Welcome to the 27th edition of the Quality Network for Medium Secure Forensic Mental Health Services Newsletter. In this edition we are looking at the implementation of a smoking ban within Medium Secure Services, a topic which was raised frequently during last years review cycle. Many thanks to all those who submitted articles and we hope you find them interesting and useful when thinking about issues around smoking within your own service.

We are approaching half way mark in Cycle 9 of the Medium Secure reviews and are looking forward to the Frontline staff event being held in December. We recently held a Consultation event looking at the Prison Mental Health Services Standards which was very successful and interest generated both from practitioners and commissioners has led to a proposal for the development of a Quality Network for Prison Mental Health Services. The Quality Network would like to thank all who attended and contributed to the event.

Dr. Paul Gilluley
Chair of the Advisory Group

Patients with mental disorder are twice as likely to smoke as the general population (El-Guebaly & Hodgins, 1992) and patients cared for in residential institutions exhibit rates of smoking in excess of 70% (Meltzer et al., 1996).

One survey estimated that 45% of all cigarettes smoked are actually smoked by individuals with a psychiatric disorder (Lasser et al. 2000).

Given such a high smoking prevalence, it should come as no surprise that smoking-related diseases are more prominent among mental health patients than in the general population (Brown et al. 2000). Patients with a mental disorder have a lower life expectancy than the general public. This situation is worsened by the fact that smoking increases the metabolism (and hence the required dosage) of some psychiatric medications which...
themselves are associated with higher rates of physical illness. Smoking, for example, increases the metabolism of Clozapine which is linked to metabolic syndrome (associated with heart disease, stroke and diabetes) (Lamberti et al 2006).

A complete non-smoking ban was introduced by Arnold Lodge Regional Secure Unit, Leicester during April 2007, as part of Nottinghamshire Healthcare NHS Trust premises becoming smoke-free sites. In the period of time leading up to the smoking ban the Primary Healthcare team provided intensive smoking cessation support and advice to all patients. The basic level 1 smoking cessation training was delivered to all members of staff, whilst other members of staff, including Sports and Leisure and nursing staff, received training to enable them to provide individual and/or group smoking cessation sessions. This initiative enabled the Unit to successfully implement overnight a total ban on smoking for all staff and patients within the grounds and on escorted leave for all patients and it remains in place to this day.

Despite concerns, there have been very few smoking related incidents within the service since the implementation of the ban; however, the challenge we have faced is how we ensure patients refrain from smoking again when they are granted unescorted leave. This remains an area we continue to work on individually with all patients.

Smoking cessation continues to play an important aspect in a patient’s care at Arnold Lodge, especially for the newly admitted patient, who may have been smoking right up until their admission to us.

The Primary Healthcare team offer advice to nursing staff on care plans, which includes a cessation plan with the use of nicotine replacement therapy and support over this period and also offer one to one support as well as smoking cessation group work as part of the Health Promotion course provided by the service.

Marie Ainsworth,
Assistant Practitioner, Health and Wellbeing Facilitator and Resuscitation Officer Primary Healthcare,
Arnold Lodge, Leicester.

Smoking Cessation: An Overview

Given how well the dangers of smoking are publicised in the media and have been for years, I have often wondered why people start in the first place especially as it is just as well known how hard people find it to give up.

From the 1st October onwards patients in secure and forensic psychiatric secure hospitals nationwide will no longer be able to smoke on hospital premises. Many inpatients together with the staff whose duty it will be to reinforce this are unlikely to be looking forward to this. However help is at hand. There seems to be a myriad of smoking cessation aids on offer to the would-be ex-smoker; patches, inhalators, mouth-spray, lozenges, gum, micro-tabs and nasal sprays together with the somewhat controversial electronic cigarettes. It must be quite challenging to decide which nicotine replacement therapy to go for and of course even harder to stick to it when the cravings kick in and your fingers feels that certain twitch.

Whilst giving up smoking has undeniable health benefits, it shouldn’t be overlooked that it is clinically recognised that smoking conveys a certain advantage to the smoker’s mood and increases concentration levels. Some patients will look forward to be prompted to quit however for others, especially those newly admitted, having to forego their ‘fags’ will add more to the burden of stress they are under. This doesn’t seem very helpful, at least not in the short-term.

Unfortunately as many former inpatient ex-smokers will testify, the lure of relapse and submitting once more to the spurious comfort of ‘a smoke’ will continue after discharge, even if patients have the resolve to abstain whilst on S17 leave. I recall a former colleague of mine saying to me ‘Oh Sarah, you do not know the agony of the smoker. You do not want to smoke, but you have to.’

Dr Sarah Markam,
Patient Reviewer
Smoking Cessation in the Shannon Clinic

Background
Shannon Clinic is a 34 bed Regional Medium Secure Unit located on Knockbracken Healthcare Park in the Belfast HSC Trust area. Compared to the general public, a disproportionate number of people with Mental Illness smoke, 42% in comparison to 23% of the general public (Ratszen, 2013). This contributes to huge health inequalities, potentially reducing a person’s life span by up to 20 years. Belfast Trust has recently announced its intention of becoming a smoke free service in the next few months.

NICE guidelines (2013) recommend that health care professionals take a more active role in promoting Smoking Cessation. In response to this Belfast Trust sought to develop a Smoking cessation service for inpatient mental health on the Knockbracken site. The appointed smoking cessation nurse for mental health is seconded two days per week from Shannon Clinic and funded by the Public Health Agency. Being an existing member of the Shannon team was undoubtedly an advantage as they brought a pre-existing knowledge of the patient population. This familiarity with her cessation clients allowed rapport to be quickly established.

Training Role
An important aspect of the work is the delivery of Brief Intervention Training (BIT) to healthcare staff, intended to impart a clear understanding of the benefits of smoking cessation. In this way it is hoped that staff could more effectively and confidently discuss cessation and be in a good position to refer individuals to the smoking cessation service. Delivering the training was initially problematic partly due to the ongoing burden of mandatory training and the fact that smoking cessation was not seen as high priority by some staff. One way to address these barriers was that training was offered at 8 am, a time when both day and night staff were able to attend and when there were fewer clinical demands on the nursing team.

The general consensus from staff raised through the BIT was that smoking cessation would be a positive for the patient population. There were, however, anxieties expressed of a possible increase in levels of patient agitation and aggression, seemingly confirming the theory that a smoking culture existed within the clinic.

Next Issue
“Frontline staff”
Some areas that could be covered:

The importance of frontline staff in patient recovery

What would you like to see frontline staff doing?

Any successes/challenges that your service has encountered with frontline staff engaging family and friends.

For more information or to submit articles please contact Tiffany Rafferty at the Quality Network
TRafferty@rcpsych.ac.uk
Engagement
Following referral, staff gave a brief report including details of the patients’ diagnoses, medication, risk status and strengths and weaknesses. Subsequently, an individual assessment was undertaken, which took place off ward in the Clinic’s Health and Wellbeing room, an attempt to emphasise the importance of stopping smoking.

All patients consented to have a base line measure taken of their Carbon Monoxide levels. A comprehensive smoking history was taken, including current use, previous quit attempts, products used and triggers for their smoking behaviours. Following this suitable nicotine replacement therapy would be suggested, along with advice on best usage and simple, individualised, diversional tactics were discussed. Efforts were then made to explore their motivation to quit/cut down. Their reasons varied from looking after their health, to saving money, to challenging themselves, to detesting the smell. Patients were then encouraged to think of something to spend the money they saved on, as a way of maintaining motivation.

A Harm Reduction Approach
A characteristic of the forensic patient group is one of limited success and even failure, often having failed academically, in relationships, at being a parent and having failed to keep themselves well, both physically and mentally (Curley 2014). With the average person taking at least 5 attempts before a successful Quit, there was a reasonable concern that if someone failed to quit smoking this perceived failure could also have an unhelpful psychological impact. Feedback from ward staff was that a surprising number of patients were interested in quitting; however, many were unwilling to commit to a Quit Date. Adopting a “Cutting down to Quit” approach proved more palatable to most, which was consistent with the advice given in the NICE (2013) guidelines. Adopting a harm reduction approach therefore seemed a reasonable way to proceed.

A combination of brief health advice, nicotine replacement therapy and behavioural support has been shown to be an effective treatment approach (McNally, 2006). Further behavioural support was offered on an individual basis, to support the patient with their smoking cessation, which often took the form of motivational advice with most patients being seen weekly. Prior to review appointments, feedback from ward staff was obtained. Patients self-reported their cigarette / tobacco intake. Most were eager though often anxious to have their carbon monoxide levels measured. Some patients likened it to going to the dentist, ‘something that you know is good for you but not always good news’; the visual aid of the CO reading was clearly a motivating factor for many patients. Inevitably though, some patients struggled and needed help re-focusing. Frequently this took the form of revisiting their initial reasons for wanting to quit / cut back. Discussing pitfalls with the patient and suggesting alternative ways to deal with cravings and peer pressure were often required.

Conclusion
Despite the challenges presented by population, culture and environment, to date 3 patients have completely quit and 3 have reduced their tobacco intake and carbon monoxide levels by half. Our hope is that all this additional worthwhile effort will make the transition to a totally smoke free environment a smooth one and that the health of our patient population can improve.

Rose McGurnaghan
Smoking Cessation Nurse for Mental Health
In 2011 an audit in the SLaM Medium Secure Unit (MSU) revealed the prevalence of smoking was close to 90%. People with mental health problems lose on average 17 years of life, with smoking rated the number 1 causal factor. There is now good evidence on the dangers of second hand smoke and how nitrosamines, one of the 70 cancer causing components of tobacco, continues to increase in the air after a cigarette is extinguished. Smoking is also the trigger for coronary heart and respiratory diseases. It gets in the way of the metabolism of most medications and this requires higher does to be prescribed which in turn leads to more unpleasant side-effects. Facilitating smoking accounted for 90 minutes of valuable nursing time each day in our services, this was a big driver to release time to care in line with our professional codes. Developing smoke free policies with an emphasis on providing tobacco dependence treatment as standard is now accepted as an essential component of a modern mental health service.

Staff in forensic services have struggled with facilitating smoking and often used cigarettes as both punishments and rewards with neither being an acceptable component of good quality therapeutic intervention. In the MSU environment smoking presented particular security and risk issues for staff who strive to provide a safe environment balanced with imposed restrictions around smoking that were time consuming, blurred and ineffective.

The Health Act (2006) kick started the smoke free initiatives in the high secure hospital settings and despite reassurance provided by the outcome to the Rampton patient’s legal challenge which concluded that it was not a human right to smoke, the MSU estate has been slow to follow this lead. However with the launch of the NICE Guidance on smoking in secondary care (2013) this has kick started a renewed focus on this pressing issue.

SLaM forensic services comprising of six MSU wards, one low secure unit and one ward in the community introduced a smoke free policy on March 13th 2013 to coincide with National No Smoking Day. Prior to the policy launch patients and carers were consulted and engaged in planning for the huge cultural change. Staff were trained in smoking screening and cessation interventions. Pre-admission assessments were adapted to incorporate planning for either temporary abstinence or quit attempt on arrival at the service. A range of Nicotine Replacement Therapy is provided within 30 minutes of admission. Smoke-free messages are also incorporated into other aspects of health promotion provided and cues for smoking have been withdrawn.

The work is not without its challenges.

“Sometimes patients manage to get visitors or unaware staff to buy tobacco for them and start to trade it or smoke it in their bedrooms or in a hidden corner in the garden,” says Aurelia Hossu, acting team leader on the forensic intensive care ward. “On occasions patients who have leave from the hospital have returned with tobacco and traded it to vulnerable patients charging inflated prices”.

But despite these issues that have required intensive focus, there have been many reasons to celebrate. Patients are more active, they engage in more activities, and are more involved in their therapy programme. For some the motivation has been to be granted community leave so that they can return to smoking. All the patients even those with leave have significantly reduced their smoking. Many have made successful quit attempts and enjoyed the benefits of having medication reduced. There has been a big reduction in the prescription of antibiotics, the referrals to the GP service and the number of patients accessing the local acute hospital services. This is good news for the patients improved wellbeing but it is also a huge reduction in costs associated with escorting. When patients quit it gives them confidence to address other issues in their lives. It improves their self-esteem and of course patients with more money in their pockets are using this to purchase new clothes, get new glasses, get their hair done and buy make-up.

Ward two patients made a countdown calendar as part of their preparation for March 13th.
**Case Study 1:**

Joe*, 32, has serious mental health problems and a history of offending. He has been detained in hospital for the last six years. Since his early teens, he has smoked 20 cigarettes a day. “When I heard about the smoke free ban I was furious. Everything I do in hospital is controlled. Smoking was one of the few things I could do and it was being taken away from me. These feelings were very powerful but I talked to my nurse and attended a group on the ward. Two of the staff were very helpful and I realised that I could get help to quit and that it would be in my best interest. Learning more about the harmful effects of smoking helped. I always knew that cigarettes were bad for me but seeing pictures of lungs affected by smoking and seeing my own carbon monoxide results was very real. Leading up to the quit date I drew up a plan with my nurse to gradually cut down. I also started using NRT. First patches, but they did not take away the craving, so my doctor added in the lozenges. I didn’t like the taste of them so he suggested the inhalator. This helped because it gave me a more immediate nicotine hit when I needed it. Quitting is a very hard thing to do. The help and support is very important. I realise that the staff want me to have a long and healthy life; they are not just making me suffer. I still have an occasional cigarette when I am out on leave with my friends because they all smoke. But I do have hope that I will be able to finally give up for good.”

**Case Study 2:**

Jane* has chronic asthma, she was very resistant to the idea of cutting down or quitting her smoking habit of 20 per day. Over time she prepared for the change with encouragement from staff, friends, and family. She used a range of NRT products with some effect but still had cravings. When she switched to using an e-cigarette she was able to stop smoking. Her health improvements have been very encouraging with marked changes in her carbon monoxide readings, peak flow, and spirometer tests. She is taking it one day at a time and recognising her improvements has been a big motivator.

*Names changed to protect anonymity.*

**Ward One** – transformation from cigarette waste outside the main entrance door to clean space, blooming flowers in pots and the removal of the smoking shelter.

**Ward three** – staff prepared easy read smoke-free plans for their patients

**Stop smoking**

**Start Living**

Mary Yates, RNHM, RMN, MSc. Matron, Behavioural & Developmental Psychiatry, River House Medium Secure Unit, Bethlem Royal Hospital

Celebration well-being event on March 13th 2013 with a variety of sports activities facilitated.
A personal perspective on the smoking ban

I am a Family and Friends representative for the Quality Network and my son has been in several MSUs over the past 6 years.

I feel very strongly about whether smoking should be banned, as I have seen my son start smoking since being in a unit where smoking is still permitted. Before he was admitted, he was a very fit young man who loved exercise-and who hated me smoking! He was always trying to persuade me to stop and eventually I managed to give up, about 3 years ago.

But since moving to the unit he is currently in, he started going out for the smoking breaks - initially just to get some fresh air and to socialise. It wasn’t long before I noticed the signs that he had started smoking and he eventually confessed that he had started smoking and that it had already had a negative effect on his health. His exercise regime has gone out of the window and he plans his day around the smoking breaks. He says that the 7 breaks give him something to look forward to during the day.

However, while he was at different units where smoking has already been banned, patients were given aids such as patches to help stop the withdrawal from smoking and very quickly got used to it, without too much discomfort. There were still some opportunities to get fresh air-and I feel that it is very important that this should continue even when smoking is banned-perhaps for longer periods, rather than frequent, 15 minute breaks. If breaks of 30 minutes were provided, patients could have the opportunity to get some exercise, with their greater lung capacity!

As society moves towards being non-smoking, it is getting more and more uncomfortable for the smoker-there is now talk about banning smoking in public parks! Patients in MSUs will be more prepared for this when they are discharged if the ban is enforced now-and they will be healthier and richer!

My son continues to look forward to his 7 smoking breaks a day and has mixed feelings about the potential ban, but knows that he will again become a non-smoker once he is out. He tells me of patients who have little pleasure in their lives apart from smoking and it is this group that are going to miss smoking the most. So the importance of providing regular fresh air breaks even after the ban is crucial-as well as the provision of smoking-cessation aids.

I know how this addiction can be life-long from my own experience and how health is badly affected after years of smoking. MSUs need to come in line with society at large to offer equal opportunities to its residents and to help the patients through the three weeks it takes to break a habit!

I, personally, hope that the ban eventually comes into force and that patients who already suffer from health problems related to the medication will be given the support they will need to get through the first weeks-and to become smoke-free. Patients in the mental health system are as precious as people who are lucky enough not to be in the system and deserve to protected from the diseases linked to smoking!

Gail McCabe
Family and Friends representative
In September, some service users from Thames House volunteered to train as Peer Support Smoking Cessation Advisers.

**Thames House has offered a smoking cessation service since opening in 2007.**

We have had a member of the Occupational Therapy team, namely health and fitness instructor, trained as a level two lead smoking adviser and additional MDT members within the wards trained as level one advisers. Linking in with the expertise of Oxfordshire Smoking Advice Service (OSAS), a smoking cessation service is available for all patients during their admission.

Due to recent changes in the provision of smoking facilities on site and the view to go smoke free in the near future, it was decided to implement an additional layer of service user support - Peer Support Advisers. With help from OSAS, a training course was delivered to interested patients to receive the same level one adviser training open to staff members. This was open to anybody, in particular those who may have used the service themselves. The training ran over 3 sessions, covering the facts about smoking; habit, dependence, and addiction; how to talk to someone about their smoking, and support them through a quit attempt; motivations for both smoking and quitting; and other forms of support available, such as Nicotine Replacement Therapy.

Both wards on Thames House now have posters telling patients who their Peer Support Advisers are alongside the trained staff, if they want to go to someone for support. Additionally, the Peer Support Advisers have agreed to support staff in delivery smoking cessation sessions in the Occupational Therapy programme.

We hope that a peer-based support system may provide additional levels of support to those on the wards undertaking a quit attempt, particularly outside of therapy hours, and with a peer to peer approach.

We have had a positive response so far from the patients who took part in the training. One of our Peer Support Advisers, said:

‘I was recently asked if I would like to become a Smoking Cessation Peer Support Adviser and do some training for it. At first I was a little hesitant because I wasn’t sure what I could offer anyone.

I was a smoker from the age of 19 until the age of 27. I gave up because I became pregnant with my daughter and it seemed like an ideal time. It was rather easy for me because I had something to look forward to at the end of the struggle (now I’m not suggesting you all go and get pregnant!) but having something at the end of your struggle might make it all worthwhile.'
I have learnt on the course that your health is a main area that will improve if you give up and a few other benefits include: more money to spend on nice things, your sense of smell and taste will improve and you can gain some control back into your life. Not being tied down to the first cigarette in the morning and the last one at night.

You will experience withdrawal symptoms but with help from your GP, Key Nurse, OT’s and Peer Support Advisers I hope it would make things a little more bearable for you.

I have also learnt that there are many items on the market that are there to help you give up and by speaking to any advisor you can be given one that is suitable for your needs.

I enjoyed my time in training and did learn a great deal. It will be nice to pass my knowledge onto someone else to help them to give up smoking.'

Looking forward Thames House will continue to increase the smoking cessation service provided by:

- expanding on the peer support training to ensure there is someone available on both wards,
- continue advertising and encouraging the wider MDT to undertake the adviser training, and
- staying up to date on the latest intervention and product advice.

Kristi Ludlow, Health and Fitness Instructor
Zoe Gray, Occupational Therapy Assistant
H, Patient

The National Health Service (NHS) was born out of a long-held ideal that good healthcare should be available to all and the core function is emphasised in the value of “Improving Lives” by helping people take responsibility for living healthier lives. Principle 1 of the NHS Constitution (DoH, 2013) articulates that it is “designed to diagnose, treat and improve both physical and mental health issues and that in addition to respecting individual human rights it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population”.

This premise has been reiterated over the intervening years in a number of publications and more latterly in the Department of Health documents “Healthy Lives, Healthy People” (DoH, 2012) and “No Health without Mental Health” (DoH, 2011) and these values and principles of the NHS are the underpinning foundation of implementing smoke free hospitals particularly within a Mental Health Setting. Further backing has been given in the recent publication by the National Institute for Clinical Excellence (NICE,2013) supporting smoke free implementation within all in-patient settings.

It is now recognised and well published that there is a strong association between smoking and mental health disorders (RCP, 2013) making people with mental health problems at greater risk of smoking related physical disease such as cancers, cardiovascular and respiratory diseases (De Hert, Dekker, Wood et al, 2009). “Healthy Lives, Healthy People” (DoH, 2012) highlights the links between smoking and raised morbidity and mortality rates in the general population and confirms that smoking is the largest cause of preventable death in the United Kingdom (UK), reducing life expectancy, on average, by around 10-15 years. Nicotine stimulates the subcortical reward system and the prefrontal cortex, both of which have lowered functioning in people with schizophrenia (Chambers et al, 2001) and a clear relationship has been identified between the amount of tobacco smoked and the number of depressive and anxiety symptoms in people with existing mental illness and those without mental health problems (Faculty of Public Health, 2008).
However, research evidence has shown that people with mental illness are generally able to quit smoking if they are given evidenced-based support (ASH, 2013) also leading to a possible reduction in doses of prescribed medication (Campion & Hewitt, 2011).

As an NHS Mental Health provider the clinical and operational leadership within the Specialist Service Network (SSN) providing Medium (MSU) and Low Secure (LSS) care and treatment for adults and adolescents based within Greater Manchester West Foundation Trust believe that People within our care should not be treated in a different way to other members of the wider general public in terms of looking after both their mental and physical health and that continuing to allow smoking on site perpetuates inequalities in the treatment of people with mental health problems. As such in March 2013 the process began of putting forward a compelling argument to institute a smoke free environment driven by our Clinical Service Director commencing with an options appraisal.

National research, legal processes, policy and best practice evidence were reviewed and collated which included other Services published experiences of “what worked and what didn’t”, including debunking the myths around smoking bans and “increased violence” and tackling head on the issues of providing the right individual support (pharmacological and non pharmacological) and a phased approached that provided information, training, reduced smoke breaks and increased activity levels (Campion & Hewitt, 2011; Shetty, Alex, Bloye, 2010; Prasad & Worley, 2013), Baseline figures of existing smokers and current education and training were collated highlighting that a larger percentage of smokers existed within the Service User group and only individuals trained in smoking cessation were found in the staff group but this imbalance could be addressed going forward as part of the action plan in liaison with local Stop Smoking Services (SSS) who could assist in providing this.

Local consultation processes were put in place via focus groups and visiting wards to hear first-hand our Service Users views, concerns and expectations. The “right to choose” and “individual choice” were the two overarching statements received from service users during feedback. This was counter balanced by information giving to ensure that “choice” was “Informed” by facts that potentially had a personal impact on peoples’ physical and mental health. The importance and role of ward staff in this proposal was also not ignored both as recipients for those who were smokers themselves and in delivering the strategy (McNally, 2006; Ratschen et al, 2009; Ratschen, Britton & McNeill, 2011).

Information gained during this process formed the foundation of our proposed Service Delivery Strategy in March 2014, presented to and then supported by our Trusts’ Corporate Quality Governance (QGG) and Service User and Carer Team (UACT) Steering Groups. A three strand approach to implementation was used outlined by Cormac & McNally (2008) to capture processes that would direct our inclusive action plans pre, during and post Implementation. Service Users who felt passionately about this issue both for and against implementation were recruited to sit on the newly formed multi-disciplinary network steering group (chaired by the Deputy Network Director) and which has met monthly since April 2014 to review and update the action plan. Individual Steering Group members take responsibility and lead in their own right on specific project objectives, feeding back progress at each meeting to keep identified timescales on track leading up to smoke free implementation by 1 January 2015. To date this is on track.

Andrea Livesey
Advanced Practitioner,
Deputy Project Chair
(SSN Smoke Free Implementation Group)
Adult Forensic Mental Health Service Directorate
Prestwich Hospital,
Prestwich, Manchester

References
• ASH (2013) Smoking and Mental Health Fact Sheet May 2013
• Cormac I and McNally L (2008), ‘How to implement a smoke-free policy’, Advances in Psychiatric Treatment, Royal College of Psychiatrists, 14, pp198–207.
The Department of Health policy on reducing obesity and improving diet notes that over 60% of adults are overweight or obese. Health problems associated with this cost the NHS over £5 billion per year. (DOH 2013)

Wathwood Hospital continues to innovate with learning approaches to meet best practice and further plan what is possible. To this end the healthy lifestyles group which began in 2009 focuses on patients with high BMI levels or dietary lifestyles which, with input could change to reduce the impact of obesity and/or reduce adverse effects of a poor diet.

The healthy Lifestyles group consists of a one hour weekly course facilitated over eight weeks with a maximum of eight learners. The style of learning used Visual Audible Reading and Kinaesthetic (VARK) was chosen to best support learners’ needs within the context. To capture current and new knowledge a quiz was undertaken at the beginning and at the completion of the group. To measure the efficacy of the group BMI, weight and waist measurement was taken. Using these measures demonstrates the impact of the group.

Patient A commented

"Attending the Healthy Lifestyles Group, facilitated by staff at Wathwood Hospital educated patients in a number of areas relating to general health and wellbeing. There were sessions that focused on understanding your body mass index, guidelines for a healthy weight. We also looked at how to prevent over eating and the benefits of having a diet containing less fat, sugar and salt; and the danger of having too much of these. The group also looked at the benefits of maintaining a healthy heart and the importance of exercise combined with diet. I found the group to be informative and motivating in the early stages of recovery, particularly the session relating to the effects of medication on weight gain."

Patient B commented:

"At least when I choose a meal I am aware of the right choices, before the course I wasn’t aware of what things were bad for me. I now know I need to exercise regularly”.

Patients and staff reinforce lessons learned from the healthy lifestyles group through undertaking level 2 Certificate in Nutrition and Health accredited training through distance learning. To support learners within this collaborative process staff work as mentors to patients. This enables a supportive approach and opportunity to consolidate learning. The aim of the qualification is for the individual to improve their understanding of nutrition and diet, their role in improving and maintaining health and wellbeing, and how attitudes toward food can influence and impact on wellbeing.

Patient A commented.

"Level one and two of the nutrition and health course gave me a better understanding about what a healthy balanced lifestyle consists of, such as the different food groups and the right amounts in which to consume them. Having this knowledge of dietary requirements and a more active lifestyle has allowed me not only to combat obesity but also to dramatically reduce cholesterol levels, improve blood pressure and heart rate, but also to prevent tooth decay and heart disease.”

Level 2 Health and Nutrition- a patient /student perspective (Patient C)
"It is now 8 months since I finished the second assignment. I live in a different part of the hospital where I self-cater using a weekly allowance to purchase all I need from the local supermarket. I find it relatively easy to make the right food purchasing choices with the knowledge I gained from this level 2 qualification. I make nearly all my meals from scratch using plenty of vegetables and fruit and trying to adhere to the "healthy eating plate" approach."

In conclusion, staff will continue to promote the benefits of exercise. As patients move through the wards and arrive at the lodges they can then budget, cook and prepare their meals, with the advantage of an increased awareness of a healthy lifestyle choice after completing either healthy lifestyle or Nutrition and Health courses, or both. The Nutrition and Health course is relatively new and will continue to be promoted with patients and staff who will be available for help with collaborative learning if required.

Patient A kindly gave permission to release a before and after photograph. Following active participation in the group and regular exercise this individual saw a weight loss of 32kg or 5 stone. See below.

BEFORE (BMI 38)  
AFTER (BMI 25.9)  