In this issue

01 Enhancing Transitions in Forensic Services.
03 Path-Nav: Clear Navigation With Patients Sharing The Driving
05 Patient Pathways and Outcomes
05 Individual Pathways
07 Occupational Therapy Project Within The MSU
09 Increasing Patient Involvement in Service Delivery Using Patient Representative Meetings
10 A Personal Experience of Recovery
12 MSU Patient Artwork Competition
14 Patients Accounts of OT Recovery Pathways
16 Steps Towards Post-Discharge Outcomes
17 “Not Another Questionnaire!” Creatively Evaluating the Patient Experience in Secure and Forensic Services
20 Useful Links

WELCOME

Welcome to the 30th edition of the Quality Network for Medium Secure Forensic Mental Health Services’ Newsletter. This issue is a themed edition on patient pathways and outcomes. There are a range of articles written by both patients and staff at medium secure unit’s across the UK highlighting key initiatives in place around CPA processes and vocational opportunities. We also have some articles from our patient and family and friends representatives from the Quality Network. The team would like to thank everyone who contributed to this edition and hope you find the articles both interesting and useful.

Since the last edition, we have had both our MSU and LSU Annual Forums in which we received good feedback on the events. We have also been busy preparing for the start of the new review cycle, with peer reviews starting in September.

Dr Quazi Haque
Chair of the Advisory Group

South West London & St George’s Mental Health NHS Trust
Enhancing Transitions in Forensic Services: Supporting the Discharge Process

The forensic service in South West London and St George’s Mental Health Trust (SWLSTG) consists of four medium and low secure wards working with male and female patients and a community team. Patients will typically receive 2-3 years of treatment before being discharged. Around 13% of patients are discharged to either their family home or previously arranged accommodation, whilst 15% are discharged to a forensic hostel. Like many other services (e.g. Dolan & Khawaja, 2004), our service had experienced some challenges in successfully discharging patients, with around 7% being recalled and readmitted to service within a year.
We conducted a survey of our patients and their family and friends (F&F). Whilst many patients said ‘I just want to get out of here’ they also reported feeling considerable anxiety as did their F&F, who expressed concern that their loved one would not be able to cope in the community. Other research indicates a similar picture in other secure services (Absolom et al., 2011).

Our service facilitates groups for patients nearing discharge (e.g. ‘moving on group’) but it was felt more was needed. We set up a steering group consisting of all of the stakeholders (Patients, F&F, service and hostel staff and commissioners). The outcome of this group and the survey conducted suggested that family work may help to solve problems experienced by patients, F&F and hostel staff, thus reducing the likelihood of recall or readmission back to hospital. Family work (FW) is one of the best evidence-based psychosocial interventions recommended by NICE (2009) and the DOH (2002; 2007) recommends its use in PICU, medium and low secure services. This recognises that 70% (Absolom et al., 2010) of patients have regular contact with their families, friends and carers who describe a heightened need for support with psychotic and/or anti-social behaviours (Absolom, et al., 2011). In addition to these benefits, FW reduces burnout rates, and improves attitude and knowledge about serious mental illness amongst staff (Bradshaw et al., 2000).

Our service has more than 30% of registered mental health nurses (RMHNs) trained in psychosocial interventions including FW; however this had not been consistently delivered. Psychosocial interventions play an integral role in patient recovery and discharge planning and RMHNs are uniquely placed to adapt and implement FW work within the discharge process.

The ‘Forensic Family Work Service’ that we developed therefore seeks to support the discharge process through the use of FW. We receive referrals from the four inpatient or the community MDT, identifying problems in the ability of F&F or hostel staff to support the SU immediately prior to or post discharge. Two qualified nurses work with each case, typically offering 4-6 sessions of FW, although this varies depending on the needs of patient, F&F and hostel staff: 1) providing psychoeducation to hostel staff or F&F about specific conditions (e.g. personality disorder) and effective approaches to helping Patients with these conditions (e.g. DBT or MBT); 2) helping Patients to problem-solve more practical difficulties; 3) helping to resolve difficulties in the relationship between SU and F&F or SU and hostel staff. If after several sessions, it is found that problems in the relationship between two stakeholders are entrenched and severe, then they may be referred for more in-depth family therapeutic work.

In June 2014 the service successfully applied for funding from the Trust securing almost £10,000 to support the implementation of the work over a nine-month period. The majority of the funding would be used to back fill the wards when RMHNs were working off the ward. The service launched with leaflets, posters and a presentation to all the major stakeholders and an invitation to the ward and community MDTs to refer patients to the service. In order to evidence that what we were delivering was a useful and cost effective intervention, the team developed an operating protocol and idiosyncratic pre- and post-questionnaires (based upon the goals that each stakeholder had for the sessions). The project has since evolved and we now have a clinical psychologist who works with the team and offers FW supervision.

The service is in its infancy and we believe, has a potential to grow. It has given opportunity to staff to use learnt skills that have previously remained dormant. We have received positive feedback from the people we have worked with so far; however it maybe too early to say that the service is successful. We anticipate in the coming months having data to support our findings and hope to develop the service further.

Martin McIntyre RMHN, Dr Simon Wels
Clinical Psychologist
MSU and LSU forensic services at South West London & St Georges Mental Health NHS Trust
Earlier this year at Llanarth Hospital we set out on a journey to make terms like ‘pathway’, ‘recovery’ and ‘outcomes’ mean something firm for our patients and our staff. We wanted to develop a way of working that was transparent and accessible to patients, and one that met the challenge set down by the refreshed 2014 standards the Quality Network published in respect of Clinical Effectiveness.

Our goals are simple. We want every patient to know what his or her full path of care is expected to look like. We want our patients to have absolute clarity about the things they need to work on to move on; and we want them to understand what levels of achievement they’ll need to complete to progress to the next point in the pathway. We want our staff to be focussed on helping patients reach their goals and the activities and therapies people undertake to have a stronger relationship with the outcomes they’re trying to achieve. We want every patient to have a clear overall plan of action they can discuss in their Care Reviews and we want everyone to have an estimated ‘length of stay’. Oh, and we want CPA to be repositioned as an approach to care, rather than just a periodic meeting. So, not much then!

At Llanarth Hospital we’ve been the first service to fully test PiC’s new software for building and reviewing Care Plans. It’s called PathNav. Patients and their care teams use the software together to plan health outcomes and therapies and to see how the patient is performing against the goals we’ve agreed on. It’s vastly improving our patient engagement in care planning and giving us a continual focus on health outcomes performance.

There’s still some way to go before we’re fully implemented but we’ve already learned a lot from the process.

One of the first things we learned was that agreeing the construction of a Care Plan and defining a Health Outcome is pivotal to success. By writing a clear definition of each we’ve been able to avoid blurring the boundaries between patient experience measures, targets, aspirations, interventions and measurable health

**Partnerships in Care**

**PathNav - Clear Navigation With Patients Sharing The Driving**

References


outcomes. All of those things are really important and do have their own place in PathNav but when you’re designing an operational system, it’s clear they all have to be handled quite differently and you can’t do that unless you understand the important differences between them. We’ve defined health outcomes as being ‘the planned benefits of the work we put in’ and used SMART methodology to ensure goals can actually be accomplished and measured. We’ve re-defined the construction of a Care Plan to ensure the plans we have in place for a patient are all integrated into one Plan of Care but with a clear delineation between the plans designed to achieve health outcomes and the plans we have in place that support people while they’re in our care.

Obviously, at Llanarth we have both English and Welsh patients, but we’re able to use the same framework of health outcomes for all our patients because PathNav maps our outcomes to the outcome headings in the Welsh Care & Treatment Plan guidance. This means both our English and Welsh patients have the same approach to care planning. Each health outcome has a performance scale of 1-5 (ranging from Major Difficulties to Major Strengths) with its own definition set, so it’s easy to identify where the patient is on the scale now and the point at which they could move on.

What do our patients think? They tell us they like it. “It’s easy to use”, says one patient and she likes being able to see what the clinical team think about her progress. For the first time, those patients who are ‘live’ on the system have a clear vision of the journey they’re likely to take and a printed plan listing the outcomes they need to work on. It doesn’t always give them the news they were hoping for but they can see where they are against each health outcome and which of those outcomes are essential to move on. “Having a PD doesn’t mean you need to stay locked in medium secure wards anymore, the team will move me on if they see I’ve achieved all of my outcomes”, says a patient to our Clinical Implementation Lead during a PathNav presentation to patients at Llanarth.

Patients have their own Profile Page on PathNav so they can share what’s important to them and can see everything we’ve said about their progress. They can even make their own notes into their clinical record. “I like being able to add my own notes”, says a female patient during our early testing and she thinks using PathNav will help her develop IT skills.

Our teams are quickly getting used to working with PathNav because it’s designed more like an app than a conventional clinical record system and although we’re still learning, we can already see how this is going to release time to care, help us deliver quality health outcomes and achieve meaningful patient engagement.

Why Should I Join the MSU Discussion Group?

The Quality Network run a discussion group to enable any member of staff from a member service to post questions to the Network and receive responses and suggestions from other units. This might include OT’s, frontline nursing staff, security staff and hospital managers.

This facility is only available to Quality Network members and is a great way to receive advise and share good practice across low secure sites.

“A very useful service, which helps with a wide variety of tasks ranging from policy information to ethical issues”

If you would like to join the MSU discussion group, please email ‘Join’ to: msu@rcpsych.ac.uk
It is of course of vital importance that patient pathway and outcomes are meaningful to individual patients and incorporate opportunities and support (when needed) for continued recovery and personal growth. For instance to reduce the risk of relapse and recidivism post discharge, it is crucial that patients are able to lead fulfilling lives which give them purpose and a positive sense of self. Very often, although patients and clinical teams may agree on the overall direction and destination of recovery pathways, tensions may arise in discussing and deciding specific details, such as level of security, location, patient activity and relationships. Patients can feel disempowered and ignored by care teams and experience a significant degree of distress. There can be so many barriers to progression outside of the patient's control; disagreement within clinical teams, the attitude of other teams e.g. those who manage patients in the community and in less secure settings. There is also the somewhat uncertain and time-consuming process of referral, assessment and applications for funding. For patients facing uncertain unknowns the time leading up to a transition as well as the transition itself can be a stressful and upsetting time. It is helpful when disagreements arise between a patient and their team, for both parties to be able to state their case and consider each other's reasons for advocating one choice over another. The final decision will inevitably rest with the clinical team but for the patient, being able to appreciate the team’s reasoning will make acceptance of their decision easier when it fails to coincide with the patient's own aspirations and plans. The sense of not owning your own life is to varying degrees, invalidating, stressful and anxiety-provoking. Allowing patients to have as much responsible influence as possible over pathways and the nature and measurement of outcomes, whilst working to optimise clinician patient communication, will help to aid recovery and increase patients’ quality of life.

Dr Sarah Markham
Patient Reviewer, QNFMHS

Stockton Hall hospital is a 112 bedded medium secure service for males and females. It is based on the outskirts in York in North Yorkshire. Recovery pathways in the hospital are individualised and dependent on patient need. Section 17 leave is structured, graded and allows flexibility in terms of the environments visited in order to suit patient's needs, goals and treatment interventions.

A goal identified by one of our patients was to build his vocational skills and increase his social integration back into the community. St Nicks on the Fields was identified as a place that could potentially meet these needs. The nature reserve is a former landfill site and is a charity which provides opportunities to volunteer and join Eco-therapy groups. The centre is open to members of the public to enjoy throughout the year. Volunteers take part in a range of conservation activities. The Eco-therapy groups run on a referral system. Within the sessions, mindfulness is utilised and one-to-one support is offered. The aims are to promote good physical and mental wellbeing with the main focus being around nature. The benefits of Eco-therapy include reduction in stress levels, improved self-esteem, increased levels of physical activity, enhanced social interaction, confidence in learning new skills and happiness in contributing positively towards the environment. All sessions are free which makes the facility accessible to a wide range of people.

Initially volunteering was instigated with a patient to integrate him into groups before progressing to an...
Eco-therapy group independently. The patient perceived this as a positive aspect of his recovery pathway. He identified being there had ‘worked out beautifully’ and going there was a ‘supportive introduction back into community life’. A brief narrative of his time there included ‘I leave Stockton Hall, walk out of the car park, hop on a bus, walk a mile or so and spend 2 to 2 ½ hours with people who are sharing the same collective experience.’ He also reported ‘no one wanted to push me’ with regard to going there by himself and ‘I don’t have any regrets’ about going. Other benefits from the group included finding a role ‘I identified with being a helper and helping someone’. This was in reference to supporting other people, for example helping a gentleman in a wheelchair with sawing wood – these are transferrable skills which can be applied in his future pathway. A risk assessment was completed however the leader of the Eco-therapy group was highly supportive and receptive to people with criminal backgrounds being involved, and this was supported by the other volunteers on the project. Our patient reported the people there were ‘accepting of where people are in their recovery and wanted to get me involved.’ The workers there were also ‘enthusiastic’ and ‘supportive’ and the work ‘helps me to develop as a human being’. Our patient reported being there allowed him to ‘work outside of a secure perimeter’. He stated he experienced occupational enrichment through the demands of physical exercise and engaging in a different range of occupations to those provided within the secure unit.

Recovery pathways need to be innovative and increase pro-social opportunities both within and out with the secure environment. Accessing community facilities such as St Nicks can partially meet this need alongside social integration and inclusion into the local community.

Rachel Wilkinson
Senior II Occupational Therapist
SA, Patient
Stockton Hall Hospital

NEXT EDITION:

Staff Supervision: Clinical and Managerial

Some areas that could be covered:

- Challenges faced by services in ensuring all staff receive a minimum of one hour of supervision per month and/or how management are overcoming this.
  - New initiatives in place around staff supervision.
  - The use of peer supervision and supervision trees.

For more information or to submit articles please contact Tiffany Rafferty at the Quality Network trafferty@rcpsych.ac.uk
Those with severe and enduring mental health problems have the lowest employment rate of all disability groups at just 7.3% (Health and Social Care Information Centre, 2013). Additionally, only 10% of those who leave secure services are likely to have meaningful employment (Davies et al., 2007).

However, work is extremely important in maintaining mental health and wellbeing, and promoting recovery, as it can build resilience, develop social networks and identity, develop mental capacity, and provide structure and routine (National Social Inclusion Programme (NSIP) et al., 2006; Department of Health (DH), 2011). It can also facilitate self-belief, achievement, satisfaction and increase confidence (McQueen, 2011), and is associated with better health outcomes (Office of the Deputy Prime Minister, 2004).

Additionally, many people with severe mental health problems want to work (NSIP et al., 2006), and rate vocational rehabilitation as highly important in medium and low secure units (Craik et al., 2010). The Government is also committed to supporting people who want to work (NSIP et al., 2006), and want people with mental health problems to have better employment rates, and develop the necessary skills for living and working (DH, 2011).

Therefore forensic mental health services should provide access to vocational opportunities (Joint Commissioning Panel for Mental Health, 2013; Royal College of Psychiatrists, 2014).

Work skills and vocational rehabilitation are key Occupational Therapy (OT) interventions (McQueen, 2011), which are recommended by forensic OT best practice guidance (College of Occupational Therapists (COT), 2012).

With all this in mind, in February 2015, the Shaftesbury Clinic OT team officially launched Cafe Connect: a new innovation in the forensic service.

Cafe Connect, which forms a central part of the OT Vocation project, is a patient run cafe open to all four Shaftesbury Clinic wards, including two male and one female medium secure wards, and one male low secure ward.

The project came about due to the OT service completing 12-weekly service satisfaction questionnaires where patients had commented that the previous vocation project was dated and did not represent real life work opportunities. Patients did not consider their work schemes to be related to their overall recovery, just seeing them as a way to pass the time. Patients also spoke about there being no social space in the unit to meet with peers or host family and friend visits.

Additionally, the OT service completed an audit using COT's (2012) practice guidance, and identified vocation as an area for development. Following an OT away day, a vocation project steering group was formed consisting of staff and patients. This group made the vital decisions about Cafe Connect, from colour schemes and fabrics to accounts systems and suppliers.

Plans were drawn up, and funding was acquired from the Capital Works Community Projects Fund within the Trust, and the Trust’s League of Friends. Local companies also donated products. Work began in October 2014 and staff and patients then painted and decorated the café.

Co-production has been at the heart of this project. Patients operationally manage and develop the café alongside OT staff. There are over twenty work roles supported by Cafe

South West London and St George’s Mental Health NHS Trust
Occupational Therapy Vocation Project Within The MSU
Connect, including shop assistants, baristas, cleaners, courtyard maintainers, runners, stockists, accounts assistants and kitchen assistants.

Individuals are usually referred to the project following an initial assessment and brief intervention period. After discussion about potential roles, there is an emphasis on providing ‘real life’ work experience, where patients are given a job description, undertake any necessary training, agree a start date, attend monthly team meetings and complete regular performance reviews. They can work within the project throughout their admission and potentially following their discharge to help achieve a successful transition into community employment.

There are also opportunities to move on from Café Connect senior positions to community based roles through links with community projects, which are currently being built upon.

There are plans to use the Work Star (Triangle, 2009) with all service user employees to measure and support their progress, which will be reviewed every three months.

We have received overwhelmingly positive feedback about the café from both patients and staff:

“Café Connect means a lot to me. It’s a nice place to work and I feel important here. There is always something new to learn and I’ve been able to learn so much since I started!... I could now imagine working when I leave.”

“I enjoy working here, it gives me the chance to do something a bit similar to working.”

“There’s always a helping hand or someone to talk to over coffee... It provides a metropolis which has been felt across the whole unit. Sometimes we have soup with freshly grown vegetables from the allotment... Café Connect- where would we be without it!”

External agencies such as the Care Quality Commission have also provided positive feedback:

“We would highlight the creation of a patient led café since our last visit... The OT team has invested considerable time and effort to develop this in partnership with patients and it is now open, providing a new resource to further the successful rehabilitation of patients in preparation for discharge” (December 2014).

The project is continuing to expand and plans are being made for an additional catering service. An accredited work readiness course is also planned, which will link into the clinic’s education provision. The courses will be written and taught by OT staff, who are trained to provide adult education courses within the clinic, which is an accredited Open College Network Assessment Centre. These courses will run alongside other work-based training provided by the Trust, including food hygiene, health and safety, fire training and basic life support. All of this will play an essential role in supporting patients to gain the skills, training and experience required for future employment.

Alaina O’Sullivan (OT student)
Shaftesbury Clinic, South West London and St George’s Mental Health NHS Trust

Reference List


Health and Social Care Information Centre (2013) Routine quarterly mental health minimum data set


Embedding My Shared Pathway into SLaM Secure Services has been a thought provoking experience for both patients and staff. It has led to patients being given the opportunity to drive their own care on an individual level through developing collaborative care plans and driving recovery orientated care.

As a service we felt it was essential that patients were also able to shape their own services and that there was a need to “bridge the gap” between patients and the Senior Management Team (SMT) which is also in keeping with My Shared Pathway principles.

Following discussions with the patient council the “Patient Representative Meeting” was developed. The aim of this meeting was to create a monthly forum for all the patient representatives from SLaM Secure Services to meet to discuss issues and ideas and take these forward to the SMT for further discussion.

We are currently implementing this new model into our service with patients driving forward the agenda and embedding the meeting into practice.

Implementation Phase:
Patient Representatives:

All wards already have a patient representative and weekly community meeting where issues and ideas are raised and discussed. The elected ward representatives then bring forward the issues from wards for discussion at a monthly meeting.

Terms of Reference:
The meeting developed its own Terms of
Reference collaboratively with its overall aim to

“To discuss concerns raised by patients on the ward and discuss potential resolutions. To provide a link between patients and senior management to voice compliments and complaints”.

Its key objective was “To build an open forum from service users to senior management to discuss key issues and work in partnership”.

Monthly Meetings

The meeting is fully patient led and an agenda is set at the beginning of the meeting. Support is often given in completing the minutes and forwarding these via email to the SMT.

Attending SMT

Following the meeting a patient representative will need to be elected by their peers to attend the SMT Meeting to discuss the issues raised. It is planned that Patients will begin attending SMT in August 2015 as it was felt it was important the patients had time to establish the meeting prior to attending. In the interim copies of the minutes are set to the SMT for discussion. Feedback is shared with the patients in the next monthly meeting.

Discussion points:
The meetings to date have been very enlightening and have highlighted the current needs of our patients. For example as a result of the smoking ban being discussed within the meetings the Trust’s Modern Matron attended the next meeting to discuss different types of Nicotine Replacement Therapy available. There have also been new initiatives raised by patients such re-designing the way MSU patients prepare for discharge into our LSU services. It was felt that multiple visits with a “buddy” would be useful so that patients could really get a “feel” for the ward environment.

Next Steps

This meeting is still establishing itself and is in the early stages however the response and commitment from the patients has been instrumental in making this a success. The Senior Management Team are also fully supportive of patients attending the meeting monthly, and are looking forward to the first collaborative meeting in August.

Conclusion

The implementation of the patient representative meeting so far has been a resounding success. We still believe we have a long way to go however in the words of Ian Callaghan et al, “Increasing secure mental health patients’ engagement in deciding their care pathways will be difficult, but it will improve outcomes and is the right thing to do”.

Anna Gillespie
Senior Occupational Therapist

Quality Network for Forensic Mental Health Services
A Personal Experience Of Recovery.

Hi Folks! My name is Gee (really!) I’m a 40-year-old man living in my own flat having previously come through the forensic system. Overall I’ve spent around 5 years in hospital, over a 10-year period, which would probably be about average for a lot of people reading this.

Each time I’ve been in hospital I’ve tried to make the most of a bad situation. The first time, I at least came out with a Fitness Instructor qualification (thanks Nick!). During my second stint I managed to get myself a Level 5 (2nd year university) Distinction in Physics from the Open University; I also got myself registered with Crisis Skylight (viz. European Computer Driving Licence and Advanced ECDL), whose services I’m still using today. In my third and final spell in hospital, in 2012, I even began Masters (in Business Administration), which I completed and passed (B+) at the tail-end of last year.

I’m glad that, for the most part, I tried to keep myself busy, knowing that, ‘One-Day’, I would be free again to live my life and pursue my dreams.
One such ambition has been to get my book, my first novel, published. It is entitled *Book One of Ancient Lore: The Knight’s Lore* and the second print edition will be out presently together with endorsements (including one from the late, great UK horror writer, James Herbert). If you like [epic] fantasy, horror, adventures and/or spiritual books, Star Wars and/or Lord of the Rings, you’ll like this one too. It’s the first in a series of ten novels and is a stunning read (even if I do say so myself!). Hopefully, the enclosed cover will whet your appetite.

However, until the coffers start overflowing with the Dollars, I still believe that a man should try to make a dime to earn a living. And that’s where Teresa comes in. With her help, in the past few months alone, I have had two firm job offers (as a Patient Reviewer with the Royal College of Psychiatry and as an Expert by Experience for Choice Support and the CQC). I have also worked in another role, as a Service User Representative, for the West London University Public Involvement Program, although this is yet to be confirmed for the long-run. I am truly thankful for her assistance in finding me these positions and I really do appreciate the overlap and synergy each role brings to the table.

To anyone reading this missive, I would encourage you to keep busy. I’m not necessarily saying work a standard 09:00 – 17:00 job as I don’t really believe in that, especially for people coming from our backgrounds. But I would say do something. Find out what you’re good at and pursue that with all your vigour. Maybe at the same time hook-up with Teresa and she will also help you find something worthwhile for you to do, something which will earn you some extra coppers (without it negatively affect your benefits!) Remember, we are all mind, body, soul and spirit and each part of our nature needs to be nurtured, appropriately, or else we find foolish things to occupy us instead.

‘When I get out...’ is a common refrain for folks inside hospital. Although it’s good to think of what to do when one is free, it’s best to start preparing for that eventuality now! Keep yourself busy, keep yourself occupied, be a learner and then become an expert, in whatever it is that you do. Work hard and play hard – it is important to have a balance.

Finally, maximum respect to Crisis; maximum respect to my outreach team; big shout out to Teresa; and thank you God for everything, especially for my family for their love and patience. I am truly grateful for being able to work with you guys. G.

**Godwin Uto Nkere**  
Patient Reviewer, QNFMHS

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**Membership Resources**

The MSU network are updating the ‘membership resources’ section of their website with up-to-date policies.

If anybody has any policies that they are prepared to share then we would be very grateful to receive them.

Any policies that are submitted will be put onto the Quality Network website in a password protected members area to enable the sharing of resources.

For more information contact the MSU Team at [msu@rcpsych.ac.uk](mailto:msu@rcpsych.ac.uk)
MSU Patient Artwork
This year we received over 200 entries for the Cycle 9 Medium Secure Patient Artwork Competition and you can see the majority of entries on these pages. We would like to thank all of the patients that entered the competition and the winning entries can be found on the website, www.qnfmhs.co.uk. The five winning pieces will be used on the front cover of our Cycle 10 Annual Report, Cycle 10 Local Reports and other publications.
Patients engaged in OT Adult Education sessions at Ravenswood House were invited to write about their individual OT Pathways. Ideas were initially mind-mapped in Literacy sessions, engaging each individual in discussion to draft and develop a final word-processed piece in CLAIT sessions, ready for publication.

This writing process encouraged each patient to reflect on the different OT Pathways that had helped him on his recovery journey. It became clear that each one valued highly the chance to have a vocational role supported through OT; the opportunity to learn and obtain qualifications through education, as well as gains in motivation and well-being through taking part in gym and physical activities and other OT sessions such as cooking and music.

One unfinished piece: “Finding my feet with OT - Learn from Yesterday, Live for Today and Hope for Tomorrow”, highlighted the importance to the patient of applying for and “to my surprise” getting a job, and stated that starting music in OT “massively helped me with my confidence as I had to perform in front of other people…and (it was) a good way to deal with frustrations.”

Writing with a purpose enabled each writer to express their own voice; gave the opportunity to put Literacy and IT skills into practice, increasing self-confidence and giving a better insight into what the patients valued most in OT. We felt we got to know them much better through the collaborative process, thus helping to agree more personalised future goals. We were able to see real growth in patients who took pride in their writing, patients who would have been unable to write independently or at any length before embarking on their OT Pathway journeys.

Sarah Brazier
OT Tech at Ravenswood House
Marion Kinnear-White Adult Education Tutor

ACCOUNT 1:
When I came to Ravenswood I was unwell. I am now well through taking part in a number of activities and achieving goals. Firstly, doing the Ward Representative job which has helped me to develop my English, to have self confidence, as well as helping others to sort out their problems. The role of the Ward Rep. depends on reading and writing skills for taking notes and IT skills for writing minutes. I hold a community meeting every week, attend Patients’ Reference Group monthly meetings in order to raise patients’ complaints and to feed back.

Another task of this job is to do “buddy system” with the new patients, to show and describe to them how to use the different parts of the unit, from how to use the canteen to finance and to engage with OT activities. I interview new staff who come to the unit and give my views about the candidates before they are selected to work here. The nature of the job is flexible, as I respond to other’s needs, from week to week. The hours vary, but the total hours are ten per month, otherwise it affects benefits. I am very pleased to be a Ward Rep. because I am assisting people to sort out problems. My employer is assisting me to have good feedback to my doctors and Multi-Disciplinary Team which in turn improves my mental state. I will get references from my employer which will help me to get a job after being discharged from the hospital.

Secondly, joining OT activities like educational sessions in English and refreshing my mind in CLAIT (Computers) is developing my knowledge. In CLAIT I am typing documents and bringing back forgotten things to my mind. I achieved a Diploma in CLAIT and I am now reviewing skills I learned in the past and learning new ones. The best activity for me in computers is to type and print.

Thirdly, I am going to the gym to do the fitness program, using the running machine and playing badminton. This keeps me fit and relaxed; now I can concentrate perfectly and I feel better.

Finally, doing different things is more beneficial than concentrating on one thing. I now feel fit
enough to be in the community and I expect to be discharged as soon as possible.

**Account 2:**

Woodwork has been a good learning experience for me because of how it makes you really think about what you have to do when using certain tools that are quite sharp and you need to be really focused to use the equipment for the job in hand. The overall experience was very enjoyable.

My woodwork experience started some months ago. The first thing you do in a woodwork session is that you have to start of with a project to work with. My first project was to make some picture frames for my brother and girlfriend. I had to cut 4 pieces of wood, two being the same sizes on each side. Then I had to cut the angles of 45 degrees. With that being done, it was all stuck together and finished. It has made me feel good inside that I finished the project and it should be a lasting masterpiece of woodwork in the family home.

Education is another thing that has been good and useful. It has helped me with Clait (Computing), English and Mathematics. I was really surprised when I did a maths test to see what level I was on and was very surprised that I got 84%. This has given me confidence to go on and do my qualifications in maths.

Now that I’ve done all those courses, it’s such a fulfilling achievement that I would recommend it to anybody to try and brush up on their skills whenever they have the opportunity to do so.

In OT I also do drumming once a week which has also given me joy, I also was in the units band which was a confidence builder for me as we performed in front of all service users and staff on many occasions.

The gym is another way which has been fun for me because I get to do badminton which is one of my favourite pastimes, plus there are other cardio machines down there to build up your fitness. Without the gym, life would be quiet and I would have to try other alternative ways to get fit; ways like press ups, sit ups and other simple cardio methods in my bedroom space. Going down the gym keeps your mind focused and your mind clear in day to day life.

All these activities that I’ve taken part in have shaped the way things have gone for me in my life while being here and has taken up a lot of my time and has kept me focused in everyday life which has also kept me very healthy.

**Account 3:**

When I came here, I was on ICA, which is a bit isolated. I then moved to Malcolm Faulk Acute Admissions ward. I am always trying to motivate myself. Through OT, I got a job working in the courtyard. I kept the place clean and free of cigarettes - I was helping to keep the environment nice for other people. I wanted to do a job and it was done properly. The staff were always praising me and that feedback made me feel worthwhile because the quality was good.

I tend to strive for perfection and to please the person I am working for, then every one feels good.

I moved to Mary Graham, a continuing care ward and then to Ashurst, a rehabilitation ward. That is when I applied for the OT wood work job - a hot job that many people want. I made my application and had a successful interview. I was always on time and ready, so that helped me get the job. It has made me motivated; I do everything the OT instructor says and that makes me feel good about my self and they feel happy.

The key thing for me, above all, is my praying time which gives me joy every day. It has given me a sense of responsibility and
motivation and helps me carry out my jobs well. Another path that OT has helped me with is going to the gym to get a certain level of fitness with different exercises. I go power walking too; the physical wellbeing helps give me even more confidence in myself, giving me even more motivation to get out and do things.

I love to learn; the more I learn, the more I want to learn. It is major key to open any door.

Quality Network for Forensic Mental Health Services
Steps Towards Post – Discharge Outcomes

In my experience successful discharge from secure units is in most danger for lack of support from the professionals tasked to care for patients after discharge. It is not that C.P.N.s and Forensic Social Workers don’t do their jobs, but rather that their support is thin on the ground and contact with patients is time limited and often formulaic. There may or may not be other professional staff involved, such as hostel workers, but again their contact is proscribed. The move from secure care to this light contact delivered in the community, can be unsettling for patients and possibly more use might be made of friends and families, not just on discharge, but as a planned inclusion in the discharge process. Some of this is done already with home visits and at the formal and informal contact points between staff and loved ones. I merely suggest that it become a standard protocol when planning discharge.

Another area for development is the adoption of standards and peer review process for post-discharge services. I understand that low and medium secure units are discrete physical entities, and therefore lend themselves to the review process, and I further understand that community support comes from disparate entities, but surely work needs to be done to look at standards that would be applicable to this post-discharge care. Current political rhetoric supports the notion of “joined-up care”. Surely such care should be of a minimum acceptability throughout the country, and standards such as those developed by the quality network be applied universally.

Schizophrenia is one of the most dreadful illnesses with which the modern world is plagued. None of the current therapies, interventions, and medication offers to cure sufferers. At best modern nostrums mask the symptoms. Schizophrenia is a disability of the mind, just as surely as motor neuron disease is a disease of the body. The stigma of “madness” and the shame of criminal justice permeate societal reaction to mental illness. Whilst the quality network itself exists to set and raise standards of care, it behoves each one of us involved in the organisation to challenge prejudice and work to achieve a better understanding in the community at large.

Post-discharge, the need for gainful employment is crucial to the patient’s wellbeing. Admittedly, state benefits remain available for now, but good fulfilling purposeful work is an adjunct to good health.

Lastly, in this roundup of my concerns, it needs to be said that whilst I am eternally grateful to the forensic mental health services and to the dedicated staff that plucked my loved one from the bowels of the prison system, with the best will in the world, the outcomes that I can expect for him, are to be stable and free from those symptoms that distress.

At the moment there is an inevitable nexus of
interest between clinicians, the criminal justice system, and the drug manufacturers. Practitioners of forensic medicine are constrained by the imperatives to move a patient through the system, using those tools they have to hand. Anti-psychotic drugs alter behaviour, and despite other interventions, psychology, occupational therapy and the like, the principal method used to treat patients is medication. Once stabilised, the Ministry of Justice have an interest in minimising expenditure on individuals, and as long as the chemical handcuffs (sic), are applied, discharge may be considered. The international pharmaceutical companies invest large sums in their research and are anxious to gain a return on their outlay. New drugs come on line slowly and only after suitable recompense for previous commitment.

Placing an absolute premium on research into the nature of schizophrenia with a view to understanding its causes and identifying meaningful cures is one way to break this circle.

George Cooley
Family & Friends Representative, QNFMHS

Sussex Partnerships NHS Foundation Trust
“Not Another Questionnaire” – Creatively Evaluating the Patient Experience in Secure and Forensic Services at Sussex Partnership NHS Foundation Trust in partnership with CAPITAL

Sussex Partnership NHS Foundation Trust (SPFT) provides medium and low secure services across two sites. The Hellingly Centre is a 45 bedded medium secure service. Also on site is Southview, a fifteen bedded low secure service. A further 48 beds are located at the Chichester Centre.

In 2012/2013 in a joint project with residents of the secure and forensic inpatient services, a patient experience questionnaire was developed. The questions were based on the 15 statements that describe high quality care for patients as identified in the NICE quality standards for patient experience published (NICE 2011). The feedback from the patients following initial completion of the questionnaires was that they did not want to be asked to carry out any more questionnaires in relation to their experience of the ward. They stayed on the ward a long time and wanted a more engaging way of having their views sought. We wanted to gather patient experience information that was in a format that would inform practice on the ward and also provide Trust level quality monitoring information. It was therefore proposed to ask people via a focus group.

Independent facilitation of patient involvement is identified as best practice in Unlocking Patient Involvement Practice in Forensic Settings (2011) and by Faulkner and Kalathill (2012) therefore a proposal was developed in partnership with the CAPITAL project trust, a charity which promotes peer support and mental health patient involvement. The funding to carry out the project was agreed in the service wide leadership team. This article will describe the project to date. This will include the recruitment, training and development of experts by experience in the facilitation and writing up of focus groups with the aim of improving the patient experience. We will also share learning and initial indications of how the project is working to improve patient experience.

Recruitment and Training of Experts by Experience
CAPITAL, with the support of SPFT staff interviewed and appointed 4 peer workers. As this work means regular work with vulnerable adults, a DBS check was required. As the ideal candidates for these roles will have experience of using forensic services, discussions about risk management for relevant individuals took place
between CAPITAL and SPFT to ensure that suitable candidates were not excluded because of their past history. Peer workers took part in a bespoke induction. They were offered access to CAPITAL’s peer support training, a level 4 qualification accredited by the University of Middlesex.

The Focus Groups
The peer workers work in pairs to facilitate focus groups at the three sites across the Trust; the Hellingly Centre, Chichester Centre and Southview. Each pair facilitated one group per month on a rotational basis so that each ward is visited quarterly.

To enable inpatient peers to feel comfortable to speak freely when giving their views, the peer workers are given a room on the ward to facilitate the group. They are accompanied by SPFT staff and given a personal alarm while working on the ward. The peer workers aim to create a pleasant and relaxed group. Refreshments are offered to encourage participation and to set an informal tone. CAPITAL’s experience of running Patient Viewpoint groups on acute wards in West Sussex indicated that inpatient peers are happier to talk freely when they know that the people they are talking to have their own lived experience and are not employed directly by SPFT.

As well as offering each other mutual peer support within their pairs, the peer workers receive regular supervision. All the peer workers involved with the project meet with the project leads and supporting staff to review the findings from the focus groups and the process.

Running the Group
Peer workers are given a work process plan and follow a protocol prepared in conjunction with SPFT staff. The work process plan outlines guidance for all aspects of the group including preparation for the group, arrival at the unit, running the group, and after the group. The nine questions that are asked were developed by the peer workers and are based on NICE best practice (NICE 2011). They cover all aspects of life on the ward. The guidance to peer workers includes basic group agreements such as confidentiality, prompts for setting an informal tone, information about the purpose of the group and how their feedback will be used.

In an adaptation to the original model and in line with policies and procedures within medium secure services, at the Hellingly Centre, groups are held in the presence of a member of SPFT staff whose role is to ensure the ward are aware of the group happening, to set up refreshments and to leave the facilitation of the group to the peer workers, participating only on invitation by the facilitators.

After The Group
At the end of the group, the peer workers meet with a member of the ward team to give verbal feedback and meet with their ward contact for mutual debrief. A report is then written up by the peer worker and sent to SPFT for comments.

Initial Outcomes
In the first review of the focus groups on completion of the first cycle in January 2015 attended by peer workers, CAPITAL and SPFT staff, it was noted that the groups are well received. The average attendance was four participants (33%) and a maximum was 6 participants (66%). Strategies to raise awareness of the groups and the impact were discussed including the use of posters, the development of a ‘You Said, We Did’ and improving the communication between the groups and the ward managers. The second review held in July 2015 found the groups continue to be well supported.

At the Hellingly Centre the feedback from patients given in this group led to a change in ward practice and supported relationships between staff and patients. Feedback from a charge nurse at Southview was that the feedback from their most recent group was taken to the multi-disciplinary team and has impacted on their implementation of service changes.

In the review CAPITAL re-stated a preference for no SPFT staff presence in the groups. At the Hellingly Centre, however, accompanying staff in the group is consistent with the procedural security adopted for all outside facilitators within the medium secure unit. The peer workers reported that they felt that patients were speaking freely and were not inhibited by staff presence. They have also noted that consistent staff contact supports awareness of the group and promotes participation.

Additional Outcomes
The feedback from both reviews indicated that these groups are having additional benefits above and beyond gaining feedback about life on the
ward. Firstly the in-patients are inspired by meeting with people who have been through the system and are returning with a responsible role within the service. They have the chance to ask the peer facilitators questions and to gain support and understanding of their current situation. On the high dependency ward these questions were primarily noted to be around treatment options and engagement. In low secure services the questions focused on adapting to life outside hospital and future opportunities. These discussions demonstrate the value of peer working at all levels of the service. It is certainly a much richer experience that just completing another questionnaire.

Deborah Alred Consultant Occupational Therapist, Clare Ockwell, Director of CAPITAL, Chris Moxon, Focus Group Facilitator, Roger Sharp, Focus Group Facilitator, Graham Stewart-Hall, Focus Group Facilitator, Kathy Moore, Focus Group Facilitator, Janet Woodhouse, Clinical Specialist Occupational Therapist Hellingly Centre

References
Faulkner A & Kalathill J, The Freedom to be, the Chance to Dream: Preserving User Led Peer Support in Mental health, (Together 2012)
NICE Guideline for Patient Experience in Adult Mental Health: Improving the Experience of Care

The MSU annual report has now been published. Hard copies of the document have been sent to each of our member services and an electronic copy is available online.
Useful links

Department of Health
www.doh.gov.uk

Health and Social Care Advisory Service
www.hascas.org.uk
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

Institute of Psychiatry
www.iop.kcl.ac.uk
The largest academic community in Europe devoted to the study and prevention of mental health problems.

National Forensic Mental Health R&D Programme
www.nfmhp.org.uk
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.

National Institute for Health and Clinical Excellence
www.nice.org.uk
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.

National Offender Management Service (NOMS)
www.justice.gov.uk/about/noms
Brings together the work of the correctional services.

Prison Health
www.dh.gov.uk/health/category/policy-areas/social-care/offender-health
A partnership between the Prison Service and the Department of Health working to improve the standard of health care in prisons.

Offender Health Research Network
www.ohrn.nhs.uk

The Offender Health Research Network
www.ogr.nhs.uk
The Offender Health Research Network is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester.

Centre for Mental Health
www.scmh.org.uk
An independent charity that seeks to influence mental health policy and practice and enables the development of excellent mental health services through a programme of research, training and development.

QIPP
www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp

College Centre for Quality Improvement
www.rcpsych.ac.uk/quality.aspx

College Training
www.rcpsych.ac.uk/rainingpsychiatry/eventsandcourses.aspx
Offers courses for professional development in mental health care.

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