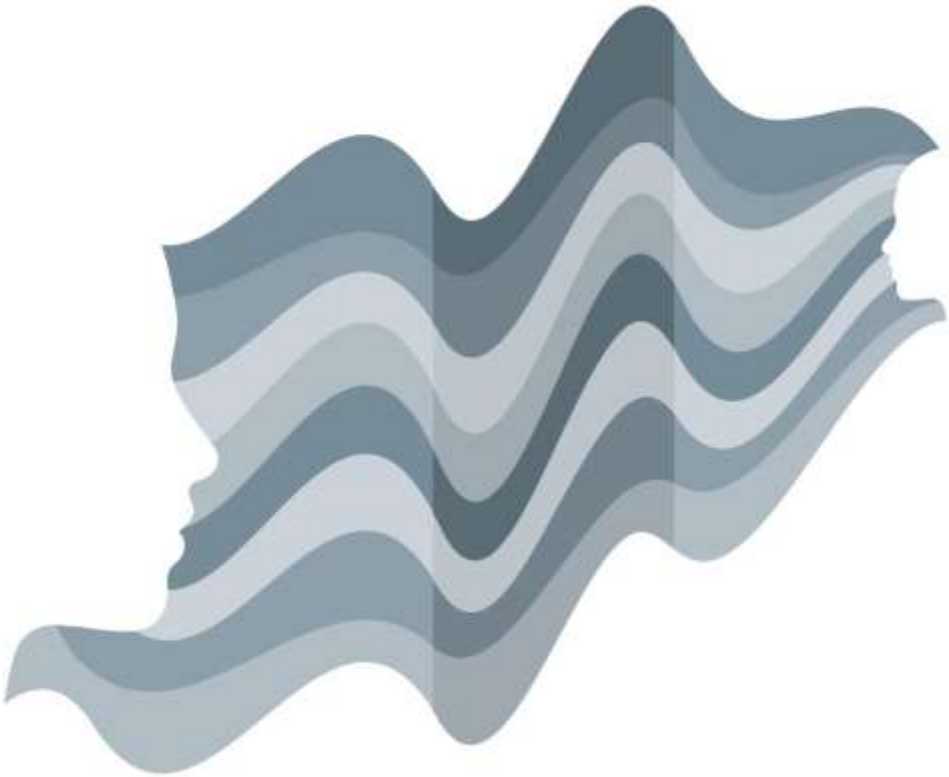
Sussex Partnership
NHS Foundation Trust

Menu of Care & Interventions

Forensic Clinical Academic Group (fCAG)



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Personal Involvement

Menu lead authors	Deborah Egleton & Kirsty Taylor
Summary paragraph explaining why this is included in the MOI	People who become patients of the forensic healthcare service have often had a long history of involvement with mental health services. However, historically there are reports of how they feel "done to" by the medical profession, having little understanding of their diagnosis, what options might be available to them and little say in what treatments they are prescribed. In 2011, NICE published quality standards to improve the experience of people using adult NHS mental health services. This focuses on ensuring professionals get to know the service users personally, enabling development of individualised treatment plans and endeavouring to provide continuity of care. It specifies that patients should actively participate in their care to enhance their experience of the NHS. Personal involvement will ensure that we are all working together with complete and accurate information to aid their recovery. In SPFT Forensic Healthcare service, we endeavour to be as inclusive of the service user as possible from the outset of their involvement with Forensic Healthcare professionals. Their narrative of their history will be listened to and valued, and their views sought when developing risk assessments and treatment plans. Through developing treatment programmes with the service users, it is anticipated that recovery pathways will be more efficient and effective. "Service user experience in adult mental health". NICE clinical guidance 136 (2011).
1. Scope of this template (what's included and what isn't)	This document focuses on: • How the service ensures the patient is at the centre of their care and treatment. This document will not focus on: • How the service truly involves the person in service development, although this is recognised and there is evidence to support it. The ethos of personal involvement should underpin all of the interventions highlighted in the Menus of Interventions.
2. This is evidence based review of	Having service-users at the centre of their care in forensic healthcare services is important (MacInnes, Beer, Keeble, Rees & Reid, 2011). When

quality, safety and effectiveness.	patients are not involved in the decisions surrounding their care, this can result in disengagement from treatment (Katsakou et al, 2012). On the contrary, when they are involved this has a positive impact on the health of the individual (Weingart et al, 2011). Based on research with patients in forensic mental health settings, the concept of patient participation in forensic psychiatric care is three-fold; being involved and having good communication, having mutual trust and confidence in staff, and being given the responsibility to take initiative (Selvin, Almqvist, Kjellin & Schröder, 2016). The evidence to support patient engagement includes: • Understanding their experience of psychological interventions in a forensic setting (Flinn, Grey & Braham, 2013). • Involvement in their own risk management (Hall & Duperouzel, 2011). • Relational security: forming a therapeutic alliance between staff and patients (Department of Health, 2007; Jacobs et al, 2010). Supporting evidence found that patients had better clinical outcomes, lower levels of psychopathology and social disability, as well as higher global functioning, quality of life and satisfaction with services (MacInnes et al, 2013). • Greater participation in developing, planning and running therapeutic activities empowers the person by being the expert (Harvey & Larkin, 2009) and that by developing new skills through sharing knowledge and experience of self-help and coping strategies, the person's confidence and self-esteem is increased (NIHME 2003).
3. What will we offer and how	• Involvement will be throughout the planning, delivery and review stages of patients' secure-recovery. • Information will be made accessible to the person and reasonable adjustments will be made to ensure that the person can be as involved as possible. • They will be given opportunity to discuss ideas they initiate for consideration as part of their treatment. • Communication needs will be identified so reasonable adjustments can be made as early as possible. • Ensuring Mental Capacity Act is adhered to (including the use of Advance Directives where appropriate), ensuring consent is gained where relevant and the patients' views are considered throughout the decision making process • Involvement in risk assessments to identify need. • Accessible information will be available regarding Care Planning Approach, Care and Treatment Reviews, clinical review meetings, enabling patients to plan how they can contribute to these meetings. • Involvement of advocacy services as appropriate. • Their feedback and views will be sought throughout. Views will be

	listened to and respected to inform support needed. • Opportunities to meet with their care team to discuss their needs, identifying their risks. This will in turn identify what care and treatment is indicated at various times.
4. Who is intervention for	This is for everyone who is in contact with forensic mental health services.
5. When	Person involvement will be evident at every stage of intervention – from first contact when the person is referred to the service, to point of discharge from Forensic Healthcare Service. With consent, information gained about supporting the person to share their views and participate in developing their care and treatment will be included in documentation written to support transitions between services as appropriate.
6. Performance indicators	Person's views will be documented on risk assessments and care plans. Feedback will indicate the person feels able to contribute their ideas and views confidently to those supporting them.
7. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale Specific outcome measures for gaining feedback from the person regarding their care and treatment will be sought by: • Patient experience survey • Patient reported outcome measures (PROMS) • Patient Experience Focus Groups
8. Examples / quotes / illustrations.	Quotes from own patients.
9. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	We aim to carry out a comparative study of how care plans are used in the community and inpatient services. This will identify best practices for engaging patients with their care and treatment.
11. References	Charlotte Flinn, L., Grey, D., & G. Braham, L. (2013). Patient experiences of a

motivational group. Journal of Forensic Practice, 15(4), 269-280.
Department of Health. (2007). Best Practice Guidance: Specification for Adult Medium Secure Services.

Hall, S., & Duperouzel, H. (2011). "We know about our risks, so we should be asked." A tool to support patient involvement in the risk assessment process in forensic services for people with intellectual disabilities. Journal of Learning Disabilities and Offending Behaviour, 2(3), 122-126.

Harvey, H. and Larkin, E. (2009) 'Patient Leads the Fairway', Occupational Therapy News, 17(4): 23.

Katsakou, C., Rose, D., Amos, T., Bowers, L., McCabe, R., Oliver, D., ... & Priebe, S. (2012). Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study. Social psychiatry and psychiatric epidemiology, 47(7), 1169-1179.

MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2011). Service-user involvement in forensic mental health care research: Areas to consider when developing a collaborative study. Journal of Mental Health, 20(5), 464-472.

MacInnes, D., Kinane, C., Beer, D., Parrott, J., Craig, T., Eldridge, S., ... & Priebe, S. (2013). Study to assess the effect of a structured communication approach on quality of life in secure mental health settings (Comquol): study protocol for a pilot cluster randomized trial. Trials, 14(1), 257.

National Institute for Mental Health in England. (2003) Cases for Change – User Involvement. London: NIMHE.

Selvin, M., Almqvist, K., Kjellin, L., & Schröder, A. (2016). The Concept of Patient Participation in Forensic Psychiatric Care: The Patient Perspective. Journal of forensic nursing, 12(2), 57-63.

Weingart, S. N., Zhu, J., Chiappetta, L., Stuver, S. O., Schneider, E. C., Epstein, A. M., ... & Weissman, J. S. (2011). Hospitalized patients' participation and its impact on quality of care and patient safety. International Journal for Quality in Health Care, 23(3), 269-277.

Family, Friends and Carers

Menu lead authors	Lynne Clayton and Chris Moxon
Summary paragraph explaining why this is included in the MOI	Family, friends and carers are part of your present and future rehabilitation, which provides a positive connection and integration with the community. Their knowledge and experience increase the effectiveness of mental health care and treatment, which is a huge cost saving to the service. Although family, friends and carers' support is fundamental, there is often a lack of involvement because of the index offence, geography and the secure setting, which can lead to the breakdown of the patient's personal network. It is therefore important, that family, friends and carers' involvement is considered core to inclusion in the Forensic Mental Health Service Menu of Interventions, to make a Triangle of Care.
1. Scope of this template (what's included and what isn't)	This document will illustrate the importance of involving carers, whether that be relatives or friends to the patient, in their journey through Forensic Healthcare Services. Family intervention is listed as one of the interventions we offer, however information and research specifically on family intervention is covered in the Social and Occupational section of the menu of interventions.
2. This is evidence based review of quality, safety and effectiveness.	It has been well-recognised by Support in Mind Scotland and the literature on family and carer involvement, that this is a core requirement within forensic healthcare services (Cormac, Lindon, Jones, Gedeon, & Ferriter, 2010). A large-scale study of Scottish services found that good practice in carer involvement included: exchanging information with carers, carer support workers, carer support groups and behavioural family therapy (Ridley et al. 2014). Family interventions have also been found empirically effective amongst prisoners with mental health difficulties (Roberts et al. 2017). It is often found that patients and carers have different perspectives on treatment outcomes (Chester, Geach & Morrissey, 2017). It is therefore important that the carers' needs are recognised met supported individually, and in isolation to the patients' needs. It is especially important that staff are willing to support carers equally as they would with patients, and recognise that family belongingness can be a positive resource for the patient (Hörberg, Benzein, Erlingsson, & Syrén, 2015).

	Additionally, research piloting psychoeducation for family and carers in low-secure forensic mental health settings have been well-received by both staff and family members (Nagi & Davies, 2015). Carers of forensic mental health in-patients have reported that by staff providing the appropriate information and signposting, this has a large impact on their overall satisfaction and experience with forensic inpatient services (Macinnes, Beer, Reynolds & Kinane, 2013). Similarly, a good relationship between staff and carers is beneficial for both the carers and the patients' well-being. A key component of this is good communication between forensic healthcare staff and the carers involved (Canning, O'Reilly, Wressell, Cannon & Walker, 2009). Conversely, when families are not supported this can have a knock-on effect on the patients recovery in secure forensic settings (McCann, McKeown & Porter, 1996). Families, friends and carers who have experienced interventions within forensic services have been found to hold an overall positive attitude towards having family interventions (Abasalom-Hornby, Hare, Gooding & Tarrier, 2012). Interviews with parents about their experience with forensic mental health services has found that psychiatric healthcare professionals providing information, education, and support of family members is crucial for all involved in the process (Nordström, Kullgren & Dahlgren, 2006). There are four areas to the menu of interventions; support, therapy, assessment, signposting. Carers are often traumatised when they find themselves in forensic mental health services, the support of others with a shared experience is helpful in dealing with some of the issues that otherwise can become a barrier in the relationship between carer and patient. At the right time Family Intervention can be helpful in breaking down some of these barriers. Carer assessments are helpful in supporting carers, also signposting carers to other services.
3. What will we offer and how	In order to provide the menu of care and interventions to inpatient and community services it is important that carers are identified even if patients do not want their carers involved in the decisions of their care. Within our service we offer: • Forensic Family, Friends and Carers' Support group at Hellingly (invitation only through forensic services) • Family, Friends and Carers' Support group at Chichester, • Annual Carers' Day at Hellingly • Bi-annual Regional Carers' Day • Forensic Carers' Peer Support Worker • Referral and undertaking of Carer's Assessments • Onward signposting to local support services • Family Intervention

4. Who is intervention for	If you give unpaid support to someone with a mental health issue and they rely on that support, then you are a carer. This applies even if the person doesn't live with you. This term is confusing and not always a comfortable one to accept as it is also used for paid care workers. It may be easier to see yourself as a parent, partner or friend. However, it is the word used in Government policies, law and generally accepted by professionals, so it is worth recognising that it applies to you even if you prefer not to use it. It can be the key to recognising what help and resources are available to you. Patients may be inpatients in the local area but they may sometimes be placed outside of the local area, it is important that carers are introduced to their local forensic support group by the patient inpatient hospital. Carers of community based patients are also able to access interventions through the patient's mental health team.
5. When	It is important that the menu of care and interventions to carers is accessible when appropriate but that carers are aware of care and interventions available.
6. Performance indicators	Family, friends and carers tests and carer surveys will be performance indicators.
7. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale In addition, specific evidence based outcome measures relevant to the interventions described above will be used where appropriate.
8. Examples / quotes / illustrations.	Quote from carer following carer day at Hellingly – "all the therapy in the world is worth nothing if it is not provided with love" and she believes that is the difference we have in our service. Hellingly Centre - A modern, unique, caring and loving environment. Hellingly Family, Friends and Carers' Support Group "What a wonderful meeting last week was with so many new people all starting their difficult journey. That is what the group is all about, finding a place where you can express how you feel knowing you are with people you are safe to talk about your own loved one. No one knows what that feeling is you have when you are thrown into this situation, where you are so scared and frightened yourself; yet alone provide the support for your loved one. It's being able to share those moments when a small

	improvement means such an amazing achievement. To be able to hear other people's journey has been as traumatic as yours yet you understand and have the empathy to offer your help; a tissue, a shoulder to cry on. It is also so important to listen to others further on the journey who can give you such hope and encouragement that you will feel life can go on , even if in a different way. Despite what ever has happened once entering Hellingly to find staff who pick you up and understand without explaining was like being wrapped in a blanket, safe from all that had happened and treated like a human being not 'that person whose son had done ...'. To let someone else take full responsibility with your son when you have struggled for so long was like a weight being lifted for the first time. To have people who listen to every small concern and respect what you said was important for recovery. These are the real professional people working with seriously ill people with mental health illness, they should be shown as an example of excellence. I don't think anyone has truly understood how we have felt apart from this group and staff at Hellingly. They have ensured that our journey is as important as our Son's recovery. I know that I am stronger now to embrace the new members and can offer the support they need when they arrive so frightened feeling life has stopped. Life does go on, if so differently but you are not on your own. This group has been so important to me"
9. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	This is an area of on-going development locally and nationally and new research findings will incorporated accordingly.
11. References	Abasalom-Hornby, V., Hare, D. J., Gooding, P., & Tarrier, N. (2012). Attitudes of relatives and staff towards family intervention in forensic services using Q methodology. Journal of psychiatric and mental health nursing, 19(2), 162-173. Canning, A. H., O'Reilly, S. A., Wressell, L. R., Cannon, D., & Walker, J. (2009). A survey exploring the provision of carers' support in medium and high secure services in England and Wales. The Journal of Forensic Psychiatry & Psychology, 20(6), 868-885. Chester, V., Geach, N., & Morrissey, C. (2017). Treatment outcomes from forensic intellectual disability services: The perspectives of patients and their family/carers. Journal of Intellectual Disabilities, 1744629517728841.

Cormac, I., Lindon, D., Jones, H., Gedeon, T., & Ferriter, M. (2010). Facilities for carers of in-patients in forensic psychiatric services in England and Wales. The Psychiatrist, 34(9), 381-384.

Hörberg, U., Benzein, E., Erlingsson, C., & Syrén, S. (2015). Engaging with families is a challenge: beliefs among healthcare professionals in forensic psychiatric care. Nursing research and practice, 2015.

Macinnes, D., Beer, D., Reynolds, K., & Kinane, C. (2013). Carers of forensic mental health in-patients: what factors influence their satisfaction with services?. Journal of Mental Health, 22(6), 528-535.

McCann, G., McKeown, M., & Porter, I. (1996). Understanding the needs of relatives of patients within a special hospital for mentally disordered offenders: a basis for improved services. Journal of advanced nursing, 23(2), 346-352.

Nagi, C., & Davies, J. (2015). Bridging the gap: brief family psychoeducation in forensic mental health. Journal of Forensic Psychology Practice, 15(2), 171-183.

Nordström, A., Kullgren, G., & Dahlgren, L. (2006). Schizophrenia and violent crime: The experience of parents. International journal of law and psychiatry, 29(1), 57-67.

Ridley, J., Mckeown, M., Machin, K., Rosengard, A., Little, S., Briggs, S., ... & Depurkaystha, M. (2014). Exploring family carer involvement in forensic mental health services (discussion and summary report; final report).

Roberts, A., Onwumere, J., Forrester, A., Huddy, V., Byrne, M., Campbell, C., ... & Valmaggia, L. (2017). Family intervention in a prison environment: A systematic literature review. Criminal Behaviour and Mental Health, 27(4), 326-340.

Treatment for Specific Mental Disorders

Menu lead authors	Dr Mike Lawson & Iftekhar Khan
Summary paragraph explaining why this is included in the MOI	Treatments can support people by reduce distressing symptoms and experiences; Improving people's ability to cope with challenges; reducing the likelihood of further offending or hospital admission; and helping people to understand and manage their own thoughts, feelings and behaviour. Treatment can also help individuals to recognise their strengths and the sources of support around them. It can help individuals learn new skills, to help manage a range of challenges often faced by people with a mental health diagnosis. Treatment that supports Individual recovery is likely to include a combination of medication and evidence based therapies (psychological and occupational), to support and compliment an individual's own recovery capital.

1. Scope of this template (what's included and what isn't)	• To provide patients, their families, clinicians and stakeholders with a clear set of expectations regarding the current therapies and interventions available within the Forensic Healthcare Service for the treatment of specific mental disorders.
	• Specifically this menu will address:
	  ◦ Evidence-based medical and biological treatments for specific mental disorders.
	  ◦ Evidence-based psychological therapies for specific mental disorders.
	
	• In general this menu will overtly reference and link to the relevant disorder-based CAG menus developed by Sussex Partnership NHS Foundation Trust.
	• Where appropriate additional (to the disorder-specific CAG menus) recommendations may be made and interventions offered within the FHS.
	• To explore and take into account up-to-date evidence-based research and practice, and to implement recommendations from the literature regarding the medical and psychological treatment of specific mental disorders.
	• It will not be a 'one-fits-all' model and so interventions may differ, and

	hence tailored to each individual's needs.
2. This is evidence based review of quality, safety and effectiveness.	Evidence base for psychological therapies: The basic treatment principles and evidence base for the psychological treatment of specific mental disorders in forensic populations does not differ greatly from the treatment of disorders in other care groups. For further details of the evidence relating to specific psychological therapies for particular disorders please refer the Menus of Intervention developed by: • Psychosis CAG; • Mood and Anxiety CAG; • Complex Emotional Disorders CAG; • Intellectual Disability CAG; • Mind and Body CAG. However, due to the complex nature of forensic mental health work, psychological interventions are almost always provided as part of a multidisciplinary intervention strategy, using collaborative care planning, and taking in considerations of risk to others (as well as to self). NICE guidance supports the use of psychosocial and psychological interventions for people with: • Psychotic disorders and schizophrenia (CG 178), and psychotic disorders that include co-existing substance misuse (CG 120), • Common mental health problems such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), social anxiety disorder (CG123) bipolar disorder (CG 185). • Antisocial (CG 77) and borderline (CG 78) personality disorder (QS 88). • Other physical health disorders and addiction behaviours (particularly contingency management approaches) • Learning disabilities • Paraphilias (abnormal sexual desires) when part of a research programme. More specific to psychological interventions in forensic mental health services, there is NICE guidance covering the assessment, diagnosis and management of mental health problems in adults who are in contact with the criminal justice system (NG66). In forensic mental health treatment, a notable difference between forensic and non-forensic therapeutic endeavours is the additional focus on outcomes pertaining to reduction of recidivism / risk of harm to others. (See risk reduction MOI). This falls within the guidance as part of a requirement to modify interventions to suit the criminal justice context.

	Particular emphasis is placed on reducing recidivism for those with convictions for aggression, violence and sex offences. Other context specific modifications include an enhanced emphasis and expertise in risk assessment and management, considering continuity of psychological interventions across or between institutions (including transitions and institutionalisation), considering the increased likelihood of complex formulation (particularly the comorbid presence of substance misuse and personality disorder), considering the likely need for longer term, higher intensity, multimodal treatments, and considering motivational issues relating to court assessments and potential evasion of criminal justice outcomes. Specific short and long term management approaches for self - harm behaviours are also offered within a forensic context, in compliance with trust policy (Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure) NICE clinical guidance for over 8's (CG133 and CG16) and quality standards (QS34). As many patients within forensic services have presented with both mental illness and some form of antisocial / criminal behaviour, there is also an emphasis on the reduction of antisocial behaviour more generally and a corresponding increase in prosocial behaviours, social problem solving and life skills development. When working with individuals presenting with antisocial behaviour, it may be required to also address treatment engagement, impulsivity and interpersonal difficulties. Evidence base for medical/biological treatment: The basic treatment principles and evidence base for the medical/biological treatment of specific mental disorders in forensic populations does not differ greatly from the treatment of disorders in other care groups. For further details of the evidence relating to specific medical/biological treatments for particular disorders please refer the Menus of Intervention developed by: • Psychosis CAG; • Mood and Anxiety CAG; • Complex Emotional Disorders CAG; • Intellectual Disability CAG; • Mind and Body CAG. Medical/biological treatments for specific mental disorders are recommended only after extensive systematic review to provide evidence on efficacy, safety and tolerability. In general evidence includes published research (especially Randomised Controlled Trials, Systematic Reviews & Meta-analyses) MHRA guidance, technology appraisals and consensus statements. However the majority of treatments covered by the Sussex Partnership NHS Foundation Trust Menus of Intervention are all supported by NICE clinical guidance, technology appraisals and quality standards.

	Sussex Partnership NHS Foundation Trust has ratified these medications via the Drugs & Therapeutic Committee to produce Trust clinical policies from practice across all the Trust directorates. Sussex Partnership NHS Foundation Trust. (2018). *Medication.* [online] Available at: https://www.sussexpartnership.nhs.uk/medication
3. What will we offer	The S&F directorate will offer the most suitable treatment choices detailed in the Trust Drug Formulary. The Trust provides patient information leaflets through Choice and Medication Website. Sussex Partnership NHS Foundation Trust. (2018). *Choice and Medication.* [online] Available at: http://www.choiceandmedication.org/sussex/ <u>Psychological interventions will also be offered in-line with the disorder-specific Menus of Intervention. For details of the interventions which will be offered and how these will be delivered please refer to the relevant disorder-specific CAG Menus of Intervention.</u> • Psychosis CAG • Mood and Anxiety CAG • Complex Emotional Disorders CAG • Intellectual Disability CAG • Mind and Body CAG
4. Who is intervention for	This menu covers all patients in contact with FHS, wherever they may be (e.g. prison, secure hospital, community).
5. When	From the first time medication is prescribed for patients, and throughout a patient's entire period of contact with FHS.
6. Performance indicators	Audit, including National Audit of Psychosis, local medication audits
7. Outcome measures	There will be no single ideal outcome measure in any given clinical situation. Information may be gathered from various sources (e.g. patient, family, clinician, others) and may measure varying aspects of clinical care (patient experience, quality of life, daily functioning, levels of symptoms). The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis

	• Measures of functioning – such as Work and Social Adjustment Scale
8. Examples / quotes / illustrations.	See other CAG Menus for examples of specific interventions for mental disorders.
9. Link to other CAGS	Treatment of mental disorder will involve common links to other CAGS - as conditions being treated are not unique to one or other directorate. Specifically the menus which have been (or are currently being) developed by: • Psychosis CAG • Mood and Anxiety CAG • Complex Emotional Disorders CAG • Intellectual Disability CAG • Mind and Body CAG
10. Plan to develop evidence base	Trust Drug and Therapeutic Committee will help to ensure new treatments are evaluated before adding them to Trust formulary. Key issues related to S&F – rapid tranquillisation when patients are restrained, high-dose antipsychotic prescribing, and co-morbid substance misuse.
11. References	National Institute for Health and Care Excellence (2014). Psychosis and schizophrenia in adults: prevention and management. Clinical Guideline 178 National Institute for Health and Care Excellence (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Clinical Guideline 120 National Institute for Health and Care Excellence (2011). Common mental health problems: identification and pathways to care. Clinical Guideline 123 National Institute for Health and Care Excellence (2014). Bipolar disorder: assessment and management. Clinical Guideline 185 National Institute for Health and Clinical Excellence (2009). Antisocial personality disorder: prevention and management. Clinical Guideline 77 National Institute for Health and Clinical Excellence (2009). Borderline personality disorder: recognition and management. Clinical Guideline 78

	National Institute for Health and Care Excellence (2015). Personality disorders: borderline and antisocial. Quality Standard 88 National Institute for Health and Care Excellence (2017). Mental health of adults in contact with the criminal justice system. NICE Guidance 66

Risk Reduction and Safety Planning

a) Risk Assessment

Menu lead authors	Louise Minchin & Sarah Markham
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside service users to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in service users losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf
1. Scope of this template (what's included and what isn't)	Included: • Use of Structured Clinical Judgment Tools to assess risk Not included: • Collaborative Working – whilst this can be mentioned it will be covered by 'Personal Involvement' • Substance Misuse/Addictions – covered by 'Interventions Aimed at Addressing Addiction' • Risk to self (as this is not forensic specific)

	• Use of medication (rapid tranquilisation) • PMVA / Seclusion
2. This is evidence based review of quality, safety and effectiveness.	The UK forensic service standards stipulate that forensic mental health services should provide risk assessments using structured professional judgement principles. Structured Professional Judgement (SPJ) allows decision making to be guided by a systematic review of relevant information and the SPJ tools ensure the areas considered are those that are evidence based. The SPJ approach conceptualises "violence risk assessment & management in preventative rather than predictive terms" and were developed to guide "individualised case management". They are "developed on the basis of systematic reviews of the relevant scientific, clinical, and legal literature rather than on the basis of a single study or set of studies" (p13; Douglas et al, 2013) There are a large number of structured instruments created to assist in the assessment of anti-social, violent and sexual risk, and their use appears to be increasing in mental health settings [Khiroya et al., 2009; Singh, et al., 2011]. However, it is important to recognise that risk is not a static concept (such as measured by actuarial risk assessments) but a dynamic concept which evolves over time, and may also be dependent on context, e.g. social circumstances. Many risk assessment tools have been developed and the reported predictive validity of these tools varies. There is a case for choosing the specific risk assessment tool according to the context and purpose for which it is being used (Coid, Ullrich & Kalllis, 2013; Yang, Wong & Coid, 2010). When considering risk assessment of people with mental health difficulties, the Royal College of Psychiatrists (2016) recommend a formulation based approach to risk assessment that incorporates dynamic factors and SPJ's such as the HCR-20 (Webster et al 2007; Douglas et al, 2013) utilise this formulation based approach. In addition, there is emerging evidence (e.g. Judges, 2016) that combining the HCR with an assessment of protective factors against risk increases the predictive validity of the tools (the protective risk assessment tool used in this study was the SAPROF; de Vogal et al, 2012). There is some evidence to suggest risk assessment tools are best administered using multi-disciplinary rather than lone practitioner approach (Logan & Watt, 2001).
3. What will we offer	A Risk Assessment which is based on a Structured Clinical Judgement Tool which incorporates protective factors against risk and is regularly reviewed as part of the CPA process and used to inform safety and care planning. As part of CPA process, patients' care teams will co-produce risk assessments with patients.
4. Who is intervention for	This menu covers all service users in contact with FHS, wherever they may be (e.g. prison, secure hospital, and community).
5. When	Risk assessment is an ongoing process, which will occur throughout a service user's entire period of contact with FHS.

6. Performance indicators	All patient care coordinated by FHS will have a HCRV3 or RSVP which is renewed every 6 months as part of CPA process. Trust Wide Clinical Risk Audit
7. Outcome measures	All care/safety plans reflect the areas of need identified within the risk assessments especially the My Shared Pathway 'My Safety and Risks' care plan. My Shared Pathway. (no date). My Safety and Risks. Retrieved from http://www.recoveryandoutcomes.org/assets/files/My%20Safety%20and%20Risks.pdf
8. Examples / quotes / illustrations.	
9. Link to other CAGS	The Risk Reduction and Safety Planning Menus which have been produced by the Forensic Clinical Academic Group (fCAG) will be available and relevant to service users primarily coming into contact with services and CAGs out with the FHS as well as those under the direct care of FHS.
10. Plan to develop evidence base	Continuous Review of Risk Assessment Literature
11. References	Coid, J., Ullrich, S. & Kallis, C., 2013. Predicting future violence among individuals with psychopathy. The British Journal of Psychiatry Nov 2013, 203 (5) 387-388 de Vogal, V., de Ruiter, C., Bouman, Y & de Vries Robbe, M. (2012) SAPROF Guidelines for the assessment of protective factors for violence risk, 2nd Edition; http://www.saprof.com/ Douglas, K.S., Hart, S.D., Webster, C.D. & Belfrage, H. (2013) HCR-20V3 Assessing Risk for Violence, Mental Health, Law, and Policy Institute, Simon Fraser University Judges, R. (2016) An exploration into the value of protective factors in violence risk assessment of psychiatric inpatients. DForenPsy thesis, University of Nottingham. Khiroya, R., Weaver, T., and Maden, T. 2009. Use and perceived utility of structured violence risk assessment in English medium secure forensic units. Psychiatrist, 33, 129-132. Logan, C. & Watt, K. (2001). Structured professional guidelines approaches to risk assessment: Single practitioner vs multidisciplinary team administration. Paper presented at the International Conference, Violence Risk Assessment & Management: Bringing Science Closer Together. Sundsvall, Sweden. Rettenburger, M., and Eher, R. 2007. Predicting reoffence in sexual offender subtypes. prospective validation study of the German version of the sexual Offender Risk Appraisal Guide. SORAG. Sexual Offender Treatment, 2, 1-12.

	Royal College of Psychiatrists. (2016). Risk Assessment Guidance. Retrieved from http://www.rcpsych.ac.uk/pdf/CR201GPGx.pdf Singh, P., Grann, M., and Fazel,S. 2011 Comparative study of risk assessment tools. A systematic review and metaregression analysis of 68 studies involving 25,980 participants, Clinical Psychology Review, Doi 10.1016/.cpr.2010.11.009 Webster, C. D., Douglas, K. S., Eaves, D., and Hart, S.D., 1997. HCR-20 Assessing risk or violence. version 2. Barnaby, BC. Simon Fraser University, Mental Health, and Law Policy Institute. Yang M, Wong SC, Coid J. (2010) The Efficacy of Violence Prediction: A Meta- Analytic Comparison of Nine Risk Assessment Tools. Psychological Bulletin, 135, 5, 740-767

Risk Reduction and Safety Planning

b) Relational Security

Menu lead authors	Louise Minchin, Sarah Markham and John Canning
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside service users to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in service users losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf
1. Scope of this template (what's included and what isn't)	Included: • Reducing the need for restrictive practices within in-patient settings • Improve collaborative working on risk management in all settings which includes the community • A psychologically informed approach to de-escalation using the CARES model

	• Effective team working and apply these principles in practice • Understanding the Interpersonal Dynamics Model of reflective practice in developing a Formulation • Understanding the continuum of psychological and physical containment when managing high levels of distress • Understanding emotional dysregulation and evidence based techniques to intervene • How to facilitate a post incident exploration with service users using the behaviour chain analysis model • Understanding the spiral of change model and the importance of instilling hope Not included: • Collaborative Working – whilst this can be mentioned it will be covered by 'Personal Involvement' • Substance Misuse/Addictions – covered by 'Interventions Aimed at Addressing Addiction' • Risk to self (as this is not forensic specific) • Use of medication (rapid tranquilisation) • PMVA / Seclusion
2. This is evidence based review of quality, safety and effectiveness.	Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. Effective relational security is critical to providing safe, purposeful and well-led services. See Think Act was first published by the Department of Health for medium secure care in 2010. In 2015, the Quality Network for Forensic Mental Health Services along with Elizabeth Allen, the original author of the work, undertook a review with high, medium and low secure providers, patients and their friends and family, of what had been learned since the first publication. The emphasis of the 2nd edition of See Think Act reflects how secure services have evolved in the last five years and importantly, is now written for all levels of secure care. According to See Think Act, 'Patients need to see that staff understand and care about how they feel. Staff who don't and who are passive or insensitive can do more harm in a service than good. They create feelings of resentment and mistrust, undermining the whole team. The staff's job isn't just to watch patients; it's to find every way they can to help them manage their recovery, taking every opportunity they get to encourage participation and reinforce new skills. That doesn't just mean having the right numbers of staff, it means having the right kind of staff: people who want to make a difference. That means being prepared to examine their own feelings and being continually aware of the things they say and do, and how someone else might interpret them. Their relationship with a patient must always be professional and respectful.' (RCPsych, 2015).

	See Think Act also places emphasis on planning health outcomes and being clear about goals, together with advice on how to involve and maximise the contribution of friends and family. The Department of Health (DH) launched Positive and Proactive care: reducing the need for restrictive interventions in April 2014.The guidance is aimed at promoting the development of therapeutic environments and minimising all forms of restrictive practice, so they are only used as a last resort. The MHA Code of Practice (2015) states that staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. In some services such a care or treatment plan is referred to as a positive behaviour support plan. The Containment Advance directive Regulation Exploration and Sprial of change Model (CARES) (Livesley, 2012) acknowledges that caring for someone who suffers from a co-morbid mental illness (MI) and personality disorder (PD) is better framed in terms of attachment theory and containment. This approach gives staff an understanding of the task ahead, and realistic markers of progress, that helps to provide an optimistic framework to be established and maintained even through the most difficult stages of the patient's recovery. It is based on John Livesley's research in 2012 which examined all current psychological treatments for working with PD, and forms an evidence based summary of the most effective interventions. Key concepts identified by the CARES model include the following: Containment The primary goal is to ensure the safety of the patient and others through psychological containment or physical containment when absolutely necessary. Advance directive All staff follow the patient's individualised, co-designed "my support and containment" care plan to provide a consistent approach in trying to understand and support the patient in managing their distress. Regulation Staff will support the patient to settle their unstable emotions and impulses, and restore behavioural control. The patient's primary concern is understood as relief from distress, which comes from feeling understood. Exploration

	Patient self-reflection is promoted to look for a chain of events beginning with a triggering event (often interpersonal for PD and intrapersonal for MI) that may have aroused feelings of abandonment and rejection (PD) and/or paranoid thoughts and cognitive distortions (MI). It is also important to recognise patients as people who have good days and bad days. Spiral of change Staff will acknowledge to the patient just how difficult it is to make changes, as feelings of fear and rejection (PD) and paranoia (MI) are likely to be evoked.
3. What will we offer	Staff receive training in the CARES training model to be able to implement the My Support and Containment Care Plans with patients. This model has been developed using a range of psychologically informed processes, to provide an evidence based approach to working therapeutically with patients suffering with both a mental illness and/or personality disorder. My Support and Containment careplan is individualised and cover various aspects of relational security. • Primary preventative strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances. In FHS these will be included within the core careplans; "My mental health recovery", "My safety and risks" and "staying healthy". • Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm (including de-escalation), and safe and therapeutic responses to disturbed behaviour. • Tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, if appropriate, possibly including continued attempts to de-escalate the situation, and are used in such a way as to minimise distress and risk of harm to the patient. For example, following the CARES model, the following interventional approaches may be appropriate: Containment The care worker maintains an "adult – adult" mind-set and focuses on the "signal" (how the person if feeling" rather than the "noise" (what the person is saying). Advance directive Giving the patient choices at each stage of the limit setting process whilst always trying to engage the patient in a 1-1 meeting, aims to minimise the use of restrictive practices, and allows a detailed collaborative reflective

	process to take place when restrictive practices have been required. Regulation The patient's primary concern is understood as relief from distress, which comes from feeling understood. The patient is supported to reframe the focus of change from others to self, by using feedback skills and listening skills. Exploration Care workers will talk to patients sensitively about what they think their likely triggers are. Planning will take place with patients regarding how care workers will respond to their triggers and support them. Staff will explore short term and long term consequences of such experiences with patients to support them to increase their self-knowledge, self-monitoring and self-reflection. Spiral of change Staff work with the patient to clarify the problem behaviour, build an alliance and establish a commitment to change. Finding new solutions to unhelpful behaviour may to increase frustration and have an impact on significant others. Staff will acknowledge to the patient just how difficult it is to make changes, as feelings of fear and rejection (PD) and paranoia (MI) are likely to be evoked. The attachment relationship (Bowlby, 1982) formed between staff and the patient through the ongoing use of the "My Support and Containment" careplan is designed to act as a transitional object (Winnicott, 1953) and a template for future professional relationships, especially at key transitional points within the FHS pathway. By mitigating the risk of anxiety and negative experiences in the face of transfers between wards, levels of security, returning to the community and transitions within the community, we can minimise the number of "gate fever" incidents and "failed" transfers. Furthermore all patients are offered the following socialisation and risk reductive interventions: • Weekly Community Meetings (inpatient only). These meetings are open to all inpatients to attend. They allow patients to discuss and resolve ward-based issues with staff in a collaborative manner. • Collaborative Risk Assessment. All patients are invited to attend regular risk clinics in order to participate in the formulation and update of the various risk assessments deemed pertinent to their care and treatment. • Keywork/1:1 Sessions. All patients are encouraged to meet regularly with their keyworker to discuss their care and treatment and plans (daily for inpatient). • Weekly reflective practice sessions for all teams which includes See,

	Think, Act principles in maintaining patient safety. In addition to this the service is developing the use of the Interpersonal Dynamics model (Reiss & Kirtchuk, 2009) which is designed to improve the clinical communication by the MDT by exploring the underlying dynamics of patients interactions in a way that can be understood and contributed to by all staff. The accurate appraisal of interpersonal dynamics may assist in detecting the early warning signs of problems. It may also provide staff with additional insight into a patient's functioning, thereby improving interventions.
4. Who is intervention for	This intervention is for all mental health care and prison in-reach patients.
5. When	Relational Security is a core component of security management in all services. Individual interventions can be accessed as required
6. Performance indicators	Following any clinical incident, the My Support and Containment Careplan will be reviewed with the patient within 24 hours. The number of successful transitions is increased The use of restrictive practices is decreased
7. Outcome measures	Patient Reported Outcome Measures and Patient Reported Experience Measures will be used as well as the EssenCES measure of social climate including clinical staff and patients.
8. Examples / quotes / illustrations.	
9. Link to other CAGS	The CARES training model in the use of has also been put forward to the CedCAG.
10. Plan to develop evidence base	To link in with the Trust Reducing Restrictive Practices including training on PMVA (Prevention Management of Violence and Aggression) PICUs (Psychiatry Intensive Care Units) PROMs and PREMs (Patient Reported Outcome Measures and Patient Reported Experience Measures) EssenCES (Essen Climate Evaluation Schema) A screening tool for assessing the social and therapeutic climate of forensic psychiatric wards. Interpersonal Dynamics and MDT team working
11. References	Bowlby, J. (1982) Attachment and loss: Retrospect and prospect. American Journal of Orthopsychiatry, 52(4), 664. (DH, 2014) Positive and Proactive Care: reducing the need for restrictive interventions. Guidance for all those working in health and social care

	settings: commissioners of services, executive directors, frontline staff and all those who care for and support people. (Department of Health and Social Care, 2015) Code of practice: Mental Health Act 1983 Last updated 31 October 2017. (Livesley, 2012) Integrated Treatment: A Conceptual Framework for an Evidence-Based Approach to the Treatment of Personality Disorder. Journal of Personality Disorders: Vol. 26, No. 1, pp. 17-42. Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf Reiss, D., & Kirtchuk, G. (2009) Interpersonal dynamics and multidisciplinary teamwork. Advances in psychiatric treatment, 15(6), 462-469. (Schalast et al, 2008) EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. Crim Behav Ment Health. 2008;18(1):49-58. doi: 10.1002/cbm.677. Winnicott, D. W. (1986) Transitional Objects and Transitional Phenomena: A Study of the First Not-Me. Essential papers on object relations, 254.

Risk Reduction and Safety Planning

c) Restorative Justice

Menu lead authors	Louise Minchin. Sarah Markham & Andy Cook
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside patients to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in patients losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf
1. Scope of this template (what's included and	Included: Use of Restorative Justice practices Not included: • Collaborative Working – whilst this can be mentioned it will be

what isn't)	covered by 'Personal Involvement' • Substance Misuse/Addictions – covered by 'Interventions Aimed at Addressing Addiction' • Risk to self (as this is not forensic specific) • Use of medication (rapid tranquilisation) • PMVA / Seclusion
2. This is evidence based review of quality, safety and effectiveness.	Restorative justice (RJ) is an approach to justice which strives to repair harm to all parties affected by an offence or wrong-doing. Restorative Justice is a voluntary process bringing those harmed by crime or conflict, and those responsible for the harm, into communication. This can occur within a face-to-face encounter at a restorative conference or by less direct means. The role of the facilitator is to maximise the potential of meaningful and restorative communication between the parties through the preparatory work and by providing a structured intervention (Restorative Justice Council, 2011). Restorative Justice aims to allow each person to process and share how they are feeling through helpful communication, relationship building, and communication of moral values. Restorative justice has been found to benefit both the person who has caused harm and the person who has been harmed. For the person harmed the process has been shown to; i. Offer a process in which they may reach a sense of closure and reassert some control over their situation. ii. It allows them to tell the person who harmed them the real impact of their act, and it provides the possibility of getting answers to their questions and also the possibility of an apology. iii. The process has also been found to empower the person harmed by giving them a voice. With regard to the person who has caused harm the process has been shown to; i. Give them the chance to reflect more on the impact of their behaviour. ii. Offer them an opportunity to think about and relearn how they might behave in the future. iii. It also holds them to account for what they have done and helps them to take responsibility and make amends. Victim Satisfaction Many studies have reported that victims who have engaged in RJ report feeling satisfied with the process (see for example Shapland, et al; 2004; 2006; 2007; 2008). Strang, Sherman, Mayo-Wilson, Woods, & Ariel (2013) completed a systematic review of 10 published papers exploring the use of

restorative justice and found victims' satisfaction with the handling of their cases was consistently higher for victims assigned to restorative justice conferences than for victims whose cases were assigned to normal criminal justice processing.

Recidivism

Sherman and Strang (2007) systematically reviewed 16 studies which provided outcome data regarding the impact of RJ on repeat offending and effects on victim. RJ was found to reduce repeat offending for specific populations. They concluded that RJ is most effective in cases that have a personal victim, and when the crime is violent or a burglary. Strang, Sherman, Mayo-Wilson, Woods, & Ariel (2013) found that restorative justice conferences reduced incidents of future detected crimes.

Victim well-being

Angel et al (2014) examined the impact of face-to-face restorative justice meetings on symptoms of post-traumatic stress for victims of burglary and robbery. Their findings suggested that restorative justice conferences reduce clinical levels of post-traumatic stress symptoms in a short-term follow-up assessment.

Restorative justice in forensic mental health settings

Research in mental health settings is very limited to date, with the majority of published material being theory-based. Cook, Drennan & Callanan (2015) explored the experience of restorative justice approaches in a forensic mental health setting; they looked at what aspects of restorative justice were particularly suited to a forensic mental health setting and shared what they learnt from the process of implementing restorative justice. The types of restorative justice cases they included were; patient/staff conflict, index offences (preparatory work), inappropriate sexual behaviour towards staff and assaults towards staff. They found that overall participants reported positive experiences with high levels of victim and perpetrator satisfaction. Restorative Justice was seen to complement and contribute to the therapeutic goals of the service. Drennan, Cook and Kiernan (2015) conclude that 'restorative practices could make a powerful contribution to the development of insight and emotional understanding in offenders with serious mental health challenges' whilst acknowledging that there is a lack of knowledge regarding how mental health factors mediate the transformative power of the restorative intervention.

Patients and staff in inpatient settings are at an increased risk of exposure to violent and harmful events (Bowers et al, 2011). Such incidents can have a negative impact on patient and staff mental well-being and on subsequent patient and work experiences. Current responses within the service address the needs of individuals; yet they fail to address the violation that has occurred between these individuals; restorative practice will bridge this gap.

	Restorative Justice approaches have been shown to add value in a number of ways. i. Restorative Justice Interventions help to reduce harm, build relationships, and facilitate helpful dialogues. ii. Restorative justice offers victims a process in which they can reach a sense of closure and reassert some control over their situation. iii. Restorative justice allows a perpetrator to reflect more greatly on the impact of their behaviour and relearn how they might behave in the future. iv. Restorative justice can support with therapeutic processes, including offence paralleling behaviour, victim empathy, preparing for discharge, awareness of self, perpetrator & mental health recovery.
3. What will we offer and how	We will offer the opportunity to engage in a restorative intervention which will include an assessment and preparatory stage. Referrals for restorative interventions can be made via the psychology team. A restorative facilitator will be allocated from the internal pool of facilitators. A decision will need to be made regarding partnership working (Sussex restorative justice partnership; SRJP) or providing both facilitators internally. Factors effecting this decision will be whether the victim is external to the service (in which case partnership working is essential), the level of harm caused (with greater harm indicating the likely advantage of partnership working) and the need for facilitator neutrality. If working in partnership then a written referral will be made to SRJP and a facilitator will be allocated. There will be an assessment process, including consultation with the treating team, a period of preparatory work with individual participants, and, if indicated, a face-to-face conference. If it is not deemed appropriate to proceed to conference there are other possible ways forward. If all parties are in agreement, and it is indicated, this will proceed to a facilitated restorative conference between the person who has been harmed and the person who has caused harm. If this is not possible, or not indicated, then there are other possible options such as facilitated indirect contact or use of a proxy victim. In some cases it will not be appropriate to proceed beyond the initial preparatory work.
4. Who is intervention for	Restorative Practice may be used where harm has been caused. The harm may take the form of physical and/or psychological harm. The intervention is for both the harmed person and the person who has caused harmed. Participation is voluntary and the intervention should only proceed when participants have given informed consent, having understood the reasons and process. There will be an identifiable victim who has suffered personal harm. The types of cases that may warrant a referral include: • A conflict occurs between patient and patient. • A conflict occurs between staff and patient.

	• Staff and patients make complaints or have concerns about one another. • Occurrence of physical aggression, verbal abuse, or sexual harm. • Where psychological harm has resulted because of a patient's behaviour. • A patient has caused harm to a member of the public. • In relation to a patient's index offence. Cases not appropriate for Restorative Practice include: • The person who caused harm denies their crime and/or actions or blames the victim. • If either the person harmed or the person who has caused harm choose not to participate; neither party must be forced, coerced, or bribed to take part. • Where the motivation to engage is driven by a desire to humiliate, threaten, harm, or undermine the other party. • When risk assessments highlight concerns regarding how a Restorative Conference may impact on the harmed, harmer, or other parties. • Mental disorder is not a bar to participation, however, those suffering with psychopathy, severe anti-social personality disorders, unstable psychiatric disorders, or a severe risk of self-harm are unlikely to be suitable. • If participants do not have capacity to consent to engagement or to engage in the intervention.
5. When	A restorative intervention can be considered at any point following a harmful incident. It is likely that incidents in the clinical setting will be addressed relatively soon after the event, whereas restorative practice relating to the index offence is likely to need a period of stabilisation and preparation. The intervention should be victim-led even if not initiated by the person harmed. This is particularly important to hold in mind given that our focus is usually the perpetrators. Ensuring that the intervention is victim-led entails ensuring the victim has a voice regarding engaging in the intervention, the timing of the intervention, the pace of the intervention, the location of the intervention and having support throughout the process.
6. Performance indicators	• All known victims offered the opportunity to take part in a restorative process • All patients considered regarding the suitability for restorative justice in relation to their index offence
7. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure

	• Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale For this specific area, the outcome measures used are: • Qualitative information regarding participant satisfaction • Recidivism rates
8. Examples / quotes / illustrations.	A victim stated 'I felt very safe and I felt it was very contained and controlled. And if there had been any chink at all, it's so easy to sort of fall through or that's how it felt, feeling really fragile'. Another victim said 'it takes you on a whole journey, but sign-posted all the way, so it's not like you're on this emotional journey and you don't know where it's going to go and it's like, you feel… absolutely safe the whole way and that, that was a big thing for me is the sort of feeling safe'. A patient who had assaulted staff members several times per week prior to the RJ intervention and said '…it just made me realise that people's got families to go back to' and 'I've been more thoughtful about things…' and 'I didn't assault anyone [over the next 2 weeks]… I didn't want to do it again'. (Cook, Drennan & Callanan, 2015)
9. Link to other CAGS	Restorative Justice approaches will be made available to patients of all services within the Trust and those receiving interventions under other CAG menus. All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	Recommendations: • Collect participant satisfaction data • Collect recidivism data • Networking with other forensic healthcare services using restorative interventions
11. References	Angel, C.M., Sherman, L.W., Strang, H., Ariel, B., Bennett, S., Inkpen, N., Keane, A., & Richmond, T.S. (2014). Short-term effects of restorative justice conferences on post-traumatic stress symptoms among robbery and burglary victims: a randomized controlled trial. Journal of Experimental Criminology. Bowers, L., Stewart, D., Papadopolous, C., Dack, C., Ross, J., Khanom,H., & Jeffery,D. (2011). Inpatient violence and aggression: A literature Review. A report from the conflict and containment reduction research programme. Kings College London, Institute of Psychiatry.

	Cook, A. Drennan, G. & Callanan, M. (2015). A qualitative exploration of the experience of restorative approaches in a forensic mental health setting. The Journal of Forensic Psychiatry and Psychology 26 pp. 510-531. Restorative Justice Council (2011). Best Practice Guidance for Restorative Practice Shapland, J., Atkinson, A., Colledge, E., Dignan, J., Howes, M., Johnstone, J., Pennant, R., Robinson, G., & Sorsby, A. (2004) Implementing restorative justice schemes (Crime Reduction Programme) A report on the first year. Home Office Online Report. Shapland, J., Atkinson, A., Atkinson, H., Chapman, B., Colledge, E., Dignan, J., Howes, M., Johnstone, J., Robinson, G., & Sorsby, A. (2006) Restorative justice in practice – findings from the second phase of the evaluation of three schemes. Home Office Online Report. Shapland, J., Atkinson, A., Atkinson, H., Chapman, B., Dignan, J., Howes, M., Johnstone, J., Robinson, G., & Sorsby, A. (2007) Restorative Justice: the views of victims. The third report from the evaluation of three schemes. Ministry of Justice Research Series 3/07. London: Ministry of Justice. Shapland, J., Atkinson, A., Atkinson, H., Dignan, J., Edwards, L., Hibbert, J., Howes, M., Johnstone, J., Robinson, G., & Sorsby, A. (2008) Restorative Justice: Does Restorative Justice affect reconviction. The fourth report from the evaluation of three schemes. Ministry of Justice Research Series 10/08. London: Ministry of Justice. Sherman, L., & Strang, H. (2007). Restorative justice: The evidence. Cambridge: The Smith Institute. Strang, Sherman, Mayo-Wilson, Woods, & Ariel (2013). Restorative Justice Conferencing (RJC) Using Face-to-Face Meetings of Perpetrators and Victims: Effects on Perpetrator Recidivism and Victim Satisfaction. A Systematic Review. Campbell Systematic Reviews

Risk Reduction and Safety Planning

d) Violence

Menu lead authors	Louise Minchin & Sarah Markham
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside patients to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in patients losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf

1. Scope of this template (what's included and what isn't)	Included:
	• Anger and Violence Management Intervention
	  ○ Violence Management Programme (community)
	  ○ Inpatient Violence and Anger Management Programme (IVAMP, inpatient)

	Not included: • Collaborative Working – whilst this can be mentioned it will be covered by 'Personal Involvement' • Substance Misuse/Addictions – covered by 'Interventions Aimed at Addressing Addiction' • Risk to self (as this is not forensic specific) • Use of medication (rapid tranquilisation) • PMVA / Seclusio
2. This is evidence based review of quality, safety and effectiveness.	A study carried out by Gilbert, Daffern, Talevski, and Ogloff (2013) concluded that offenders with high trait anger were prone to activate aggressive behavioural scripts which were activated for longer than non-offenders. Gilbert et al also suggested that intensity, frequency, and the duration of the anger problem were more prominent than normative beliefs about violence in determining future violence. It was therefore concluded that addressing anger dysfunction may prevent future acts of violence. The importance of offending behaviour treatment being linked to the client's readiness to change is well documented (e.g. Howells & Day, 2003; Ward et al, 2004) and has been applied within both the criminal justice and health settings (e.g. Kassinove & Tafrate, 2002). The Violence Management Therapy Programme and IVAMP incorporate Prochaska & DiClementes's (1992) transtheoretical model of change, which describes the change process as incorporating a number of stages including pre-contemplation, contemplation, action, maintenance and relapse. It is assumed that a client who opts into the programme has reached the contemplation and /or action stage of the model and that attendance to the programme will help facilitate their move through the action and maintenance stages. Self-Determination Theory (Ryan & Deci, 2000) suggests that a lack of self-efficacy can be a great barrier to behavioural change. It is important therefore that the programme helps participants to consider their potential for change and incorporate it as an integral part of the programme. Additionally, consistent with many of the psychological approaches to the complex interpersonal difficulties experienced by clients with personality Disorder diagnoses (e.g. the approaches of Aaron Beck, Marsha Linehan and Anthony Ryle), an core part of the Violence Management Therapy Programme is the shared formulation and understanding of the client's use of violence and the explicit agreement between clinician and client of working towards shared treatment goals. IVAMP also aims to address these areas through group exercises. There is large evidence base around the use of CBT based anger management interventions on reducing recidivism amongst adult male offenders. A systematic review and meta-analysis completed by Henwood, Chou and Browne (2015) investigated the effectiveness of CBT

	based anger management interventions on reducing recidivism amongst adult male offenders. Overall, anger management appeared to be effective in reducing the risk of recidivism, especially violent recidivism. Moderate-intensity anger management interventions were associated with larger effect than the high-intensity correctional programmes for violence reduction. Treatment effectiveness has also been demonstrated for community-based male offenders (Henwood, Browne and Chou, 2016). There is also evidence that anger management treatment has been effective in female populations (e.g Eamon et al, 2001; Bahrami & Hasanzadeh, 2016).
3. What will we offer	There are two programmes currently on offer across the forensic services. Inpatient services offer group therapy (IVAMP) to address issues around violence and aggression. The Violence Management Programme is the resource offered in the community on an individual basis. IVAMP: IVAMP is a group treatment programme offered to both male and female patients in the inpatient forensic services. The intervention consists of 25 sessions split over five modules. • Module one addresses the patients understanding of anger, the process of change and aims to develop a basic understanding on the CBT model of anger. • Module two focuses on the management of aggression. This module aims to define aggression, assertive communication, dealing with criticism and other interpersonal communication skills such as saying no and apologising and forgiving. • Module three focusing on stopping interpersonal violence. During this module patients are provided with educational information around violence and the law, restorative justice and the assessment of violence. Patients are encouraged to think about the impact of violence and decision pathways to violence. • Module four consists of two sessions focused on developing an individualised relapse prevention plan. • Module five consists of a follow up after a one month practice break. Violence Management Programme: The Violence Management Programme is an individual based therapy programme for adults who are motivated to stop being violent to others. The programme offers clients up to ten one to one sessions which aim to help the client gain a better understanding of their use of violence and to help identify more appropriate strategies for expressing and managing

	their anger and aggression. This ten session programme is designed to help clients develop their understanding of their violence and to reinforce their decision to change. It utilises motivational and cognitive behavioural strategies to help the client develop their own, personalised approaches to expressing and managing their volatile emotions and behaviour. The ten sessions are divided into three stages which aim to help the client develop a clearer understanding of their anger and aggression (the preparation stage), develop their existing coping strategies through reviewing aggression-reducing cognitive, behavioural and physiological techniques (the change stage) and identify personalised risk management strategies (the relapse prevention stage). The length of each stage of treatment will vary depending on the client's individual needs and readiness to change.
4. Who is intervention for	IVAMP: IVAMP is offered to male and female patients in inpatient forensic services with a history of violent offending. Patients need to demonstrate a basic ability to think using cognitive-behavioural framework and show suitability for group-based intervention. Patients need to show some motivation to attended and be at least in the contemplation stage (from the stages of change model), additionally if the patient has previously completed significant work, and is in the maintenance stage, the programme is unlikely to be of benefit. Violence Management Programme: The Violence Management Programme is offered to adult community clients (male and female) who are case managed / care coordinated by secondary mental health services and who have a history of violent offending. The Violence Management Programme is not specifically targeting at domestic violence, therefore Clients with a domestic violence history, in the absence of any other violent offences, may not be accepted. Clients must demonstrate: • An ability to discuss and reflect on violent behaviours • An ability to articulate desires to reduce their use of violence • An ability to attend scheduled appointments and remain in the therapy room
5. When	IVAMP: Patients are referred to the group via their multi-disciplinary teams. They are then assessed using a standardised framework by two of the group

	facilitators. From this assessment a report regarding the patient's suitability is shared with them and their team outlining their suitability for the group. If accepted patients are sent an invitation letter containing the starting date and time for the group. Violence Management Programme: Upon acceptance of a referral, clients are offered an appointment by two staff from the Forensic Healthcare Service. This initial assessment focuses on the client's treatment goals and whether the programme can realistically meet these. The assessors aim to engage the client in an active discussion about their understanding of their use of violence and the reasons why they have chosen to attend an appointment at this time. Some understanding of the client's background and the link between this and their violence is incorporated into this first contact. Clients will then be sent a formulation letter. This letter to the client will provide a summary of the issues covered in the assessment, including a description of the 'problem', the motivation of the client to change and recommendations for further work and whether the programme would meet their current needs. If the programme is appropriate they will be sent an appointment date.
6. Performance indicators	• Referrals to the service for violence management programme will be tracked through the community forensic services referral audit. The availability of IVAMP can be monitored through therapy planning meetings. • Purpose of sessions can be monitored through the use of diarise on care notes. • Regular clinical supervision will monitor the quality of intervention provided. • Evidence of completed interventions will be identified by both the presence of a Formulation and Discharge letter on care notes. • Attendance and completion rates.
7. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale Outcome measures such as regularly monitoring the patients readiness, stage of change and attendance to sessions should be used.

	Pre and post assessment as measured by the State-Trait Anger Expression Inventory (STAXI) can be used to assess experience, expression and control of anger.
8. Examples / quotes / illustrations.	Feedback from the 2017 IVAMP group: What I liked most about the group so far? "Videos, discussions" "It was easy to follow" "I learned a few things" "It was interesting learning about what is behind anger and violence and how to avoid it" "It is a very helpful group" What have I learnt from the group so far? "How to think through my response to difficult situations so I can avoid anger and violence" "Controlling anger" "Don't be violent. Think about situations before you act." Quotes from previous group: "I liked watching videos, being involved in role play and some of the work where we split into groups" "I learnt that violence has a huge impact on not just those directly involved, it also has a ripple effect which can have an impact on lots of people" Below is an example of the assessment outcomes of a patient who completed the Violence Management Programme in 2008: 'The client who completed the VMP increased his ability to control his anger by calming himself down and reduce his anger as soon as possible' (outcome obtained from STAXI assessment)
9. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	Audits have been completed around attendance and attrition rates to the community violence management programme and there is some data

	collected regarding pre and post measures. Further research may be needed in to the efficacy of both the programmes using a larger sample and considering a follow up period to assess its medium-long term effects.
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	Disorder. The Model and the Method. Chichester: Wiley. Ward, T. Day, A. Howells, K. & Birgden, A (2004). The Multifactor Offender Readiness Model, Aggression and Violent Behaviour, 9, 6, 645 – 673.

Risk Reduction and Safety Planning

e) Sexual Offending

Menu lead authors	Louise Minchin & Sarah Markham
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside patients to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in patients losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf
1. Scope of this template (what's included and what isn't)	Included: • Treatment to address sexual offending • Follow on treatment to address sexual deviancy Not included: • Substance Misuse/Addictions – covered by 'Interventions Aimed at

	Addressing Addiction' • Risk to self (as this is not forensic specific) • Use of medication (rapid tranquilisation) • PMVA / Seclusion
2. This is evidence based review of quality, safety and effectiveness.	In order to assess risk of violent offending best practice risk assessment recommend the use of a structured professional judgement (SPJ) tool. For the risk of assessment of sexualised violence SPJ tools include the Risk for Sexual Violence Protocol instrument (RSVP; Hart et al., 2003); It is the most widely used sex offender risk assessment tool, (Sutherland et al., 2012). The VRS-SO (Olver, 2010) is another SPJ tool that assesses offending risk in a series of area. These tools allow clinicians to assess risk, and therefore need of treatment, as well as dynamic risk factors that can be targeted as part of treatment. The functional link between sexual offending and even very severe mental health symptoms is unclear or tenuous and as such it is important to address the dynamic risk factors associated with general sexual offending in any treatment for mentally disordered offenders (Gannon et al., 2011). The literature (Ireland et al., 2012) supports a formulation based approach that focuses on treating areas of dynamic risk such as: - Motivation to change - Emotional awareness and normalisation - Collaborative Development of formulation of sexual offending - Interpersonal skills - Relapse prevention Sexual deviancy work should be offered individually if necessary. This is because it is suggested that as few as 50% (Seto, 2008) of those with sexual offending histories have sexual deviancy towards their chosen victims. Therefore sexual deviancy should be discussed as part of the formulation within the main programme if relevant but it would be considered disproportional to include this as a core feature of the main treatment. Treatment Programmes / Approaches: A meta-analysis of sex offender treatment programme (Losel et al., 2005) showed a decrease in sexual offending (and offending in general) for those attending CBT based programme. Ward (2002) has developed the Good Lives Model, a strengths based approach to work with sexually violent offenders. The basic premise is that offenders, like all humans, value certain states of mind, personal characteristics, and experiences, which are defined in the GLM as eleven primary goods. Treatment focuses on helping offenders to use pro-social means to achieve these primary goods. Ward (2002) argued in his Good Lives Model that treatment delivered with a whole client view rather than just a risk focused intervention is more likely

	to support a reduction in offending. The prison based SOTP was not specifically for mental health patients but as a long running, highly attended, manualised sex offender treatment programme research into its efficacy is likely to have some relevance to treatment of sexual offenders more widely. SOTP was recently reviewed to suggest some increase in sexual offending (or at least detection of offending) following attending the programme when compared with a control group (Mews, 2017). However, it is notable that some of the control group, with lower reoffending rates, had received individual elements of treatment such as emotional regulation or social skills training. These findings suggest that at least for SOTP, a highly manualised approach was not as effective as had been hoped. Hanson et al. (2009) found differing treatment effects depending on adherence to the risk- need- responsivity principle, that is the treatment 'dose' is appropriate to risk level, the treatment needs of the individuals are addressed and that treatment is delivered in an accessible way for the individual; these results suggest a need for clinicians to be able to tailor the treatment to suit individual needs. Literature suggests that responsiveness and programme adaptation is more important with certain sub-groups such as those with ASD (Higgs, 2015) and women (Gannon, 2012). It maybe that individual treatment, will be most appropriate in these cases.
3. What will we offer and how	As part of a recovery focused care package in the inpatient services we will offer individual or a group based six month talking therapy treatment programme, once weekly. If the intervention is delivered in group, individual sessions would run alongside to support learning and individualise material. The programme will include components that with address both non-sexual and sexual violence In the community provide a formulation based individualised intervention which is tailored to the patient's area of need and heightened risk including sexual deviancy and development skills to maintain pro-social behaviour (utilising the principles of the good lives model).
4. Who is intervention for	Patients with a history of sexually harmful behaviour.
5. When	First group proposed early 2018 Individual interventions can be accessed as required
6. Performance indicators	Audit data collecting: - How many patients with harmfully sexual behaviour are admitted

	into the service? - How often the programme is running and in what form? - How many patients start and complete the intervention?
7. Outcome measures	There will be no single ideal outcome measure in any given clinical situation. Information may be gathered from various sources (e.g. service user, family, clinician, others) and may measure varying aspects of clinical care (patient experience, quality of life, daily functioning, levels of symptoms). The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale For this specific intervention, outcome measures should include: -Pre and post psychometric data and SPJ risk assessment - Pre and post behavioural data and SPJ risk assessment
8. Examples / quotes / illustrations.	The proposed group programme is new to Forensic Healthcare and work has been previously provided on an individualised basis, based on recognised models such as the Good Lives Model (Ward, 2002).
9. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	No current formalised plan but assessments should include: -Pre and post psychometric data and SPJ - Pre and post behavioural data and SPJ
11. References	Gannon, King, Miles, Lockerbie & Willis (2011) Good Lives sexual offender treatment for mentally disordered offenders. The British Journal of Forensic Practice Gannon, T. A., Hoare, J., Rose, M. R., & Parrett, N. (2012). A re-examination of female child molesters' implicit theories: Evidence of female specificity? Psychology, Crime & Law, 18, 209-224. Hart, S. D., Kropp, P. R., Laws, D. R., Klaver, J., Logan, C., & Watt, K. A. (2003). The Risk for Sexual Violence Protocol (RSVP). Burnaby, British Columbia, Canada: The Mental Health, Law, and Policy Institute of Simon Fraser University

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Risk Reduction and Safety Planning

f) Fire Setting

Menu lead authors	Louise Minchin & Sarah Markham
Summary paragraph explaining why this is included in the MOI	Our Forensic Healthcare service works alongside patients to assist in a recovery pathway that promotes desistance from offending behaviours that cause harm to others and result in patients losing their liberty. The UK forensic service standards stipulate that our services should provide risk assessments using structured professional judgement principles and specialist interventions related to the management of criminogenic needs. We provide these through individualised packages of care which can include specific interventions focused on offending behaviour (e.g. sexual offending, violence and fire setting). Relational security and collaborative working underpins our secure recovery ethos and we were one of the early mental health providers of restorative justice. Kenney-Herbert, J., Taylor, M., Puri, R. & Phull, J. (2013). Standards for Community Forensic Mental Health Services. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/PDF/QNFMHS Standards for Community Forensic Mental Health Services - Final.pdf Holder, S., & Souza, R. (2016). Standards for Forensic Mental Health Services: Low and Medium Secure Care. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from https://www.rcpsych.ac.uk/pdf/QNFMHS_Standards_2016%20(002).pdf Royal College of Psychiatrists (2015). See Think Act: Your guide to relational security. *Forensic Quality Network for Forensic Mental Health Services.* Retrieved from http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO). PLEASE NOTE: The service has adopted the new name of Firesetting Intervention programme (FIG). This was decided by the patients in the first group that was run in the service who felt the title was too long and they found the terminology of 'Mentally Disordered Offenders' slightly

	stigmatising. FIP-MO and FIG are used interchangeably in this document.
1. Scope of this template (what's included and what isn't)	Included: • History and evidence base for FIG. • What is involved for patient attending FIG? • Who is FIG aimed at? • Why and where FIG is offered. • When FIG is run. • Performance indicators linked to FIG. • Outcome measures. • Quotes from previous patients. • Link to other CAGS. • Plans to develop evidence base. • References. Not included: • Collaborative Working – whilst this can be mentioned it will be covered by 'Personal Involvement' • Substance Misuse/Addictions – covered by 'Interventions Aimed at Addressing Addiction' • Risk to self (as this is not forensic specific) • Use of medication (rapid tranquilisation) • PMVA / Seclusion
2. This is evidence based review of quality, safety and effectiveness.	Prior to FIP-MO, a UK national survey (Palmer, Caulfield, & Hollin, 2007) identified no standardised interventions available for adult firesetters across prisons, probation, or mental health services. This lack of specific treatment was also identified as an issue in Australia and the US (Doley, Dickens, & Gannon, 2015; Gannon & Pina, 2010). Due to this, there has been little guiding information for consulting clinicians on "what works" with deliberate firesetters (Tyler, Gannon, Lockerbie, & Ó Ciardha, 2017). The development of FIP-MO was to address the dearth in forensic mental health literature regarding this topic and client group. The programme was developed from an extensive review of the existing empirical and theoretical literature on firesetting (Gannon & Pina, 2010; Tyler & Gannon, 2012), incorporating elements of leading theories of rehabilitation and firesetting (i.e., the Risk Need Responsivity Model, Andrews & Bonta, 2010; the Good Lives Model, Ward & Stewart, 2003; and the Multi-Trajectory Theory of Adult Firesetting, Gannon, Ó Ciardha, Doley, & Alleyne, 2012; Tyler et al, 2017). The FIP-MO adopted a cognitive behavioural therapy (CBT) approach to treatment and contained strong psychotherapeutic elements to promote a positive therapeutic relationship, emotional and social expression, and self-

	reflection (Gannon & Lockerbie, 2011; 2012; 2014). The FIP-MO focused on five key areas: fire-related factors (i.e., problematic fire interest and associations with fire), offence supportive attitudes, social competency, self-management/coping skills, and traditional relapse management (i.e., understanding the factors associated with firesetting and developing a personalised coping plan). Patients engage in reflective work to help them understand the factors associated with their firesetting; prepare accounts of their treatment needs, childhood experiences, and the factors leading up to their firesetting for group discussion. The FIP-MO emphasises skills development throughout the programme for each of the five areas of treatment need (Tyler et al, 2017). To evaluate the effectiveness of FIP-MO, a multi-site study (which Sussex Partnership NHS Foundation trust was part of) occurred between 2012 and 2016. Sixty-three male and female patients with a history of deliberate firesetting commenced FIP-MO treatment. Patients who met the referral criteria for treatment but who resided at hospitals where FIP-MO treatment was not available were recruited as a Treatment as Usual comparison group. The treatment group completed a battery of psychometric assessments pre and post treatment, with the comparison group completing these at similar time points. Results showed that participants who completed the FIP-MO made significant improvements post-treatment, relative to the comparison group on fire-related measures (e.g., problematic interest and associations with fire) and anger expression. Further, effect size calculations showed that the treatment group made larger pre-post treatment shifts on the majority of outcome measures compared to the comparison group. These findings suggest that FIP-MO treatment is effective for reducing some of the key factors associated with deliberate firesetting (Tyler et al, 2017).
3. What will we offer and how	Group intervention: • 28 sessions in total, each last 2.5 hours with a 15 minute break delivered by a trainee or qualified psychologist, with co-facilitators and between session workers being from the MDT. • One follow up session approximately 6 weeks following programme completion. • Completion of clinical assessment interview, completion of pre and post group psychometric questionnaires and evaluation form which will enable a review of the effectiveness of the intervention to take place. Post group report will provide overall feedback to the patient and the team. What does it involve? Patients attend the group sessions as well as individual 1-1 between session work (BSW) once a week. Individual intervention: The group programme can be offered on an individual basis, if there is a specific need for it. Individual sessions are one hour in length and there is

	no between session work meeting. Between session tasks and review of these are incorporated into the individual sessions.
4. Who is intervention for	FIP-MO is aimed at: • Forensic mental health patients who have a history of firesetting (repeat or single incidents) or who have been identified as posing a risk of intentional firesetting that may be harmful to themselves or others primarily in inpatient services. • Patients do not need to fully admit their firesetting to be eligible for the group and neither do they have to have set a fire. • The programme has been delivered on an individual basis in the inpatient medium secure service and the community. Patients unlikely to be unsuitable: • Fire in service of clear antisocial goal (e.g. to destroy evidence) • Isolated childhood firesetting • Historical minor firesetting with no clear consensus • Have major untreated drug or alcohol problems. • Currently going through legal proceedings as this may affect their ability to concentrate on the material. • Anyone suffering major mental health difficulties that makes group membership problematic.
5. When	• FIP-MO has been delivered when there has been an identified treatment need within the service. • Within the medium secure inpatient service, approximately every 6 months a firesetting treatment audits occurs to ascertain treatment need. • The service aims to run this group a minimum of once a year within the low and medium secure services. This frequency can change depending on treatment need within the service which fluctuates depending on admission and discharge of patients. • As required on an individual basis in the community
6. Performance indicators	• Attendance and feedback at Recovery Reviews (were appropriate). • Attendance and feedback at CPA's. • Post group report. • Post group evaluation report.
7. Outcome measures	There will be no single ideal outcome measure in any given clinical situation. Information may be gathered from various sources (e.g. service user, family, clinician, others) and may measure varying aspects of clinical care (patient experience, quality of life, daily functioning, levels of symptoms). The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure

	• Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale A range of qualitative and quantitative approaches have been utilised to assesses if FIP-MO has been effective. For example: • Clinical assessment interview and observations within the group sessions. • Pre and post group psychometrics. • Completion of post group evaluation forms. • No further firesetting behaviour observed during inpatient stay.
8. Examples / quotes / illustrations.	"Seeing videos of the fires that the firemen brought in and….seeing just how easily some fires took hold was powerful". "It made me realise what fire is capable of…I have a better understanding of fire now". FIP-MO feedback 2012.
9. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
10. Plan to develop evidence base	The first two FIP-MO groups run in the service (male group 2012, female group 2014) were part of a multi-site evaluation programme assessing the effectiveness of the group programme. Publication of the results from this study is due imminently (Tyler et al, 2017).
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Social and Occupational Interventions

Menu lead authors	Ellen Clay & Julie Payne
Summary paragraph explaining why this is included in the MOI	Evidence highlights the importance of engaging in meaningful occupations, including leisure, self-care, work and learning to support and maintain recovery. It is therefore important to provide a personalised plan of therapeutic and skill-developing activity which will be arranged throughout the week. Patients need to be supported and encouraged to maintain and develop social engagement through links with local community organisations, voluntary and statutory services recognising cultural and religious needs. Guidelines state that this should begin at the point of admission and continue into support in the community. The service recognises the importance of ensuring that patients maintain contact with friends and family including providing appropriate space for meaningful visits. In keeping with NICE guidelines therapeutic family work will be offered where appropriate. Evidence points to the importance of bearing in mind patient's care pathway planning including discharge and after-care arrangements. Identification of the relevant services early on and involving them in the patients care and treatment, ensures that appropriate services are in place the point of discharge. This has been shown to assist in a successful return to the community, while at the same time ensuring public protection.
1. Scope of this template (what's included and what isn't)	The aim of this document is to describe and evidence the range of social and occupational interventions available to forensic patients both in inpatient settings, in prisons, and under the care of community forensic teams. Social Work duties under the Mental Health Act and in relation to risk management (e.g. liaison with MAPPA) will be covered in another section.
2. This is evidence based review of quality, safety and effectiveness.	Evidence highlights the importance of engaging in meaningful social and occupational activities, including leisure, self-care, work, learning, meaningful relationships to support and maintain recovery (Sweet et al, 2017; Pinfold et al, 2015). There is a strong link between the recovery process and social inclusion.

	A key role for services is to support people to regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else. There is a growing body of evidence that demonstrates that taking part in social, educational, training, volunteering and employment opportunities can support the process of individual recovery." (Mental Health Foundation, 2018) The role of occupational therapy in forensic settings has been defined as helping people to engage in occupations which give their lives meaning and value, and mitigate alienation and anti-social behaviour (Couldrick, 2003, p13). Duncan (2008, p516) additionally suggested that occupational therapy should assist people to develop their interpersonal capacity, pro-social values, their personal identity and skills for life participation." (Royal College of Occupational Therapists, 2017, p.15) Social and occupational interventions not only contribute to better mental health, but also reduction in recidivism (e.g. working towards vocational goals). Work, leisure activities, life goals, social networks and intimate relationships, and living circumstances are all domains within the SAPROF risk assessment tool which focuses on protective factors against future violent behaviour (de Vries Robbe & de Vogel, 2013). Current guidelines and Statues support supports providing these interventions in prisons (RCOT, 2017) and relevant legislation (The Care Act 2014). The Care Act 2014 clarifies the responsibility of local authorities to ensure that social care for adults in prisons and approved premises is provided on the basis of equivalence to people living in the community. Prisoners under the care of the Trust will be referred for an assessment of need. The social work service is delivered within secure inpatient settings and within the Community Forensic Outreach Service. Interventions are driven by the statutory framework within which social workers are required to work (e.g. Mental Health Act 1983/2007, Care Act 2014, Domestic Violence, Crime and Victims Act 2012). The statutory supervision of conditionally discharged patients who are subject to supervision under section 41 of the MHA (1983/2007) will form much of the work of community forensic outreach services. Forensic social workers lead on safeguarding children and adults and they maintain links with the home areas to which most patients will eventually return. Early identification of the responsible authority and care pathway will is central to reducing length of stay (RCPsych 2013). Social workers are involved in writing mental health tribunal and other reports, and in care pathway planning, in order to minimise delays and ensure suitable community placements in line with Care Act (2014) requirements. Forensic social workers are involved in the community management of patients, particularly those who are subject to conditional discharge or

	community treatment orders (Bogg & Barkham 2016).
3. What will we offer and how	Social and occupational interventions offered are in keeping with the recovery model which has been adopted within the Forensic Healthcare Service. It should follow these principles: • Interventions need to address 'offender recovery'. "This means addressing guilt, shame, confusion, turmoil – sometimes denial – with sensitivity and respect." (Drennan et al, 2014). • General recovery principles also apply to forensic patients; social and occupational interventions are in keeping with these principles of hope, choice, being strengths based, and having meaning and purpose. • Social and occupational interventions may include looking at occupations associated with offending behaviour and promoting alternative, pro-social occupations, activities and relationships which also make use of the person's strengths and interests and support their ongoing recovery. <u>Interventions Offered</u> • Occupational interventions include self-care, leisure, work and learning, to support and maintain recovery. These may include cooking groups, art groups, walking groups, education to improve English and maths skills and support to find voluntary work. • Comprehensive assessment (e.g. the Model of Human Occupation Screening Tool (MOHOST), Parkinson, Forsyth & Kielhofner, 2006) within the first three months of contact with the service will inform a personalised plan of therapeutic and skill-developing activity. These will be arranged throughout the week including in the evenings and at weekends. • Identification of care pathway as early as possible ensuring engagement of the relevant community services. Collaborative working with relevant agencies to determine eligible needs, focusing on the individual, their well-being and the outcomes they want to achieve using a strengths based approach. • Social and occupational care planning will be tailored to the needs of the individual within a family and social context and access resources as required (financial and social) bearing in mind the overlapping legislation and other professionals involved in the patients network. • Currently three peer-support workers are employed on a part-time basis at the Hellingly medium secure site, with the intention to expand the peer support worker role further into the low secure service and community services. • Social work interventions will include discharge planning and implementing discharge arrangements including effective liaison

	with external agencies such as Children's Services, Victim Liaison Unit and Ministry of Justice, National Offender Management System, and Multi Agency Public Protection Arrangements, and preparing families and communities for the resettlement of individuals in the community (National Group of Social Work Managers in Secure Services, 2010). • Facilitating transition and sustainable settlement in the community of patients from secure care; particularly those with high risk profile. • Community forensic services are in the process of developing links with a local provider of Individual Placement Support (IPS) to support people gaining and retaining competitive employment. The IPS model has been shown through research to be successful and it is recommended that mental health patients have access to employment specialist who use this model (Mental Health Taskforce, 2016; Centre for Mental Health, 2010). • Family Intervention is available • The Trust's Recovery College is available to all patients who are able to access the community locations where the courses are delivered. There are a range of courses, with the timetable changing on a term by term basis (see www.SussexRecoveryCollege.org.uk). A recently published study has shown that regular use of the Recovery College can reduce use of inpatient services (Bourne, Meddings & Whittington, 2017). The Forensic Recovery College is also under development which will enable access to specific Recovery College courses for inpatients.
4. Who is intervention for	This menu covers all patients in contact with FHS.
5. When	Throughout a patient's entire period of contact with FHS.
6. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale
7. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).

8. Plan to develop evidence base	D. Alred is currently conducting research as part of a PhD, which is looking at forensic patients' views on how they get out and stay out of secure care, including what is useful and what some of the barriers can be.
9.	For detailed information on the available evidence for Occupational Therapy interventions in secure settings please refer to the Royal College of Occupational Therapists Practice Guidelines for Occupation Focused Practice in Secure Hospitals – Second Edition (2017a). REFERENCES: Baron, R. (2011). Forensic peer specialists: An emerging workforce. New Brunswick, New Jersey: Centre for Behavioural Health Services & Criminal Justice Research. Bourne, P., Meddings, S. and Whittington, A. (2017) 'An evaluation of service user outcomes in a Recovery College', The Journal of Mental Health, [online ahead of print 23 December]. Available at: https://doi.org/10.1080/09638237.2017.1417557 [Accessed 25 January 2018] Centre for Suicide Prevention (2010). Independent investigations after homicides by people receiving mental health care report. Manchester: University of Manchester. Centre for Mental Health (2010). Briefing 42: Beyond the gate: Securing employment for offenders with mental health problems. London: Centre for Mental Health. de Vries Robbé, M., & de Vogel, V. (2013). Protective factors for violence risk: Bringing balance to risk assessment and management. In C. Logan & L. Johnstone (Eds.), Managing clinical risk: A guide to effective practice (pp. 293–310). Oxford, UK: Routledge. Drennan, G. and Alred, D. (2012) Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings (Issues in Forensic Psychology). London: Routledge, Taylor and Francis Group. Drennan, G., Wooldridge, J., Aiyegbusi, A., Alred, D., Ayres, J., Barker, R., Carr, S., Eunson, H., Lomas, H., Moore, E., Stanton, D. & Shepherd, G. (2014) Briefing 10: Making Recovery a Reality in Forensic Settings. London: Centre for Mental Health & Mental Health Network NHS Confederation. Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of forensic mental health services. London: Joint

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Addictive Behaviour and Substance Misuse

Menu lead authors	Marisa Marrocco and Richard Love
Summary paragraph explaining why this is included in the MOI	Within the forensic mental health population a large number of individuals have experienced issues with addictions, especially alcohol and substance misuse problems. There are numerous reasons for this, such as negative self-worth, shame, guilt, relationship problems, mental health issues etc. but addictive and self-destructive behaviours, which can have a detrimental effect on self and others, can ultimately increase risk and offending behaviour. In 2011, NICE guidelines stated that substance misuse issues are also associated with poorer clinical outcomes, a worsening of psychiatric symptoms, poor medication adherence, homelessness and increased contact with the criminal justice system. In the Forensic Healthcare Service we aim to offer a wide range of therapies and interventions to assist individuals to explore and address addictive patterns of behaviours with the aim of not only reducing risk and re-offending, but also to improve a person's self-worth, and assist them to find meaning and purpose in their life. NICE (2011). Clinical Guideline 120
1. Scope of this template (what's included and what isn't)	• To provide patients, their families, clinicians and stakeholders with a clear set of expectations regarding the current therapies and interventions available within the Forensic Healthcare Service for individuals with addictive patterns of behaviour. • To provide information and sign-posting regarding external addiction services. • To explore and take into account up-to-date evidence-based research and practice, and to implement recommendations from the literature regarding addictions, in particular substance misuse. • It will not be a 'one-fits-all' model and so interventions may differ, and hence tailored to each individual's needs.
2. This is evidence based review of quality, safety and	Within the forensic mental health population a large number of individuals have experienced issues with addictions, including alcohol and substance misuse problems. There are numerous reasons for this, such as

effectiveness.	negative self-worth, shame, guilt, relationship problems, mental health issues etc. but addictive and self-destructive behaviours, which can have a detrimental effect on self and others, can ultimately increase risk and offending behaviour. NICE (2011) guidelines stated that substance misuse issues are also associated with poorer clinical outcomes, a worsening of psychiatric symptoms, poor medication adherence, homelessness and increased contact with the criminal justice system. The literature also identified that forensic patients who misuse substances have also been found to be at higher risk of violent recidivism and reconviction following discharge. This supports the need to ensure therapies and interventions aimed at addressing addictions within their treatment, rehabilitation and risk management is considered and offered (CCQI 2013). According to the National Confidential Inquiry into Suicide and Homicide (2017, p4) 'In all four UK countries, most patients convicted of homicide also have a history of alcohol or drug misuse, between 88% in England and 100% in N Ireland. In other words it is unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse'. The findings also suggested that much of the risk to others from mental health patients was related to co-existing drug or alcohol misuse rather than mental illness itself. As a result of these statistics, the report recommended that a greater focus on alcohol and drug misuse was required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together. Public Health England (2017) stated that death by suicide was also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental health problems. Substance misuse was also associated with physical health problems and early death. The report made various recommendations including that mental health practitioners were competent to respond to presenting alcohol and drug use conditions, and that a wide variety of services should be made available to individuals (and their carers) including assessment, treatment and recovery focused care, including harm reduction. In relation to the literature regarding mental health and addictions it was recognised that any care package should take into account each patient's holistic needs, as these can be interwoven with addiction issues, rather than interventions focusing purely on the addiction (NICE 2016, No 58; NICE 2011, No 120). In regards to substance misuse, there was no overwhelming evidence to

	indicate a particular model of care (NICE 2016, No 58). Various psychosocial approaches were however recognised within the literature including: • Motivational interviewing which aims to address motivation to affect change in addictive behaviour • CBT techniques focusing on adaptive behaviours and building coping strategies • Social skills training • Supportive counselling • Psychodynamic therapy • Behavioural couples therapy • Relapse prevention and harm reduction interventions • Crisis and contingency management focusing on changing specific behaviours • Brief interventions, health education and self-help material should also be available for those in limited contact with addiction services (NICE 2007, No 51; CCQI 2013). The evidence also identified that time to engage the individual should be paramount, using a flexible and motivational approach. Issues of stigma and discrimination should also be taken into account, and verbal and written information adapted according to each individual's level of understanding. Treatment and care should take into account the patient's needs and preferences, which is person-centred and individualised. (NICE 2011, No 120). The literature also encouraged partnership working between agencies, and for a variety of different services, internally and externally, to be discussed with each individual, to ensure a bespoke range of therapies were offered to maximise engagement (NICE 2016, No 58).
3. What will we offer and how	<u>Assessment</u> Collaborative assessment and care planning, with the patient, and their carers (where appropriate) should take into account: • The patient's past experiences and coping strategies • How the patient can be supported to meet their goals, exploring any barriers • How services can help patients engage in specific pieces of work, which are reviewed on a regular basis. (NICE 2016, No 58; NICE 2011, No 120). The assessment should take into account relevant health and social factors.

- Involve the patient, and their carer where appropriate, in the assessment process to devise a package of care that takes into account their needs (see Personal Involvement Section)

- The assessment will also aim to identify where the person is on the cycle of change in order to target appropriate interventions in relation to their substance misuse or addiction.

- A comprehensive risk assessment and risk management plan, will be written with the patient (and carers where appropriate), which includes how to keep safe, monitoring relapse signs, and crisis and contingency plans

The holistic assessment will take place prior to and following admission and will be an on-going process whilst under the care of the Forensic Healthcare Service.

<u>Interventions</u>

- Following a comprehensive assessment, appropriate packages of care will be discussed and interventions offered that take into account the patient's needs and level of motivation to engage.
- Approaches to treating substance misuse commonly identify 4 stages of treatment (CCQI 2013), which should be considered when planning and offering care:
    - Engagement involves the development and maintenance of a therapeutic relationship between staff and patient, through a non-confrontational, empathic and respectful interactional style. It is enhanced by addressing the patient's immediate needs rather than focusing solely on the addiction.

    - Motivation building draws on the cycle of change model for addictions and the principals of motivational interviewing to encourage the patient to move between motivational stages.

    - Active treatment is the phase of harm minimisation and reducing drug use.

    - Relapse prevention is the fourth stage and is essential in a chronic relapsing condition.

- A range of therapies and interventions will be offered to assist patients to address their substance misuse or addiction, with the aim of reducing risk and re-offending, will be discussed and identified. These therapies can be delivered on a 1-1 basis and/or within a group depending on the patient's needs.
- These interventions will include a range of therapies and interventions, including:

	○ Motivational interviewing which aims to address motivation to affect change in addictive behaviour ○ CBT techniques focusing on adaptive behaviours and building coping strategies ○ Relapse prevention and harm reduction interventions ○ Crisis and contingency management focusing on changing specific behaviours ○ Brief interventions, health education and self-help material will also be made available ○ Other therapies/interventions will be offered as appropriate i.e. mindfulness, stress management, recovery college (where able) • Patients will also be offered a range of other interventions, not just related to addictions, in order to assist them in a variety of areas, taking into account their holistic assessment needs, such as recreational, accommodation, finances, activities of living etc. A package of care will be devised with the patient, taking into account all their needs. <u>Liaison</u> • Providing information and signposting to other local external addiction services • Liaison with external addiction services in the community, including joint working arrangements and sharing of information where appropriate/agreed. <u>Training</u> • On-going supervision and training for staff in regards to addictions, specifically substance misuse, which includes motivational interviewing, shared understanding of the issues facing those with addictions, and up-to-date treatment approaches.
4. Who is intervention for	This menu covers all patients in contact with FHS, wherever they may be (e.g. prison, secure hospital, community)
5. When	Throughout a patient's entire period of contact with FHS.
6. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment

	Scale Outcome measures for this specific intervention include: • Honos Secure
7. Examples / quotes / illustrations.	Within the Dual Diagnosis Strategy 2011-2016 (Sussex Partnership NHS Foundation Trust), feedback from patients and cares identified two main areas of need: • Developing awareness, extending knowledge and increasing the skills which drug workers need to respond effectively to patients with a dual diagnosis • The targeting of vulnerable patient groups and the provision of appropriate treatment, services and support must be achieved through inter-agency collaboration across substance misuse, and mental health services both statutory and voluntary and the criminal justice system.
8. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
9. References	Healthcare Quality Improvement Partnership (2017) National Confidential Inquiry into Suicide and Homicide. Executive summary Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers. Public Health England, 2017. https://www.yhne.org.uk/research-and-reports/public-health-england-better-care-for-people-with-co-occurring-mental-health-and-alcoholdrug-use-conditions/ NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services. Clinical Guideline 58. NICE, London NICE (2011) Psychosis with coexisting substance misuse. Clinical Guideline 120. NICE, London NICE (2007) Drug misuse in over 16s: Psychosocial Interventions. Clinical Guideline 51. NICE, London Royal College of Psychiatrists Centre for Quality Improvement (2013) Standards for Interventions to Address Problematic Drug and Alcohol Use

	in Medium Security. CCQI 146, London. University of Manchester. (2017). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. UoM, Manchester.

Improving Physical Health and Wellbeing

Menu lead authors	Jake Harvey & Karen Friel
Summary paragraph explaining why this is included in the MOI	Physical health and mental health are inextricably linked and it is detrimental to a person's overall wellbeing to regard these as two separate entities. The Five Year Forward View for Mental Health (2016) highlights that people with mental health problems have poorer physical health than the general population, often they are unable to access the physical healthcare they need and experience unnecessary health inequalities. People with severe mental illness are particularly at risk and die on average 15-20 years earlier than the general population. We aim to promote your physical (as well as mental) health recovery and wellbeing by supporting contact with your GP and/or other community or hospital based services, or by providing this care ourselves where appropriate. We will provide the same level of access to services and as for people who are not in contact with specialist mental health and/or forensic services.

10. Scope of this template (what's included and what isn't)	• To provide patients, their families, clinicians and stakeholders with a clear set of expectations regarding the current therapies and interventions available within the Forensic Healthcare Service to promote and support physical health and wellbeing.
	
	• Specifically this menu will address:
	
	  • the increased cardio-metabolic risk in the population with serious mental illness (SMI);
	  • the management of long-term and chronic physical health disorders (including liaison and collaborative approaches with primary care providers);
	  • therapeutic drug monitoring (TDM);
	  • the principle of 'equivalence of care', meaning that patients in contact with FHS will receive an equivalent standard of care to the general population, wherever they may be (eg. prison, secure hospital or community).
	
	• To provide information and sign-posting regarding external physical

	health and wellbeing services. NB. the FHS cannot offer comprehensive primary medical or specialist physical health care services. • To explore and take into account up-to-date evidence-based research and practice, and to implement recommendations from the literature regarding physical healthcare provision in secondary mental health services. • It will not be a 'one-fits-all' model and so interventions may differ, and hence tailored to each individual's needs.
11. This is evidence based review of quality, safety and effectiveness.	<u>The Five Year Forward View for Mental Health</u> "Making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness." (N. H. S. England, 2016). "Physical and mental health are closely linked – people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking." (N. H. S. England, 2016). "There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months." (N. H. S. England, 2016). "By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage

	monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018." (N. H. S. England, 2016). <u>Health Screening Programmes</u> The UK government currently offers screening programmes for the adult population covering the following conditions: • Diabetic eye screening (for anyone over age 10 with diabetes) • Cervical screening (for women aged 25-64) • Breast screening (for women aged 50-70) • Bowel cancer screening (for men and women aged 60-74) • Abdominal Aortic Aneurysm (AAA) screening (for men in their 65th year All users of forensic mental health services (including those in secure services) should have access to the appropriate screening programmes. (UK National Screening Committee, 2015) <u>Therapeutic Drug Monitoring</u> The majority of Patients will be prescribed psychotropic medications at some stage in their contact with the Forensic Healthcare Service (FHS). In addition to optimising treatment efficacy, therapeutic drug monitoring (TDM) is essential for monitoring, managing and minimising adverse effects and associated morbidity (Taylor, Paton & Kapur, 2015). <u>Improving the physical health of people with mental health problems: Actions for mental health nurses</u> "Mental health nurses have unparalleled opportunities to help people improve their physical health alongside their mental health, both in inpatient settings and in the community. Building on their skills and knowledge this resource will assist mental health nurses to identify the key risk factors that are known to adversely affect the physical health of people with mental health problems. By following the activities to achieve change, and learning from the good practice examples in this resource, they can build up their confidence and expertise and make improvements to people's health outcomes." This resource focusses on guidance and recommendations for mental health nurses relating to the following 8 priority areas: • Support to quit smoking • Tackling obesity • Improving physical activity levels • Reducing alcohol and substance use • Sexual and reproductive health • Medicine optimisation

	• Dental and oral health • Reducing falls (Department of Health, 2016) <u>The Lester Tool</u> Specific recommendations and guidance for assessment, monitoring and intervention regarding cardiometabolic risk factors can be found in the Lester Tool. (Shiers, Rafi, Cooper & Holt, 2014). <u>NICE Guidance</u> Additional detailed guidance can be found in the National Institute of Clinical and Healthcare Excellence (NICE) Clinical Guidelines, Public Health Guidelines and Quality Standards (see 'References' for further details).
12. What will we offer	The 3 main threads to physical health care in forensic services are: 1. Cardio-metabolic risk <u>Inpatients</u> • Full physical examination and investigations within 24 hours of admission (as per Trust admission protocol) • 'ALL – Physical Health Assessment' completed within 7 days of admission and recorded on Carenotes. Re-assessment (every 3 months) needed at the time of each CPA. <u>Community patients</u> • Physical health clinics running at local community mental health bases and rehab facilities. All cardiometabolic indices assessed and advice/signposting as appropriate within the clinic. • Any abnormal results are reviewed and interventions discussed with patient when reviewed at CPA meeting. Specific interventions to lower cardio-metabolic risk: • Smoke-free inpatient units and smoking cessation trained staff in inpatient and community settings • Nicotine Replacement Therapy • Medical management of hyperlipidaemia • Improving food within units and limiting takeaways • Alcohol-free and drug-free inpatient units alongside substance misuse treatment programmes and advice (inpatient and community) • Gyms facilities in each unit with links to local community-based gyms and health promotion organisations (eg Brighton & Hove Albion football club) • Fit-4-Health prescriptions in local community gyms • Recruiting of GP provision for all inpatient units

	• Access to dietician (including prescribing metformin in non-diabetic metabolic syndrome and obesity) • Regular referral and liaison with GPs 2. Management of long-term health conditions and screening programmes <u>Inpatients</u> • Soon to have a GP covering secure wards who will consult with the patient and/or clinical team (ward doctor) prior to each CPA in order to assess any new/arising problems. • GP will keep a register of chronic/known/long-term physical health problems to monitor and feed into the CPA process • All inpatients registered with CCGs and Public Health England for National Screening Programmes. <u>Community patients</u> • All community patients are registered with local community GPs • CPA process ensures liaison with GPs regarding all chronic physical health problems, IDC-10 codes and medications. • Sharing cardio-metabolic risk factor information (including interventions offered) with GPs. 3. Therapeutic Drug Monitoring <u>Inpatients & community patients</u> • All medications initiated by FHS will be subject to appropriate physical, haematological/biochemical and other recommended investigations prior to starting (as per Trust guidance and Maudsley Prescribing Guidelines). • Access to regular medication reviews under the guidance of a consultant psychiatrist (at minimum there will be a comprehensive medication review at each CPA) • CPA-based reviews will include appropriate Therapeutic Drug Monitoring (including physical, haematological/biochemical and other investigations as indicated by medication regimen). NB. for patients who come into contact with Police & Custody Liaison & Diversion Service (PCLDS) – PCLDS Physical Health Screening Assessment is used covering 8 key areas identified by NHS England (see below)
13. Who is intervention for	This menu covers all patients in contact with FHS, wherever they may be (e.g. prison, secure hospital, community).
14. When	Throughout a patient's entire period of contact with FHS.

	See specific elements of menu for timings/frequency of specific interventions.
15. Performance indicators	• CPA indicators • Physical Health Assessment Report (weekly Trust reporting) • ? inclusion in National Diabetic Audit • National Audit of Psychosis • Physical Health CQUIN performance indicators (cardio-metabolic risk recording and interventions offered & information sharing with GPs)
16. Outcome measures	The range of outcome measures currently used within the FHS includes: • National NHS Patient Experience Survey • Clinician reported outcome measures – such as HONOS-secure • Patient Reported Outcome Measures – such as the Forensic PROM • Condition or intervention specific measures – such as PHQ9 for depression, PANSS for psychosis • Measures of functioning – such as Work and Social Adjustment Scale Patient specific outcome measures: • QRisk3 score • Physical comorbidity • Life expectance (reduction in premature deaths)
17. Examples / quotes / illustrations.	Trust Physical Health Assessment Report – Forensic Health Service increased from 50 to over 80% patients meeting target (Oct 17 – Jan 18) Community Forensic Physical Health Clinics nominated for Positive Practice Awards 2017 (Sussex Partnership NHS Foundation Trust).
18. Link to other CAGS	All Forensic CAG Menus of Intervention have been developed to have regard to the specific Menus being developed across the other SPFT CAGs (especially the disorder-based CAG menus: Psychosis; Depression; Bipolar Affective Disorder; OCD).
19. Plan to develop evidence base	There is already a well-established evidence base for the need for physical health interventions in mental health services, which is used nationally and in our service. See NICE Guidelines and Quality Standards in References section for more details.
20. References	England, N. H. S. (2016). The Five Year Forward View for Mental Health. A report from the independent Mental Health Taskforce to the NHS in England. NHS England, London.

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