disorder which is a nature and/or degree warranting detention in hospital for medical treatment and appropriate treatment is available.
- Detained under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).
- Individuals will predominantly present a risk of harm to others and to manage this risk requires in-patient care, specialist risk management procedures and specialist treatment interventions.
- Those suitable for transfer from prisons will generally be charged with, or have been convicted of, a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson.
- Individuals may on occasion, be accepted without criminal charges pending, where there is clear evidence of a danger to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats.

- Potential to benefit from the treatment/assessment provided or to prevent deterioration.
- The individual is not safely managed in an open environment.
- Individuals may present a significant risk of escape.
- Individuals with a mental disorder directed to conditions of security by the Ministry of Justice.

Exclusion criteria

- Individuals who present a 'grave danger' to the general public should not be admitted to medium or low security and will be referred to High Security.
- Medium or low security is not required for those who present with disturbed or challenging behaviour (as distinct from dangerous behaviour) during episodes of mental disorder, which are likely to be relatively brief. Such individuals are more properly cared for in local generic mental health provision.
- Individuals will not normally be admitted to medium or low security if the predominant risk is of self-harm and who do not present a significant risk of harm to others. An exception to this might be for individuals serving long prison sentences for non violent or non-sexual offences who, because of the risk of escape or as a result of Ministry of Justice direction, cannot be transferred to a non-secure environment.

2.5 Interdependencies with other services

- Medium and low secure services are part of a spectrum of services whose function is to best meet the needs of those with mental disorder and /or neuro-developmental disorders who will benefit from specialist care and treatment within a secure environment. Secure services support patients in their recovery and rehabilitation so they can move to a less restrictive environment as expeditiously as possible.
- Key partnerships include:
 - NHS Commissioning Board (NHS CB)
 - Appropriate NHS/Independent/Third Sector providers (inc: adolescent)
 - High secure services
 - Local mental health services (including PICUs and community mental health services)
 - Advocacy Services including Independent Advocacy as appropriate

- Carer Support Services
 - Department of Health
 - Ministry of Justice
 - Police
 - Probation Services
 - Prison Services
 - Social Care Agencies
 - Care Quality Commission
 - Appropriate Regulators
 - Multi Agency Public Protection Arrangements (MAPPA)
 - Courts
 - Housing associations and other providers of accommodation
- The service is expected to have protocols in place to enable it to share clinical information with other agencies when appropriate which are underpinned by Caldicott principles and information governance structures.
 - Secure services will establish close working relationships with other services which form part of the individuals care pathway.
 - In support of the care pathway secure services will provide advice to referrers or other interested parties on the management of individuals as appropriate.
 - Appropriate accommodation will be made available by the provider for the provision of advocacy services. This will be underpinned by a robust protocol of engagement agreed between the NHS CB, the medium and low secure service and the advocacy provider.
 - Training, Education and Research/Development activity programmes will reflect service priorities and clinical needs in ways in which the outcomes are targeted and used to influence and benefit care and social outcomes for individuals and service development. The service will ensure that staff are able to participate in these activities, without affecting care and treatment or business continuity.
 - There will be a well-managed interface with child and adolescent services, in particular child and adolescent forensic mental health in-patient services, to ensure smooth transition in provision for high risk young people with mental health difficulties to adult services.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

- Medium secure services are defined in the National Definitions set 3rd Edition 2009 and the DH Best Practice Guidance August 2007. Guidance for low secure services is due to be published by the Department of Health in 2012. This specification must also be read in conjunction with , See Think Act (DH 2010) and the DH design guide. Guidance regarding assessments of individuals for medium and low secure services (Access Assessment Commissioning Guidance, May 2012) and guidance regarding greater patient involvement in their care (My Shared Pathway) has recently been published.
- A Quality Network for Forensic Mental Health Services led by the Royal College of Psychiatry College Centre for Quality Improvement (CCQI) is established for medium and low secure services. Medium secure services are described in the DH Best Practice Guidance (August 2007).
- Medium Secure Services will meet the High Level Performance Indicators described within the Best Practice Guidance: Specification for adult medium secure services and be subject to an annual peer review undertaken by the College Centre for Quality Improvement (RCPsych).
- Low Secure Services will be subject to an annual peer review undertaken by the College Centre for Quality Improvement (RCPsych)
- NICE Guidance for treatment of schizophrenia, bipolar affective disorder, emotionally unstable personality disorder and any other as applicable

4. Key Service Outcomes

- The service will provide for assessment and treatment during the inpatient phase of an individual's pathway. This will be achieved by delivering high-quality, individualised, pathway-based, care packages. The aim will be to help individuals back into society, whilst keeping the risk of harm to others minimal. Least restriction principles should be applied at all points.

- Services will be tested against measurable, service-wide, outcomes. These will include high levels of patient and carer satisfaction, and minimized levels of adverse incidents and complaints. The National Outcomes Framework 2013-14 5 domains will be the basis of all outcomes in secure services.
- Services will be expected to report separately to organisations concerned with the quality and safety of services, including the Quality Network of the College Centre for Quality Improvement and the Care Quality Commission.
- Services should seek to demonstrate an individual's progress against agreed outcome goals as part of quality monitoring arrangements based on the 8 outcome areas as defined within the Shared Pathway 'Outcomes, Plans and Progress' documentation relating to:
 - **My Mental Health Recovery**
The management of self-care, how much understanding an individual has about managing their mental health difficulties, how well they cope with stress and how they manage their relationship with their clinical team
 - **Stopping my Problem Behaviours**
Individual problem behaviours, what treatment they have had to reduce their risky behaviour and how they will manage these risks in the future.
 - **Getting Insight**
An individual's understanding of their mental health, behaviour and the link between these and the reasons they are in hospital. This includes how much understanding they have about all the difficulties they have experienced and how much help they think they need to deal with these difficulties.
 - **Recovery from Drug and Alcohol Problems**
Any drug and alcohol problems an individual may have had and what treatment they have had for these. It should also look at the plans that have been made for the future to help prevent these problems from happening again.
 - **Making Feasible Plans**
Plans an individual has made for the future in terms of their health, where they will live and what support they will need. Also focuses on what stresses they might face in the future.

- **Staying Healthy**

An individual's physical health, how they will manage their health in the future and how to lead a healthy lifestyle, both in hospital and when they leave

- **My Life Skills**

An individual's activities and interests as well as all the skills they will need to help them live the life they want to lead once they leave hospital.

- **My Relationships**

An individual's relationships. These not only include family or friends, but also their relationships with other people around them in hospital. Looking at how they get on with their clinical team and thinking about the relationships they will have with people who'll support them once they leave hospital

- Services will use the standardised statements and scale within the 'Outcomes, Plans and Progress' document collaboratively with individuals to gain an understanding of where the individual and clinician feel they are within each of the above outcome areas. This will lead to a collaborative outcomes plan with milestones which will support further achievement in each outcome area. This plan will be reviewed and monitored through MDT meetings and CPA's. The outcomes will be incorporated into the CPA documentation ensuring an outcome focus is embedded within the service.
- Services will need to provide evidence awareness and use of recovery focussed tools and approaches so that individuals are as fully involved as possible in the understanding their needs, monitoring their progress and engaged in developing a collaborative care plan based on agreed outcomes.
- It is unlikely that an individual will need to have reached the end of their journey in any one area before being ready to move on. The key outcomes that will determine whether an individual is likely to be ready to move to a less secure environment are those that relate to risk of harm to others. All domains are, however, likely to play a role in be important to supporting recovery for most individuals.
- All outcomes for the service should be recovery focused, patient centred and risk aware. They should focus on supporting the individual to meet the identified needs so that they can progress out of secure care into the community. They should support individuals in taking responsibility for their recovery and engagement with improvement in the individual's quality of life and reduce the need for readmission to hospital. One outcome should be the reduction in re offending and engagement in risk behaviours due to mental health issues.

Individuals should be supported to make feasible plans to manage their day to day life back in the community. This needs to include discussion and identification of their problem behaviours, identification of early indicators of relapse or risk and developing strategies for managing their risks in the community.

Outcome measures should include:

My Mental health recovery

- Readmission rates of community patients
- Occupied bed days/length of stay for patients
- Length of time from discharge to readmission
- HoNOS Secure
- MHMDS
- Mental Health Quality dashboard

Stopping problem behaviours

- SUI trends and incidents
- Care plans should identify risk and relapse early indicators and relapse prevention plan.
- Care plans should identify offence paralleling behaviours
- Level of engagement with index offence work and interventions for problem behaviours
- Use of seclusion
- Use of special observation
- HCR 20
- SAPROF
- START

Getting insight

- Advance directives
- Agreed care plan
- Individual engagement with CPA review process
- Use of recovery tool

Recovery from drugs and alcohol problems

- % of patients with dual diagnosis
- % of appropriate care plans addressing substance misuse
- Data on drug and alcohol screening

Making feasible plans

- Service user satisfaction survey responses
- Carer satisfaction survey responses
- Complaints
- Attendance of Responsible Clinician and care co-ordinators to CPA meetings

Staying healthy

- Registration with GP
- Engagement with intervention for physical healthcare
- % of appropriate patients with clozapine blood monitoring
- Physical health outcomes

Life skills

- % of individuals with regular meaningful activity for 25hrs per week

My relationships

- Identified carers
- Carer assessments undertaken
- Visitor data
- Ward climate scale (e.g. ESSEN)

¹ Reference to my shared pathway for further info

² Reference to the 20 Service User Defined CPA Standards (2009)