FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

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This Issue

WELCOME

Welcome to the 38th edition of the Quality Network for Forensic Mental Health Services' newsletter on **'Managing the Diversity Challenge Within Secure Services'.** This is a wide-reaching topic and we have articles covering several areas. Thank you to everyone that has contributed to this edition.

We are now at the end of the current review period and our first year of a revised review process. From feedback received, member services are enjoying the developmental and discussion focused 'QI' days, and they are finding them to be a useful tool for service development.

We finished the year on a high with two well-attended and successful annual forums. The programmes focused on key themes of leaving secure care, managing the diversity challenge and carer engagement, and included a range of keynote speakers and good practice workshops. We even had a mindfulness workshop from colleagues at St Mary's Hospital that had delegates making hedgehogs from old books! If you missed the events, the presentations will be available on our website and we have included some

pictures within this edition. Also, in this edition, look out for the winner of our 'ultimate MDT member' competition that was run as part of the patient engagement and involvement event that took place in April.

Later this year, we will be running a standards consultation 'roadshow' to inform the next edition of standards due for publication in 2019. See our website for more details. Have a lovely summer and we'll see you in September!

Dr Quazi Haque and Megan Georgiou

Barnet, Enfield and Haringey NHS Trust

Hip Hop Hospital—Urban Music Production in North London

Music has always been at the heart of North London Forensic Service. There are 11 wards, medium and low secure, male, female and learning disability and each part of the service has always accessed both music therapy and a range of music making sessions. For many service users, it has both a cultural and creative reference point and provides an outlet for thoughts and emotions and is a way of communicating using a genre of music that is personally meaningful.

Key Changes studio sessions are provided on the wards and are delivered in partnership with occupational therapists and ward staff to engage service users in culturally-relevant musical styles and activities. Using the latest music technology, Key Changes specially trained music industry mentors to support service users to engage in lyric-writing, beat -making, music production, recording, and live performances at regular open mic events. Musical genres tend towards urban styles such as hip hop, R&B, grime/trap, reggae and soul. These urban styles of music, in particular hip hop, have been linked with mental illness and culture – the 'conscious lyricism contains raw, unfiltered narration describing the harsh realities and coping mechanisms used to combat these detrimental circumstances' (www.hiphoppsych.co.uk).

Hip hop first began in the ghettos of New York and came out of areas of high social and economic deprivation which is often reflected in the lyrics. Hip hop music is filled with references to substance misuse, psychosis, addiction, childhood maltreatment, offending and broken relationships. The service users relate the themes and messages and use this genre as a backdrop to develop their own narrative in a way that it is both safe and creative. The genre has engaged a service user group of young men and women who have grown up in and around London, often in deprived or marginalised groups and given them a voice and platform.

The sessions are either in group or individually and service users are encouraged to develop the practical skills around beatmaking and music production but also to bring the raw lyrics and poetry that they so often write in their bedrooms between sessions. The sessions with music industry professionals aim to provide an opportunity for patients to develop insight into their mental health and recovery and reflect on offending, relationships and other life experiences. The objectives are based around social inclusion and include:

- Opportunity to re-engage in a leisure interest
- Chance to spend time with others who have a common interest in music
- Develop ability to make choices, take turns and respect the views and tastes of others
- Bring patients and staff together in positive activities
- Space to foster hope and aspirations for the future

By working with skilled musicians they work towards developing professionally produced finished tracks which can be shared with friends and family, promoted on social media (subject to the relevant confidentiality/ safeguarding protocols) and performed live at hospital and community events. For many service users, it is the first time their music and their stories have been so openly celebrated and validated and the sense of self-esteem and empowerment is palpable. Recently, service users who have developed skills within the sessions are taking on Experts by Experience positions and are co-producing music workshops for other service users with the musicians. This is part of the North London Forensic Service CHOICES

Recovery College where all the workshops and courses are co-developed and co-delivered with an Expert by Experience who is paid for their work. The philosophy of the CHOICES Recovery College is around hope, control, strengths, aspirations and creativity which is fully reflected in the 'Beats making and music production' workshop where a range of urban music genres are explored and service users supported to develop their voice and style.

During the sessions music mentors and patients explore potential progression to activities in the community for which ward leave can be worked towards and plans made for life post-discharge. Whilst music is the key engagement tool, the sessions are underpinned by a strong culture of supporting service users' successful transition into wider meaningful activity in mainstream settings. This includes pathways into studio sessions, volunteering opportunities at Key Changes central London studios and continued work as an Expert by Experience in the CHOICES Recovery College. The Hip Hop pathway is one that continues beyond the hospital setting and has kept service users connected and creative throughout their recovery.

Sarah Hill, Service Manager NLFS; Peter Leigh, Manager Key Changes and Antony Roach, aka 7Star, Beats maker

'Music to Our Ears'

Music is one of the most integral components of all service users. The professional musicians from Key Changes work hard to provide well organised activities, structure and progression for each service user. Personally, I have worked with Key Changes for some time now. They helped me from scratch, teaching me how to navigate the logic music programme which I still use to help me produce my work. I now have over a thousand music tracks and recently, I performed one of my tracks at the National Service User Awards in Coventry – it was really nerve-wracking but I loved having the chance to share my music with others. We have a monthly open mic session at Chase Farm run by Key Changes and this is where all the local talent in the hospital come together and express themselves lyrically. They make CDs and some attend Key Changes community studios. Key Changes is a life force to many.

By Anthony Roach

Royal College of Psychiatrists

Multi-Dimensional Diversity in Secure Hospitals

You only have to step onto a women's ward to witness the diversity in a secure hospital; not merely in terms of diagnosis, but in terms of stages of recovery and increasingly, gender. I have no experience of transgender patients on men's wards, but from what I have seen with my own eyes, and learned from fellow former secure patients, the phenomena of women transitioning to men on women's wards has not attracted either stigma or any other significant negative responses. Similarly, I have never witnessed any racial abuse directed towards patients in secure and forensic hospitals.

The difficulties that may present because of diversity on women's wards seem to remain those based on patients presenting with a range of diagnoses as well as varying levels of risk to self and others posed by individual patients. The problems caused by a purported lack of economic provision to

support separate wards for women with SMI and PD have long been recognised. As anyone without the diagnosis of PD will be able to appreciate, the behaviour of self-harm can wreak havoc on ward stability, routine and organisation. In the often disproportionately risk adverse context of a secure ward, the presence of such risky behaviour often triggers blanket sanctions which restrict all patients regardless of the individual level of risk with which they present. Patients whose level of self-harm leads to a one-to-one level of observation being imposed upon them can be perceived as selfish and attention seeking by other patients. Services may not be able to resource extra staff, thus an increase in the number of women on a higher than general level of observation can lead to staff being diverted from the provision of escorted leave and other therapeutic activities to 'go on obs'.

The effect of this phenomenon on ward atmosphere and the morale of individual patients can be very negative. The non-self-harming patients feel at the mercy of their self-harming peers and amongst self-harming patients there can arise bitter competitions as to who manages to obtain the most attention from staff. This diagnostic/risk diversity lies at the heart of the enduring stress and psychological distress patients can experience due to being detained on a women's ward.

If there isn't the money to provide separate provision for women with SMI and PD (not to mention those who may present with ASD or only a moderate form of mental illness, such as anxiety), how can this currently damaging diversity be best managed?

Ward models which place a greater emphasis on relational security and give more agency to patients to manage their self-harm themselves and proactively ask staff for help when needed, seem to fair better than more restrictive and controlling ward environments. Similarly, models which focus more on individual care-planning rather than blanket rules, thereby freeing patients with less risk from the burden of unnecessary restrictions, are not only more aligned to the actual secure service specifications, but also respect patients as the individuals they are and not mere risk entities or cookie cutter copies of some mental health stereotype.

As a former patient of wards with particularly oppressive cultures and a heavy bias towards physical and procedural security, I can assure you that there is nothing more damaging and anti-recovery than being treated 24/7 as though you are a risk entity, especially if you have demonstrated throughout your time as an inpatient that you are the anti-thesis of what constitutes risk.

Regardless of services' claims to be recovery oriented; be those claims aspirational or merely political, for their patients' sake, secure and forensic services and clinical teams need to start committing to recovery-focused practice and put aside, once and for all, any anti-therapeutic and superficially self-serving notions of risk.

Dr Sarah Markham, Patient Reviewer, QNFMHS

Join the **Email Discussion Groups** to network with colleagues on topics relating to secure mental health.

Email 'join' to:
lsu@rcpsych.ac.uk
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St Andrew's Healthcare

Neurodiversity in Secure Settings: De-bunking Misconceptions and Raising Awareness of Autism

Autism Spectrum Disorder (ASD) is a very well-known condition and is frequently portrayed in pop culture. However, how much do people really know about this condition?

Not very much it turns out; in a survey about ASD, 27% of people thought ASD only affected children, 61% believed it was a curable disease and 39% thought ASD came with special abilities (e.g. the 'Rain Man Myth'). This is reflected by the fact that 83% of people with ASD felt strongly that many of the problems they faced in day-to-day life resulted directly from others not understanding them (NAS, 2007).

What we do know to be true about autism is that it is a life-long neurodevelopmental condition. Importantly, ASD is not the same as a global intellectual impairment; variability in IQ can range from intellectually impaired to genius, with many falling in the average range and some people have savant abilities. ASD is characterised by the Triad of Impairments: 1) patterns of communication, 2) reciprocal social interactions and 3) restricted, repetitive and stereotyped behaviours and interests.

The misconceptions that surround ASD extend to the low and medium secure settings that we work in. The myth that ASD only affects children has contributed to individuals being unsupported or improperly placed and it is not uncommon for patients to arrive at St Andrew's Healthcare having previously resided on various other specialty wards. Unsurprisingly, without specialised ASD provision, their needs were not sufficiently met. The issue around ASD being an incurable condition continues even in secure settings, as the common 'they are autistic therefore cannot change' sentiment is prevalent not only among the general population but can also be seen in staff members.

The lack of awareness in secure settings around the variety of ways ASD can present has been especially noticeable. For example, it's understandable if people put some of the stereotypical personality traits and behaviours down to attachment style and/or mental health in certain psychiatric settings, but it is this generalisation which we think could be potentially harmful to our ASD population. Moreover, members of staff who are naïve to an individual's unique presentation and idiosyncrasies might unknowingly give inappropriate support. The staff we work with on our wards are ASD trained and are part of a highly specialised ASD pathway, so are able to adopt a person-centred approach, while recognising their specific needs. This being said, there is a general awareness deficit amongst staff members who don't regularly come into contact with ASD.

One thing that's widely known by staff members who are ASD aware and trained is that individuals benefit enormously from social skills training, sensory integration, structured timetables and a harnessing of their special interests – hence why being knowledgeable on ASD in this secure setting is crucial.

In order to help empower those with ASD and bring greater awareness to the disorder, the United Nations officially adopted World Autism Awareness Day (April 2nd) in 2007; having been recognised for over a decade now, the campaign has gained greater momentum with each passing year. With this inspirational day in mind, the patients and staff on Mackaness Ward (ASD Medium Secure) organised their own event to showcase their experiences of ASD, and to increase appreciation and understanding amongst both patients and staff. Attendees were able to peruse stalls explaining how people with ASD can have unique

requirements in relation to dietetics, speech and language, sensory differences and religion. Across the day, 75 patients attended with staff members popping in to get involved too.

With so many staff working across St Andrew's, all specialising in different fields, it was a great opportunity for information to be shared efficiently across several wards and specialist pathways. Not only did this mean that attending staff became more aware of ASD, and of course its misconceptions, but they fed back a new-found vigilance and mindfulness for traits amongst their own patients. While we never expected everyone to become immediate experts on identifying ASD, it is positive that staff members now have heightened awareness of the importance of both the ASD pathway and ASD assessment.

While the success of the event could be quantified by the number of attendees, the true successes have been far more impactful. Not only did this event help to create a more sound understanding of ASD amongst patients, it also forged positive peer relationships while acting as a catalyst for open conversations between staff and patients about ASD.

Above all, this event has spread a positive message about ASD which, with the correct approach, has huge scope for progression and positive change, which will allow individuals to live happy, fulfilled and successful lives – which is of course, always our ultimate goal.

Natalie McMahon & Nathan Simmonds-Buckley, Assistant Psychologist, St Andrew's Northampton

Southern Health NHS Foundation Trust

Developing a Creative OT Education Project to Allow for Increased Participation in a Medium Secure Setting

There are challenges in developing OT/Adult Education creative projects that are accessible for all patients at Ravenswood Medium Secure Hospital: how to choose an inclusive theme that is appealing to as many as possible; and how to engage patients of all ages, ethnicities and abilities to enable them to produce varied creative pieces successfully.

Every year, the OT/Adult Education team enter written, artistic and musical items by patients for the Koestler Awards. This year we aimed to produce more entries from more patients. Koestler suggest a possible theme for entries but that usually comes out only a few months before the deadline, not giving optimum time to work with patients to develop and complete pieces. Therefore, this year we decided to start early and come up with our own theme which would work well with all of our patients and give a wide range of opportunities for participation.

The idea for a "Courtyards" themed project came about after a patient in Literacy/ Computer sessions had been researching his own cultural history on Persia. Through this research, we found a poem "Green Riff II" about the idea of the Persian walled garden. At the same time, Jenni, our OT Tech, had been working with patients on improving the Courtyards in Ravenswood and several patients had talked and written positively about their work in the courtyards. Patients at Ravenswood all have access to the courtyards, which are vital recreational spaces to take breaks from the wards, sit or walk about and talk with other patients and staff. "Courtyards" seemed a relatable and positive idea for all.

We developed a number of stimulus ideas for writing workshops initially. There were activities and support materials at a range of levels so that patients who were well-recovered and able could allow their imagination to fly, more independently

producing several longer prose and poetry responses about their "Imaginary Courtyards". Some patients were less further along in recovery but nonetheless became engaged in the sessions and through more structured, scaffolded writing frames were able to express ideas and images for their Koestler entries. Sensory, visual, auditory and tactile stimuli were used: a patient with memory problems was able to take part successfully with some one-to-one guidance and patients whose first language was other than English were also able to build up vocabulary and sentences around the Courtyard theme through the differentiated tasks we had produced.

Patients responded thoughtfully and imaginatively, enabling everyone to draw on their own individual experiences and refer to what was important to them culturally. Patients described their courtyards in terms of colours, sights, scents, tastes and sounds; of silence or of the natural world or particular music; as places "for everyone", with accessible paths for those with mobility challenges; a place with animals and birds, amazing tasting fruits; a therapeutic place to feel relaxed and at peace. The theme unlocked unseen potential in many patients whose writing we included in an anthology, allowing computer skills to be promoted.

The theme gave scope to further develop patients' self-expression and skills through a range of workshops including mosaics, card-making, felting, papier-mache, painting and an animation, allowing for a range of interests to be catered for and to introduce new skills or build on existing ones.

"Courtyards" proved to provide an accessible means for patients of diverse ages, abilities, backgrounds and wellness to participate. We had a record number of Koestler entries across different categories and we were able to observe that the shared theme gave a sense of equality in the collaboration of the participating patients and staff.

Marion Kinnear-White, Adult Education Tutor; Jeni Hewson and Jane Anceriz, Occupational Therapy Assistants, Ravenswood House

Partnerships in Care & Priory Group

Celebrating Sexuality in Secure Services: Interagency Working, Clinical Sensibility and a Framework of Managed Risk

Kemple View offers locked and secure services for men aged 18 years and older with mental health difficulties, including mental illnesses, cognitive impairment and personality disorders. We focus on recovery and promoting independent living and required skills, within a framework of managed risk, to maximise rehabilitation for the patients in our care.

To support the development, and to drive forward our ability to support people with sexuality needs (be they patients or staff), we have been working with one of our specialist community partners *'Horizon lesbian, gay, bi-sexual and transgender (LGB&T) services and Renaissance'*. The team from Horizon, with specific direction from our diversity steering group, have developed a bespoke training package, appropriate and relevant leaflets; have updated our library resources to reflect our patients diverse sexuality needs whilst being sensitive to issues exacerbated by mental disorder and the risks sometimes associated with this; and held events which offer staff and patients up to date and evidence-based information, education and advice on how to provide the very best, diverse service for all.

<u>Staff training</u>
The steering group identified the need to increase staff education and knowledge in regards to LGB&T and other diversity issues. We decided the best way to disseminate this information would be to train a core group of

staff from a variety of disciplines using a 'train the trainer' approach, in that this core group of staff will hold regular training and information sessions for staff from across the site. The 'train the trainer' course offered participants an opportunity to increase knowledge and understanding with regards to LGB&T issues, and how to support patients and staff to actively manage these. They were given a better understanding of the legal framework pertaining to sexuality issues, dispelling some of the misconceptions about working with the LGB&T community and raising awareness on what reputable services are available in the community to support staff or patients who may benefit from help and/or advice.

Following the training, the core group of staff reported feeling more confident and competent to engage meaningfully with service users, staff and external agencies on LGB&T issues. They also reported that they felt better informed and able to access/sign post community services to support patients continued needs, both before and after discharge. The training will continue to be rolled out for all staff this year and we look forward to the feedback from the wider staff audience.

Literature

In partnership with Horizon we developed an 'info booklet' to support the training the core group of 'train the trainers' had been given. The information booklet offers patients and staff answers to some of the questions they might be facing regarding sexuality or gender. The booklet supports individuals to navigate their way through their personal journey, also highlighting that "difference is something to embrace… and there are local and national services that can offer support in many ways if [a person] was struggling" with issues of sex and sexuality.

At the suggestion of our patients, Horizon have also supported us to obtain relevant and suitable reading materials for our library, which again address LGB&T issues, offering information on the LGB&T movement and history. They also assisted us to obtain novels with diverse relationships within them that were pro-social in nature but with a recreational purpose. These reading materials have been well received by patients and staff and are a resource we will continue to expand.

Celebrating sexuality event

To launch our approach to sexuality, in collaboration with a patient representative, we planned and held a 'Celebrating Sexuality' event within the hospital. Staff from Horizon joined us in our celebration, as did patients and staff from across the hospital. The event offered an informal environment for patients and staff to explore the history of the LGB&T movement, the development of service provision and of course the history of the famous 'rainbow flag'! Attendees were asked for ideas to take the service forward, and advised they found the event informative and enjoyable. We are currently in the process of planning this year's event!

Conclusion

Since its conception, the approach to sexuality has been developed with an evidence-based approach to training staff and supporting both staff and patients with diverse needs, but within a framework of clinical sensibility and appropriately managed risk. We acknowledge that we are only at the beginning of our development journey, although we look forward to working with our community colleagues, staff, patients and their families and friends to take the service forward, to ensure that the needs of our diverse patient and staff group are supported and differences are celebrated.

Katie Jennings, Director of Therapy Services, and Lianne Powell, Substance Misuse Nurse, Trainee Advanced Practitioner & Recovery Lead, Kemple View Hospital

Southern Health NHS Foundation Trust

Exploring Cultural Diversity Through Activities at Ravenswood House

I have joined in a number of different cultural activities organised by the Occupational Therapy department at Ravenswood House. More recently, I took part in a session raising awareness about the needs of deaf people.

Chinese New Year
I enjoyed celebrating Chinese New Year. We sampled different dishes. There were lychees which were tasty and I ate a number of fortune cookies. They had nice messages inside. We read different Chinese horoscopes which predicted the future and described the characteristics of the different animals for each year people are born. We discussed the horoscopes with friends and associates from different wards. There was a game which involved using chopsticks to move objects from one pot to another. This was quite fun!

Iranian New Year
We have an Iranian patient which helped plan a celebration for the Iranian New Year. We sampled different foods such as baklava and Persian biscuits that the Iranian patient had cooked. There were different objects on a table that symbolised different hopes for the New Year. Some patients painted eggs, which are a symbol of new life. We listened to Iranian music, which to me sounded similar to Indian music, which is where my parents are from. The music really created a good atmosphere!

International Tea Drinking Day
I was lucky to attend a tea drinking day on 17th April 2018. There were eleven different types of tea including chai, peppermint and English breakfast tea. There were rich tea biscuits to go with the tea. The reason the tea tasted so good was because it had brewed for a long period of time. All the tea was served in small plastic containers for tasting. There were larger cups if you wanted more of one of the teas you had tried. I found this a sociable event and I mixed with a lot of people from different wards, talking about the different teas.

Snack Group
In a weekly Snack Group we enjoyed Scottish foods (haggis, neaps and mash), cooked by a Scottish patient. We read Scottish poetry and a bit about Robert Burns. In the same group, we had another session where we made Indian dips, such as raita and ate them with naan bread whilst listening to some Indian music. I was involved in planning this group because my parents are Indian.

Deaf Awareness
I enjoyed going to this group and wearing ear plugs to help me understand how it feels to be deaf. We chatted about how we felt not being able to hear properly and the challenges deaf people may have. We read some facts about how many deaf people there are in the UK.

I really enjoy these activities as it is interesting to try different things, to learn a bit about other cultures and groups of people and to socialise with other patients and staff. I like to talk to my parents about these different events too, on the phone and when they come to visit.

In October, I will help plan a Diwali Celebration. I look forward to sharing customs about how Diwali is celebrated.

Service User 'RB', Ravenswood House

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FrontFoot

Handling Hate

As you'd expect, when we run relational security development sessions, we talk about boundaries. We take each boundary and discuss whether it's non-negotiable (so, under no circumstances should the event occur), negotiable (there's probably a rule but, under a certain set of circumstances, you'd apply your judgement) or whether it's a 'grey area' and therefore up for discussion. The point is staff talking together about these issues. Some are easy and some are hard. Connecting with a patient on Facebook? Easy! Non-negotiable. Doing your own shopping on escorted leave? Nope - definitely not.

So, what about accepting racial abuse from a patient? "Ah, well" delegates will quickly say, "We have a zero tolerance policy. We don't accept that. It's non-negotiable". But if you allow a small pause, what can often follow is an unsatisfied silence until someone with a little courage says: "But we do, don't we? It happens. And we don't always know what to do about it".

In not knowing what to do when a patient racially abuses a colleague, we run the risk of unwittingly endorsing those attitudes, failing the people we employ and neglecting the people we care for. Just writing a zero tolerance policy, breathing a sigh of relief and considering the issue dealt with isn't enough.

I met a healthcare worker in London a few months ago. You know how sometimes you meet a member of staff and think "If my kids get ill I want you to be the person that looks after them"? This was that guy. He worked in an adult woman's eating disorder service. A patient approached him one day with a toy monkey and said, "This is what your son will look like when he's born".

He was devastated. Even months later sitting with me, he was tearful and shaken by the experience. He'd raised the incident with his manager, who responded by moving him to work on a different ward pending an investigation (despite there being clear CCTV footage that should have shut the case down in about twenty minutes). Two months later, he returned to his ward where the manager told him nothing could be done because the patient was mentally unwell. Unsurprisingly, he's looking for another job. You see, it wasn't just the experience of racism that injured him, it was the whole experience of that *plus* how it was handled by his organisation. In dealing with these important issues, it's not just a possibility that we'll miss an opportunity to handle it well, there's a real chance we can do someone harm.

It seems that we're sometimes too quick, (though in this case – too slow) to offer the diagnosis of a patient as a defense for how someone's been treated. In this case the staff member said, "I know she's mentally unwell. I've just nursed her for six months; I'm not a complete idiot! But that doesn't make it ok. It's not ok for her, it's not ok for me and it won't be ok for someone else that comes into contact with her in the future".

Another person I met worked with men with personality disorder. A patient refused to accept her escorting him on leave because he didn't want to be seen with her because she's black. The response of the service was to place another escort with the patient and explain that the patient is 'old fashioned' and ill and doesn't know any better. Personally, I'd have cancelled his leave and told him exactly why, but that's maybe just me.

I think the message here is, we know it's complex. We're required to provide services. We know we can't withhold care in these settings and that often the mental status of the patient *will* have a bearing on the course of action we're able to take. But let's not leap to formulation as the first response. Let's acknowledge first that it's a vile thing to have happened, that it *shouldn't* have happened and let's be clear about what action might have some therapeutic value, even if it's only a very small thing in contrast

with the gravity of the offence.

Here are a few themes that have emerged from relational security sessions over the last year or so, from talking to a few people in the system who've started some good work in this area (notably, Dr Paul Beckley of Avon & Wiltshire MHPT) and from a short workshop I ran with Michael Humes at the QNFMHS MSU Annual Forum this year:

- We often don't have good data relating to incidents of hatred or intolerance. I've picked up particularly on racism here, but obviously hatred is directed towards many characteristics in our flawed society. Anecdote is difficult to take seriously.

- Employee assistance programmes (if we have them) often don't have the skills to meaningfully support staff who experience hatred. Sometimes this is because of a lack of corporate clarity on the issue.

- Many 'zero-tolerance' policies (if they exist) don't really have teeth. They don't accept the likelihood that we will encounter hatred in this setting and set out how we'll deal with it when we do.

- Clinical strategies for services (again, where they exist) are silent on how such issues will be treated therapeutically. Some people will have deeply held beliefs that are impossible to shift. We can't expect to be discharging perfect citizens with pro-social habits 100% of the time. But, in deciding what our clinical strategies are, let's also decide what our principles are in relation to building community skills in the people we care for *and* give our staff the confidence and skills to deliver on that principle. While people are in our care, is it incumbent on us to address hate crime as we do violent crime? If racism or any other kind of hatred remains part of a patient's set of attitudes when they settle in the community, how likely is it that they'll settle well?

- Often staff seem to be moved away from an area or function which worsens feelings of being unfairly punished and sends entirely the wrong message back to the perpetrator.

- Relationships with police are very variable. This is not a new discovery but it affects this issue as well as it does many others and frustrates attempts to meaningfully respond to 'crimes in care'.

- People from non-minority groups are often afraid of discussing this issue openly for fear of getting it wrong. For that reason, staff who do experience an incident of hatred can feel very alone. However we support services to deal with this, it must include opportunities for all staff to express any anxiety or lack of knowledge they have about the issue.

- Some younger staff I've encountered have been under the impression that it's ok for older people to be racist because 40 years ago racism was ok. Terms like 'outdated', 'old-fashioned', 'primitive', etc. have no place in a discussion about racism. It was never ok.

To summarise the workshop consensus; sometimes we have a problem with hatred towards our staff that we're finding it hard to deal with satisfactorily. It feels especially difficult for our services because of issues relating to capacity and a clearer clinical narrative about possible therapeutic approaches to this issue might be really helpful. A small working group of people to build some short guidance on the topic might also be really useful.

We'd really appreciated your views on what might help staff and services deal with this subject better; or any other general thoughts on the topic.

Elizabeth Allen
www.frontfoot.net

St Andrew's Healthcare

"All About Me": A Deaf Recovery Package

Fairbairn is a 15-bedded medium-secure ward for deaf men at St Andrew's Hospital, Northampton. Like many other specialised deaf mental health services, the current patients have received a variety of diagnoses (including: schizophrenia, personality disorder, learning disability, brain injury and autism spectrum disorder), but all share experiences of difficulties with language and communication, either spoken, signed or both.

The majority of patients use British Sign Language as their first language. Both BSL and English are used on the ward, with BSL-fluent staff and sign language interpreters. All staff working on the ward are aware of the challenges of working with deaf men with mental health problems and risk histories. We are constantly working to adapt mainstream approaches to this population.

Most pre-lingually deaf children are born to hearing parents and consequently develop their language and communication with significantly more difficulties than hearing-children-of-hearing-parents and deaf-children-of-deaf-parents. They also experience far more difficulties in learning to read, accessing information and understanding about themselves and the world around them, which leads to higher rates of mental illness (Fellinger, Holzinger & Pollard, 2012). A significant problem in working with deaf people with mental health problems is to provide help and support that is 'culturally affirmative' and 'authentic' enough that the deaf person is able to work effectively with their recovery support (Glickman, 2013; Glickman & Harvey, 1996).

Walls, Hough and Tathata (2013) identified that deaf mental health services tended to use recovery tools based on concepts and language created for hearing people. These tools were often translated into BSL to improve accessibility, but they found this did not improve service users' understanding and are therefore of limited use. The main problem in translation is that the context of the narratives are often based on hearing people's experiences, which are usually culturally inappropriate and alien to many pre-lingually deaf people.

The "All About Me" care plan was developed in partnership with service users, NHS England commissioners and clinicians from specialised mental health services across England*. The document is patient-centred and is used to structure and plan a patient's recovery through discussing ten domains: Communication, Identity, Understanding my Mental Health, Problems, Rights, Services, Information, Healthy Living, Activities and Relationships. Detailed guidance has been written to help clinicians consider what recovery may mean for the deaf patient and what specific goals they may wish to achieve. It was officially launched in June 2016 and is in the process of being rolled out across all deaf mental health services in England.

The "All About Me" care plans were introduced on Fairbairn Ward in November 2017. The ward manager initially met with each patient to explain and discuss the ten domains. These discussions were framed positively to help the patient think about what they currently have in their life and the future goals they would like to achieve. Since then, each patient's document has been reviewed and updated every 5 weeks during ward round by the MDT and the patient. This concludes with a discussion about whether or not the patient is happy with their All About Me care plan.

So far we have identified three main challenges:

<u>Accessibility</u>
Despite the care plans being adapted to focus on domains more relevant to deaf people, the varied levels of communication ability and understanding for some of our patients continue to be a challenge in

making the process truly collaborative and accessible. The care plans rely on written English and we are considering how we can use more visual means to record the outcomes and decisions that come out of discussions with the patient.

Time pressure
Even with patients who have some literacy, the care plans took several sessions to complete. Although this is not a problem in itself, we anticipate that some patients may continue to see the care plan as something that they must complete, and find it difficult to "own", because of the focus on writing and the time taken to record the range of information. Additionally, patients with significant communication and understanding difficulties can often take longer to engage in discussions during the reviews in ward rounds.

Trying to work collaboratively.
Both of the above challenges translate into challenges for truly collaborative work. There can be pressures on the MDT to update care plans without the patient's full involvement. Patients likewise can provide an "empty nod" or collude with the staff wanting to help them so that they simply go through the motions and do not develop their motivation to recover from the difficulties that have led them into hospital.

Plans for the future
Whilst the implementation of the All About Me care plans on Fairbairn Ward is agreed to be an improvement on previous documents, there continue to be challenges for us in helping our patients gain a full understanding and involvement in their recovery pathway. We also anticipate that the concept of 'recovery' may be a difficult and unusual concept for some, if not all, of our patients to understand and 'own'. Our work in the next months and years is to address these challenges in a positive, collaborative and effective way.

*Services involved in the development of the All About Me package: Birmingham and Solihull Mental Health Foundation Trust; Cygnet Healthcare; Greater Manchester West NHS Mental Health Foundation Trust; Northumberland, Tyne and Wear NHS Foundation Trust; St George's Healthcare Group; South West London and St George's NHS Mental Health Foundation Trust; SignHealth; the Deaf Health Charity; Nottingham Healthcare NHS Foundation Trust; St Andrew's Healthcare; Rotherham, Doncaster and South Humber NHS Foundation Trust.

Dr Kevin Baker, Clinical Psychologist, and Anna Chattaway, Assistant Psychologist, St Andrew's Hospital, Northampton

The Royal College of Psychiatrists

Meeting the Needs of Transgender and Gender-Diverse People in Secure Services

Identifying the problem
There is a large gap in the understanding of patients' sexuality and sexual activities during their time in secure services. Transgender and gender-diverse people are individuals whose gender identity and/or gender role do not conform to the sex assigned to them at birth. Although the term 'transgender' is commonly used and widely known, not all gender-diverse individuals will identify themselves as transgender or the binary way of understanding gender, which has historically dominated in most cultures.

Where is the evidence?
There still remains a great level of apprehension amongst mental health professionals when it comes to discussions about patients' sexuality and sexual behaviour in a secure service. The problem of stigma and discrimination against individuals who express homosexual preferences is an on-going problem.

Evidence suggests that, in many cases, psychiatric disorders such as anxiety, depression and acts of self-harm can appear much more frequently in transgender people seeking treatment, as opposed to cisgender people (those whose gender agrees with the sex they were assigned with at birth). This disparity can be in part explained by societal responses to transgender people. For instance, research has previously demonstrated that young people presenting as transgender or gender-diverse are disproportionately affected by bullying while at school. This in turn increases their risk of experiencing mental health problems, self-harm or suicide ideation.

Recent research based on qualitative discussions with clinical staff members e.g. psychiatrists and clinical psychologists working within a forensic psychiatric unit in London, looked at how patients make sense of their sexuality and whether there has been any experience of transgender or same sex relationship discrimination. Some hypothesised that potential irrational fears and anxiety arise when addressing the sexuality of patients in secure services due to the existing stigma within society and the historical prejudice about individuals suffering from mental illness, along with the ideation of 'insanity'. This research found that patient sexuality is rarely discussed amongst clinical staff members and, if it was discussed, this was likely to be in a problematic context. Due to the lack of formalised policy on the matter of sexuality, professionals in this sample tended to use their own personal judgment to reach decisions on patients' healthy sexual activity. This research also highlighted that due to an avoidance of clear policies outlining anti-discriminatory practices amongst mental health professionals, many feel that discrimination is manifested in the behaviour and attitudes of frontline staff.

Does culture play a role?

In the research mentioned above, some clinical staff members report that displaying homosexuality tends to be more acceptable amongst liberal patients that have come from a European background. This, therefore poses the question that perhaps liberalism is related to the cultural differences that are present amongst staff members and whether attitudes towards transgender people can be reflected in these differences.

The Rainbow Alliance consists of a network of staff, service users and carers committed to enhancing the quality of services which are offered to the LGBT+ community. The focus of this alliance is to engage and empower members as individuals with autonomy and to support them in improving services over time. This involves working collaboratively with staff and service users on how to bring change across different service areas in each organisation. Rainbow.Lypft@nhs.net

What can services do?

- Facilitate and encourage open discussions with staff members at all levels to foster reflection on how best to meet the needs of patients expressing transgender or gender-diverse identities.
- Promote the need for competence in supporting the wellbeing of transgender or gender-diverse individuals and clarify that gender diversity is not a disorder.
- Provide professional education events on appropriate care and treatment when patients are transgender or gender-diverse.
- Consider contacting a local gender identity clinic to provide training to staff or support a patient who is in need.
- Design leaflets around gender identity and discrimination to raise patient and staff awareness.
- Nominate a staff champion to become a member of the Rainbow Alliance to improve support available to patients.

Jemini Jethwa and Holly Lowther, Project Workers, QNFMHS

The Royal College of Psychiatrists and St Andrew's Healthcare

'Empowering Women in their Recovery through Secure Services'

At this year's MSU Annual Forum one of the themes of the event was 'diversity' and this provided a good opportunity to explore issues surrounding women's lived experiences of secure care. As a former service user myself, I was delighted to be joined in the delivery of a workshop under the theme of 'Women in Secure Services' by current service user Becki who herself has experience of all levels of security through the Adult Secure Care pathway. Together we were enthused and committed to create an interactive workshop under the title of 'Empowering women in their recovery through secure services', in the hope that we could encourage discussion around possible solutions to some concerns about women's engagement in their recovery.

Our choice of focus for this workshop had additionally stemmed from findings during a recent piece of work around women's lived experience of secure care for NHS England which had included myself, Sue Denison and Hannah Moore, all experts by experience and Patient Reviewers with the QNFMHS. As members of the NHS England Women's Strategy Task and Finish group, the three of us were tasked between September 2017 and February 2018 to gather the views of women in secure services. Our findings were used to inform a series of NHS England Design Thinking workshops. These workshops involved a range of experts by profession and other experts by experience to co-design a set of ideas that could address challenges across the secure care pathway for women. This project involved us speaking directly with just over 200 women who had lived experience of high, medium and low secure services. The journey to connect us with these women involved us visiting all female secure services across the North West and East Midlands regions, as well as the Orchard Unit and Rampton High Secure Hospital. One of the most striking parts of this work had been the willingness and openness of the women in sharing their stories with us, many leaving us in tears and resonating with our own difficult journeys into and through secure care.

Whilst the findings discovered through the NHS England Women's Strategy project were not entirely unsurprising, this work did enable us to shine a light on some underlying issues related to women's engagement in their recovery. What should firstly be acknowledged was very powerful evidence throughout the interviewing with these 200+ women of their exceptional levels of resilience and strength in overcoming adversity. There is much written about the significance of past trauma, abuse, violence and substance misuse for women detained in secure services, and many stories that were relayed to us were proof of women's incredible strength and bravery, but for all this evidence of resilience, there were a number of strikingly contrasting messages. It was this discovery that led Becki and I to reflect on our own journeys and to ultimately choose to focus our MSU Annual Forum workshop specifically on discussing four areas, which we now recognise as being pivotal in influencing women's length of stay in secure care.

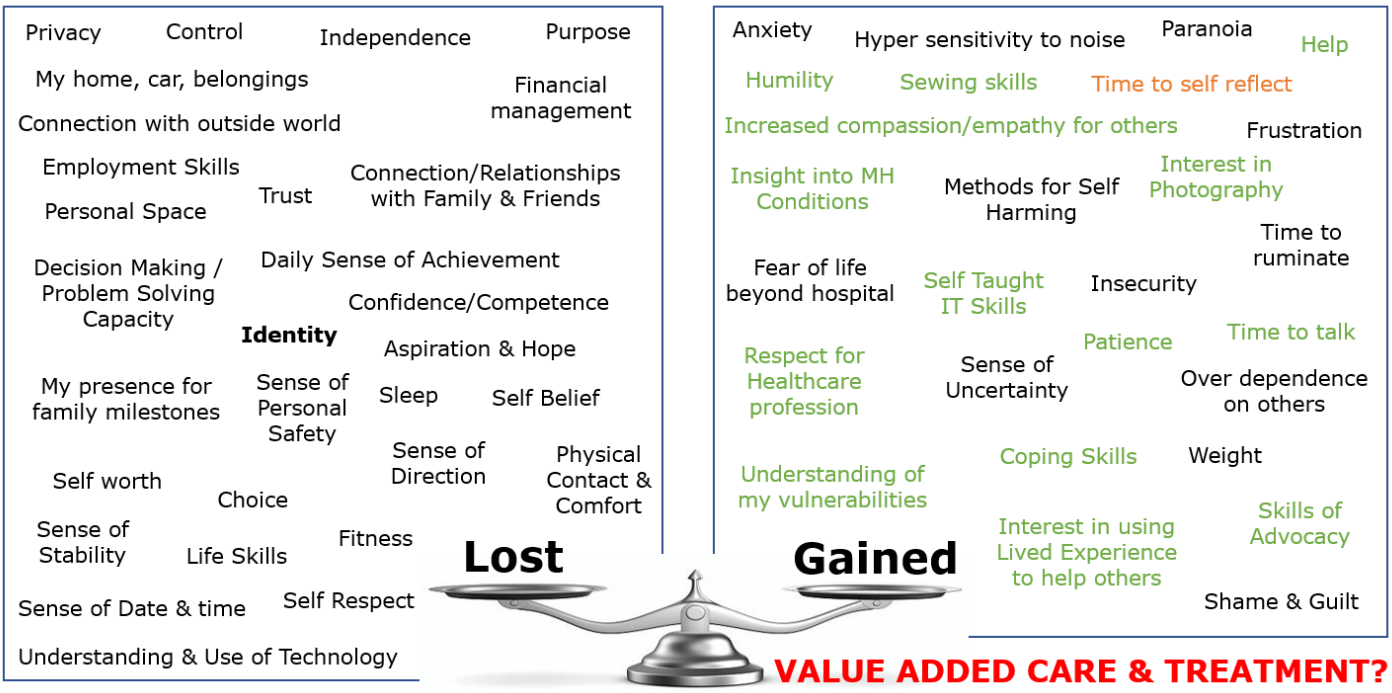
Women in secure care provided evidence of:

- High levels of dependency on staff for practical and emotional support
- Little ownership of recovery
- Low levels of self-confidence, self-esteem and identity
- Limited aspiration

These messages resonated with our own experiences and were consistent across regions, services and security levels.

In order to begin shedding light on why this might be the case, I decided to set out trying to establish the balance between what I lost and gained through detainment. I wanted to

Examples of Losses & Gains of Secure Care Detainment



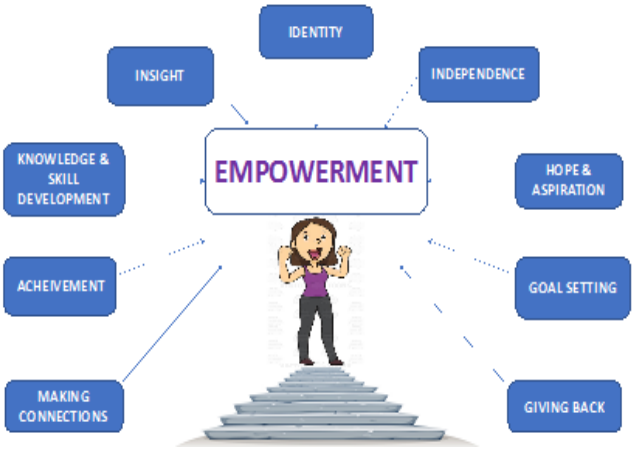
discover why for someone who, whilst enduring mental health difficulties for years, had been able to previously live and manage a home independently, had held down a number of professional roles and was notably ambitious could, suddenly through detainment, find themselves so overtly dependent at times, desperately low in self-esteem and devoid of any sense of capability. I produced the above slide, which was shared during the MSU workshop, in order to draw attention to possible contributing factors.

These lists are certainly not exhaustive but did identify a number of areas that, on reflection, were instrumental in creating a sense of frustration, despondency and perceived incompetence, which must be acknowledged is in addition to the more obvious factors associated with symptoms of severe mental illness, emotional distress and life changing circumstances for anyone finding themselves detained.

As our workshop progressed, discussion frequently became associated with how issues relating to patient dependency often appear to stem from a wards restrictive practices, protocols and routines. The obvious loss of privacy and dignity, as well as personal identity and confidence, were also identified as key issues for women when they enter secure services. Whilst these are agreed to a certain extent to exacerbate dependency, they are argued here to not solely be to blame.

We know that women are able to demonstrate innate and remarkable strength to overcome adversity in their lives. We believe the answers lie in supporting and encouraging them to channel these strengths by providing opportunities to empower them to take control of their recovery.

On researching what is required by any of us to become and feel empowered, I discovered that some key components are essential. Arguably, with these factors considered, incorporated and realised through individualised and co-produced care and treatment plans, women are more likely to feel empowered to take greater ownership of their recovery, develop higher levels of self-confidence and establish greater hope and



ambition for a life beyond hospital. If only it were that simple! But it is in the very least a really valuable starting point for services to invest in and explore further.

Becki had been one of the first women I spoke to as part of the NHS England project back in September 2017. I remember being really struck by her motivation, desire and commitment to recovery which was in direct contrast to the vast majority of feedback that we received, and it was for this reason that I asked Becki to co-deliver the workshop with me. Becki has consistently shown a real commitment to share her experiences and provide examples of good practice that could bring about change in patient ownership of their recovery. A few of the areas that Becki shared during the workshop as significant in empowering her recovery have been identified below:

- Staff belief in my abilities and consistent encouragement
- Services offering a range of activities where I could discover and develop skills – that were not always gender stereotypical
- Regular exercise where I could control my goals and commitment
- Getting a better understanding of myself, my illness and its impact on me and my family
- Regular visits, communication and support from my sister as well as engaging in Family Behavioural Therapy with her
- Regular access to leave
- A supportive and approachable MDT, who are willing to listen and positive risk take with me
- Staff helping me to develop and practice life skills and supporting me to work towards discharge
- Staff supporting me to attend a number of external recovery events, where I have met and been inspired by other patients now discharged from hospital
- Opportunity to engage in a local football team's training sessions within the community, where I needed to overcome anxieties and manage my personal narrative.

Becki shared with members of the workshop how the opportunity to co-deliver the session at the MSU Annual Forum had also been really motivating in her commitment to make a difference for other service users.

Strong Again

It's hard no one understands me. I feel alone
then, get angry, I've lost the floor that's beneath me, I'm not gonna let this illness beat me

I'm all cut up and torn, inside this feelings
still raw, I'm far from home, just want
My family 'n friendz, to call my home
I feel lost in space, don't recognize my own face like it's been replaced

In the mornings I get all groggy, I forget things coz my heads gone foggy. I
do things impulsively. I find it hard to control me, every day's a struggle, I find it hard to get by. I try and stay out
of trouble, but really I'm in my
own little bubble.

Everything ain't what it seems, I've got hopes and dreams, at the end of the tunnel is a light, it's shinning bright
waiting for me to reach it, I'm gonna get better, I will defeat it.

Becki G

For over 1300 women detained in secure services nationally, with arguably an average continuous length of stay of 8 years or so, there are over 3000 days available as opportunities, women in secure care are going nowhere! Ensuring that the 'gains' heavily outweigh the 'losses' for women, during their secure detainment, is key to their greater sense of empowerment. When these days are maximised by services with individualised, purposeful and meaningful activity; boundaried support; a daily dialogue of recovery progress; regular external connection; consistent practice; co-produced care planning and goal setting; and opportunities for improved insight and empowerment, through the efforts to secure a sense of 'normality', women can feel safe, are able to aspire, are able to visualise a life beyond hospital with a greater sense of hope and are more comfortable to take ownership of their recovery and re-explore their independence.

Su Pashley, Patient Reviewer, QNFMHS and Becki G, Service User, St Andrew's Healthcare

Findings from the workshop can be accessed on the QNFMHS website: https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/forensicqualitynetwork/latestevents/pastevents.aspx

Upcoming Events

Prison Transfer and Remission: Improving Practice, 27 November 2018

This will be a joint learning event with the Quality Networks for Forensic and Prison Mental Health Services. Visit our website for updates about this event.

Reviewer Training

Suitable for staff from our member services from any discipline with an interest in being a part of external peer-reviews for forensic mental health services. The training is free and is a great learning experience for staff members.

Dates:
Wednesday 15 August 2018, Principle Met Hotel, Kings Street, Leeds, West Yorkshire, LS1 2HQ

Thursday 30 August & Monday 15 October 2018, Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

Booking forms can be found on our website: https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/forensicqualitynetwork/latestevents.aspx

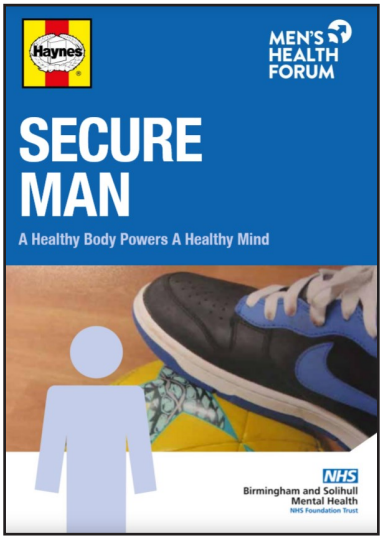
Visit our website for regular updates and further events information
www.qnfmhs.co.uk

News

NHS England Carer's Toolkit

NHS England and its partners have developed a toolkit, which helps the health and social care organisations in working together to identify, assess and support the well-being of carers and their families. It also covers new duties on NHS organisations brought about by the Care Act 2014 and the Children and Families Act 2014, including various examples of positive initiatives that are taking place which are helping making a difference to carers and their families.
https://www.england.nhs.uk/wp-content/uploads/2018/05/secure-carers-toolkit-v2.pdf

Secure Man by Men's Health Forum

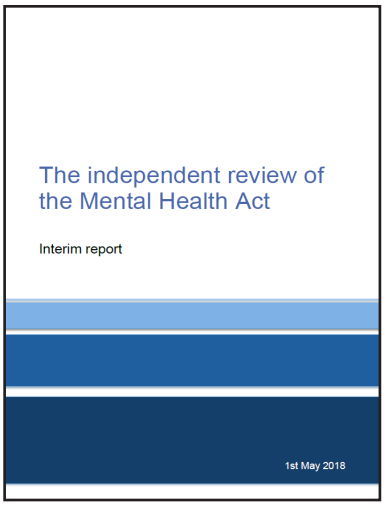


The Men's Health Forum have collaborated with Birmingham and Solihull Mental Health NHS Foundation Trust to develop a manual on physical health for men in secure services containing important information on:

- How to increase life expectancy through healthy eating and physical exercise
- Taking care of your heart
- Healthy eating advice and how to balance your diet
- Physical activity and top exercise tips
- Smoking cessation advice

The developers want to make this manual available as widely as possible and are welcoming any feedback you may have using this survey: https://www.menshealthforum.org.uk/secure-man-enquiry

Independent Review of the Mental Health Act: Interim Report



The interim report gives an update on the review's findings and the areas it will look at next. It is based on evidence including:

- Service user and carer surveys
- Focus groups
- Stakeholder workshops
- Wider discussions with organisations and professionals

The review will examine the issues as set out in the report before making its final recommendations. A summary of the review's work so far: https://www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report?dm_t=0,0,0,0,0

Getting the Most Out of Your Quality Network Review

At the annual forums, we discussed how to get the most out of your peer-review. For those of you that couldn't make it, we wanted to share some of the key points with you! This is to make sure that you are making the most out of the process and maximising the benefits for your service, your team, yourself, your patients and your carers.

We framed the discussion around four questions.

How can you involve your wider team, patients and carers in the review process?

- Take a whole team approach and ensure everyone is aware of the review, what it is and how they can be involved.
- Allocate responsibilities among team members, at self-review and peer-review, to encourage ownership over parts of the process.
- Identify patient and carer representatives to raise awareness among their peers and to lead on different areas. This may include: encouraging attendance at meetings, identifying individuals to support the tour of the unit, encouraging newsletter contributions and/or boosting involvement in Network initiatives.

What is the most effective way to approach a review day?

- Inform everyone of the review day and share the timetable in advance
- Assign roles and responsibilities
- Identify any priorities in your service that you wish to discuss with the review team.
- Invite everyone to lunch and network with the reviewing team.

Following the review, how could you make the most out of the findings?

- Disseminate the key findings to your staff team, patients and carers.
- Celebrate the identified areas of achievement.
- Develop an action plan, in collaboration with all parties and allocate responsibilities.
- Have regular meetings to keep track of progress ahead of the next year's review.

What would make the process more helpful for your service?

- Be as honest as possible when scoring the standards – this will ensure the report is as helpful as possible in identifying areas for service development.
- Hold regular meetings to keep track of progress throughout the self-review period and ahead of the review day
- View the process as supportive when being reviewed and when reviewing others. We're all in this together!
- Maintain good communication with your project link person to ensure the smooth running of the day.
- Encourage team members to attend reviewer training and actively participate in review visits.
- Promote the benefits to staff members in terms of personal development e.g. learning about other services, developing skills in chairing meetings and delivering feedback, bringing knowledge back to your service to improve your own practices, building your professional network and CPD opportunities.

Megan Georgiou, Programme Manager, QNFMHS

The Royal College of Psychiatrists

The Ultimate MDT Member – Competition Winner From the QNFMHS 'Patient Engagement and Involvement in Secure Settings' Event

The Quality Network hosted its first ever event that was dedicated to patients in secure services at the beginning of April this year. The day consisted of guest speakers talking about their own experience with mental health and the journey their disorders have taken them through. There were also several workshops run by services and patients on the work they are doing to involve and engage patients in recovery.

During one activity, run by a QNFMHS patient reviewer, groups were asked to create their ultimate MDT member (including doctor, psychologist, nurse, occupational therapist, social worker and ward manager), by thinking about what each role should look like in practice. Groups wrote down what they thought their designated MDT member should possess in terms of skills, knowledge, qualities and other abilities that are relevant to that job role. For extra measure, groups were also asked to name and draw an image of their staff member.

It was so positive to see staff and patients from different services working together to create what they believe each staff member should look like. After much deliberation, the panel came to an agreement of the winner — congratulations to Dr. I. R. Human!

Skills

- Understanding the recovery process and how it differs for individuals
- Organisational skills
- Understand MDT roles (collaboration)
- Understand all mediation
- Reflective practice
- Leadership skills
- Trust and support to make decisions

Job Role: RC/ Doctor
Name: Dr I.R. Human, the Superhero Doctor!

Knowledge

- Experience of someone with mental health issues (family or friends)
- Understand that people can recover
- Understand mental health act
- Have the knowledge to adapt and be flexible when speaking with others
- No jargon!

Qualities

- Person-centred
- Good listener
- Sense of humour
- Compassionate
- Family oriented
- Team worker
- Open minded
- Approachable
- Respectful
- Integrity and honesty

Other Abilities

- Ability to move with the times
- Think outside the box
- Proactive with friends and families who are respecting service users' voice
- Enjoys job!
- Visible on the wards
- Not afraid to get their hands dirty
- Animal lover (more compassionate)

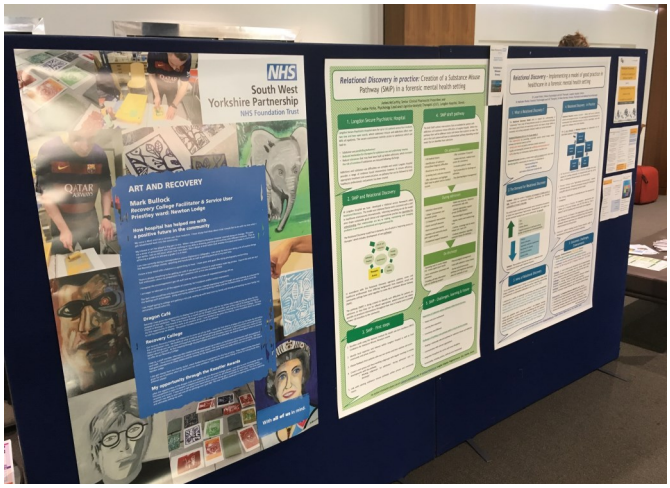
Thank you so much to everyone who got involved in this activity and the hard work you put into your ultimate MDT staff member!

The Quality Network, CCQI

QNFMHS Update

Recent QNFMHS Events - LSU and MSU Annual Forums

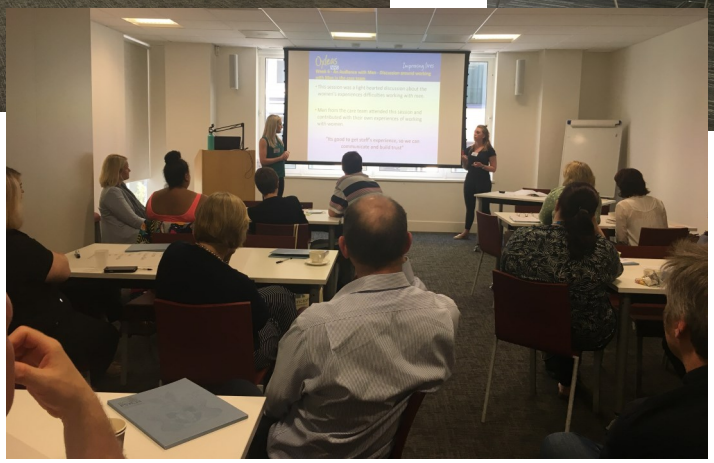
Welcoming delegates at the LSU Annual Forum



Posters covering topics such as art and recovery, restrictive practice and substance misuse pathway

Sharing best practice at the LSU Annual Forum

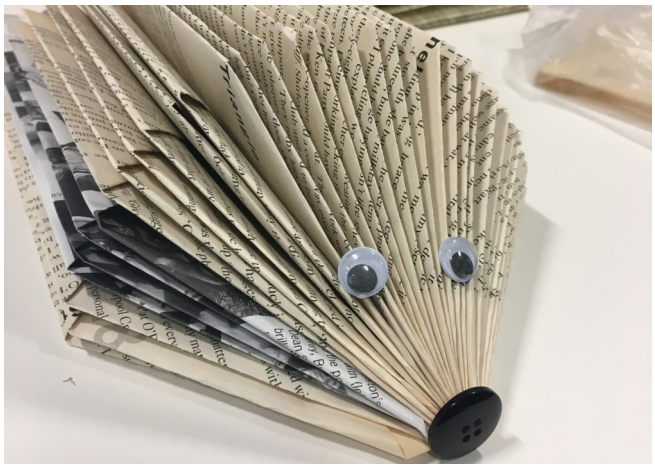
Patient Artwork Display



Women's wellbeing workshop at the MSU Annual Forum

Creative mindfulness workshop at the LSU Annual Forum.

Colleagues from St Mary's delivering the 'mindfulness through art' workshop



Finding mindfulness in art - crafting

Useful Links

Care Quality Commission
www.cqc.org.uk

Centre for Mental Health
www.centreformentalhealth.org.uk

Department of Health
www.doh.gov.uk

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

Institute of Psychiatry
www.iop.kcl.ac.uk

Ministry of Justice
www.gov.uk/government/organisations/ministry-of-justice

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

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

NHS England
www.england.nhs.uk

Offender Health Research Network
www.ohrn.nhs.uk

Revolving Doors
www.revolving-doors.org.uk

Royal College of Psychiatrists' College Centre for Quality Improvement
www.rcpsych.ac.uk/quality.aspx

Royal College of Psychiatrists' Training
www.rcpsych.ac.uk/traininpsychiatry.aspx

See Think Act (2nd Edition)
www.rcpsych.ac.uk/sta

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And use **#qnfmhs** for up-to-date information

Email Discussion Group
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lsu@rcpsych.ac.uk

To join the discussion groups, email 'join' to both addresses.

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