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# Quality Network For Forensic Mental Health Services

## Introduction

Dr Paul Gilluley  
Consultant Forensic Psychiatrist,  
Chair of the Quality Network Advisory Group



Welcome to the 12<sup>th</sup> edition of the Quality Network for Forensic Mental Health Services newsletter. With the recent announcement from the Department of Health that there is to be £15 – 20 billion per year efficiency savings within the NHS budget by 2013/14. The future in forensic mental health is, to say the least, challenging. It is important that we also keep in mind maintaining the quality of forensic mental health services with an overall aim to improve the quality of services whilst also saving costs. This is a time for innovation and reviewing how we provide services. Through our peer review process we hope we will be able to develop support for services as they face these financial challenges.

The network has now reached the end of what has been a successful fourth annual cycle, reviewing 64 medium secure units across England, Wales and Ireland, equating to 239 wards. Events organised over the last Cycle have included 4 lead reviewer training events, an outcome and activity measures workshop and a standards consultation events. In addition, the Annual Members' Forum is planned to take place on 12<sup>th</sup> April 2010 with topics of the day including: the key findings from Cycle 4, an update from the Service User Experts, the network's annual general meeting and a number of presentations from member units.

Recruitment for Cycle 5 is now underway and we are considering topics to look at over the next years as part of our strategic development. Our aim is to support and learn from each other so that we can face the challenges ahead. We look forward to working with you over the next cycle and hearing from you on ideas on how we face the challenges within forensic mental health services.

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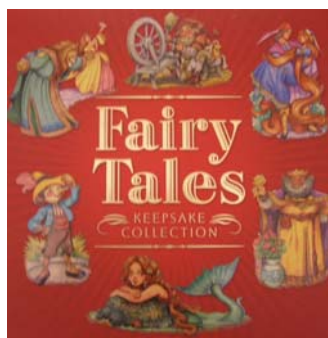
## Storytelling in a Forensic Mental Health Hospital



This article is a personal account of how storytelling has been applied in a medium-secure ward setting. It describes a little of what I have learned and experienced over the past two years at Llanarth Court Hospital, Partnerships in Care, South Wales. There is a wealth of written material covering storytelling, metaphor and its links to the therapeutic process which extends beyond the scope of this article.

Storytelling is an art; indeed it is one of the oldest arts. Stories have been passed down by word of mouth over the millennia. It is only in the past few hundred years that we have stopped telling or listening to stories in the way that we used to. But the tradition of oral storytelling is experiencing a resurgence in the worlds of entertainment, education, business and health.

In modern times, children have been regarded as the most appropriate audience for storytelling – it has become seen as their preserve. However, I know that adults are now filling theatres, halls and festivals to listen to traditional folk tales, fairy tales, legends and myths.



Two years ago I knew nothing about this resurgence in storytelling. I stumbled upon it by accident. I was nursing a patient in the intensive care suite, three-to-one. The patient had been there for a few weeks, unable to engage

in anything meaningful. The low-stimulus environment had become a double-edged sword, and boredom was a big problem. Confrontationally, the patient told me she was bored. No magazines, T.V., books, pens, pencils, radio nor the concentration to do much but be destructive. I asked the patient if I could tell her a story. To my surprise and sudden anxiety she agreed. I immediately thought I didn't know any stories but, thinking very hard very quickly, one came to me from the depths of my memory; one that I knew from my childhood.

It was a classical story of young girl, ugly step mother, wicked witch and a happy ending. It took me about 10 minutes to tell it. My two colleagues and the patient sat and listened. Much to my surprise the response from the patient at the end was: 'Can you tell it me again?' and again she sat, listened, relaxed, was distracted and, for whatever reason, was able to concentrate. I felt I had engaged with her on some meaningful level. I was so taken aback that, as soon as I got home, I typed 'storytelling' into an on-line search engine and found out just how widespread it was.

That was over two years ago now. Since then Partnerships in Care have given me a lot of support in terms of training and working with

storytelling on the wards throughout the hospital. Two storytelling clubs now run on two wards on a regular basis. I am keen to call them 'storytelling clubs' because I do not think it would be the right thing to present storytelling as 'therapy' in in-patient forensic units. Storytelling **is** used therapeutically, and it is without a doubt therapeutic, but it is also entertaining and can be developed as a hobby for patients. In the outside 'normal' world storytelling clubs take place on a monthly basis and it is that model I am trying to emulate.

### ***What benefits have I seen from storytelling?***

The storytelling clubs take place in a side room or activities room, in the evening time. I think that telling stories links in smoothly with guided discovery. Describing the landscapes that the characters find themselves in is as important as saying what happens. Storytelling relaxes and distracts patients.

Patients also tell stories themselves which can be full of nonsense and fanciful ideas because they are using their imaginations, so lateral thinking, thinking outside the box, is developed (Thomas & Killick 2007). All traditional stories, wonder tales, folk tales, myths and legends tell of triumphs and failings, emotional turmoil and long journeys – for example through fire and icy waters, over mountains and through deserts meeting scary giants and ogres and goblins. Stories are full of emotions. Most of the patients have difficulty talking about their emotions but, because the emotions in the stories are removed and external to the patients, they become safe to talk about. Thus storytelling can improve what is referred to as 'Emotional Literacy' (Thomas & Killick 2007).

In the storytelling clubs, some patients have learned how to tell stories. Not only is this good fun but it also seems to give the patient

doing the telling a huge sense of achievement as well as possibly improving confidence and memory. At the same time, all the other patients sit and listen to the stories being told by their peers, which requires good interaction skills and, some-

times, a lot of patience and tolerance.

One patient recently told me that, whilst she was nursed in the Intensive Care Suite (ICS), her mother eventually got permission to visit her there. During the visit she told her mother two stories she had remembered from the club. The patient seemed really proud of herself, and her mother enjoyed the visit.



Another patient always asks the meaning of words he does not know. In this way, storytelling can expand vocabulary. A young patient, who finds concentrating on T.V. and reading very difficult, enjoys coming to the clubs because she says she can see the pictures in her head and it stops her thinking about bad things. Interestingly, she got some story CDs from the library but reported that for some reason she could not concentrate on them. She thought that being able to look at the eyes and mouth of the storyteller helps her focus on the story. The same patient once asked for a story instead of 'PRN' medication. I facilitated this on a one-to-one basis, just before she went to bed, and she was able to settle enough that night to sleep without extra medication.

I would like to add at this point that all the patients who regularly come to the club and listen to stories also show great insight into when they are not in the right frame of mind to join in. The groups so far have never been disrupted by patients, some staying away



from them when they think they will not be able to cope.

I have already mentioned that the clubs take place in the evening. That is very deliberate on my part because that is the normal time for storytelling clubs to take place in the 'outside world'. It also does not clash with other sessions and has the added benefit of offering something meaningful during the evenings when there is always less staff around. This can take pressure off the ward for a period of time and promotes a relaxing atmosphere for the evening.

### **What is Storytelling?**

As a storyteller you do not learn the story off by heart, word for word. Nor do you read it from a book. Every time the story is told it is reinvented by the teller. The storyteller is in the story, and walks the story as they are telling it, seeing the landscapes, the objects, the animals, the creatures and the people, imagining in detail what is there and not there. The bare bones of the story - where it starts and finishes and what happens in the middle - stay the same, but the padding - the descriptive bits and the words that are used - may change. So therefore the story can be adapted to the audience listening. It can be made more or less dramatic depending on the responses from the listeners. It can be cut short or drawn out, little bits can be talked about or clarified as the story unfolds, or a word can be explained. I have experienced the end of a story being changed completely by a club because the group did not like the way it finished.

The tone of voice and the gestures used also help to communicate the story. Each storyteller finds their own unique way to tell a story, there is no right or wrong way to do this. We are all storytellers which is why, even on the wards - which contain so many different types of people - storytelling can be such an inclusive activity.

Henry D. Thoreau (1817 - 1862), an American philosopher, wrote this about nursing:

*....."I see this art every time I walk into an environment where a nurse is busy 'creating' the day for*

*another person. They are busy using the light, space, words, movement and touch to deliver the message of care. And like true artists they are willing, indeed they see it as essential, to share their performance with others.*

*It is something to be able to paint a picture, or to carve a statue and so make a few objects beautiful. But it is far more glorious to carve and paint the atmosphere in which we work to affect the quality of the day....."*

What Thoreau describes is a lot to aspire to and is no easy task, particularly in a forensic setting, but I have found that, by telling stories and running the storytelling clubs, the light, space, sound and words can be used to create something positive. This can be done by the patients as well as the staff.

### **Looking to the Future**

I will be attending the Building Bridges, International Psychiatric Nurses Conference 'Haration' in April in Prague to run a workshop on Applied Storytelling in Mental Health. I hope to see some of my British nursing colleagues there. I also keep an on-line blog ([mrsjessicawilson.co.uk](http://mrsjessicawilson.co.uk)) about what I am doing. Due to blogs being very public, it is a little bland to protect confidentiality but please have a look and even leave some feedback.

Jessica Wilson  
Llanarth Court Hospital





## Editor's Interview with Prof. Philip Sugarman

MSc MBA PhD FRCPSych  
CEO & Medical Director of St Andrew's Healthcare



### How has your time at St Andrew's been?

I have worked for the Charity for the last eight years, and have had a simply fabulous time with my team developing our secure services for mental health, learning disability,

brain injury and recently autism. There is a really strong *esprit de corps* at St Andrew's, and an ability to get things done for patients.

### What was your career prior to this?

I trained in psychiatry in Manchester and forensic psychiatry in Birmingham, before becoming consultant and Clinical Director of the Kent Forensic Psychiatry Service. Other roles included NHS Regional Advisor, Senior Lecturer at Guy's, and Trustee/Council Member of the Royal College of Psychiatrists. My main achievement was the development of a county-wide forensic service in Kent, which the team has grown further since I left.

### How did St Andrew's become a major secure provider?

St Andrew's opened as a charity in 1838, founded on the principle of "Moral Treatment" developed at the Retreat in York. It did not join the NHS in 1948, but began taking NHS patients, and by the 1980's had developed several innovative challenging behaviour services.

St Andrew's at Northampton is now a national

specialist hospital, and the largest mental health facility in the UK. The secure pathways for adolescents, women, men and older age are 100-150 beds each, and provide a varied range of environments for different needs. We have also become a regional provider of hospitals in Birmingham, Essex, and soon Nottinghamshire.

### What developments are planned for St Andrew's?

Our developments are on a large scale, and should stand for centuries as the original St Andrew's Hospital has. We open late this year William Wake House in Northampton, with medium secure services for men including deaf mental health, forensic brain injury, young adults, Asperger's, mental health and learning disability. Although a major neo-classical building with spacious new wards, its cost per bed is well below recent NHS units.

The Charity is very successful at present. Our reputation for quality translates into a high level of demand for our services. As a Charity our income is spent on high staffing levels and new buildings (we don't distribute profits or pay company tax). By the end of 2010 we will have over 1000 beds on four sites, and we have two further sites in England under consideration.

Recently St Andrew's has added research and education to its Charity Commission registration. Our strategic partnership with the Institute of

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Psychiatry is boosting the strong tradition of research and teaching amongst our senior clinical staff. In the long-term our 120-acre Northampton site will become a world class mental healthcare, research and teaching campus.

**Your current role is unusual, how did it come about?**

I applied for the post of Medical Director in 2002, but within 6 months of starting I also took on General Manager duties for the Charity. When the previous CEO Admiral Sir John Brigstocke moved to Chair NHS East Midlands in 2004, my new role was created.

My job is "CEO & Medical Director", a twenty-first century Medical Superintendent if you like, close to a continental Medical Director, or an American "Physician Executive". It has been a great privilege to develop in this unique role, applying what I have learnt about people to healthcare management, and to have responsibility for providing care to so many patients.

**What are you proud of at St Andrew's?**

We are currently caring for over 700 patients, many receiving a service they could not get elsewhere. The Charity has extended recovery pathways through medium and low security, to locked and open units for some. It is heart-warming to see patients make progress and move on. We all felt proud to extend this approach last year by opening our new hospital in Birmingham.

The real value the Charity brings is innovation in secure care. In forensic neuropsychiatry, we have led neuro-behavioural rehabilitation (the National Brain Injury Centre), and older age secure services for men and women, dementia and Huntington's. Similar our secure services for women and adolescents include well-developed treatment programmes with real integrity, from Dialectical Behaviour Therapy (for women in Northampton and Essex) and the TEEACH approach in our autism services.

**What do you think the future holds for secure mental health care in the UK?**

The pressure to develop and maintain quality

services, with effective therapies, shorter stays and better outcomes is here to stay, and will intensify greatly as public finances deteriorate. The Care Quality Commission, incorporating the function of the Mental Health Act Commission, may well cut its

teeth on secure services. Meanwhile the real need for secure care, coming out of the inner cities and the prisons, will continue to grow, as will public and Government pre-occupation with risk. Human Rights law will become increasingly central in ensuring access to proper care and treatment.

**You have many aspects to your career, how do you achieve balance in your life?**

The key challenge in roles like this is to "let go", once you know what's what. So with a good background in secure services I have increasingly delegated to others, trusting that I know what good services look like, and giving feedback as a result. I have built up a strong management team including Dr. Fiona Mason my Deputy Medical Director. This has freed me to develop market, policy and academic knowledge, and input these ideas into the Charity.

I have 90 publications, ranging across forensic psychiatry and healthcare management, and have completed an MBA, and a PhD on mental health governance. A major project on outcomes has been HoNOS-Secure, which continues to develop both in the UK and internationally. I am in London about once a week for conferences, Royal College of Psychiatry activities, and charity sector work such as the Mental Health Provider Forum, the umbrella body for mental health charities.

My outside activities help me relax – family life in Northamptonshire, ski-ing, cider making and playing the piano.



Tees, Esk and Wear Valleys   
NHS Trust

## Women's Screening Programmes in Medium Secure Care



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We have a forensic psychiatry unit with 14 female patients in medium secure beds at the Hutton Unit, St Luke's, Middlesbrough. Many of our patients have been with us long term, in other forensic units or in prison. They have had little or no access to primary care so we have set up a GP led service for both these women and the 80 or so low and medium secure men.

As part of general medical services it was decided to offer our patients the same screening as is offered to our local community, that is Cervical Cytology, Breast Screening and Colon Cancer screening ( a pilot in our region). This seems a sensible approach to take. However, the process involved in setting this up has been complicated and time consuming.

The first stumbling block was the recognition of these patients. As some have not had an NHS number nor been under the umbrella of a PCT or registered with any GP they did not appear on any screening lists or registers.

Then there was the local laboratory who analyse the cervical cytology samples, report results, to both GPs and to the patients, and co-ordinate any follow up via the colposcopy department. As the patients were not registered with a GP it was initially difficult to persuade the cytology labs to allow us to screen our patients. They were concerned that the patients could be lost to follow up.

We could not go ahead with testing until the labs provided the sample pots and forms. Both myself and my practice nurse needed a smear taker code number, which only the labs could provide.

Eventually both myself and our Unit General manager met with the manager of the Women's Services to discuss the issue. It was clear there was an obvious need for cervical cytology in our practice but given the hidden nature of our patients, from NHS databases in primary care etc it was not a straight forward exercise. The Women's Services Manager quickly understood the problem and gave support to our cause. She agreed to make it a priority to enable the cervical screening to go ahead. As we had a small number of patients, she offered to help and absorb the costs into her own budget.

Prior to this we had contacted several key members of the cervical cytology team to discuss the issue but none of them could understand our hidden patients, or could adapt the system to help.

Our practice nurse completed her cervical cytology course and spent some time in a busy general practice gaining practical experience in order to obtain her "smear taker number". She also spent time at the local colposcopy service. This was part of her training and it enabled her to develop her working relationship with the team, should any of our pa-

tients need referring.

Number duly obtained, she was then able to acquire the sample pots and forms which meant we could finally go ahead and offer the screening to all of our patients.

We decided, given our lack of space, to offer two cervical screening clinics. We set aside half an hour per patient ( a luxury compared to standard GP appointments of 10 mins) to prevent anyone waiting or meeting up with other patients, and to preserve confidentiality. Although the appointments filled up, only one patient came to each session.

We then changed it to a more opportunistic approach. This seems to be working better and so far we have screened half of the patients who are eligible. We have to wait until

those who are more severely unwell to improve before we can offer them screening.

Our patients are happy with the service and relieved, in some cases, that their physical health care

needs are being addressed. We are now in the process of linking in with the colon screening and the breast screening service. And we are about to become a registering GP unit, so we can hopefully give our patients the same high standard of general practice we have come to expect in the outside world.

Dr. Rosalind Fisher



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POMH UK  
PRESCRIBING OBSERVATORY  
FOR MENTAL HEALTH

## Prescribing Observatory for Mental Health

### POMH UK

*Helping mental health services to monitor and improve the quality of prescribing practice, meet Care Quality Commission Standards for Better Health and demonstrate implementation of NICE guidelines*

#### What is POMH-UK?

The Prescribing Observatory for Mental Health (POMH-UK) runs national quality improvement programmes open to all UK specialist mental health services. It helps clinical services maintain and improve the quality of their prescribing practice and reduce risks associated with medicines management. Services that are members of POMH-UK take part in quality improvement programmes that focus on specific topics within mental health prescribing practice. The POMH-UK team provide participants with all the help needed to measure and benchmark practice in that area.

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## Benchmarking the prescribing of high-dose and combined antipsychotics on forensic wards



### Background

The British National Formulary (BNF) provides recommended dose ranges for the licensed antipsychotics in schizophrenia. These dose ranges are determined in relation to the efficacy and toxicity data for each drug. There is

no convincing evidence that higher than recommended doses of antipsychotic drugs are more clinically effective than standard doses, but they do have a greater risk of dose-related side effects. Clinical guidelines, such as those produced by NICE, recommend that, with a few exceptions, patients should receive one antipsychotic at a time.

### Audit Standards:-

- Audit standard 1:** The total daily prescribed dose of antipsychotic drugs is within SPC/BNF limits.
- Audit standard 2:** Individuals are prescribed only one antipsychotic at a time.
- Audit standard 3:** First (typical) and second generation (atypical) antipsychotic drugs are not prescribed concurrently.

A number of the change interventions that were provided to Trusts taking part in the programme are still available in PDF format to member Trusts that wish to work on improving practice with respect to prescribing of high dose and combined antipsychotics:

### Powerpoint slide presentation with speakers' notes:

This will assist local teams to present the evidence base, guideline recommendations and the feedback of benchmarked audit data.

### Ready reckoner version 2:

(see right) This chart allows ward staff to calculate the cumulative dose of combined antipsychotics, increasing their awareness of how combining antipsychotics can lead to high-dose.

**ANTIPSYCHOTIC DOSAGE READY RECKONER VERSION 2** **POMH UK**  
PRESCRIBING OBSERVATORY  
FOR MENTAL HEALTH

02/08/07 always check you are using the latest version

Commonly used antipsychotics	Oral/IM: dose in mg/day Depot: dose in mg/week	Percentage of BNF maximum adult daily dosage																			
		5	10	15	20	25	30	33	40	45	50	55	60	67	70	75	80	85	90	95	100%
Amisulpride Oral							400			600							1000 (83%)				1200
Aripiprazole Oral							10			15				20							30
Chlorpromazine Oral		100					300			500			800			750					1000
Clorzapine Oral			150 (17%)				300	400 (44%)		450			600								900
Haloperidol Oral		1.5	3	5 (17%)			10			15				20					25 (84%)		30
Olanzapine Oral					5		7.5 (37.5%)			10					15						20
Quetiapine* Oral		75	100	150			300			375			450				600				750
Risperidone Oral			2 (12.5%)			4		6 (37.5%)		8					12						16
Sulpiride Oral				400 (17%)				800			1200			1600				2000			2400
Trifluoperazine** Oral		5		10		15		20		25		30		35		40		45			50
Zucloperthixol Oral			20 (13%)		30			50						100							150
Chlorpromazine IM				25 (12.5%)			50			100					150						200
Haloperidol IM						5 (28%)					10 (56%)					15 (84%)					18
Olanzapine IM					5					10					15						20
Flupentixol Depot		20	40			100				200					300						400
Fluphenazine Depot						12.5				25					37.5						50
Haloperidol Depot							25			37.5			50								75
Pipotiazine Depot						12.5				25					37.5						50
Risperidone Long-acting										12.5					18.75						25
Zucloperthixol Depot				100 (17%)			200			300			400			500 (83%)					600

\*100mg/day max for schizophrenia. 500mg/day max for mania. \*\*100mg/day max for schizophrenia. 500mg/day max for mania. % given are for schizophrenia. \*\*No max dose stated in BNF or SPC; 50mg used by convention.

### Workbook:

This is for clinical staff to refresh their knowledge of the evidence base around antipsychotic prescribing and reflect on their own practice.

### "What we know about PRN" poster:

Summarises the evidence around PRN prescribing.

**“Medication matters” information sheet:**

Provides service users with information about what to do if they think they are receiving a high dose or combination of antipsychotic medication.



**Method**

A baseline audit was conducted in March 2007. Twenty-one services, including 3 private healthcare organisations which for convenience will be referred to as Trusts, participated in the baseline audit. Data was submitted for 1891 patients prescribed antipsychotics, from 155 forensic wards (60 high-secure and 95 medium or low-secure wards).

The same 21 Trusts/organisations participated in the 12-month re-audit in March 2008, submitting data for 1997 patients from 184 wards (72 high-secure and 112 medium or low-secure wards).

**Data Collected**

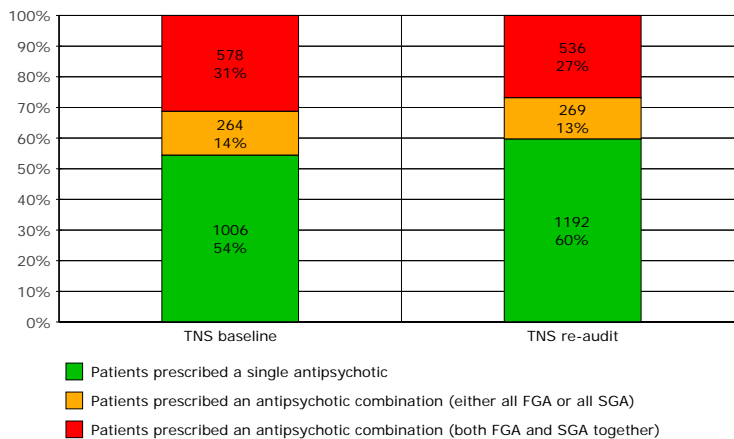
The following data were collected on all patients:

- Demographic variables (age, gender, ethnicity)
- Clinical variables (diagnostic grouping, ward type, length of stay, Mental Health Act and consent to treatment status)
- Details of prescribed drugs (names and dosage of all regular and PRN antipsychotic drugs prescribed on the census day and the types of other drugs prescribed)
- Reasons given for prescribing high-dose or combination antipsychotics (as determined by the clinical team with prescribing responsibility)

**KEY FINDINGS**

- Around a third of patients were prescribed a high dose of antipsychotic at baseline and at re-audit
- Most high dose prescribing was due to combined antipsychotics that included PRN
- Prescribing practice remained relatively stable between baseline and re-audit, with only very modest improvements against the audit standards over this period

**Figure: The proportion of the total patient sample at baseline and re-audit prescribed a single antipsychotic or combined antipsychotics**



## Topics for 2010-11

**Topic 1:** Prescribing high dose and combination antipsychotics on adult acute and psychiatric intensive care wards (PICUs)

*Supplementary audit*

**Topic 2:** Monitoring physical health of Assertive Outreach Team patients who are prescribed antipsychotics

*Supplementary audit*

**Topic 5:** Benchmarking the prescribing of high dose and combination antipsychotics on adult acute and PICU wards *Finishes April 2010*

**Topic 6:** Assessment of side effects of depot antipsychotics *Provision of change interventions in anticipation of a future supplementary audit*

**Topic 7:** Monitoring of patients prescribed lithium

*Re-audit*

**Topic 8:** Medicines reconciliation

*Re-audit*

**Topic 9:** Use of antipsychotic medication in people with a learning disability

*Provision of change interventions in anticipation of re-audit data collection in 2011*

**Topic 10:** Use of antipsychotics in Child and Adolescent Mental Health Services

*Baseline audit*



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## Caswell Clinic - Caswell Chat

This is a short article about our publication 'The Caswell Chat' and other things happening in Caswell Clinic.

### Caswell Chat

The Caswell Chat is an in-house magazine produced by patients in Caswell Clinic, Bridgend. It was started in 2001 and we have produced 26 editions since that time. There are regular articles such as 'Twitcher' (nature), Simon Says (book and CD review), Richards Roving DVDs (DVD Review) Compost Corner (gardening section), Koestler Awards (competition for secure units) Caswell Stoneware (concrete products), poems and jokes, Groups Timetable and also 'The User Friendly Group' (UFG) and UFG Shop

More topical articles are featured in 'Caswell Chat' as they happen, for example, quiz nights arranged by Friends of Caswell (a group of people in the community that promote Caswell Clinic in the local area), a local band run by a member of staff, fun days and fetes and charity events such as Children in Need.

### User Friendly Group

The UFG was formed in 1998 by ex-patients of Caswell Clinic and acts to improve the quality of life for patients in the Clinic. The UFG meets once a month and some of its achievements can be listed as follows:

- The idea to start activity coordinators in the clinic so that time is spent doing activities

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during weekends as well as in the week.

- Church of Wales and Catholic service held monthly in the clinic.
- Shop: Sale of confectionary, toiletries, crisps and flavoured mineral water, £5 phone cards, postage stamps. Second hand book section and clothing given away free of charge.
- Welcome packs for new patients coming to the UFG Shop (Patient Information Leaflet, phone card, cereal bar, water and clothes if required).
- Recycling plastic bottles.
- Drama group with the Vale and Valleys Arts Community.
- Toe by Toe Reading Scheme. This helps a patient to teach a fellow patient reading skills in an informal way.
- 'Butty Scheme'. This enables new patients to benefit from the experience of other patients who have been through the system in the clinic - This is a support mechanism and acts to build up the confidence of patients.

You can access all the information regarding Caswell Chat and UFG on our web sites. The addresses are [www.caswellchat.co.uk](http://www.caswellchat.co.uk) and [www.userfriendlygroup.com](http://www.userfriendlygroup.com) We hope that you enjoy accessing our articles and reading them as much as we have enjoyed writing them.

### The Group Activities Time Table

The 'Groups Time Table' team has been going since 2005. The group aims to gain patients views and feedback on the various groups and activities that are available in 'The Clinic'. It meets up every other month to discuss and table group activities on a daily basis. The chair is rotated by patients. We review group activities that are successful and those that are not. Some of the groups that are happening include gardening group, swimming, cycling, gym, drum tuition, African drum music, visits to different places, arts and crafts, drama group, rambling, concrete workshop

and many more activities besides these.

### Community Meetings

This is where patients and staff get together to comment and make changes to the running of the ward.

New ideas are discussed and action implemented. This happens on a monthly basis. We hope that you find this information useful and can perhaps use some of these ideas yourself.

If you have any comments please let us know as we are always looking to improve our services.

### Meeting peoples Spirituality needs at the Clinic

A few years ago, we were not meeting the spiritual needs of some of our patients. It's no good hiding this fact, if we did we would not be able to move on and address this matter. Because there is a very fine line between psychiatry and religion, everyone from the top down who work at the Clinic were happy that this important subject was now open for debate. We now have a slot in the ongoing training about meeting people's religious needs. All people who work with this client group need to understand their beliefs, because if they don't then they cannot understand the person they care for. It is therefore a very good thing that the user friendly group is an active group here at the clinic, because it can approach subjects than some times are better left alone. Spirituality & Psychiatry is now being looked into on a national all Wales level.

Written by  
Service Users at the Caswell Clinic



## Articles by the Quality Network's Service User Experts - End of Cycle Update



Now that we have reached the end of the Cycle 4 review process we would like to update you on the role of the Service User Experts over the last year - it's exciting work but not as exciting as the latest Sherlock Holmes movie.

Four Service User Experts were involved in the work of the Quality Network over the last year. All of the Service User Experts have experience of acting as a ward rep (or similar) in a medium secure setting and the team consisted of two men and two women. Mike Gatsi, a co-opted member of the Advisory Group, acts as mentor to the Service User Expert team providing valued advice and support.

During Cycle 4 the Service User Experts have had four main tasks:

1. Attending advisory group meetings
2. Service user telephone conferences
3. Attending peer-review visits
4. Writing articles for newsletter

### Advisory Group Meetings

The Advisory Group meets four times a year and there is a standing item on the agenda regarding the Service User Expert representation. At the meetings the Service Users have the opportunity to report on the progress of telephone conferences and participation in peer-review visits as well as taking part in discussion regarding the Quality Network as a whole. And of course during these

meeting we have questioned and raised many issues directly relating to how patients can expect to benefit from the quality process.

### Service User Telephone Conferences

The telephone conferences are arranged to take place between service user reps at member units and the Service User Experts with the support of the project team. The conference follows a structured interview format and mirrors the structure used in the actual peer-review workbook. The interview covers four main areas: Service User Rights, Service User and Career Involvement, Equality, Diversity and Advocacy and Personal Health and Primary Healthcare, and we ask questions such as "Do staff demonstrate respect for patients" through to questions on food and nutrition.

### Peer-review Visits

It was agreed by the Advisory Group that we would pilot a scheme to involve the Service User Experts in the peer-review visits taking place in Cycle 4. Sixteen out of the 64 visits included one of the Service User Experts as part of the peer-review team. The service users at member units were found to respond positively to the inclusion of a Service User Expert in the review team and the whole process was extremely interesting. However, the coverage of such a wide geographical area proved to be a challenge.

### Proposals for the Future

So, moving onto proposals for the future, recent suggestions that have been thrown into the melting pot during advisory group meetings have included:

- The development of a post for a full-time member of staff to co-ordinate service user involvement within the Quality Network
- Recruiting Service User Experts from diverse geographical locations in order to improve coverage of wider/different areas
- Recruiting more Service User Experts as the workload increases.



Finally, we would like to say that none of this would have been possible without the support of the Quality Network staff who help to co-ordinate the telephone conferences, plan travel arrangements to the quarterly meetings and to peer-review visits. So on behalf of all the Service User Experts thank you to Kerry, Maddy and Anna. And also thank you to Mike for his ongoing support.

Alain Aldridge  
Service User Expert

### If you would like to submit an article of interest

to the Quality Network for Forensic Mental Health Services  
newsletter please  
contact Kerry Painter:

[kpainter@cru.rcpsych.ac.uk](mailto:kpainter@cru.rcpsych.ac.uk)

### 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 three years of the group is available at [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)

Visit us online at [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)

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## Lead Reviewer Training

Tuesday 18<sup>th</sup> May 2010,  
Tuesday 20<sup>th</sup> July 2010, or Tuesday 7<sup>th</sup> September 2010  
From 09.30 To 13.40



COLLEGE CENTRE FOR QUALITY IMPROVEMENT

### **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 an application form, please visit our website**

**[www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)**

**Visit us online at [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)**

## Events



COLLEGE CENTRE FOR QUALITY IMPROVEMENT

- **Clinical supervision in the forensic setting: Is it working for you?** 23rd April 2010  
Target audience—senior multi-disciplinary professionals (clinicians, managers and commissioners) who work in forensic mental health and criminal justice settings. [Clairemusham@priorygroup.com](mailto:Clairemusham@priorygroup.com)
- **Deprivation of Liberty Safeguards (DoLS): Update Training for DoLS Mental Health Assessors** 29th April 2010  
The Royal College of Psychiatrists' Education and Training Centre is pleased to present a one day training course to provide the annual further relevant training required for Deprivation of Liberty Safeguards Mental Health Assessors.  
Please contact Hannah Graham 0207 977 6657.
- **Writing for Court - Ensuring Quality and Effectiveness**  
14th May 2010  
This training course will enable you to both understand the legal process and to give effective evidence. This course includes a practical court case study role-play. Delegates are asked to dress accordingly for a court appearance.  
Please contact Hannah Graham 0207 977 6657.
- **Safer Prescribing of Medication ... Schizophrenia** 15th June 2010  
This one day workshop will help improve your prescribing practice when treating patients with schizophrenia. Our medical and pharmacy experts are joining together to provide you with their best advice on the most up to date and effective medications and treatments including the most recent NICE guidance. There will be plenty of opportunity for debate as well as group work on case studies and discussion of your own issues. A session on patient choice will enable you to hear directly about patient preferences.  
Please contact Hannah Graham 0207 977 6657.
- **Working with Difficult Patients: Psychoanalytic Understanding Applied to Working in Psychiatric and Forensic Settings (CPD course)** 26th—30th July 2010, fee £140 per day (£630 for all 5)  
This week of 5, one-day courses will offer a model for thinking about serious and enduring mental health problems in mental health and forensic settings. The course will help clinicians reflect on their experience of difficult clinical problems and think about the effect of the patients' difficulties upon the clinical setting. For more information, and to download an application form:  
<http://www.tavistockandportman.nhs.uk/DifficultPatients>

## Useful Links



COLLEGE CENTRE FOR QUALITY IMPROVEMENT

- ⇒ **Department of Health** <http://www.doh.gov.uk/>
- ⇒ **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/>
- ⇒ **National Offender Management Service (NOMS)** Brings together the work of the correctional services <http://www.noms.homeoffice.gov.uk/>

Visit us online at [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)

## Useful Links

- ⇒ **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/>



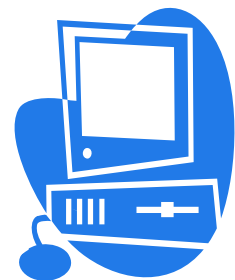
## The Policy Library

Visit the Policy Library on our website: [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)

### Members access only.

Please email the following address if your unit is a member of the Quality Network and you would like access to the Policy Library:

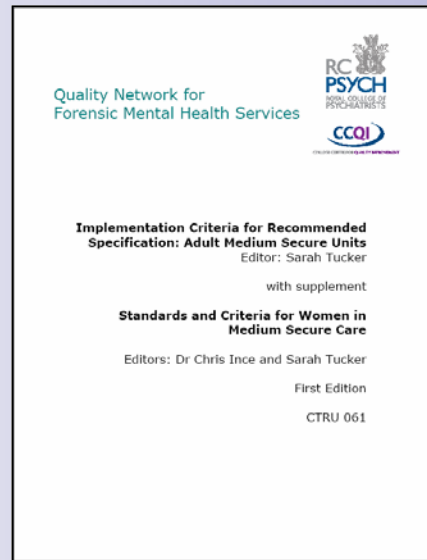
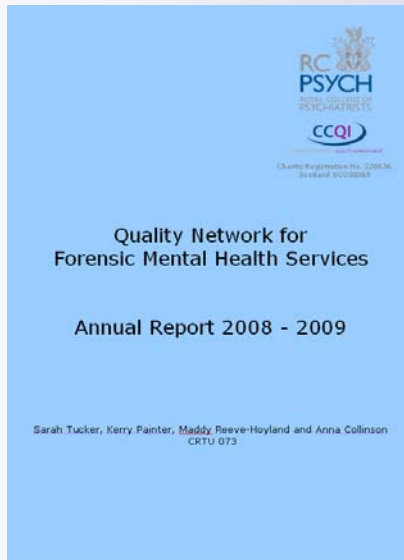
[msu@cru.rcpsych.ac.uk](mailto:msu@cru.rcpsych.ac.uk)



Visit us online at [www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)

View the Cycle 3 Annual Report and Implementation Criteria  
with Standards for Women at:

[www.rcpsych.ac.uk/QNFMHS](http://www.rcpsych.ac.uk/QNFMHS)



**QUALITY NETWORK FOR  
FORENSIC MENTAL  
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