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WELCOME

Welcome to the 39th edition of the Quality Network for Forensic Mental Health Services' newsletter on **'Leaving Secure Care'**. We have received a huge number of articles and it is clearly a topic of interest. As always, we are grateful to all the contributors! This edition also showcases the winners of our popular patient artwork competition. All of the entries were fantastic and can be viewed towards the end of this newsletter.

We are currently preparing for the next round of peer-review visits, with the first services hosting from the end of September. This next year is the second phase of our first two-year cycle; half of member services will receive a full review, whereas the other half will receive a quality improvement or 'QI' visit.

We're looking forward to catching up with you throughout the standards consultation roadshow in September and October. The first event is taking place at the Royal College of Psychiatrists, London, followed by events hosted by Ridgeway (Middlesbrough) and Fromeside and Wickham Unit

(Bristol). This is your opportunity to have your say on the what will be included in the next edition of the standards – we hope to see you there.

Later this year, we are hosting a joint event with the Prison Quality Network on prison transfer and remission. We have an excellent programme lined up and it is looking to be a popular event. Book early to avoid disappointment!

Finally, we wanted to share with you a picture from our team away day. We went out to play rounders and have a picnic at Green Park!



Dr Quazi Haque and Megan Georgiou

Leaving Secure Care

My journey through high secure services made me feel different emotions from beginning to end. However, for me now, it was the foundations to all progress.

Medium secure was scary to begin with as the structure of high secure was not there. I had to search within myself to find and implement those boundaries. Everything I was taught at high secure I had to use in my life. That is what scared me. Moreover, low secure gave me the ability and confidence to carry those skills forward and find independence.

I had been incarcerated for over fourteen years, my longest period, without community leave. Going on my first community leave was something that made me nervous and excited. It generated a lot of anxiety and apprehension. This was in the form of knowing I lacked social skills or worrying about how others in the community would react to me. I lost community leave a few times due to this deep apprehension. However, I soon began to value my leave and started to think about my life beyond hospital services. This was my biggest challenge. During all this progress no matter what challenges I encountered, I would always seek support from staff, psychology, psychiatrist, social worker, occupational therapists or whoever was directly involved in my support network. There was a gradual graded exposure introduced to the community over time. After progressing to low secure with consistent productive settled behaviour, I was given the opportunity for unescorted leave. Since, I have not looked back. I have been going out to the local gym now daily for over sixteen months alone for four hours without issue.

I constantly think about life and independence beyond hospital services.

Despite the progress and the freedom I still suffer from apprehension. I always think about **"what if."** The reality is that I have to gain confidence to continue on my **Journey in Recovery.**

Life can be very challenging in a lot of aspects. Life can throw at us trials and tribulations. Adversity after adversity. We have to be strong mentally and weather the storm. I always try to do things the best and correct way. I try hard to avoid relapse. I always seek support now but I also try to sometimes deal with issues by myself. I have a lot of independence. I also have short term and long term goals that if I keep to, will hopefully give me a prosperous future beyond hospital services.

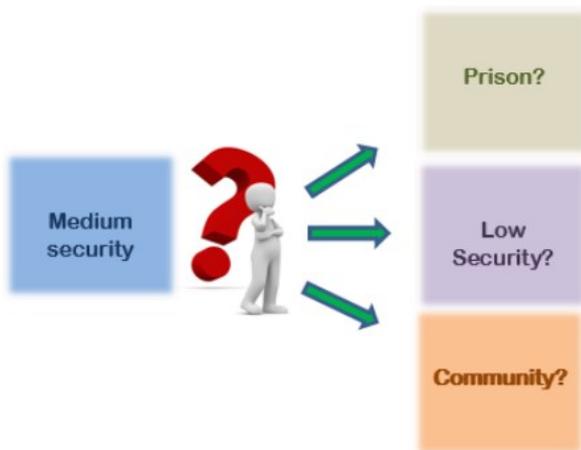
As I move more and more towards leaving secure care I have to think more about integrating skills as well as learning and adapting to the community. Sometimes it can be thought provoking and worrying to think about independence living skills such as: paying bills, managing yourself, life problems, balancing time management, diet nutrition, hygiene, physical and mental health and problem management.

There is also self-medication to think about as well as establishing your support network that can help you find and maintain independence. Moreover, some of these skills can be developed before moving into community support living. I am living proof that if you work hard and adapt to change by using the skills we learn through therapy, we can turn our lives around and progress beyond expectations. We are still human even with mental health struggles. Life can be different and enjoyable. We can certainly have a bright future.

Michael Francis John Kelly, Service User, Cygnets Hospital Bury

Movement Along the Secure Care Pathway

Secure mental health services support people detained under the Mental Health Act (2007) whose offending or risk of violence are considered to be linked with mental ill health, and so severe as to require treatment in a secure setting, before returning to the community. Services are also concerned with public safety and it is seen to be in the public interest to provide specialist mental health care that can reduce the risk of future re-offending.



Previous research on people leaving secure care in the late 90s, showed that secure mental health services reduce the risk of re-offending following discharge relative to prison. These early studies did not show how secure mental health services help reduce re-offending, or what factors are associated with success.

The last two decades has seen secure services adapt to changes in policy, legislation, commissioning and available treatments. Medium secure services have been shaped by reduced high secure beds, expanding low secure and community forensic services; amendment of the Mental Health Act (2007) has changed perspectives on the treatment of people with personality

disorders, and in Wales the Mental Health (Wales) Measure (2010) has placed care and treatment planning and carers' rights on a statutory footing. More recently, the evolving Offender Personality Disorder Pathway in England and Wales has changed approaches to working with people with personality disorders in the criminal justice system. A European Social Fund backed PhD project between Abertawe Bro Morgannwg University Health Board and Cardiff Metropolitan University, is now investigating what changes for people treated and discharged from medium security.

The first phase is a re-analysis of six year follow up data on offending outcomes from a national cohort discharged from English and Welsh medium secure services in 1997/98. We are analysing relationships between risk of reconviction and clinical decision making about levels of security and discharge placements.

The second phase is a retrospective analysis of the healthcare and offending records of people discharged from NHS medium secure care in Wales from 1998 to 2018. We are investigating changes in service user demographics, offending and clinical outcomes, and tracking how secure services in Wales have changed over the past twenty years. We are applying the DUNDRUM recovery and treatment completion scales to determine a) whether independent, retrospective DUNDRUM ratings predict discharge destinations, clinical and offending outcomes; and b) what heuristics (decision making strategies) clinicians used to plan discharge.

Uniquely, the project will include service users' and carers' voices, based on qualitative analysis of interviews with ex-patients and family members about their experiences of being in and discharged from medium security and what they perceive changed along the way.

We hope to shed light on what leaving secure care means for people, and what

influences clinical decision making about the journey through and beyond secure care.

If you would like to find out more about this project, contact Charlotte.Hill2@wales.nhs.uk.

Charlotte Hill, PhD Student; Ruth Bagshaw, Clinical and Forensic Psychologist, Andy Watt, Reader in Psychology, Caswell Clinic

Primary aims of the project:

1. Identify factors used in clinical decisions about movement along the secure care pathway.
2. Identify clinical, social and forensic factors that predict risk of reconviction, clinical and social outcomes.
3. Analyse the influence of length of stay and restriction orders on risk of reconviction.

The Royal College of Psychiatrists

Leaving Secure Care: The Sword of Damocles

My first conditional discharge occurred on 3rd April 2012. I remember it well; a lovely sunny day that seemed brimming with hope and positive opportunity. My mental health review tribunal had taken place in the morning, and as my community placement, a flat was ready and waiting for me to occupy it, the conditional discharge took place immediately.

I loved that flat; it was an airy ground floor flat opposite a very picturesque church and I was very happy living there. Being a highly independent and self-directed creature, I had already managed to line up a series of interviews for patient involvement roles with various national healthcare associated organisations and within three weeks I had managed to be accepted for each one of them.

I remember how happy my father was for me. My mother had passed away whilst I was detained under the Mental Health Act (MHA), and I recollect my dad saying his only sadness was that mom wasn't alive to see me discharged, happy and well. And I was happy, very happy. I had regained the

freedom I had sacrificed in my pursuit for appropriate treatment for the mental illness from which I suffered. Even more precious I had discovered that the key to a positive recovery wasn't to be found in the hands of secure services, but in purposeful and adaptive occupation, and I had managed to become engaged in much that gave me actualisation.

There was just one fly in the ointment; the forensic community psychiatric nurse I had been allotted was vehemently opposed to my service user involvement work. She viewed it as "tokenistic" and "hard to supervise". She was used to discharged patients spending most of the day in bed and doing very little other than shopping or going to the pub; I was an alien entity to her and she didn't like it.

For reasons which have never become clear to me, my carefully voiced concerns to the rest of my community team at my first CPA meeting, regarding my forensic community psychiatric nurse's ability to understand and support my need for meaningful activity, met with instant and intense anger. This shocked me. I remember leaving the meeting physically shaking from the trauma of it. The meeting may have been nominally a CPA, but how it played out was myself being subjected to a torrent of anger from my responsible clinician and social supervisor. I left the meeting physically

shaking, which was highly unusual for me. I could not understand why the team had responded in such a verbally aggressive and unjust manner, seemingly out of all proportion to the nature of my concerns. Looking back, I wonder if what happened may have been due to something which had occurred previously within the local secure and forensic service; something completely unrelated to me. Perhaps something which had left a very distinct mark within the service and aroused much negative emotion? Perhaps my concerns had triggered a transference of this upset onto myself? I don't know, and the service has never offered me any explanation.

To cut to the chase, the CPA dealt a fatal blow to my trust in my community team. I continued to focus on and thrive in my service user roles, but the vulnerability I was left feeling in the wake of that 'CPA', and my subsequent attempts to seek resolution via the trust's complaints department were to lead to something far worse.

I was a 'restricted patient' at the time; conditionally discharged from a S37 hospital order, but formally under the remote supervision of the Ministry of Justice (MoJ). My community team were obliged to provide the MoJ with regular reports and their claims that I, the restricted patient, was openly voicing a lack of confidence in them led to my recall to hospital.

Was the recall justified? In my opinion it wasn't. I had little trust in my community team, but this didn't mean I was a risk. My service user roles continued to blossom and bear good fruit. I was happy and found fulfilment and a sense of virtue in my work; it was important for me to make recompense for committing an index offence. Nevertheless, the community team had reported to the MoJ that given our

relationship had broken down, they were no longer in a position to supervise me, and so I was recalled.

Recall is the 'Sword of Damocles' that hangs over all restricted patients; the potential to be compulsorily admitted under section should our community teams deem us to present a risk to others or ourselves. It is not easy to challenge recall; it requires the involvement of the Supreme Court and the chances of a petition being upheld aren't exactly rosy. I could write so much more on this. Unfortunately, I was to experience another recall in 2016; one which came out of the blue and which those around me and who I was closest to at the time openly questioned. Mental health solicitors with whom I have discussed the matter, have informed me that although the case law around recall is quite strict; in practice the threshold for recall is trivially low. One barrister opined that the law regarding recall is the most abused part of the MHA.

I apologise that this article hasn't sustained the picturesque quality with which it began. However, it does end with a little bit of hope. Today I had the privilege of giving testimony of my experiences of recall at a topic group meeting of the current Independent Review of the MHA. The meeting was one of a series which I will be attending as a member of the topic group for the revision of the Criminal Justice section of the MHA. My fellow members include a judge, a lawyer, a former director of nursing, a senior researcher from a well renowned mental health research centre and a consultant forensic psychiatrist; all of whom I have the greatest of respect. Today has been a good day.

**Dr Sarah Markham, Patient Reviewer,
Quality Network for Forensic Mental
Health Services**

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

**Coventry and Warwickshire
Partnership Trust**

**Introducing a Leavers'
Preparation Group in an
Intellectual Disability Secure
Service**

Post the Winterbourne enquiry and the introduction of the Transforming Care Agenda, there has been a drive to reduce inpatient beds and the duration of hospitalisation for people with Intellectual Disabilities (ID). This has led to an increase in service users with ID leaving secure hospitals. Preparing service users for discharge/transfer is recommended in the National Standards for Low Secure Units and is of significant clinical importance. Within the Brooklands secure services, Birmingham, there has been a recent increase in the

volume of individuals in the 'exit planning' stage of their care pathway, therefore to address this, a group intervention aimed at preparation for life after hospitalisation was developed in 2017.

The Leavers' Group is an eight-session preparatory, recovery-focused group intervention focusing on supporting service users with ID as they approach discharge or transfer to lower levels of security.

The group seeks to raise awareness of, and consolidate learning in relation to, psychological, occupational, communicative and relational risk factors that are likely to be of increasing relevance in a community setting outside of hospital. It further aims to offer support, reassurance, education, reflection, goal setting and practical skills help. With the anticipation that this will lead to reductions in anxiety prior to discharge/transfer, clarify misconceptions about

Module	Session	Content Summary
1. Moving On	1	Introduction Introductory session to establish aims and expectations of group; reflections on Inpatient journey and key relationships
	2	Legal Aspects of discharge/transfer Review of detention, legal requirements for discharge
	3	Models of care Models of care beyond hospital Steps to discharge process model CCG Representative
2. Life Skills	4	Practical community skills: Daily living skills (e.g. banking, travel) and constructive use of time Sharing ex-patient stories
	5	Healthy Living Aspects of healthy lifestyles within the community (e.g. meal planning, exercise, health checks)
3. Relationships	6	Relationships Review types of relationships, endings and new relationships The law and potential risks within relationships
	7	Social media and the internet Benefits and risks associated with the internet and modern technology
4. My Future	8	Endings Supporting individuals to reflect on their experience of hospital and discharge/transfer

Table 1: Group content/structure

potential future lives and also to meet needs identified by patients, staff and community teams.

The group is co-facilitated by a multidisciplinary team of three staff members including a clinical psychologist, occupational therapist and a speech and language therapist, with a guest speaker from the local clinical commissioning group (CCG) present for one session. Sessions are held once weekly for eight weeks, lasting for two hours. *Table 1* outlines the group content.

The group is evaluated using Subjective Unit of Distress (SUD) scales regarding specific anxieties, qualitative feedback and reflective practice.

Through the delivery of this group a number of learning points have become apparent. There is an evident need for thorough discharge preparation commencing from the point of admission involving all relevant external agencies; an internal inpatient Social Worker can provide critical support in this process. Inpatient services should strive to pursue progressive drives to reduce restrictive practices whilst balancing the needs and responsibilities of risk management if we are to ensure effective resettlement; this should include

consideration of access to restricted items, in particular the internet and smart technology. There is a responsibility on staff teams to appreciate the anxieties involved in discharge/transfer and for services to pay careful consideration to the use of language in goal planning, being mindful that "getting back to the community" can for some individuals feel more stressful than remaining in hospital. It should be a constant effort to foster cultures of open transparency and collaboration with service users and we should seek to appreciate the distress that can be engendered in the length of time taken to discharge/transfer individuals. Finally, we feel that the value of relationships people develop whilst in secure services and how these endings are managed needs formal recognition in ending phases of treatment pathways. Whilst secure services undoubtedly strive to achieve these aims, we have found having the opportunity to reflect on these points throughout the course of running the Leavers' Groups to be a rewarding experience.

Dr Gareth Hickman, Clinical Psychologist; Nicola Booth, Speech and Language Therapist and Thuy Hoang, Occupational Therapist, Brooklands Hospital

Barnet Enfield and Haringey Mental Health NHS Trust

Moving on from Secure Care: Simeon's Story

I spent two years under section in a secure mental health hospital and I wanted to share my own personal journey of recovery and moving on from a secure hospital.

Growing up as a teenager, it became clear

that I was suffering from some form of a mental health condition. I was initially diagnosed with depression and then psychotic depression, both misdiagnosed. Obsessive compulsive disorder (OCD) developed strongly through my teens alongside symptoms of psychosis. It was only after being sectioned in hospital that my doctors then diagnosed me with paranoid schizophrenia, another misdiagnosis as it was later confirmed that I am actually living with hebephrenic schizophrenia. Hebephrenic schizophrenia

means disorganised schizophrenia, which if you knew me is the exact opposite to my natural state.

I became incredibly ill as my schizophrenia took hold of my life in every area. When I arrived in hospital it felt like my whole personality and natural self was completely covered and coated in my own delusions and hallucinations. It took me quite some time to realise that I was even in a hospital and that I couldn't just leave and go back home. My doctors placed me on different medications, but it was only when I was put on clozapine that I started to become well again. One day I gained a significant self-realization that these voices in my head weren't actually real, so I decided to stop talking to them, which was hard, but as of today I no longer hear voices.

My main goal while hospitalised was to get out, which I am sure is the same for many people. I identified what steps I needed to meet to reach this goal. I recognised early on that keeping myself busy with a well-structured routine was key to my recovery. I did so many different things such as: working at the Tea-bar, volunteering at a local charity shop, music therapy, guitar lessons, attending the gym regularly, working as a ward representative. I tried to keep a social life while in hospital which was also vital for my own recovery, so I would meet and speak to family members and friends regularly. Being in hospital is tough and having even just a quick chat over the phone with someone that cares for you helped me out incredibly. I spent two years sectioned in hospital and I have now been out of hospital for over three years. I was absolutely discharged a year ago, which was definitely one of my most important goals. Even though being sectioned made a massive impact on my life, I feel that things happen for a reason and that you always have the option to create something positive out of something negative, which I strive to do.

Living with both OCD and schizophrenia is hard and can be very debilitating at times, so regardless of being in hospital or not, this is a form of recovery that will probably be a part of my life for as long as I live. For many years, I felt that I had to cure my mental illness, where as now I've realised that it's not about getting rid of mental health conditions, but learning to live with them and with a decent quality of life. People with schizophrenia are incredibly under-represented in public, especially amongst famous celebrities. This needs to change - it would help so many people, including myself. Schizophrenia affects 1% of the population, so why are there so few prominent people talking about their experiences with this condition?

My personal goal when I left hospital was to go back to studying again. So, I enrolled at a local college to study motor vehicle maintenance, and I then went on to complete a two-year course in creative media production and I am about to start university studying Film and Television Studies part-time. I also found a job working as an expert by experience for the CQC and with my local secure hospital and I have attended courses and groups to develop my skills. This was the building block for me to take a care worker role in a local hostel and to start working as a peer worker with people with mental health problems.

But none of this happened quickly. I had to build up to all of these things gradually which I think is important, as you don't want to take on too much too fast. I think that successful recovery is definitely dependent on doing the right thing at the right time and having the right support. When I have taken on new challenges or roles I have always had key people who have supported me and made sure that I was comfortable with the expectations and the workload and that I was supported to develop the necessary skills. I spent three years living in twenty-four hour supported accommodation and I really wanted to regain my full independence

by moving into my own flat, which I recently managed to achieve. This felt like a massive goal and I am so glad I managed to achieve it.

My recovery is a constant process and I know it will be with me throughout my life. It can change and evolve over the years, but is

always there regardless of whether I am in hospital or not but having the right support has been, and continues to be, vital.

Simeon, Expert by Experience, North London Forensic Service

The Royal College of Psychiatrists

Leaving Secure Care – A Successful Discharge

During the QNFMHS Low Secure Annual Forum in June, as patient reviewers, we discussed our views on a successful discharge and an overview of our personal journeys when leaving secure care. This article summarises our workshop presentation and the findings we gathered from table discussions with the audience on the creation of an effective discharge pack for service users leaving secure care.

Factors to a successful discharge

- Planning and preparing from admission
- Developing skills, strengths and qualities
- Managing finance, such as budgeting
- The types of appropriate accommodation
- Paid work or voluntary work opportunities and available courses
- Leisure, hobbies and interests
- Community services available
- Family and friends are available to provide support
- Developing a social network

Unsuccessful discharges: when do things go wrong?

- Lack of mental health community support
- Lack of any practical support

- Lack of a support network, such as friends
- Lack of effective discharge planning
- Feeling let down by services

This can result in patients feeling as though they had a better life in hospital, which is a counter-intuitive impact of discharge from secure care.

Mark's Recovery Journey

I keep a busy timetable, active lifestyle in hospital and in the community, community alternative team (C.A.T), activity groups such as pool, bowling and the cinema, independent living and life skills, mental health community team, support received from family and friends and receiving family therapy.

Where I am now

I have re-established my relationship with my family and friends. I'm living in my own flat, having a totally independent life. Working for the Quality Network, helping to train psychologists at Leeds University and still involved with C.A.T and Hollybush.

Michael's Recovery Journey

Recovery in mental health has been defined in a number of ways, such as 'feeling good and functioning well', finding and believing in myself, building a meaningful life, taking responsibility and control and developing a positive identity.

I've gone from hopelessness to hopefulness, grasping opportunities, having realistic

expectations, attending moving on groups which prepared me for the transition to community and going back into the outside world.

Where I am now

I am a patient reviewer for the Quality Network, a service user consultant for South London Partnership, delivering Mental Health First Aid courses with Rethink, expert by experience NHS England Projects, enjoying family life and participating in hobbies such as the gym, cycling, bass guitar, music, theatre and attending socials.

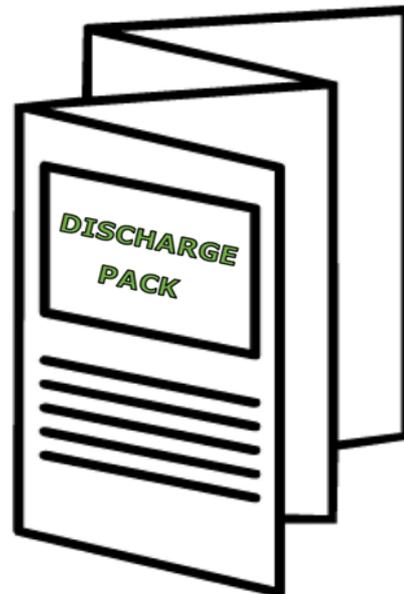
In terms of self-care, I ensure I manage my time well and maintain a family life and work balance, enjoying time out, reading prayer and meditation, resting, relaxing and reflecting.

As part of the workshop, groups of delegates were asked to develop a discharge pack for service users when leaving secure care. The following findings are what the groups came up with.

A Discharge Pack should include:

- Community links and support networks
- Agencies, names, contact details
- Map of the local area
- Details of a pre-identified GP, hospital and community mental health team
- Visits to new placement
- Motivational messages from peers
- Information about local services
- Gyms, groups, third sector organisations
- Spiritual and pastoral support

- Less restrictive practices in low secure
- Experiences of independent travel and use of (mobile) technology
- Active email account
- The patient to identify their needs, what support they would like in the community
- Self-care and support leaflets
- Job opportunities in the area
- Housing
- Skill building at a local college
- Mentor/peer support
- Community projects – networks
- Engagement plans/events
- Recipes
- Relapse prevention plans
- 'Get out, Stay out' programme



**Mark Haslam and Michael Humes,
Patient Reviewers, Quality Network for
Forensic Mental Health Services**

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

Email 'join' to:
lsu@rcpsych.ac.uk
msu@rcpsych.ac.uk

NHS Tayside

My Story: Learning at Murray Royal Hospital

I am due to move from a low secure unit to supported accommodation soon and it was suggested by my occupational therapist that doing the transition course (bronze award) would help me prepare for moving out of the hospital and into my own place. I've missed a lot of stuff since becoming unwell; I've spent most of my adult life in hospital. This course has helped me see how life has changed and how much the internet is an integral part of life now. I'm enjoying doing all of the activities and having a learning plan which is specifically for me and my circumstances which is great. It's very interesting and has taken away some of the anxiety about moving into my own flat. Recently I've enjoyed meeting the guy from the fire brigade who came along to talk to us and I enjoy being a student and visiting the college. I feel like I have more to talk about now. It's been good to have discussions and use my brain again. It's encouraged me to



do other things like sign up for the digital literacies class on a Friday too. I'd say - definitely do the course. It will help you survive outside of the hospital and it will help you save money too.

"It made me feel less like a patient and more like a normal person out on the street"

'Dan', Service User, Rohallion Clinic

Abertawe Bro Morgannwg University Local Health Board

'A Person Centred Approach to Moving On' Development of a Transition Workbook and its Use Within a Medium Secure Hospital

Most people who find themselves in medium secure mental health care services have many pre-existing difficulties including attachment problems, poor coping resources and a low threshold to stress. It is common for service users to report histories of multiple, often precipitous moves into, out of and between families, institutions and services.

A transition is defined by Schlossberg (1981) as any event, or non-event that results in changed relationships, routines, assumptions and roles. A transition is so defined by the perceptions of the person experiencing it. People will go through many transitions during their lifetime. A frequent transition for people with mental health problems is a change in their living environment (e.g. moving to a new ward, new staff or patients arriving at a ward, discharge from hospital). People can experience such transitions as overwhelming and stressful if they feel ill-equipped to deal with them. When transitions are poorly planned and the person has inadequate preparation, we might see mental health relapses, increased self-harming behaviour, setbacks in progress, and/or re-admission to hospital.



Schlossberg suggests that the success of a transition is dependent on the way a person perceives the transition event; the nature of the transition itself; the person's coping resources at the time of the transition; their individual characteristics; and the wider environmental context (e.g. social support). This model suggests that exploring these features, particularly focusing on the balance between coping resources, liabilities and what resources can be drawn upon to help the person cope, might be helpful in supporting people leaving secure care.

Attachment theory offers hypotheses about why some people transition more readily than others. Attachment is an emotional bond that connects individuals across space and time (Ainsworth, 1973). The more securely attached a person, the better their emotional adjustment and resilience during times of change. Similarly, research on coping suggests that the ability to manage transition is dependent on how someone appraises the change and how equipped they are to deal with it (Lazarus & Folkman, 1984). For instance, a transition judged as negative is more likely to be experienced as problematic and unhelpful coping strategies such as avoidance and denial are more likely to be used.

When clinicians anticipate transitions with service users in secure care, there can be a greater focus on the practical/operational arrangements rather than the emotional

impact and process of change for the service user themselves.

To support service users to recognise and cope effectively with the impact of transitions, particularly when leaving secure care, we have developed a brief, manualised intervention integrating elements from the literature on transitions, attachment and coping. The intervention comprises seven sessions: Working Through Transitions; Endings and Letting Go; The Neutral Zone; Coping with Change; Saying Goodbye & New Beginnings; Thoughts and Reflections about Me & My Transition. The final session focuses on developing a personal plan detailing, in their own words, the service users' personal history, what they want their new care team to know about them and what strategies might help their transition (e.g. visits, information about the new placement, orientation to the area, prior identification of a primary nurse). Whilst manualised, this intervention was designed to be flexible enough to allow service user's particular needs in the transition process to be easily accommodated by the therapist as and when they arise.

So far 19 service users, both male and female, have participated in the intervention. Outcomes are being evaluated, but subjective reports suggest it reduces stress and anxiety and offers much needed emotional support and containment during transition periods. Use of the workbook appears to have helped service users with more anxious/ambivalent attachment styles successfully move through the service towards discharge. It is not yet clear what the active ingredients of the intervention are, how much we can ascribe to the content and how much is due to having additional therapeutic support during the period of transition. We would hope to tease out these questions as we gather more data.

**Dr Kim Liddiard, Clinical Psychologist,
Caswell Clinic**

Leaving Secure Care

My name is Janice, I am a 56-year-old lady who has spent 15 consecutive years in mental health hospitals until I was discharged in 2018.

I was admitted to an MSU following a court order, due to severely self-harming in prison. I was high risk and intent on killing myself. I was out of control having so much anger and hate towards everyone. I was angry towards my son, my husband, I didn't care about anything. No-one liked me because I was so horrible. I would physically attack staff and my peers. Following an attempt to attack my consultant, I was sent to a high secure hospital. I was fighting staff and was in seclusion all the time. No-one liked me there either. Within two weeks my husband told me that he had found someone else, and had moved her in the house. I wanted to kill him, I was so aggressive and violent to staff I didn't care about anything or anyone. I stopped eating and drinking, and continued to physically harm myself including ligaturing. There were two occasions where I lost consciousness, and had to be resuscitated.

I continued fighting with staff, blocking airways, not eating and gave up. I was like this for two years. Sometime into my admission, I asked to go into seclusion, the staff wouldn't let me so I threatened to hit them, and I was then secluded. I gave up the fight. I refused meds, drinks, food and for a week I just laid there.

I woke up one morning and thought '**what am I doing???**' I said to Lorraine who was on my obs '**what am I doing?**' Lorraine said '**you are wasting away and slowly dying, that's what you are doing**'. I decided that day that I was leaving secure care as I had family to be with. I thought, **I**

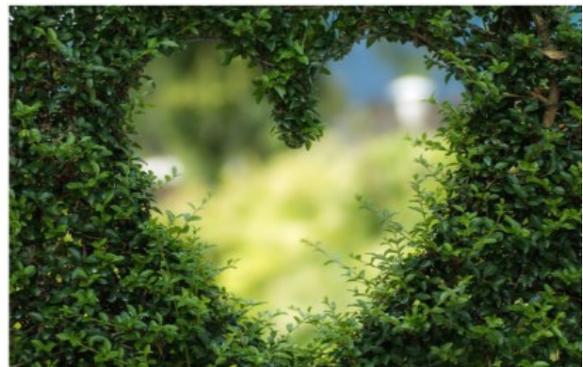


am not doing this anymore. I came out of seclusion, and did all the therapies I could.

I learned that fighting the system doesn't get you anywhere, and that you have to trust people. This was hard, as I didn't trust anyone at the beginning. I do now which has helped a lot in my recovery. I had seven lots of therapies — trauma, CBT, psychology, anger management, alcohol misuse, REM, art therapy, and have never looked back. I have not self-harmed since either.

I was transferred to a step down unit — I was nervous, and didn't get any leave for about two to three weeks. When I did I was only escorted a couple of times in the community and then allowed to go on my own. People were saying '**look who's back!!**' I was nervous at first wondering who I would see when out, which got easier in time.

I went to my son's wedding — I was terrified at first seeing my ex-husband and his new partner, and other family members, though everyone gave me a hug. My ex-husband and his partner chatted to me all day. I have no hard feelings any more as I have worked on this as part of the therapies I did when at



the high secure hospital. I realised that I want to spend time with family and live a life. It takes a lot to get me angry now. In the past someone only had to look at me!

It took three years from the light being switched on to my discharge from hospital. You have to want to do it, and I have never looked back. There is hope for everyone, and you need support from staff to do what I have done. There is a fight in everybody - it's not easy; I fought temptation to self-harm, and thought '***I am going to do this!***'



I have been really well supported by the MDT during my recovery, who have enabled me to be involved in decisions about my care and transition into the community. Whilst I

was disappointed in not being able to move straight into sheltered accommodation upon discharge, I can now understand this decision, having more support for my mental health needs than I would have had. This is something that I can consider in time.

Whilst I have been in hospital, I have engaged in lots of activities to support my recovery, I just wish that more therapies were available in MSUs, and that they were easier to access?

I have completed the peer mentoring programme at a local college which supports other service user's recovery, and hope to be involved in providing this as a volunteer soon. I have attended Quality Network events and enjoyed sharing my experiences.

My family think I have done brilliantly, and I am now in contact with all my siblings (being the youngest of six). My son and I have always been very close, he has been in contact with me throughout my admissions. He now has a daughter who I like to spend a lot of time with.

Janice, Service User, Guild Lodge

Abertawe Bro Morgannwg University Local Health Board

Leaving Security Behind: Reflections on Twenty Five Years of Medium Secure Throughcare in South Wales

Caswell Clinic opened in 1992 with nineteen beds in a slowly fading Victorian asylum: an admission/treatment ward and an intensive care ward, with two multidisciplinary teams caring for service users across both wards. From the outset, we had social workers and community forensic psychiatric nurses in the teams and each team cared for the service

user from initial assessment, throughout their stay and then provided social supervision and aftercare in the community. The model of care embodied the person centred ideal this new service was built on. Three years later, the clinic added a rehabilitation ward, expanding to 33 beds and a third clinical team working across all the wards.

Teams differed in character and style influenced by their individual members. Different approaches to procedural and relational security within the same ward could create confusion for staff and service users. Nonetheless, the service was small enough to iron out those differences. We strengthened nursing leadership on the

wards, with ward managers providing both operational and clinical leadership, augmented later by clinical nurse specialists trained in cognitive behavioural and psychodynamic therapies, who helped balance the individuality of teams with the need for consistent ward practices.

Caswell Clinic was always a mixed gender service, although initially, scant attention was paid to the fact that women were an obvious minority. As awareness of the safety, privacy and dignity needs of women grew across the secure care sector, we developed our gender awareness, then created a women only ward within the clinic. Continuity of clinical team care remained a core value of the service. It made sense then, that when we expanded into a new, purpose built, 65 bedded unit in 2004, three teams would expand to five who would work across all the wards, following the service users' journey. But, having several teams working on a ward became an obstacle to consistent, gender sensitive care, so, we created a hybrid model: placing one team onto the women's ward to develop a more integrated, attachment focussed model of care. The four men's wards still worked with four clinical teams and we began to see the contrast between these two ways of working, and recognised a need to contemplate changing our model across all the wards.

In 2017 we conducted a survey of seventeen MSU's in England and Wales. Twelve services allocated one clinical team to a ward, one service had teams working across two wards and four had teams working across several wards. Some services offer aftercare into the community (mostly NHS), and some don't. We agreed eventually to move a model of care in which teams have a close affiliation with two wards, and possibly service users moving between teams if they need to change wards.

We are now contemplating what change might mean for our service, our service users, and our staff. Leaving the security of

our familiar model and changing our ideas about what relational security means in our service is anxiety provoking. As we edge towards our thirtieth birthday, we remain committed to discharging as many service users directly into the community as possible, from a secure base, and providing a safe haven for a period of time afterwards. How we ensure service users receive safe, secure care and support in the least restrictive environment balanced with the expectations of local health boards with stretched budgets and new low secure services seems as yet, uncertain.

What we have learnt since 1992 is that it is relational security that counts. That doesn't just mean the ratio of staff to service users, it means how well do we know the service user and their family? How often have we stood beside them as they weather the storms of relapse and crisis? How well do we understand their personal values and the obstacles they face in trying to follow them? How well do we recognise their strengths and potentials? How comfortable are we knowing and managing the worst of what they are capable of doing to harm themselves or others? And how bold are we in expecting them to try hard, and then try harder again to build themselves a meaningful and fulfilled life?

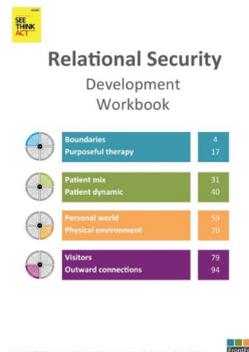
Leaving secure care starts with entering secure care, and our task is to shape a journey that remains person centred, safe and secure, even whilst services become larger and more complex.

Ruth Bagshaw, Consultant Clinical and Forensic Psychologist; Joanne Sullivan, Clinical Nurse Specialist in CBT; Amanda Watkins, Lead Social Worker; Andrew Simmonds, Case Manager; Mark Janas, Consultant Forensic Psychiatrist, Caswell Clinic

News

Developmental Workbook for Relational Security

We've worked with Liz Allen, who through her own company FrontFoot, has researched, developed and published a Relational Security Development Workbook. This framework for supported learning and reflective practice covers three main levels of development:



Relational Security Development Workbook	
Boundaries Purposeful therapy	4 17
Patient mix Patient dynamic	31 40
Personal world Physical environment	59 70
Visitors Outward connections	79 94

LEARN - Basic areas of relational security that you'd expect to be covered in orientation

DEVELOP - Developing relational security capability to be clinically effective

LEAD - Advancing strategic relational security skills to lead, support and develop others.

For more information, please follow this link: http://www.frontfoot.net/relational-security-resources/?dm_i=43OD,BTE3,22HOG4,1AZHW,1

Transforming Services for Forensic Patients

As the NHS prepares to celebrate its 70th birthday, the New Care Models programme shows how NHS England is working with its partners to transform mental health services and provide equal status with physical health. As reported recently in the national media, during 2017 many patients were placed in beds a long way from their communities and families. The New Care Models programme aims to deliver the best possible support and care, typically closer to their own communities, means better patient experience and outcomes



Find out more here: <https://www.england.nhs.uk/blog/transforming-services-for-forensic-patients/>

Vulnerable Offenders Steered Towards Treatment

In five pilot areas, justice and health services have signed up to a new protocol that will help to divert relevant offenders away from frequently ineffective short-term custodial sentences and towards treatment that aims to tackle the root cause of their criminality.

Psychologists will be present in courts to assess offenders whose crime makes them eligible for a Community Order.

The initiative brings together the Ministry of Justice (MoJ), Department of Health and Social Care, NHS England and Public Health England to improve access to treatment programmes for offenders serving community sentences.

Find out more here: <https://www.gov.uk/government/news/vulnerable-offenders-steered-towards-treatment>

Preparing Individuals for Community Living Through Personal Development Programmes

Background:

"Occupational alienation, deprivation and imbalance are terms widely used within Occupational Science and describe the effects that living in a secure environment for a prolonged period of time can have on individuals" (Molineux 2004). Occupational therapy (OT) aims to reduce these effects by supporting people to achieve a balanced and structured routine which includes a variety of activities in the areas of leisure, self-care and work/productivity.

It is intrinsic to the role of OT to not only plan programmes which teach skills for domestic tasks, but should also emphasise those related to community and social reintegration: "Occupational therapy should assist people to develop their interpersonal capacity, pro-social values, their personal identity and skills for life participation".

At the Rohallion Clinic, the occupational therapy department have partnered up with Perth College to deliver the Personal Development Award Programme. The programme is aimed at those close to discharge, to support the development of key community living skills, helping individuals to build and maintain a life outside hospital, in their homes and communities. The personal development programmes (Bronze, Silver, Gold) are included within the award scheme development accreditation network (ASDAN) offering nationally recognised accredited learning opportunities based around the development of personal, social and employability skills.



Personal development Programme – The 'Bronze' Award

To achieve the 'Bronze' award participants are required to complete challenges within their workbook to gain 6 credits which roughly equates to 60 hours of work and evidence this within their portfolio. Challenges were pre-selected by the OT to ensure topics covered will support individuals to develop the identified skills required for successful transition into the community as well as provide a focus and structure to each session. The programme runs for the whole academic year (September-June) and students are expected to attend a weekly 2-hour structured session where they will cover course material and complete the corresponding challenges.

The programme covers different topics each week, for example:

Sport and Leisure - Evaluating how I spend my time, finding and participating in structured leisure activities, social benefits of occupations, trying something new.

Home Management - What to do/who to contact in an emergency, planning and budgeting a weekly shop, domestic tasks and using appliances safely, recycling.

World of 'Work' - Volunteering, expectations in the workplace, difficult scenarios, identifying my skills, disclosure, writing an application/CV, preparing for an interview.

Health and Survival - Basic first aid, fire safety in the home, food hygiene, benefits of healthy eating and exercise.

Number Handling - Transport and planning journeys, understanding bills/bank statements, cost of living in a bedsit.

Where possible, external agencies were contacted to facilitate sessions specific to their field (e.g. fire service, dietician, citizens advice bureaux, vocational rehabilitation specialist etc). This not only helped create positive links with community agencies but also helped individuals feel

more included within their local community, raising awareness of mental health issues as well as creating more varied and interesting sessions. Another, less anticipated, benefit of the programme was the sharing of personal experiences by group members which acted as a powerful learning tool for others.

Patient feedback:

"Visiting and enrolling at the college made feel like a proper student"

"I enjoyed the structure of having a workbook to complete"

"There's a lot more to do in the community than I thought"

"It's made me more aware of what I need to do before I leave hospital"

"I really enjoyed the session on basic first aid – a skill everyone should know!"

"I enjoyed sharing my personal experiences with the rest of the group"

Challenges:

- Identifying enough suitable referrals close to discharge for the group to run
- Sustaining motivation and engagement for the full academic year
- Material that needed to be covered as part of the 'bronze award' and topics that were identified as an occupational therapy need were not always compatible
- Tailoring sessions to meet the needs/ learning styles within a group of varied abilities
- Encouraging individuals to transfer their learning into real-life scenarios
- Resource intensive - creating worksheets for individuals to build their portfolios and identifying and establishing links within the community

Future developments:

- Review material covered and create a master folder of session plans and resources
- Create a pathway for individuals to progress onto the silver/gold programme encouraging more Independent learning and further preparing them for accessing further education within the community
- To open the group up to existing community patients to encourage discussion and learning from a wider pool of personal experiences
- Encourage more external speakers to facilitate sessions, further establishing community links and creating more varied and interesting sessions



Janey Fisher, Occupational Therapist, Rohallion Clinic

The Royal College of Psychiatrists

Leaving Secure Care: A Personal Journey

Having spent ten years in services, the thought of being released into the community filled me with dread.

I knew the routine in hospital, which had become a way of life and all of a sudden things became very different.

When I left the last step down service (still locked front door) I was in, my accommodation consisted of a one bedroomed bungalow in a small village where I knew no one and only had minimal transport facilities. Although I had the support of the community mental health team, this was all I had (no knocking on the office door anymore).

I still remember my first night in my new home being so quiet, I got up at least three times to check the doors and windows were locked, the slightest noise unsettling me. With no piercing alarms going off at random times during the day and night, the silence was deafening.

All of a sudden I was expected to know how to deal with all my bills and getting equipment for my property. This is something everyone should learn/find out about before leaving secure care as it was a hell of a shock, bearing in mind I had been in services a long time and never had to deal with any of this from before. My ex-partner always had control over my money.

I found with nothing to do during the day/evening, I fell into the trap of online gambling and was soon in a lot of debt and didn't know where to turn for help. This was not something the community mental health team could help me with.

After a lot of soul searching I got help with this problem through my family and a housing support worker who I still see occasionally. This was not an easy process as I had very quickly become addicted and it filled part of my days.

I have now been living in the community for three years and loving life; I am in my fifth year of working as a Patient Representative with the QNFMHS and also engage in voluntary work. I have also moved to a better area (more facilities) and am on top of my problems.

I still use my DBT skills, (ingrained in my memory) and now realise that being in hospital saved my life. I now know what helps me in a crisis and make sure I use those skills.

Don't get me wrong, leaving secure care is scary but life is what you make it and remember to ask for help if you need it, I did and it's not a bad thing to accept it.

I am also very lucky to have such a supportive family. I also have supportive friends – all of whom I have met in services or through my work with The Royal College.

Helen Slater, Patient Reviewer, Quality Network for Forensic Mental Health Services

Follow us on Twitter @ccqi_ @rcpsych
And use #qnmhs for up-to-date information

Birmingham and Solihull Mental Health NHS Foundation Trust

Understanding Me and My Autism: A Co-Designed Intervention for Staff Working With a Service User Recently Discharged from Secure Care

Individuals with autistic spectrum disorder report experiencing a lack of understanding from others about their condition, with increased feelings of loneliness and stigmatisation observed among this population. Staff working with this population report experiencing difficulties working with individuals with autism, as they may not understand the condition, their needs or ways to meet them. This is especially important in secure services, where service users are complex, and present with multiple difficulties including risk and co-morbid mental disorders. Previous studies have highlighted the positive impact that staff training about Autism has on service users' wellbeing, rates of aggressive behaviour and staff confidence. NICE Guidelines have outlined the need for service providers to ensure that staff are trained in autism, and how to manage associated behaviour that challenges systems.

The Forensic Intensive Recovery Support Team (FIRST) supports individuals in the secure care pathway, helping them to remain in their local communities by providing personalised care that manages risk, mental health and wellbeing. FIRST work collaboratively with individuals, carers and families to avoid admission to hospital whenever safe to do so, and actively engage with service users who are in hospital to support them to effectively transition to less restrictive environments. FIRST utilises personalised pathways which build on service users' strengths, fosters hope and supports them in their recovery. A male

service user, 'Robert*', was discharged to supported accommodation to continue his rehabilitation after spending six years in secure services. His forensic community care was offered by FIRST.

A key factor identified as a possible barrier to Robert remaining in the community was his difficulties in social communication and interaction, which may impact on his relationship with staff at the placement. In team discussions, Robert identified that he worried that staff at the new placement did not understand him, and said that it was hard to speak honestly to them. Staff reported that some of Robert's behaviours were difficult to understand, including sticking rigidly to routines, preferring solitary activities and only speaking to certain staff members. It was agreed with Robert that FIRST would work with him to design a training package for staff at his accommodation to help them understand his needs. He was actively involved in developing the training, and attended one session.

The training was comprised of two, two-hour-long sessions. The purpose of this was to provide a brief introduction to understanding and supporting people with Autism, and the second was to express how Robert's Autism impacts on him, including his perception and that of staff who have known him in secure services. There was a focus on a strengths-based, person-centred approach within the training.

Following training, staff were asked to provide anonymous feedback. A total of 24 staff completed feedback forms. 93% of staff reported that they learned what they had hoped to in the training, whilst 100% reported that they would use the training to assist their practice.

Staff reported that the training helped them to understand things from Robert's point of view.

'This training has given me more

empathy and understanding’.

Staff reflected that training would make them more sensitive to service users’ needs, making it easier to build relationships.

‘This will help me to build a rapport with Robert and we can use this to help him achieve his goals’.

Staff also reflected that the training taught them about the importance of applying person-centred care to their work.

‘Supporting individuals with autism is using a person centred approach’.

Overall, staff reported that they felt more confident working with other service users with autism, with the skills learned being generalisable.

As a result of the training, staff worked to develop strategies that they could use to support Robert to meet his goals, and

developed a plan about how they would work on this collaboratively with him and his family, who are important to him. Robert reported that he felt *‘freer to ask staff for help’* after the training, that for the most-part staff understood him and that he gained further knowledge about autism.

The experiences of Robert and staff highlight the benefits of providing training about Autism to staff working with this population. Robert’s experiences of being involved in the development of the programme, along with staff’s feedback about how having his point of view helped them to develop empathy, also highlights the role that service user involvement plays in training of this type.

**Pseudonym used to anonymise service user*

Dr Siân Allen, Principal Forensic Psychologist and Niamh Grace, Assistant Psychologist, Reaside Clinic

Oxford Health NHS Foundation Trust

Leaving Secure Care and Transitioning into the Community

Lambourn House is a pre-discharge unit and part of the secure services. It is an open facility with 15 beds, mixed ward. All our service users are from our medium secure and low secure units and the unit acts as a stepping stone from secure care into the community.

Even though we are part of the forensic services, the unit does not have the physical aspect of security as in medium or secure care. Relational security is key to our success and our aim is mainly to assist our services users in gaining more independence, autonomy and hope.

We offer a good transitional programme from the time they have been referred by their care team, working through their stay on the unit, preparing the service users for their Mental Health Review Tribunals, parole board meetings etc. and support their discharge into the community.

We have a full multidisciplinary team working with the service user in different aspects of their care. The service user is given a food budget weekly and are expected to budget and cater for themselves. We also put more emphasis for them to access community services working with occupational therapist staff in joining the local gym, sourcing out vocational placements for studies and work placements and eventually to find paid jobs.

We work closely with local/charitable organisations like Restore shop/café, resource centres, talking shops, work access

programmes etc. Some of our community placements include, Aspire (active voluntary work placement), Restore access for woodwork and gardening, Mind resources like the Mill and Cowley wellbeing group, placement at the Animal Sanctuary, Coasters sport group, to name a few.

We also provide in house programmes like teaching IT skills, dog therapy and most importantly over the last two years we have been facilitating moving on groups to look at challenges/solutions about moving into the community. We also have a self-medication programme.

The team will provide ongoing support with the aim to reduce their input as the service users feels more empowered and more independent in managing themselves. We support our service users to apply for bus passes, library cards, open bank accounts and promote visits to local places of worship of their choice.

We also work collaboratively with Mind and offer advice and assist service users with their benefits applications. Recently working with our forensics community mental health team, we have created hybrid posts where support workers work both on the unit and in the community whereby support is more consistent, and the service users are not left by themselves to cope especially in their initial discharge from the unit.

Our challenges come in the way of positive risk taking in promoting the service users taking more and more responsibility for themselves.

It is a very difficult place to be after years in secure care and being on an open unit can be overwhelming.

The challenge we also face is the difficulty moving service users who are on two statutory sections like the Mental Health Act and the prison system. They both run parallel to each other and sometimes the service user has to wait a long time before



they have a parole board hearing set up after they have had a Mental Health Review Tribunal where a conditional discharge is made.

Equally, service users become stuck (delayed discharge) and may need to wait a long time before they are offered a placement in the community.

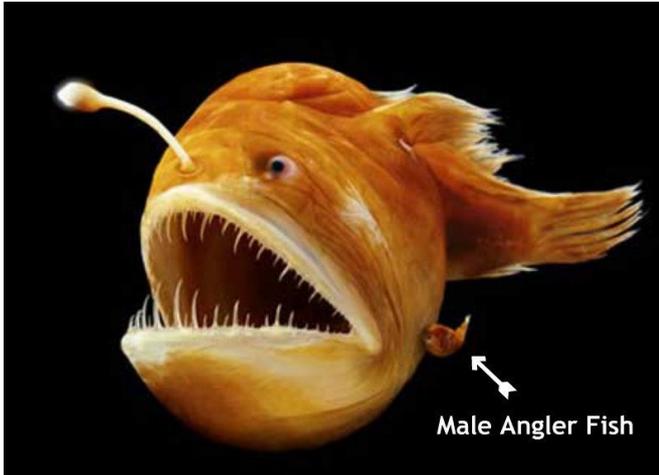
Overall feedback from the service users are mainly positive and appreciate the way the service is managed. They say they are more involved in their care, staff are less restrictive and being here consolidates their chances of being discharged safely into the community.

To finish, we are proud to include this piece of feedback from one of our service users who had to go back to a level of security for medical reasons.

He commented that "going back to a secure unit make me reflect on how Lambourn is important to me in my hope of moving on and my solicitor said that I am lucky to have this type of service here as it is unique in the country".

Ehsan Meethoo, Ward Manager and Jill Downs, Ward Occupational Therapist, Oxford Clinic

Anglerfish and Assertive Discharges from Forensic Services



Anglerfish (also known as monkfish) are a group of mostly sea bed dwelling and deep sea fishes of the order Lophiiformes. They are best known in the United Kingdom for their tail meat which has been described as similar to lobster. It is most classically cooked by roasting after being wrapped in Parma ham.

What is less well known is their breeding habits. In some species there is a symbiotic reproductive pattern. The smaller males locate and then bite the larger females. They then dissolve the females skin and their own jaws, fusing the pair down to the blood vessel level and become dependent upon them for nutrition. In return they provide sperm for the females when required.

This is considered to be advantageous for both parties with regards to finding a mate but also with regards to obtaining sufficient food within a relatively barren environment.

But of what relevance is this to the future development of forensic services?

Forensic psychiatry can be considered to be a branch of general psychiatry although

dealing with a population who have offended. It is a smaller sub-speciality of psychiatry in this regard.

Since the famous 'Water Tower Speech' delivered by Enoch Powell in March 1961, the direction of travel for general psychiatric services has been towards an increase in community services and integration of psychiatric services with general medical services. Whilst the stated aim was to improve the lives and outcomes for patients, there has always been a question as to whether there was also an un-stated financial drive behind this.

This was a watershed moment and heralded the start of the psychiatric asylum closure programme and the development of community psychiatry as we now know it.

Forensic psychiatry would now appear to be at a similar crossroads. Secure bed provision has expanded though only approximately a half of NHS forensic services have developed an aligned community forensic service. Yet there is also now clear evidence that having an aligned community forensic service shortens in-patient admissions considerably. These earlier discharges would not appear to be associated with any detrimental effects especially related to re-offending. This would appear to be a success both with regards to patient outcomes and financial management and has led, in part, to the expectations that forensic services will develop community out-reach services.

But this still begs the question as to the relevance of anglerfish to forensic services.

More recently, NHS England asked for expressions of interest to develop new teams to pilot new and novel ways of working towards community discharges. The expectation would be that these new teams would accelerate discharges even further, working to reduce length of stays and develop innovative community packages of care. In order to be able to apply for these

pilot monies it was important that the services already had an embedded community service (and therefore hopefully a lower baseline length of stay). In addition, the larger NHS Trust of which the forensic service was a part had to have at least a 'Good' CQC rating overall.

With anglerfish, the health of both the male and larger female fish are important and this symbiosis increases the chances of future success within a challenging environment.

Within a challenged health economy the general health of both the larger NHS Trust and the associated smaller forensic service are also therefore essential for future success.

Dr Richard Noon, Consultant Forensic Psychiatrists and Clinical Director, Hellingly Centre

The Royal College of Psychiatrists

Moving on from Secure Care

I can't speak for all carers but I always think if I have certain feelings, views and experiences about my son moving on I won't be alone, however isolated I may feel. If you put a group of carers from secure services together they can always find connections. We may have the same worries yet as soon as our relative leaves we may have little or no support. This is possibly one of the most important times that we need support.

So, what does it feel like for a carer when their relative begins to talk about leaving secure services. Is he really leaving or is it something he's been asked to think about and aim for? Is this an example of giving hope to someone? Nobody has spoken to me about anything. I want him to move on but he hasn't yet had any unescorted leave. The only constant, for the last three years is "he needs to do more psychology work." I find this confusing. There seems to be real investment in a psychological approach to his care but because he has yet to leave the unit unescorted how can he put his learning into practice? How can he gain confidence in his ability to move on if he constantly has an escort?

I'd like to understand how patients are

prepared to move on to life beyond the gates. There are programmes for assertiveness training and drug and alcohol abuse. Will these help him use a computer, smart phone, budget within his means, build friendships or find meaningful daytime occupation? I've heard that preparation for discharge should begin at the point of admission - that was 10 years ago; the world has changed. How long does it take to prepare someone for moving on? What needs to be covered? What has my son got to do to show he can move on? What can I do to help?

The choice of accommodation is stark. It's mostly in the town. I worry about the area being awash with a wider choice of drugs than ever before despite my son being clear that he doesn't want to take any. I trust his word and believe him completely but it's the people who prey on the vulnerable that I fear. He is kind and thoughtful and would give his last pound to someone living on the street if he, himself, had a roof over his head. Unescorted leave would test his ability to say no; it would give him a glimpse of what he has to deal with. He could then talk about his experience safely with staff he trusts. This doesn't seem to be an option. It seems common sense to me.

I remain optimistic; my son has so far survived the secure care system with dignity

and courage. He has worked hard and taken every opportunity offered and deserves a place where he can thrive. My faith is in the new forensic community team who I met quite by chance at the AGM in our Trust. The manager seems kind, professional and willing to engage. I felt she was as open and honest as I'd found the ward staff to be. Knowing the face of the person who will be responsible for my son in the community is a comfort. The question is would I ever have met her if it was left to my son or the ward staff. Is there a protocol in place that allows a person's social network to meet the new team? We are the people who care the most and have visited for the last 10 years but there seems to be little awareness of us at all and what we could offer in terms of support for our son when he moves on.

How many secure services have a clear discharge process in place that includes carers?

I read this through and it appears a little muddled, a little unsure about what's going to happen and that's exactly how it is. I have far more questions than answers. I'm not clear what will happen and I can't make sense of the process. What I do know, with great certainty, is that all over the country, in every secure service there will be a carer, just like me, wondering and worrying about their loved one moving on. It's time we were involved or at the very least given some consideration.

Sheena Foster, Family and Friends Representative, Quality Network for Forensic Mental Health Services

Northumberland, Tyne and Wear NHS Foundation Trust

Gateway Recovery College Discharge Group

The Gateway Recovery College within secure services ran a discharge group during the summer term. This group was aimed at anyone working with the secure outreach transitions team or community transitions team within Northgate Hospital, across medium and low secure services as well as locked rehabilitation.

The group ran for six weeks, one session per week and examined various topics such as "introduction to discharge", "routines", "roles", "coping strategies", "legal framework" and the final session incorporated a review of the group overall and a group outing was planned to follow and celebrate the completion of the group.

Group session outlines below:

1. Introduction to discharge
 - Feelings towards discharge
 - Worries about discharge
 - Skills learned during time in hospital
 - Planning outing
2. Routines
 - Types of activities (self-care, productive, leisure)
 - Good routines vs bad routines
 - Planning your time
 - Planning outing
3. Roles
 - What is a role?
 - Previous, current and future roles
 - Current people involved in care
 - Roles of people involved in care following discharge
 - Planning outing
4. Coping strategies
 - Effective and ineffective coping strategies
 - Sensory box activity
 - Planning outing

5. Legal Framework

- Conditional discharge/Community Treatment Orders (as appropriate)
- Planning outing

6. Review

- Reflection on topics covered
- Certificates
- Planning outing

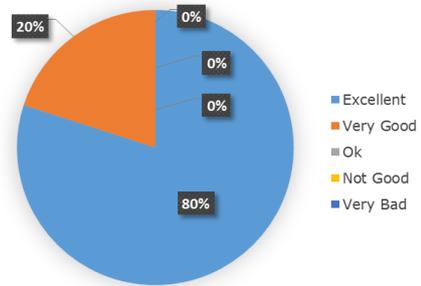
The group also aimed to help members learn new skills to help move on from hospital, such as, gaining insight and understanding risks, developing risk management strategies, reflecting on emotions related to discharge, developing self-formulations and building healthy lifestyles incompatible with offending behaviour as well as skills in relapse prevention.

The discharge group ran through the Gateway Recovery College this term. The college is based around various principles such as hope and recovery.

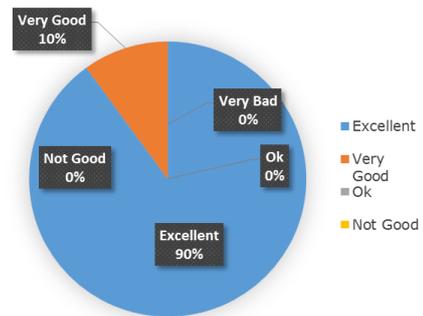
Students evaluate their experience related to development of their own self confidence as well as their motivation to do things. As well as questions relating to feeling listened to and having hope. See below for results of evaluation of the discharge group.

Overall students reported a positive experience from the skills they had learnt during the course and reported that their self-confidence and motivation had increased from taking part in the course. Group members felt that they had been listened to and this had helped group members to feel comfortable in reflecting on their thoughts and feelings regarding discharge, which in turn helped to alleviate some anxiety relating to leaving hospital, which proved to be a very positive outcome in relation to the overall objectives of running the group.

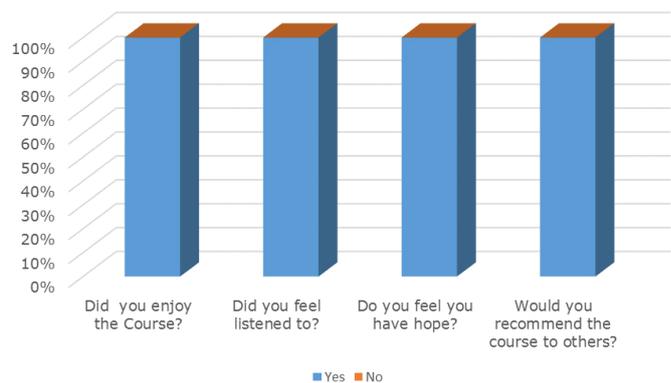
**Discharge Groups:
How would you rate your self confidence?**



**Discharge Groups:
How would you rate your motivation to do things?**



Discharge Groups:
Feedback Scores



Jo Inskip, Recovery College Co-ordinator, Northgate Hospital

Getting the Measure of Outcomes in Forensic Services

Patient groups, professionals and the government have recognised the importance of measuring the impact of the care provided by the NHS. Increasing emphasis is being placed on making sure that we have the tools to measure these outcomes and ensuring that these include the priorities of patients, as well as professionals. In July 2016, NHS England and NHS Improvement published their guidance paper 'Delivering the Five Year Forward View for Mental Health: Developing quality and outcome measures'. This set out a number of key principles for outcome measures to adhere to, including the need for clinical relevance, to reflect what people who use the service want, align with system-wide objectives and to be measurable using metrics with established validity and reliability.

Previous research has shown that while some measures do already exist for use in forensic mental health services, these are often limited by several factors. One limitation is that the measures can focus more on the risk that people pose to the public or on the state of their mental health and not enough on a person's quality of life or the progress they are making towards rehabilitation back in to society. Another key limitation is that many existing measures are rated solely by professionals and do not take in to account the views of the people using such services.

What is a good outcome and how can we measure it? This question is likely to have different answers depending on who you ask. A positive outcome for a patient may be quite different to that from the perspective of a clinician and any two patients or professionals are likely to have different approaches. So how do you best capture this information?

A new study by the University of Oxford seeks to explore what it means for patients in forensic mental health services to be making progress in their care. It will consider the perspectives of patients themselves and the professionals caring for them. The aim will be to develop a tool to measure the outcomes identified as most important. This new tool would be rated by both patients and professionals and will cover a range of areas, such as patients' health, the level of risk they pose to themselves or other people, how good their quality of life is and how well they are progressing towards rehabilitation back in to society. It is hoped that by measuring what is most important for the people using forensic mental health services and the professionals looking after them, we can ensure that the care such patients receive is the best possible.

The first part of the process will be to look at what research has already been published in this area. The outcome tools that already exist will be evaluated to see how good they are at measuring people's progress in forensic psychiatric services. Patients at different stages of the forensic pathway will be interviewed in depth, to gain their views about what are the most important outcomes for them. Focus groups of professionals will aim to explore the themes that are most relevant from the perspective of clinicians. In the next stage panels of patients and professionals will be presented with new potential items, derived from the first stage, and asked to rate the best questions. This will happen repeatedly, until there is agreement about the questions to include.

This will produce a new tool consisting of one set of questions for patients and another for professionals. A small number of patients and professionals will be asked to complete these questionnaires and feedback whether they make sense and if any improvements can be made to the language, order or presentation. The final tool will then be used

in the clinical setting to see how it works in practice and how it compares to the other measures that are currently in use.

Patients and the public will be closely involved, not just as participants in the research, but also in determining the way it is carried out. A small advisory group, consisting of former users of forensic services and carers of people in forensic

services, has been assembled to help steer the project and feed in to the research at key points.

If you would like to be involved in this work, please see the bellow advert and contact the Chief Investigator for the study, Dr. Howard Ryland by emailing howard.ryland@psych.ox.ac.uk.

Developing a new outcome measure for forensic mental health services

As part of a research project currently being conducted by the University of Oxford, you are invited to take part in one of a series of focus groups, which are being organised as part of the Quality Network for Forensic Mental Health Services' standard consultation events. The focus groups are the initial stage in a programme of work that seeks to understand which patient outcomes are of most importance to professionals working in forensic mental health services.

These insights will be used to help develop the clinician rated component of a new outcome measure for forensic services, which will also have a companion patient reported scale.

Each focus group will last **up to one hour** and will contain a mixture of around **8-15 clinicians** from different professional backgrounds. The focus groups will be audio recorded to allow for a formal thematic analysis. Please see the attached participant information sheet for more details.

Each focus group will take place directly after the QNFMHS standard consultation events for one hour:

- 26 September 2018, Middlesbrough Football Club, Riverside Stadium, Middlesbrough, TS3 6RS.
- 17 October 2018, Fromeside and Wickham Unit, Blackberry Hill Hospital, Bristol, BS16 1EG.

If you would like to join a focus group, please email an expression of interest to holly.lowther@rcpsych.ac.uk.

How to be further involved:

If you are interested, there will also be the opportunity to participate in latter stages of this process, although there is no obligation for further involvement. This will include a Delphi process and cognitive interviews.

Health Service Executive

The Power of Peer Support for Smoking Cessation

In a recent smoking cessation group facilitated in the community for service users and staff of the National Forensic Mental Health Service (Ireland), one of the

participants, Declan, a former smoker, was participating in the group as a 'refresher' to reaffirm his commitment to not smoking. Declan's participation in the group evolved into an informal role as a peer support for the smokers as they made a quit attempt. Declan was open and honest around his previous attempts before successfully quitting more than three years ago and he shared his experience and motivation around

quitting which other participants found inspiring. Below Declan tells the story of quitting for good.

The Price of a Guitar

"Today it is three and a half years since I successfully quit smoking. Keeping fit is important to me and also maintaining a healthy weight – these are two things that motivate me to stay free of smoking. At the moment, I go for a forty minute run three or four times a week and I have also started swimming in the pool again which is something I want to build on. These are activities I wouldn't be able to do if I was still smoking.

My hopes for the future are also important to me. I hope to run the Dublin City Marathon next year (2019) and also to do a sponsored swim. I also hope to go back to college and I'm saving up for this at the moment. When I was smoking I was never able to save any money and I lived from one pay check to the next.

Looking back to when I gave up smoking three and a half years ago it didn't look likely that I would succeed. I was a patient in an acute unit in a forensic psychiatric hospital at the time. I had only been back smoking for around six months since I had become unwell. I tried a few times to give up but hadn't succeeded but I think the important thing is persistence.

As I have mentioned, I was strongly motivated by health and fitness and also financial reasons. When I made my last attempt to give up I started using nicotine replacement patches for a few days. I also used a mindfulness method for giving up cigarettes that I had read in a book once – unfortunately I can't remember the book. A few more weeks passed in the acute unit and I was still managing to stay smoke free. Then thankfully I was moved to a step-down unit in the hospital. At the time I was on allowance of approximately €20 per week. This would normally have been all spent on

tobacco. Instead I started to save up for a guitar. Three months later and also with the help of a family friend Nancy, who sent me money for Christmas, I managed to buy a guitar. Thankfully music is an important part of my recovery.

If I could recommend anything to anyone who wants to quit it would be to have something to motivate you, both financially and health related. It could be something like wanting to bring the kids on holiday and to run a 5k in six months' time. I also found it useful to write this down and to keep track of savings each week."

Declan's story of quitting while admitted in an inpatient acute unit is a hugely inspiring one and his experience, participation in the smoking cessation group and his willingness to share his story led to the suggestion that he might like to undertake training in smoking cessation group facilitation so that he might be in a position to co-facilitate smoking cessation groups in the future. Pending leave approval, Declan plans to undertake this training shortly and he is enthused to develop a role in which he will contribute positively to the service as he makes the transition from hospital to community. Across the research literature there is evidence that peer support for smoking cessation in mental health settings is important and that it contributes significantly to successful quit attempts by service users. In developing a role for peer support facilitation for smoking cessation, the service will draw upon the lived experience of service users to enhance a service that is responsive to service user needs and in which recovery principles are further embedded in each pillar of care.

Declan, Service User (Smoking Cessation Group Participant) and Teresa McDonagh, Staff Nurse (Smoking Cessation Group Facilitator), National Forensic Mental Health Service

Patient Artwork Competition Winners!

In May, we ran our annual Patient Artwork Competition! This competition was open to all patients in secure services who wished to put forward their creative pieces of artwork, for a chance to be featured on the Forensic Network's publications and displays. We received a fantastic range of artwork from some very talented patients. All the entries can be found on the next page!

We are very excited to showcase our ten winners! Please see below for details of the artwork and the services they were submitted from. These brilliant pieces of artwork will be displayed on our website and you may find them on the some of our posters, postcards, reports and other publications.



AM, Guild Lodge



Patient, The Spinney



Patient, Northgate Hospital



Garry C, Ridgeway



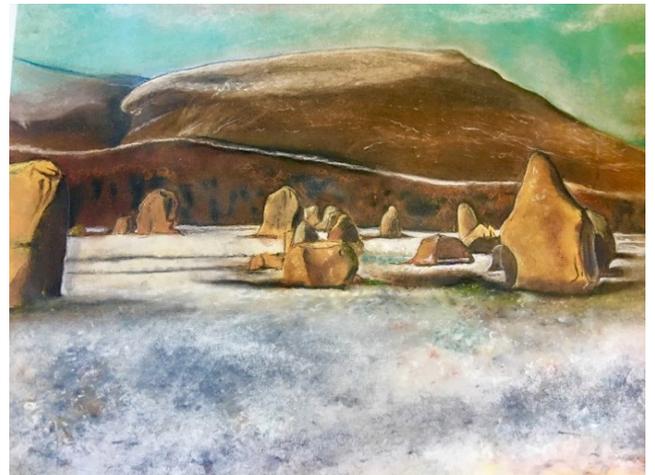
DD, Cygnet Hospital Bury



Patient, St Andrew's Northampton



BH, St Magnus Hospital



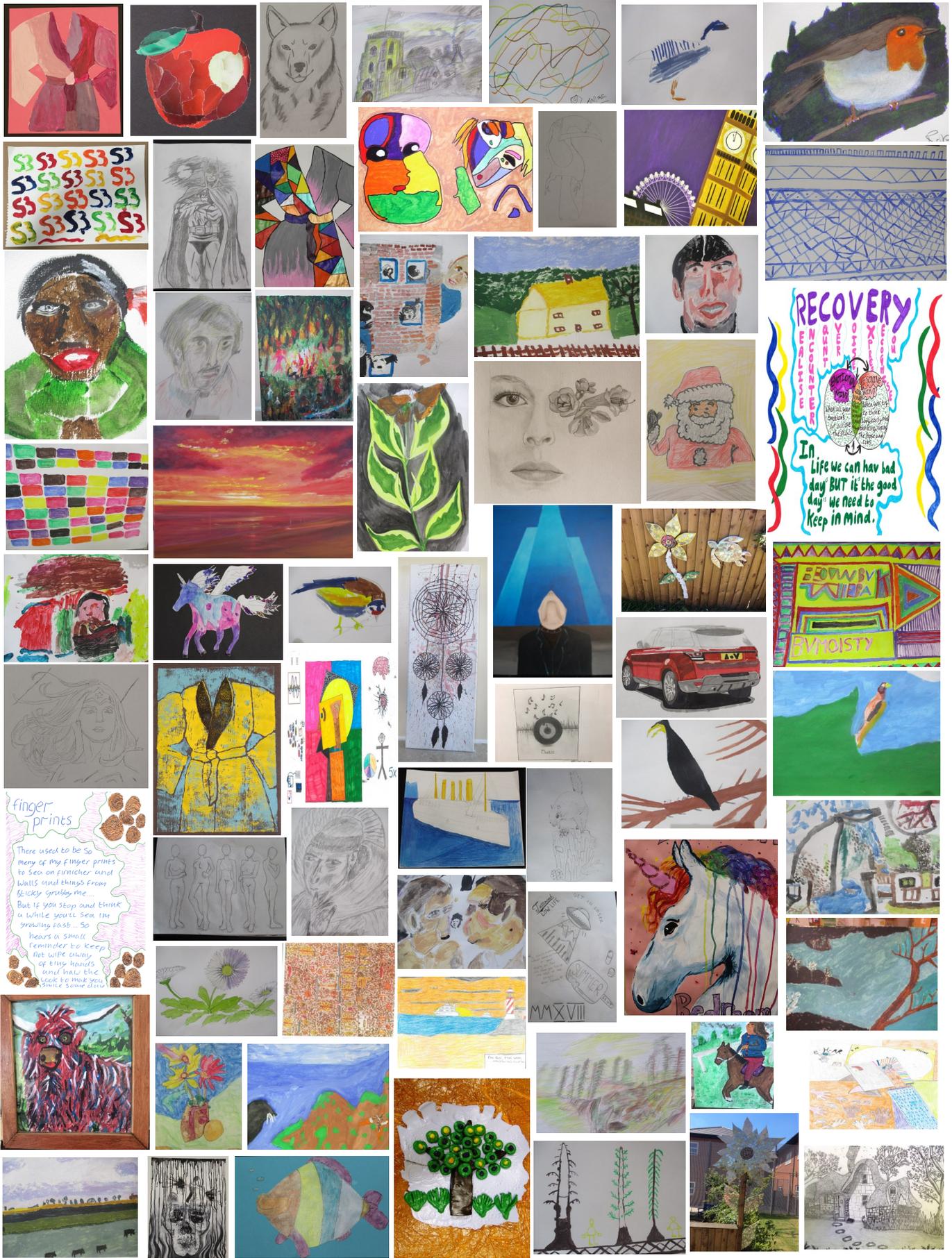
AM, Guild Lodge



OT Groupwork, Guild Lodge



Patient, Northgate Hospital



The Royal College of Psychiatrists

Maximising Patient Involvement with the Quality Network

The perspectives of patients are a very important aspect in improving the quality of services and helping to meet the needs of those with lived experience in these environments. As well as having discussions with senior management and staff on the frontline, we also listen to patients and their family and friends. We aim to promote the sharing of good practice and provide a forum for advice, discussion and honest reflection.

How can patients get involved with us?

Throughout the year, we advertise a range of opportunities for involvement with our network. Here are some ways that patients can get involved with us:

- Writing articles for our newsletters which are published quarterly. Each newsletter is based on a particular theme and we always welcome the perspectives of patients in these newsletters, which are sent around to all of our member services.
- Attending events, whether these are our special interest days or our Annual Forums, which are aimed at sharing good practice.
- Submit artwork for our annual artwork competition, where winning entries are displayed on various network materials, including service level reports, annual reports and other documentation.
- Co-present workshop presentations with staff members at our events to gain skills in presenting and group facilitation.

How patients can get the most out of our reviews:

Every year, our member services receive a peer-review visit which involves a meeting with patients. Here are some ways patients can get the most out of these visits:

- Complete the self-review survey before each review visit, to provide feedback

anonymously.

- Attend the patient meeting on the review visit and encourage other patients to attend this meeting.
- Attend or facilitate the tour of the unit for the peer-review team on the review day.
- Be part of the lunch and networking session during peer-review visits to engage with staff and the visiting peer-review team.

Introducing a 'Quality Network Champion'!

This role can provide one or more individuals with the responsibility of informing other patients of the Quality Network and the purpose of the review visits, encouraging engagement from other patients and seeking involvement during the review day.

This can include; completing the self-review surveys that are sent out prior to the visit; attending the peer-review meeting on the review day; gaining the top areas of achievement or challenges from other patients to feedback to the peer-review team on the peer-review visit; completing the self-review with staff for the standards relating to patient focus and experience.

The Quality Network Champion can act as the first point of contact for other patients with regards to what is going on within the Network, such as upcoming events and information about the peer-review visit.

We are constantly looking for ways to further promote patient involvement with our network. If you have any suggestions on how you would like patients to get involved with us, please let us know!

Jemini Jethwa, Project Worker, Quality Network for Forensic Mental Health Services

Upcoming Events

Prison Transfer and Remission: Improving Practice, 27 November 2018

For the first time the Quality Networks for Prison and Forensic Mental Health Services will be running a special joint event on 27 November 2018.



The event will be on Prison Transfer and Remission: Improving Practice. The day will involve a range of workshops, expert panel discussions and presentations. This event will be an interactive day with interesting talks and speakers including representatives from NHS England and the Ministry of Justice.

Standards Consultation Events

We will be running three consultation events for the current **Standards for Forensic Mental Health Services: Low and Medium Secure Care – Second Edition**.

This will provide an opportunity for you to discuss and share your views on the current standards and how these can be improved in subsequent revisions.

We very much welcome input from those within our member services, and patient and carer representatives.

The remaining two dates are as follows:

26 September 2018 – Middlesbrough Football Club – Hosted by Ridgeway

17 October 2018 – Fromeside and Wickham Unit – Bristol

If you are interested in attending any of our events, please visit our website for further information www.qnfmhs.co.uk

External Event

Trent Study Day - Working with Sexual Offenders, New Approaches, 29 November 2018 (09:00–15:30)

This is an annual conference which is hosted by the Forensic Services Division of Nottinghamshire Healthcare NHS Foundation Trust and the Institute of Mental Health. The conference is aimed at professionals working in the field of forensic mental health and the criminal justice system including clinicians, managers, commissioners and others.

Venue: Mike Harris Learning & Development Centre, Rampton Hospital DN22 0PD

If you would like to register to attend the event then please complete the registration form found on the Institute of Mental Health website and return to

imh.events@nottshc.nhs.uk

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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Twitter

Follow us: @rcpsych @ccqi_
And use #qnmhs for up-to-date information

Email Discussion Group

msu@rcpsych.ac.uk
lsu@rcpsych.ac.uk

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

Royal College of Psychiatrists' Centre for Quality for Improvement

21 Prescott Street, London, E1 8BB

www.qnmhs.co.uk