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# Quality Network For Forensic Mental Health Services

## Introduction

**Dr John O'Grady, Consultant Forensic Psychiatrist,  
Chair of the Quality Network Advisory Group**

Welcome to the 9<sup>th</sup> edition of the Quality Network for Forensic Mental Health Services newsletter. The network has now reached the end of what has been a successful third annual cycle, and is soon to embark on its 4<sup>th</sup> cycle. The Annual Members' Forum is planned to take place on 7<sup>th</sup> April 2009 with topics of the day including: the key findings from Cycle 3, an update from the Service User Experts, the network's annual general meeting and a number of presentations from member units.

Recruitment for the fourth cycle is well underway and we look forward to working with you over the coming year. We hope that participating in the Quality Network is a useful and interesting process for all involved.



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# Examples of Good Practice in Medium Secure Units:



Nottinghamshire Healthcare   
NHS Trust  
*Positive about mental health and learning disability*

## Wathwood Hospital's Horticultural Project: Growing in Confidence

### Introducing the service:

Over a decade ago Horticulture was introduced as a means of extending the therapeutic engagement of Service Users at Wathwood Hospital. The early concept (albeit not for long) remained faithful to the definition 'the science or art of cultivating fruits, vegetables and flowers'. The concept was to engage Service Users innovatively, blur the role of staff and promote involvement through collaborative learning and working in a meaningful way. The team succeeded in every way, indeed early feedback hinted that the benefits of horticulture were to be far greater than originally expected.

Service Users involved readily expressed their enthusiasm reporting outcomes such as "I feel supported in gaining more confidence", "promotes your well being" "gives energy and an idea of what I can cope with,

learnt not to take on too much" "feel satisfied from doing something good" "I don't feel like a patient, I feel trusted by staff". Staff involved similarly reported that Service Users had developed not only their ability to communicate but in other matters of self efficacy including rising self confidence, positive means of coping, enhanced problem solving and empowerment.

Although none of the initial team involved had any special 'horticulture' qualifications the project continued to develop and yield results. Seated areas and background music were introduced early on as a means of encouraging team members to socialise and share ideas whilst working helping to reach and maximise both individual and team potential.

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### A developing service:

As funding was located the team engaged in formal training to enhance their knowledge and ability and thus to extend service provision they were given the contract to complete groundwork around the hospital site. The team were given the opportunity to design and develop their environment and a chance to apply newly acquired skills and knowledge in a safe manner. This marked the beginning of a rapidly expanding service which has continued to



this day. Ideas for development followed the purchase of specialist farming machinery including a tractor increasing efficiency and maximising the potential. A plan to construct a 9x9 metre automated greenhouse quickly followed. Once constructed within the secure perimeter this development meant that services users without access beyond the secure perimeter could now become part of the team, this was a resounding success met with a huge amount of enthusiasm.



“this meeting became the start of a great relationship. The communication between patients and residents is tremendous and the project is an ideal opportunity for the patients to show the wider community the skills that the patients have achieved. As the years have passed, lots of patients have returned to the community. We lost friends, but hope we had a small part in their rehabilitation”. This positive working relationship enabled the team to cast the net wider and culminated in the development of links with a number of outside agencies with whom the horticulture team continue to work closely, including South Yorkshire Police Service and several local farms. It is these relationships, and others now being developed, that have enabled the team to break down barriers and challenge stigma encountered by users of mental health services, particularly those services that come with a secure or ‘forensic’ tag.

### Stepping outside:

The time came when every inch of possible space within the hospital grounds was being used so the team looked beyond and attempted to extend the horticulture project outside of the hospital grounds. Liaison with the resident warden of a local sheltered housing facility for senior citizens provided just such an opportunity and the extension into the community was established with the bi-annual production of hanging baskets to be put up on every bungalow throughout the centre. The resident warden explained that



From the beginning of the early community projects it was realised that participation in Horticulture should be formally recognised

and rewarded; in order to achieve this, the team registered on to an NVQ in horticulture and amenities. This saw the beginning of formally recognised training for the team, which soon included training in animal husbandry.

### **New approaches and making the most of practice based approaches:**

As the new century unfolded and whilst engaged in animal welfare activities, Service Users within the team were noted by staff to be using a variety of integral interaction skills. In order to have a closer look at this evidence de-

veloping in practice a piece of research into the use of animal assisted therapy within secure environments was designed and conducted. The method used was a series of structured telephone interviews with all forensic services in the UK who had a stated horticulture project of some kind. Results demonstrated that working with animals as a therapy was not a new theme. Further; that Horticulture enabled Service Users to develop both emotionally (improved social skills, self-esteem, motivation to engage in therapies and self confidence) and practically (placements, college courses and community conservation work). Most identified benefits appeared to relate to self improvement (e.g. responsibility, improving self-esteem) rather than directly improving/maintaining mental health. However, no institutions reported an absence of benefits through horticultural projects, though it is not clear whether these benefits have longevity.

Wathwood Hospital Horticulture Team took the results as affirmation of the idea to develop the service further with the inclusion of small animals, such as rabbits and later, farm animals, highland cattle. This development was named AIM (animals in mind). The team developed and agreed a plan that individuals would work initially with small animals, gradually building up the depth and breadth of responsibilities taken on. At this stage individuals were observed to develop greater empathy, positive coping mechanisms, and caring skills as well as the practical awareness of the environment. The team then worked with the larger animals including the

highland cattle and kina pigs. These animals appeared more intimidating because of their size, manor and appearance. Service Users at this stage reported improved levels of confidence and social acceptance. They further expressed that although something may appear intimidating, it often isn't and reported being able to transfer this learning to people and situations that they may come across both within and outside of the hospital.



### **Success:**

In the present day, the horticulture team at Wathwood Hospital no longer relate the term horticulture to 'the science or art of cultivating fruits vegetables and flowers', instead it denotes a far reaching concept more inclusive than the term suggests.

The success of the horticultural service at Wathwood Hospital lies in it's ethos of acceptance and empowerment of those who attend. The team work hard in fostering sup-



portive relationships and there is a strong emphasis on the value of pulling together and collaboration. Within the team there is a tangible and appropriate shift in the balance of power between Service Users and staff, a felt sense of ownership and acceptance apparent to all and the encouragement to grow as both an individual and a team.



### Moving forward, being all that it can be



The team is keen to maintain progress, they believe their work is a tool by way of reaching the po-

tential of others, a means of garnering responsibility, developing self respect, self efficacy and empowerment. In order to continue to reach this goal they are happy to push into as yet new territory. Ideas for the future are many though some examples include the purchase of a small holding or plot of land at a distance from the hospital: widening the service by being able to maintain team member input even after discharge from the hospital and expanding the work range to develop further skills, working with new machinery, providing a safe environment for different types of animals to state a few.

Sussex Partnership   
NHS Foundation Trust

## Ashen Hill MSU: Activity Week

The Secure and Forensic Services in Sussex Partnership Foundation Trust is made up of Ashen Hill, a 26 bedded medium secure unit incorporating male and female areas. Southview, Jupiter and Neptune providing a total of 42 low secure beds. Rosslyn a 4 bedded hostel and 12 specialist women's community based beds.

The summer activities week takes place every July. For one week the therapy programme is suspended and is replaced by a range of summer activities. The initiative grew out of staff concern that residents did not have the opportunity to go away for a summer holiday. They wanted to ensure ser-

vice users had the opportunity to experience the break from routine, chance to try something new and the rest and relaxation that a summer break can provide.

The summer activity week is coordinated by the Secure Recovery Steering Group. This is a multidisciplinary group, which is leading the incorporation of recovery principles within secure services. In order to acknowledge the specialist aspect of recovery in secure settings we have elected to rename it Secure Recovery and have defined it as follows:

*Secure Recovery acknowledges the challenges of recovery from difficulties that lead*

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*to offending behaviour. This recognises that the careful management of risk is a necessary aspect of recovery in our service but this can happen alongside working towards the restoration of a meaningful and satisfying life.*

The summer activities week was initially carried out on Southview, the low secure unit in 2004. Since that time all of the units have become involved with the initiative. It has become a highlight of the year proving popular and successful galvanising staff and service users from across the service.

All members of the multidisciplinary team are involved in planning and carrying out the social and recreational activities. Each unit plans their own activity week based on the interests and skills of the residents and staff. There is some coordination between the units for some activities, for example football matches. On one afternoon the same quiz is carried out on each unit. Each unit has a winner and by comparing scores the overall winner for the service is found out.

There is a mixture of on and off ward activities to ensure all service users have an opportunity to participate. A range of new activities and challenges are introduced. One year residents were given the opportunity to have a taster session of sailing, some residents have continued to have sailing lessons following this. Nursing and medical staff have made their specialty meals for the residents on the unit and the administration staff also host an event, a BBQ in a local nature spot. The activities week brings the service together as a community.

Workshops are also carried out, specialists are invited to the unit, there have been art and drumming workshops which inject energy and novelty to the in patient units. Last year the highlight was the erection of a mobile climbing wall within the grounds for the afternoon. This provided a new opportunity

for the residents and staff, some have continued to use a climbing wall in the local area.

The summer activities week is funded from the staff and patient endowment fund.

Apart from the recreational nature of the summer activity week there are a wide range of benefits that have been gained from it.

It provides an important training opportunity for staff. They learn all the elements to planning and carrying out an activity, including careful and detailed risk assessment for the activity, planning transport, anticipating any practical difficulties that will arise from the activity itself including the mix of individuals participating and identifying finding ways of managing them.

It provides the opportunity for service users to try out different, unusual and challenging activities to identify future interests. Staff and residents can get to know each other on a different level, this provides opportunities for assessment and development of close working relationships. The Arts Therapists used the opportunity to showcase work that had been carried out during the year with an art exhibition. The Summer Activities week also provides a highlight to the year. A point for staff and residents to look forward to.

The success of the week relies on the commitment and hard work of all the staff groups working together and bringing their personal and professional skills.

**Deborah Alred**

**Senior Occupational Therapist**



Birmingham and Solihull   
Mental Health NHS Foundation Trust



## First Review Cycle of Reaside Clinic, Birmingham

Reaside Clinic is part of Birmingham and Solihull Mental Health Foundation Trust; it provides the Men's Forensic Service to a catchment area consisting of most of the West Midlands. The Clinic has 90 beds including acute, intensive care and rehabilitation wards. In addition there is a low secure unit, Hillis Lodge, occupying a separate site nearby. Reaside is over 20 years old and in some aspects the building struggles to support modern standards of care and security. For example, ensuite rooms are not available. Previous reviews have highlighted shortcomings of the building. Since the Quality Network peer-review took place in January construction work has commenced on enhancing security to meet one of the standards not met, a 5.2 meter fence and to provide CCTV in our Family Visiting Room.

Initially we felt a slight anxiety that the review would expose some of our shortcomings, putting us in a bad light. However the experience of the peer-review was that it was a positive experience that should help facilitate further improvements in service and reinforced that in many ways we are providing a quality service. Recommendations in the peer-review will, we hope, be useful in discussion and negotiation with the commissioners.

Completion of the self-review workbook prior to the peer-review visit was a useful team exercise providing information on the 3 units to be visited and the clinic as a whole. The three units chosen were a 14 bed acute ward, a 12 bed rehabilitation ward and our 8 bed intensive care unit. It highlighted that we needed a more robust system for compiling some information. For example we were meeting the standard for response times to referrals however we were not monitoring this in a very systematic way. Since the review we have introduced a new system. The information will now be readily available for future reviews and our own clinical governance processes.

When the peer-review took place the clinic was praised for the extent of therapeutic engagement with our residents. Programmes of treatment were looked at in detail. The Best Practice Guidance for Adult Medium Secure Units states that patients should be offered a minimum of 25 hours per week of therapeutic activity. The Quality Network peer-review broke this down into meaningful components. Individual treatment programmes included: Occupational Therapy, psychological therapy, substance misuse therapy, offence related therapy, access to work, structured leisure time. All were commented on in detail and although we do not

yet meet the 25 hour standard the review scored us highly on our provision of therapies. We are about to offer internet access to our service users and are aware that some members of the Quality Network are already doing so. We are developing a more comprehensive primary care service to be available within the clinic. Participation in the Quality Network will I think help us to meet these challenges. It provides a mechanism for cross fertilisation of ideas, sharing experience and knowledge between clinician's and forensic services across the country. At the Annual Forum on April 7<sup>th</sup> we shall be



presenting a paper looking at the therapeutic activities and therapies programme here at Reaside.

The participation of fellow clinicians in the review process allowed for a well-informed dialogue to take place adding to the written information in the Review Summary provided following the review. Our Clinicians used the opportunity to talk about case examples. There was a balanced appraisal of issues for example when security was examined there was a full understanding of the importance of maintaining this within a therapeutic environment. The review had much more than a security focus, even when examining specific aspects of security. We were very pleased that the reviewers commented on the very positive relationship they observed between staff and service users which we believe to be a vital component of relational security and for the delivery of high quality care.

So for other services anticipating their first cycle review we would say fear not; it is more a carrot than a stick! For Reaside it has proved a very positive experience, which we will be anticipating next year. It has and will in the future help us to develop our service and to provide excellent care and treatment to our service users. We are looking forward to our Women's service at Ardenleigh being part of the cycle next year.

Terry Pugh  
Service Manager

Dr J Kenney-Herbert  
Clinical Director

Dr Alison Reed  
Consultant Forensic Psychiatrist

## The MSU Email Discussion Group Join the discussion

If you would like to join the network's email discussion group, please email [msu@cru.rcpsych.ac.uk](mailto:msu@cru.rcpsych.ac.uk) with 'JOIN' in the subject line, and your email address will be added to the group.

A summary of the topics raised over the first two years of the group is available at:  
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Avon and Wiltshire   
Mental Health Partnership NHS Trust



## Third Review Cycle of Fromeside

### Fromeside

Fromeside is an 80 bedded medium secure unit providing services for the West of England. The new service opened in 2005 and provides excellent facilities for both males and females from this area. The unit has 68 male in-patient beds spread over 7 wards and 12 female in-patient beds self contained in one ward split into two areas. Each ward has a minimum of dedicated education and therapy rooms as well as access to the Malago centre which facilitates all aspects of group and 1:1 activities including sports, arts psychotherapies, education and occupational therapies. The Rivers Café, situated at the heart of the unit, provides sandwiches, snacks and drinks and is run by service users, supported by OT staff, as part of a vocational rehabilitation programme. We work within an integrated service model and act as a hub service to facilitate referral for secure care on behalf of the LSSCG and its PCT's.

Moving into a brand new, purpose built and much larger building was a challenge in itself. So to take on a further challenge by signing up to the peer-review, was perhaps an option that some may have chosen not to take, within their first year of opening. However, as a unit we felt that engaging in this process in our infancy stage would give us the chance to 'unveil' ourselves to a wider field of profes-

sionals and to take stock of our services by listening to others perceptions of or service.

### Cycle 1

Although having been inspected by various organisations over the years, this was a new process and we didn't know what to expect. Receiving the self-review workbook became the first hurdle to jump. The workbook was detailed but lengthy, so a group of us sat down and made our first attempts at the self-review process perhaps being a little too critical of ourselves. A lesson well learnt for the following reviews. Then followed the peer-review, which no matter how many times staff were informed, it was still seen as an 'inspection'. However, overall, particularly as it was the first ever medium secure review, it was a success and we received valuable feedback and suggestions for addressing some areas that we had identified as needing further work.

Our mistake, after the final summary was received, was not getting together immediately to process the recommendations and write action plans. This meant that we perhaps didn't do ourselves justice by planning in advance and being fully prepared for the 2<sup>nd</sup> cycle.

## Cycle 2

The second review was less 'daunting' and having completed one cycle, we understood the process and it became easier to get staff together to complete the review, using those who had participated in cycle 1 and recruiting new staff to support this process. We did much more preparation with staffing groups and service users in respect of understanding the process and expectations of the visit. This supported the unit and elevated some of the concerns raised in the previous cycle.



Again, we received very positive feedback and took on board the recommendations that we felt that we could address and set about writing an action plan, soon after the review summary had been received. This allowed us more time to achieve our own goals before the next cycle.

## Cycle 3

In between the 2<sup>nd</sup> and 3<sup>rd</sup> cycle all medium secure establishments underwent a Department of Health "Health Check". This in itself, further supported our preparation for the 3<sup>rd</sup> review and gave us opportunity to put some robust processes in place to address some of the issues raised within the Health Checks. I for one, know that the background work and effort that has been undertaken prior to cycle 3, gave us confidence in addressing the self-review and peer-review process with satisfaction. Completing the workbook, reassuring staff and service users and being fully prepared has become a far smoother process. Because we have fully embraced this process and include it in our SBU and Trust reporting mechanisms, it has become embedded in practice and remains high on our priority for service delivery. The process and report is recognised as being valuable in providing excellent evidence to the Trust in respect of meeting service users' needs and service requirements.

### Value of the Quality Network

I have already mentioned some benefits but certainly having this process gives us a good understanding of how we are delivering our service, it provides an assurance process in meeting standards and targets expected by the Trust and provides commissioners with valuable information about how the service is working as a whole. The process has become embedded in practice and is talked about through all service meetings relating to service delivery and performance. In particular, the MSU E-mail discussion group has been a useful tool in gathering and providing information when issues have arisen, allowing a thorough process to take place before changes are implemented. Also being able to share policies and procedures has gone a long way to 'reducing' the cycle of re-inventing the wheel.

The annual forum has been a good place to hear about the work of the Quality Network member unit's experiences. It also provides an arena to air and share concerns and to work on issues that appear to be a problem for most/all units. In particular the supervision standard has been a contentious issue, so much so that the Quality Network have undertaken some workshops and are hoping to develop this further to support member units in addressing what appears to be very common themes. There are also plans underway to begin working on outcome measures.

### Advice to others

If, as a unit you are undertaken the cycle for the first time, my advice to you is to prepare yourself in advance. Get your staff on board and work with them to fully understand the process, so that it is not seen as a threat to their delivery of care. But most importantly, keep the whole process live, don't treat it as a once a year event, it is a cycle and there to support you and your service.... and actually, with all of the hard work put to one side, it is a very rewarding and enjoyable process.



**Nikki Churchley**  
Service Improvement Lead

## Cycle 4: What to Expect

### June 2009:

- Project Team offers options of dates to host your unit's peer-review (September 2009—March 2011)

### July 2009:

- Project Team disseminated dates of host peer-reviews
- Your unit needs to put forward four staff to form part of two peer-review teams
- Project Team disseminates self-review workbook with guidance
- Your unit has until 6 weeks before the date of the review you are hosting to complete and return the self-review documentation

### 6 weeks Prior to Your Peer-review:

- Our Service User Experts arrange a telephone conference with service user reps

### The Peer-review:

- Takes place over one or two days
- Is designed to be supportive and not an inspection
- The review team collects data via interviews with staff, service users and senior managers
- Is an opportunity to share common problems and examples of good practice
- Will provide preliminary feedback from the peer-review team

### Local Review Summaries:

- The draft will be received within 4 weeks of the peer-review and the final will be received within 8 weeks

### Action Planning:

- Feed review finding into the clinical governance structures to ensure meaningful action planning takes place

### April 2010:

- Cycle 4 Annual Forum and National Report published

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# The Quality Network For Forensic Mental Health Services



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Kent and Medway   
NHS and Social Care Partnership Trust



## 'A New Horizon?':

### The Trevor Gibbens Unit's successful approach to meeting the challenge of substance use treatment for mentally disordered offenders in conditions of medium security'

*Dr Helen Miles (Chartered Clinical Psychologist, Kent Forensic Psychiatry Service (KFPS) & Honorary Lecturer, Institute of Psychiatry) & Ms Carol Guinan (Assistant Psychologist, KFPS)*

Despite a national MSU survey finding just 16 (59%) had substance use treatment programmes (Durand *et al*, 2005), forensic services should address substance use in mentally disordered offenders as prevalence rates are high. For example, Isherwood & Brooke (2001) found almost 60% of their MSU patients had substance use problems. Substance use increases the risk of mental health relapse and re-admission to hospital, results in longer admissions, non-compliance with treatment and poorer social functioning, as well as increasing the risk of offending behaviours, including violence (McMurrin, 2002).

Other difficulties associated with substance use in forensic settings include non-compliance with prescribed medication, interactions between prescribed and non-prescribed drugs, adverse effects on mental state, overdoses, drug dealing, intimidation, peer pressure to use or bullying, and increased rates of violent incidents; either between patients, or between staff and patients (Sandford, 1995; Williams & Cohen, 2000; Snowdon, 2001; Phillips & Johnson, 2003). Moreover, the Department of Health (2002) note within their 'Dual Diagnosis Good Practice Guide' that: ***"the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse***

***should lie within mental health services"***.

As a consequence, Leach *et al* (1998) argue that forensic services should adapt existing addictions models to focus on prolonged engagement and coping skills training, with monitoring of violence potential and mental state, and the use of Restriction Orders to encourage compliance to avoid recall. Isherwood & Brooke (2001) also note that treatment should develop social and practical skills, teach coping and problem-solving techniques, and include education, motivational interviewing, goal-setting and relapse prevention.

Importantly, preliminary evidence is optimistic. Miles *et al* (2007) devised a 3-stage Substance Use Treatment Programme (SUTP) in a South London MSU, which resulted in 74% of participants becoming abstinent post-SUTP, rising to 79% at 6-month follow-up. Stages 1 and 2 'treatment' significantly increased abstinence, but Stage 3 'booster sessions' were needed to maintain gains. The SUTP increased self-reported insight, confidence to make changes to substance use and adaptive beliefs, and decreased craving. Participant satisfaction with the SUTP was high. Moreover, Derry & Batson (2008) found that MSU in-patients who participated in a 24-session substance use programme remained

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significantly longer in the community, suggesting such programmes can be effective in reducing re-admission.

Consequently, the Trevor Gibbens Unit (TGU) within Kent Forensic Psychiatry Service (KFPS) adapted the Miles *et al* (2007) SUTP, taking into account local differences (e.g. a lack of active substance use in the unit due to consistent screening and searching procedures, and a on-site 'drug dog', different substances used, gender specific issues, and different concentration levels, expectations and motivation of participants). The TGU SUTP is a **three-stage integrated substance use treatment approach**, facilitated by members of the multi-disciplinary team.

Stage 1 is a 6 session weekly 2-hour group supporting participants in their initial abstinence from substances, through psycho-education about alcohol and drugs and their effect on physical and mental health, motivational interviewing to strengthen change beliefs, goal setting and discussions linking substance use and offending behaviour. Stage 2 builds upon Stage 1, and is a 6 session weekly 2-hour group supporting participants to maintain abstinence from substance use in the longer term, through relapse prevention strategies to manage high risk situations, lapses and craving, development of coping strategies and assertive refusal skills, enhancing self-esteem and social skills/support, discussions to understand the function of substance use and development of appropriate alternative activities. Stage 3: 'New Horizons' or 'Women Only' consists of ongoing monthly booster sessions, which serve to provide social support and an opportunity to 'refresh' and 'practice' strategies from the treatment sessions, and are offered for up to 6 months post-discharge to support participants' transition back into the community.

On the 1<sup>st</sup> April 2007, of the 53 in-patients at the TGU (42 males, 11 females), 44 (83%) were referred to the SUTP. To date, there have been two completed SUTP's (41% of male and 60% of female referrals on the basis of 'pragmatic selection': those most likely to be discharged and needing treatment as a priority). There were no significant differences between the 'referred' and the 'waiting list control'. The majority of those

referred (93% males, 83% females) completed Stage 1 and 2, and over two thirds regularly attend Stage 3 sessions, including those subsequently discharged.

Importantly, the initial evaluation of the TGU SUTP

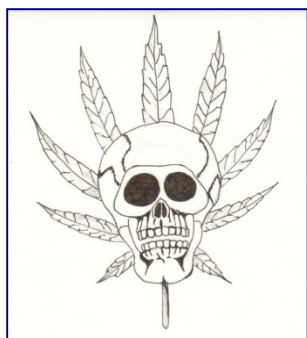
has noted some positive results. Whilst there has been mixed success in the long term modification of their beliefs that substance use is a problem and that they need to change their use, participants have shown increased confidence to change their use and at the end of the Stage 1 and 2, have increased beliefs that substance use effects offending behaviour and mental illness. At 1 year into Stage 3, male participants also show increased adaptive beliefs about substances and craving. Whilst male participants were no different from 'waiting list' controls, females participants showed significant increases in motivation and self-esteem following treatment. Both male and female participants showed decreases in anxiety and depression.

Finally, the majority of participants reported high levels of satisfaction with all 3 stages of the SUTP. The most highly rated sessions included 'linking cannabis to mental health', followed by sessions on relapse prevention strategies (e.g. learning to deal with cravings and negative feelings, increasing social support). Many rated the usefulness of the group process highly, noting the helpfulness of *"being able to talk things over ... sharing information and opinions ... not feeling judged"*, which was further evidenced in the monthly booster sessions with some participants reporting the experience of meeting and discussing their substance use regularly as instrumental in remaining abstinent in the longer term. Other service user reflections post-SUTP, include both art and poetry:

*'Smoke it, get high ... Snort it, try ...  
Shoot up, go on ... Take a trip.  
Will you ever be the same again?  
Don't give in to the pressure to take drugs ...  
Make your own mind up.  
Seek out the facts about the danger of drugs ...  
Don't be insane, use your brain!'*



COLLEGE CENTRE FOR QUALITY IMPROVEMENT



Consequently, we believe that substance use amongst mentally disordered offenders should be treated, not criminalised in forensic secure settings, and that clinicians should remain optimistic that positive gains can occur and be maintained. Further adaptations to the TGU SUTP (e.g. provision of service user information leaflets, adaptations for a forensic learning disabilities population) are therefore planned for the future.

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If you would like to submit an article of interest to the Quality Network for Forensic Mental Health Services newsletter please contact Kerry Painter  
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## Running secure care: rights, risks and recovery



**Philip Sugarman, forensic psychiatrist and CEO at the charity St Andrew's Healthcare, shares work on quality governance.**

### Overview

Risks in mental health not amenable to community care are managed in the UK in both state and independent secure units. A model of governance for these services based on rights and recovery, as well as risk, would be at the forefront of contemporary thinking (Mental Health Act Commission 2008). Recovery principles that truly embrace service-user choice across treatment and outcome must be central. However there is a lack of confidence in the "governance" of mental health services (Oyebode *et al* 2004, Grant 2006) and little research, perhaps because recovery involves individuality and creativity (e.g. Deegan 2003). Can good governance transform complexity and risk into clarity, safety, and well-being? Service users' rights and the rights of others would need to be safeguarded, and risks to these rights managed, whilst recovery is driven forward. A truly integrated approach, covering policy, training and audit, can manage clinical risks, protect rights and promote recovery.

### Rights and risks

Human Rights have many cultural sources including English traditions (e.g. Paine 1791). Since 1945 they have been promoted internationally, especially in Europe, and returned to the UK as the Human Rights Act 1998. Secure service users should benefit, as "unsound mind" is specifically mentioned under Article 5 (Sugarman 2002), but in practice this is complex and sporadic. Interpretation by practitioners in secure settings is a challenge (Sugarman & Dickens 2007), though the Mental Health Act 2007 is now worded in line with European requirements.

The basic rights of free citizens in any hospital have been summarised as two: to choose

to refuse treatment, and to leave hospital (Hoggett 1990). Without legislative protection, mental health service users are vulnerable (Legemaate 1988, Sugarman & Collins 1992), with poor levels of information and awareness (Sugarman & Long 1992, Sugarman & Moss 1994). Colleagues can judge whether protections for detained patients in their jurisdiction meet Hoggett's formula, i.e. rights to independent review of treatment, and to judicial appeal for discharge.

Modern ideas of risk management press health professionals to learn from experience, often amidst unhelpful governance initiatives (Hutter 2008). It seems simplest to allow healthcare governance to be based on good

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clinical risk management. In mental health, clinical risks imperil patients and others, and require both restrictions and protections for service users' Human Rights. Serious risks to others are managed by detention and reviewed by court-like Tribunals, as required under the Human Rights Act 1998 (Article 5 Right to Liberty). However at the interface between law and clinical risk, lawyers' claims of unfair reports to Tribunals (Article 6 Right to Fair Trial) are partly supported by evidence (Sugarman & Roychowdhury 2000).

Most clinical risks relate to one or other of the Human Rights Articles, only some of which can be *proportionately* restricted – a key point for clinicians (Sugarman & Dickens 2007). The prevention of suicide follows the Article 2 Right to Life, an absolute, unrestricted right. However the Article 8 Right to Privacy and Family Life as well as Article 5 Right to Liberty can be restricted where there is a pressing need in a democratic society (Curtice 2009).

### Recovery and risk

The practical definition of recovery in mental health has moved from discharge from care, toward customer (i.e. service user) experience of outcome. The global leading measure of mental health outcome is still HoNOS (Wing *et al* 1998). Integrating the HoNOS family of tools with measures of care planning, therapeutic activity, and incident data into a Balanced Healthcare Scorecard (Sugarman & Watkins 2004, Sugarman 2007) can provide clinicians with clear data on their effectiveness, and commissioners with comprehensive outcome data (Sugarman, Walker & Dickens 2009).

In secure settings static risk assessment approaches need to be complemented by tracking clinical risk as well as recovery over time. HoNOS-Secure was developed (Sugarman & Walker 2004) to rate the need for risk management and security, as well as wider out-

come, and has been shown statistically reliable (Dickens, Walker & Sugarman 2007).

### New mental health Governance

Governance has grown in the NHS from financial controls, through clinical governance toward integrated healthcare governance (Department of Health 2006). However bureaucratic governance can erode clinical autonomy (Callaly *et al* 2005). The key challenge is cultural innovation amongst senior staff toward effective teamwork (Bevington *et al* 2005) and clear reporting on what really matters for service users (Sugarman 2007). Explicit healthcare standards must be at the core of policy, audit and training (Sugarman & Midgley 2005).

A good model of mental health governance has service user need as the primary goal for the provider. It groups complex real-world requirements strategically into *rights* (legal protections in theory), *risk* (law-driven regulatory action) and *recovery* (service user outcome in practice). Information on the "three R's" then flows into rights-based policy, risk-based training, and recovery-based audit standards. This approach is in use at St Andrew's Healthcare to develop and integrate healthcare quality governance into the service culture.

This model of governance generates important research questions about services. These include: does setting policy on service users' rights actually help? Interestingly the Article 3 Right - to Freedom from Inhuman or Degrading Treatment - can be met through training in safe and respectful physical restraint (Southcott *et al* 2002), and this can also reduce the number of incidents (Department of Public Welfare 2000). Whilst there is evidence that risk-based training prevents suicides (Knox *et al* 2003, Mann *et*



al 2005), does this extend to risk to others? (e.g. Webster *et al* 2002). A key question is - does measurement of clinical risks and outcomes actually improve outcomes (Macpherson *et al* 2002, Morley *et al* 2007, Sugarman *et al* 2009)?

## Conclusions

What really matters in mental health care is to protect people and help them recover. A good model brings legal, regulatory and user requirements together with clinical perspectives. This helps run services to produce better outcomes.



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For a summary of author's PhD thesis and related research, see Sugarman & Kakabadse (2008).

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Hampshire Partnership   
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## Ravenswood House: Ward Representative Pilot Project



**Alain Aldridge - Service User Expert**

This pilot project was developed by Occupational Therapy as a permitted work scheme and commenced at Ravenswood House, Hampshire, in January 2008. Five service users were appointed as ward representatives (band 1) on Hampshire Partnership Trust six-month fixed term contracts. Previously the roles had been carried out by service user volunteers.

### **The aims of the project were to:**

- Explore the feasibility of introducing a paid role for ward representatives
- Develop a pool of service users who have skills to contribute to the development of the service
- Provide another vocational project where patients receive payment for real work
- One of the main challenges of this pilot project was the movement of ward representatives between wards as they progressed in the service and ward representatives handing in their notice (discharge, personal reasons etc). Training for the post has been offered on an on-going basis and the work is monitored through supervision and appraisal and an audit of community (ward) meetings is currently being undertaken.

### **From a Service User's Perspective:**

*"We work approximately 1-2 hours a week in the role. Our regular duties include chairing and minuting community (ward) meetings, and attending the monthly reference group meeting. The latter, a meeting in which all the ward reps attend together with management staff (Clinical Director, Service Manager, OT Manager, and Lead for User Involvement). The ward reps now provide a revolving chair for this group.*

*On top of this we meet with the OT Manager for a fortnightly supervision meeting to discuss any issues arising or any difficulties we are finding with the position. We have also become involved in conducting surveys (Service User to Service User) for various unit projects and have also become involved in showing around potential new staff and helping the unit compile interview questions. In fact the demand for our involvement is generally increasing.*

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*The role helps you to learn and develop your skills. It is great to get paid for doing some work, and when you move on you can ask for references. The reps are taken seriously by the unit and listened to. This allows us to make a positive contribution to the services that we are receiving. It's a very worthwhile and rewarding job".*



## The Quality Network's New Service User Experts

The Quality Network is delighted to have recently recruited two women into the role of Service User Experts. They will be warmly welcomed at the Annual Forum on 7th April 2009 and at their first Advisory Group Meeting held on 14th May 2009.

Firstly, we would like to welcome Carol Micalleft to the Quality Network. Until recently, Carol was an inpatient at the newly built Orchard unit in West London and had now been discharged. Carol has gained experience of being a ward representative at this service and is looking forward to representing women service users at the network's Advisory Group Meetings.

Secondly, we would also like to welcome Emma Sigmund to the network. Emma is currently an inpatient at the Bracton Centre in Dartford. Emma has provided the following introduction:

*"My name is Emma Sigmund and I am the newly appointed Service User Expert. I expect to participate in the Peer Group Reviews at Forensic Hospitals in various locations. I also intend to take part in the Telephone Conferencing in which other Service Users are asked questionnaires over the phone. I hope to be an effective operator."*

The work that Carol and Emma will be involved in during Cycle 4 is detailed below:

- Attending and contributing to quarterly Advisory Group Meetings
- Writing an update article for the newsletter
- Setting up links with Service User forums at member units
- Arranging telephone conference with lead service user representatives during the self-review stage to gain the service users' perspective of their service.
- Attending a number of the Cycle 3 peer-review visits and meet with service user representatives face to face.
- Attending and presenting at the Annual Members Forum April 2009.

Finally, we would like to thank Mike Gatsi for his ongoing help and support in the co-ordination of the Service User Experts' involvement in the network.

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# Lead Reviewer Training

Tuesday 19th May 2009,  
Tuesday 2nd June  
and  
Tuesday 15th September 2009



## **WHO IS IT FOR?**

Forensic mental health professionals from all disciplines with an interest in leading external peer-reviews for the Quality Network for Forensic Mental Health Services

## **THE WORKSHOP:**

### **AIM:**

To enable staff from forensic services that are members of the Quality Network to lead peer-review visits of other forensic services.

### **LEARNING OUTCOMES:**

participants will gain practical and theoretical knowledge of all aspects of leading a peer-review visit.

### **TEACHING METHODS:**

The day will involve presentations, seminar discussions and role-play scenarios.

### **CERTIFICATION:**

Those who complete the workshop and then lead a peer-review visit will be awarded a certificate in peer-review leadership by college Centre for Quality Improvement.

### **The training will be held at:**

College Research and Training Unit, Standon House, 21 Mansell Street,  
London, E1 8AA

For more information and an application form, please visit our website  
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## Events

- **A Practical Guide to Developing and Implementing Good Practice in Consent: Patients and Doctors Making Decisions Together for All Members of the Clinical Team** - This conference provides a practical guide to the new GMC consent guidance with a focus on effectively communicating information to patient, ensuring patients understand the implication of their decision and nurse led consent. **6th May 2009** Please contact Healthcare Events on 020 8541 1399.
- **Implementing the Mental Capacity Act: Deprivation of Liberty Safeguards in Health and Social Care** - This one day conference begins with a keynote address from Paul Gantley, National Programme Implementation Manager, Mental Health Capacity Department of Health, who will discuss what the Deprivation of Liberty Safeguards are, why they were introduced, the code of practice and key points for implementation. A series of case studies will also give perspective on moving forward. **15th May 2009** Please contact Healthcare Events on 020 8541 1399.
- **Patient Involvement and Empowerment 2009** - This conference provides an important update on recent changes in patient involvement and empowerment including delivering high quality of care for all, involving patients in the delivery of quality indicators and quality accounts, involving the patients and the public in commissioning and working with patients to deliver improvement and redesign through lean thinking. **21 May 2009** Please contact Healthcare Events on 020 8541 1399.
- **Measuring and Monitoring Outcomes in Mental Health** - This conference provides an important update on the latest thinking in measuring and monitoring outcomes in mental health. With a focus on delivering the Ara Darzi Review High Quality Care for All and monitoring collective outcomes for directorate and organisational performance you will learn about the challenge for clinicians and the goals of the individual service user. **9th June 2009** Please contact Healthcare Events on 020 8541 1399.
- **A Practical Guide to Transforming Patient Safety: A Risk and Safety Focus to Implementing High Quality for All** - This one day conference opens with an update from the National Patient Safety First Campaign. You will have the opportunity to learn from the many successful patient safety initiatives being implemented throughout the UK, and internationally, and how the approaches can be used to deliver the patient safety elements of High Quality Care for All. **17th June 2009** Please contact Healthcare Events on 020 8541 1399.
- **Governance Between Organisations (GBO): Consensus on Effective Practice** - This conference provides a practical guide to implementing Governance Between Organisations across health and social care boundaries including lessons from outside the NHS and the role of the effective board. The conference also looks at how to measure effective GBO through quality metrics and quality accounts and further, managing risk and handover at the boundary. **1st July 2009** Please contact Healthcare Events on 020 8541 1399.



## Useful Links



COLLEGE CENTRE FOR QUALITY IMPROVEMENT

- ⇒ **Department of Health** <http://www.doh.gov.uk/>
- ⇒ **The Forensic Directory** Provided by the St Andrews group of hospitals, this is an up to date resource detailing Forensic and other Secure Mental Health Services in the UK, provided by both the NHS and Independent Sectors. <http://www.theforensicedirectory.info/>
- ⇒ **Forensic Psychiatric Nurses' Association (FPNA)** Aims to promote the art and science of forensic psychiatric nursing, thereby improving the quality of care to patients <http://www.fnrh.freeserve.co.uk/fpna/>
- ⇒ **Health and Social Care Advisory Service** An evidence based service development organisation working in all aspects of mental health and older people's services across the health and social care continuum <http://www.hascas.org.uk/>
- ⇒ **Healthcare Commission** Promotes improvement in the quality of the NHS and independent healthcare <http://www.healthcarecommission.org.uk/homepage.cfm>
- ⇒ **Institute of Psychiatry** The largest academic community in Europe devoted to the study and prevention of mental health problems <http://www.iop.kcl.ac.uk/>
- ⇒ **National Forensic Mental Health R&D Programme** Recently completed programme of research funding to support the provision of mental health services for people with mental health disorders who are offenders/risk of offending <http://www.nfmhp.org.uk/>
- ⇒ **National Institute for Health and Clinical Excellence** An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Includes the National Collaborating Centre for Mental Health (NCCMH), a partnership between the RCP and BPS <http://www.nice.org.uk/>

## Useful Links

- ⇒ **National Offender Management Service (NOMS)**- brings together the work of the correctional services <http://www.noms.homeoffice.gov.uk/>
- ⇒ **Prison Health** -a partnership between the Prison Service and the Department of Health working to improve the standard of health care in prisons <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/fs/en>
- ⇒ **Prison Health Research Network**— DH funded initiative, led jointly by the Universities of Manchester, Southampton and Sheffield, and the Institute of Psychiatry <http://www.phrn.nhs.uk/>
- ⇒ **College Centre for Quality Improvement homepage** <http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement.aspx>
- ⇒ **College Education and Training Centre** Offers courses for professional development in mental health care <http://www.rcpsych.ac.uk/crtu/cetchomepage.aspx>
- ⇒ **Sainsbury's Centre for Mental Health** - an independent charity that seeks to influence mental health policy and practice and enable the development of excellent mental health services through a programme of research, training and development. <http://www.scmh.org.uk/>



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# Quality and Innovation in Secure Mental Health Commissioning

Wednesday 20 May 2009 – 28 Portland Place, Central London

Fast paced growth in the provision of secure services and a rapidly developing field of secure commissioning means both service providers and commissioners are facing increased pressure to produce meaningful results and deliver 'World Class' commissioning. Set against the challenges of finite resources, effective care pathways and the increased emergence of subspecialties across the public, private and voluntary sectors, this conference looks at how we ensure that what we commission is clear, deliverable and measurable – whilst also offering a platform for providers and commissioners to evaluate the impact of their services.

Aimed at mental health commissioners and practitioners, delegates will hear from renowned experts and participate in afternoon work streams whilst sharing knowledge and networking with peers. There will also be an opportunity to present questions to the key speakers.

## Key Speakers

### **Anne Milton MP**

Shadow Minister for Health

### **Lord Victor Adebowale**

Chief Executive of Turning Point

### **Professor Tom Fahy**

Head of Forensic Mental Health Science at the Institute of Psychiatry, King's College London

### **William Laing**

Director of Laing & Buisson

### **Caroline Reid**

Deputy Director, London  
Specialised Commissioning Group

### **Dr Philip Sugarman**

Chief Executive and Medical Director, St Andrew's Healthcare

**For further information  
or to book your place,  
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[jnairn@standrew.co.uk](mailto:jnairn@standrew.co.uk)**

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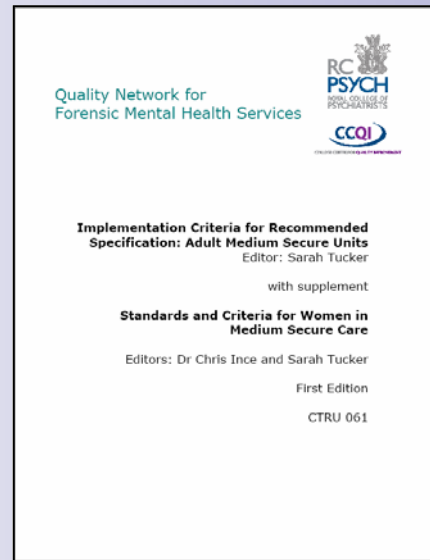
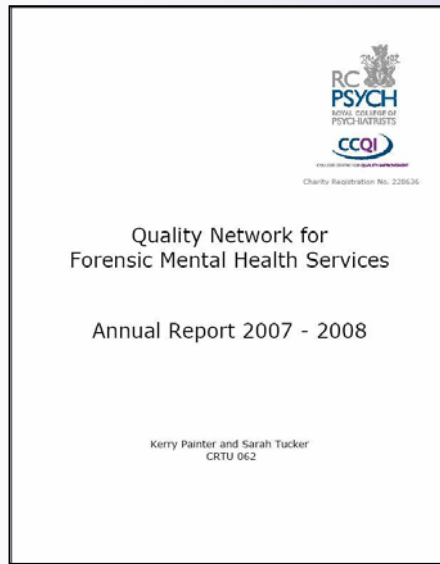
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