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# WELCOME

Welcome to the 43rd edition of the Quality Network for Forensic Mental Health Services' newsletter on 'Staff Training and Support'. We're impressed by the number of articles received and we hope you can use them to improve training and support for staff within your service. Thank you to everyone who has contributed!

Already we've opened workbooks for the first round of visits in September. The summer period is spent finalising reports, quality checking, aggregating data and producing the national reports and regional reports (for new care model services). In addition, we've been revising our tools and materials to bring them in line with the new standards.

This autumn, we have a fantastic event planned for you on trauma-informed care in secure and prison mental health services. The programme includes Lady Edwina Grosvenor and Dr Stephanie Covington who are both recognised as pioneers in developing and implementing trauma-informed services in the UK and USA. The event sold out in under a week so if you have booked on but you can no longer make it, please do give up your place to someone on the waiting list.

We're also currently working on the physical security document. This document will eventually replace the physical security section of the standards with just one standard, to maintain the document. All services will be expected to use this document as a 'live' tool that is subject to continual review. It is being developed by a small steering group and we hope to pilot it next year before it goes live in 2021. Please get in touch if you are interested in being involved in any way.

Finally, we had our team away day on the hottest day of the year. We had to cancel our sports day and decided to hide in an air conditioned board games café!

**Dr Quazi Haque and Megan Georgiou**



## Developing Reflective Practice – Our Journey So Far

Reflective practice is a vital component of good quality care and treatment, especially within a secure hospital. It is instrumental in improving care, supporting individual professionals in an MDT setting and fostering staff wellbeing.

There had been several unsuccessful attempts at introducing reflective practice at St Mary's Hospital over the years. Previous attempts started with a 'hospital-wide' session immediately after handover, targeting day and night staff, but attendance was low (3-4 staff). 'Bite-size' sessions of 15 minutes were tried in handover meetings, but handover often overran, and staff brought few issues at the start of the day. More recently the psychology team tried offering '1:1 reflective practice clinics' on the ward, but staff were typically unable to attend due to pressures on the ward. Now it seems, we have struck upon a formula for reflective practice that works for us.

The process of embedding reflective practice at St Mary's Hospital started well before sessions were offered to the staff team. Knowing that for change to be successful you need 'buy in' across all levels of the organisation, the psychology team first started discussing the benefits of reflective practice with the hospital management team. Following this, the psychology team attended handovers to discuss the benefits of reflective practice with all staff members. The next and most integral part of the process was finding a suitable time that would work for the ward-based staff. The psychology team canvassed opinion from all wards and it was agreed that monthly, between 8-9am would be most feasible. As the wards were quieter, this meant that the wards could send staff to support each other to allow staff to attend reflective practice. Support from the hospital management team was also enlisted which has proved a great support both in terms of relieving staff to attend but also in promoting a sense of team-work across the service.

One of the vital ingredients of any reflective practice is trust; trust that the staff team hold in their psychology colleagues, trust that the staff team have for each other, and trust in the process of the reflective space. Many of

the staff that attended the first reflective practice sessions had not shared their opinions or experiences in this sort of arena before. It was a daunting process, one which required the facilitators to 'contain' the space while at the same time offering some gentle challenge. As the culture of reflective practice has grown, we have seen this trust also grow, both in terms of the topics raised and in the support and understanding that the staff are now able to offer each other.

The response from staff has been positive as they embraced the sessions as a safe space to share and explore their experiences, positive and negative effects of change and the impact on them. They described the challenges of delivering person-centred care in a highly stressful environment. The provision of tea/coffee, bacon butty and pastries has also gone down very well. Staff were able to recognise their passion for their work, and often brought innovative solutions to problems on the ward. Feedback from staff at the end of sessions was that they felt better in attending the session and using the safe space to talk.

The psychology team and those attending initial reflective practice sessions felt it was important to ensure that comments raised were communicated to senior managers in a meaningful way. The psychology team now collate the comments from reflective practice and identify key themes before communicating these in the hospital clinical governance meeting every four-weeks. This allows the voices of those on the ward to be heard by all the senior managers at St Mary's Hospital and actions taken to address these themes. While helpful and reassuring to staff, the psychology team have been careful to assert that this was not the primary goal or purpose of reflective practice.

It is hoped that the culture of reflective practice will continue to grow and become embedded at St Mary's Hospital. The psychology team recognise that working in a secure setting is stressful for all staff and are keen to expand this practice to include therapy staff, managers and non-clinical staff over the coming months. We recognise that our current reflective practice is far from perfect and there will be challenges ahead but believe there is now a forum to continue improving.

**Dr Andrew Leigh, Lead Clinical Psychologist, Dr Leona Rose, Clinical Psychologist, & Abi Akinyemi, Forensic Psychotherapist, St Mary's Hospital**

## Greater Manchester Mental Health NHS Foundation Trust

### Training and Supporting Volunteers to Run Activity Groups in an Adult Forensic Service

The adult forensic service at Greater Manchester Mental Health NHS Foundation Trust consists of 226 beds incorporating low (The Lowry Unit) and Medium (The Edenfield Centre) secure care.

Over the past six months the Lowry Unit has been exploring the use of volunteers to provide additional activities for service-users on two low-secure male wards.

Volunteers can provide additional skills and expertise in specific activities, which can give service-users an opportunity to engage in an increased variety of things to do (Miller and Cameron, 2011). Engaging volunteers fosters a stronger community connection between the hospital and the local area and helps reduce the stigma around mental illness (Fieldhouse and Donskoy, 2013). The volunteers also provide additional opportunities for service-users to form positive and meaningful relationships, aiding their overall recovery journey (Doroud, Fossey and Fortune, 2015).

The recruitment process for volunteers is the same, in every sense, to that followed by all employed members of staff. Volunteer roles are advertised in various ways, including on the Trust website and local job centre. Interested parties are invited to apply for a volunteering role and suitable applicants are then invited to attend an interview. Following this, successful applicants are appointed subject to clearance of Disclosure and Barring Service (DBS) checks and required to complete Trust induction processes and all necessary mandatory training requirements.

Service specific induction training is also provided, which covers a security awareness session of physical, procedural and relational security matters. This induction training provides the volunteer with vital information on how the service runs, how to raise concerns, what to do in difficult situations, and covers confidentiality and safeguarding. Volunteers are also signposted to the Trust's Recovery Academy, which provides key training and learning opportunities in a variety

of personal well-being, life-skills, psychological techniques and creative workshops. These courses vary in length from one-off sessions to those with multiple, weekly sessions.

*"I had 2 and half days training covering topics such as the hospital set-up, service-user characteristics, contraband, personal safety and safeguarding, culminating in a key induction."*

**- Lydia (volunteer)**

In line with exemplary volunteer practice management (Hager and Brudney, 2015), the Lowry Unit follows a structured procedure to ensure that the recruited volunteer is well-matched to the ward environment. The opportunities for volunteers to work directly on the ward with service users is unique and, as such, careful consideration is given to skill-matching the volunteer with a suitable role. To date, volunteers have been recruited to provide support in creative art, gardening and fitness development sessions.

Volunteers for the occupational therapy (OT) department are given regular supervision and line management support by the OT team leader. These processes include a handover prior to starting each session, collaborative negotiation about the possible activity projects. Reflective practice is used to help ensure the volunteer feels fully supported within their role and can adapt to the challenges associated with working within a secure environment with complex individuals. Occupational therapists are, in this sense, well placed to support volunteers in grading activity projects to meet patient recovery goals.

One challenge faced by the volunteers has been the reluctance from service-users to participate in group activities. Having a collaborative approach between the OT Team and volunteers has been vital in managing and overcoming this. OT staff have supported volunteers in considering the various alternative options, such as where to locate their sessions, the use of different strategies to encourage service-user engagement and what activities may be most appropriate within the constantly changing nature of the ward environment. Job specific training and coaching from OT staff has helped the volunteers to manage their expectations and maintain a sense of purpose and pride. Increased effort has been made to ensure the

volunteers feel valued and that the time they offer to the service is utilised effectively.

*"The main challenge is the lack of engagement. It's disheartening when very few people want to take part."*  
**- Lydia (volunteer)**

Volunteers have been encouraged to develop their ideas into projects that promote recovery and that service users can gain a sense of achievement from. A number of creative projects are being incorporated into visual displays throughout the wards, including the Hive of Hope, which was co-produced by volunteer Avril and service-users (see photo). These displays provide the volunteers with a sense of recognition and accomplishment that feeds back into their overall training package.

Overall, the combination of challenging ward environments, supplemented by structured, regular training and support has allowed the

volunteers to achieve personal growth, develop their skills and bring an extra dimension to the rehabilitation and inclusion of service users.



**Duncan Lewis, OT Student & Nigel Sharp, OT Team Leader, The Lowry Unit**

## **Ludlow Street Healthcare**

### **Co-produced Training: Involving the 'Real' Expert**

Despite the drive for Service User (SU) involvement in mental health services (NICE Guidelines, 2012), training within forensic settings is typically delivered by those deemed as 'experts' (often by status of qualification). The active participation of those with lived experience, based on their knowledge of what works best for them, can often be overlooked. In this article we consider the benefits of involving SU's in staff training within a secure setting. Drawing directly from reflections of two SU's, Meg and Chelsie, we discuss the benefits of co-development and co-delivery of training aimed at nursing staff.

SU involvement means the active inclusion of their perspectives in the design and development of training packages. It is this early stage in the co-production, that SU's may begin to shift from passive to more active involvement in their care. As described by Meg:

*"It was great to be asked to use my skills in a way that allowed me to inform staff about myself."*

Consistent with the Good Lives Model (Ward, 2002), Meg and Chelsie drew from the information within their collaborative formulations, and their own technological skills, and achieved a sense of creativity, agency, and mastery. As Chelsie reflected:

*"Developing the PowerPoint was an achievement as I was asked to do something that would be beneficial and I did it."*

Meg described co-development as "fun" as she utilised her creative skills to develop an engaging and artistic presentation.

Such projects can offer useful activity and focus within a secure environment that can be beneficial as a form of distraction from distress. It enables people to look beyond their difficulties and creates hope that things can improve. Such hope can be essential to emotional wellbeing. As Meg recalls:

*"Being involved in a project that allows me to train staff about me, gave me a sort of energising feeling."*

In the role of the 'trainer', SU's move temporarily into a position of power, holding and delivering information to the ward staff that typically hold the control. This can feel an

alien concept for SU's who have frequently been marginalised due to the more typical model of expertise (Perkins and Slade 2012). Despite totalling seven years in services, Meg and Chelsie stated:

*"I didn't think it was possible for a SU to be a trainer. I see myself as 'just the patient.'"* (Chelsie)

*"Delivering training was a unique experience and something I've never actually done"* (Meg)

Providing these opportunities challenged the historical focus on client's deficiencies to a focus on strength and resilience. Both confirmed how:

*"It was nice to be seen as capable and not just a person with a diagnosis that is Sectioned."* (Meg)

*"I showed people that I can be in control and capable. When I struggle, I will think about the training as an example of taking control of my life."* (Chelsie)

The experiential nature of the SU's knowledge offers a unique opportunity for staff to gain a perspective from the 'real expert'. Consequently, it was noted that:

*"Staff are more likely to approach me for suggestions of what I should do when I'm struggling."* (Meg)

*"Staff have a better understanding ... everyone is responding in a better way."* (Chelsie)

*"I can approach the team with confidence that*

*they will know what to do when in Crises."* (Chelsie)

The training appeared to lessen 'them and us thinking'. Frequently trainers utilise case studies to provide personal accounts to taught topics, however the SU sharing their experiences offered a more meaningful, emotive connection. It is arguably easier to connect to the topic, when they do this, in hope that it will lead to a greater understanding and support from the audience. As Chelsie reported *"who better to deliver training?"* Subsequently, implementation of suggested approaches resulted in SU's feeling validated:

*"After years of people not understanding, they get it now."* (Meg)

*"I realise that I have a voice and people are listening."* (Chelsie)

*"It was awesome...projects like this can make the person feel very important."* (Meg)

In our experience, the only potential obstacle for SU's is that training can be anxiety provoking. Although such feelings are typical for 'professionals', it is likely to cause greater anxiety when training focuses on your own personal difficulties. Nevertheless, feeling anxious should not exclude involvement. The very nature of therapeutic work within such settings is to experience and tolerate negative affect. And, as this article reveals, the benefits are abundant.

**Meg Barrett, Service User, Chelsie Owen, Service User & Siân Hughes, Forensic Psychologist, Heatherwood Court**

## Knowledgehub

**Join the Quality Network for Forensic Mental Health Services (QNFMHS) online discussion forum!**

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Email 'join Knowledge Hub' to [forensics@rcpsych.ac.uk](mailto:forensics@rcpsych.ac.uk)

## A Pinch of SaLT

A communication workshop was designed to enable staff working with people with learning disabilities and mental health conditions, to reflect on and adapt their communication skills to the needs of the individuals they work with.

### Context

Northgate is a secure hospital for men with a learning disability offering various levels of security; MSU, LSU and hospital based rehab, with a total of approximately 50 beds. The staff team is made up of nursing assistants, nurses, psychology, psychiatry, occupational therapy, therapeutic activity and education staff, pharmacy and speech and language therapy (SaLT).

There was a growing sense amongst the team that the complexity of the patients admitted was increasing and that patients appeared to present with greater cognitive and communication needs than in previous years. Misunderstanding of communication, banter and difficulties understanding time were frequently noted as triggers for incidents of violence and aggression.

The aim of the training was to increase staff awareness of the importance of their communication level, and manner in interactions with patients and be able to adjust their communication to the needs of individuals, understanding the value of this in reducing incidents of violence and aggression.

The SaLT team felt that staff would benefit from a specific communication workshop to address the following areas;

- A simple model of communication
- Understanding the way in which communication skills can be affected in learning disability
- The impact of communication on risk and on potential for treatment
- Adapting communication

### Design

The training is interactive throughout with various tasks, discussion and activities illustrating the learning points. Staff are given opportunities to practice the skills they are developing within the training session, and

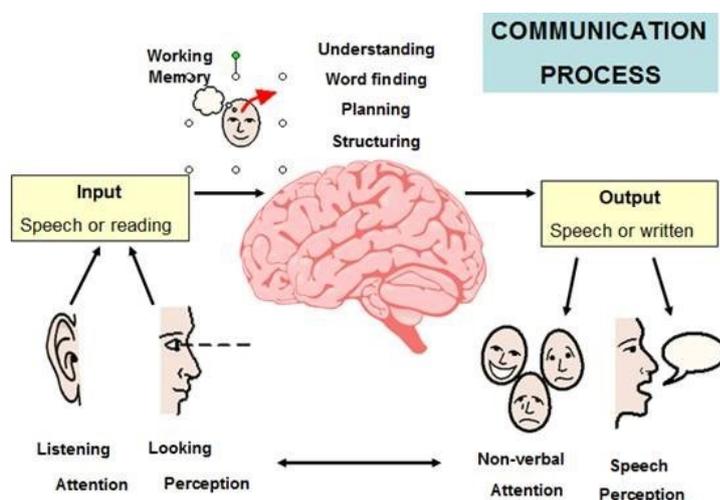
case studies of familiar people are used.

The training lasts a full day and there is a commitment from management to support people to attend, because of the recognition of the impact that communication plays in quality of life, incident reduction, and every aspect of the ward day.

The training is delivered by SaLT on a bi-monthly basis as a rolling programme. A key part and sometimes contentious part of the training is a discussion around the use of banter. Its therapeutic benefit is discussed as is the challenge it can create for individuals with communication needs. Therapeutic roles and boundaries are discussed and the difficult and switching role that nursing staff in particular fulfil is reflected upon.

To date, over 80 staff have attended from a variety of different disciplines. Feedback received has been overwhelmingly positive, and adaptations of the training have been delivered to teams working in the mental health secure wards to support them in recognising communication difficulties in their clients.

This training is then supported and complemented within formulation sessions and reflective practice for ward teams.



**Jo Brackley, Principal Speech and  
Language Therapist, Northgate Hospital**

## Deaf Awareness and Training



Here at Elysium we have a Deaf Service where we provide medium, low and open ward services to deaf patients who have been detained under the Mental Health Act. On these wards we have deaf and hearing members of staff. When new staff start, as part of their induction training they will attend a deaf awareness session that is delivered by myself, a Forensic Social Worker and one of the deaf patients from the ward. This is a fantastic opportunity for the deaf patient to impart their views and needs about being deaf in the hospital, to discuss their cultural needs and this has proven to have a positive impact in their rehabilitation as it helps to foster a sense of self belief and worth.

Likewise, it is an opportunity for those new members of staff who have perhaps never worked with a patient, or colleague who is

deaf and a sign language user to meet us and see how they can best communicate and work with us. During the session the patient delivers training to the new inductee's in how to 'meet and greet' a patient who is deaf, or deaf colleague, with confidence. For each session we have from 10 to 20 participants and this ranges across the board in terms of the roles they will be fulfilling in the hospital (front of house staff, clinicians, health workers and directors). It is noteworthy that for the most part our deaf patients will not have this kind of opportunity in their life outside of the hospital; to be stood at the front of the room delivering a training session to a group of people who are not able to communicate with them. Additionally, they get to work with me and see how a deaf professional is able to fulfil this role, and have a positive role model to work alongside.

For each session that we have delivered the evaluations that have been completed by the inductee's have been very complimentary. In fact, it has inspired many of them to look into developing their skills and knowledge around deafness and British Sign Language further.

**Gillian Jeffery, Forensic Social Worker,  
St Mary's Hospital**

## Royal College of Psychiatrists

### Restorative Practice – Supporting Staff in Secure Services

The need for staff in secure services of all grades, shapes and sizes to have access to support, be it supervision, reflective practice or perhaps, if the need should arise, say in the aftermath of traumatic events, even counselling and psychological therapy, is well recognised. The majority of patients just want to keep their head down; get their escorted, then unescorted leave and be discharged, but some do act out causing both psychological and physical harm to staff and fellow patients. The victims of such maladaptive behaviour, both staff and patients, need support to come to terms with their experiences.

The use of restorative practice in mental

health settings is steadily gaining impetus. Restorative practice can be used to resolve interpersonal conflicts between staff and patients, thereby facilitating the development of better relations via developing a shared understanding of unhelpful events and how to avoid them. In my local mental health trust restorative interventions have been deployed for this purpose following assault of staff members by patients.

The practice focuses on supporting genuine dialogue between the staff member and the patient. It is thought that engagement in the restorative process may allow patients to reconfigure their self-identity and narrative in a manner which promotes well-being and desistance from violence. One of the key outcomes of such practice is that it contributes positively to the experience of support within the trust.

A crucial aspect of secure recovery is to address responsibility for causing harm which chimes well with the principles of restorative

justice. It is an unfortunate myth that secure and forensic patients are somehow incapable of taking responsibility for the harm they may do to others. Any reluctance on their part, to engage in conversations regarding harm they may have caused, is understandable if they fear the consequences will be predominantly blame and shame. Restorative practice offers a safe and supportive mechanism within which patients can be presented with the personal and relational impacts of their actions and be supported to learn from their mistakes and make recompense.

One of the core principles of the intervention is that the ward staff are at the heart of the intervention. This is in keeping with the important role staff play in developing and sustaining relational security and clearly aligned with See Think Act. Healing received harms and restoring therapeutic alliances can be essential for a patient to progress in their recovery, both in a psychosocial and logistic sense. Staff may move within services and should a patient's pathway intersect with the career pathway of a staff member whom they have harmed, there is a real need for mechanisms in place to resolve matters so that patients are prevented from making transitions to less secure settings.

Within the restorative intervention the facilitator has the task of creating and maintaining the environment where relational transformation and healing can occur, or at least begin. The process may involve both parties opening up and displaying vulnerability and hurt which can be both emotional and potentially traumatic. The facilitator's preparatory work with participants, together with their situational awareness within meetings is crucial to promoting and maintaining a therapeutic sense of safety, containment and trust. The structured nature of the restorative dialogue provides additional support.

The mutual sharing of experiences, emotions, perspectives and reflections with the restorative intervention can promote the development of empathy and compassion

between both parties, sometimes surprising both. This can lead to defensive barriers being dismantled and new rapport and trust emerging. Both staff and patients have reported finding value and humility in the process. It has also been reported that there are secondary benefits in terms of improving or at least maintaining a therapeutic ward atmosphere.

The nature and extent of stress on secure and forensic wards should never be underestimated. As a former patient I experienced such settings as 24/7 oppression; an insidious and exhausting horror which was relieved only when I was on leave. Such environments can foment tension and risk through the very procedures which are designed to reduce the potential for harm. It is important that restorative practice takes into account environmental factors and if possible acts to steer positive relational and procedural change on wards.

I hope that at some point in the future my local trust will develop the confidence to extend the paradigm to situations where patients feel they have been harmed by staff. Secure and forensic settings are essentially closed environments in which patients' rights are qualified and various restrictions imposed. This has led to forensic patients being identified as the most vulnerable of patient cohorts with regard to relational neglect and potentially abuse. I am aware that both organisations and individual staff members hold significant anxiety with regard to acknowledging the harms that patients might experience when under their care. I would like to suggest that restorative practice would be a safe approach to address such issues, allowing both patients, carers and staff members to develop a better understanding of mutual vulnerabilities and thereby improving the safety of services and quality of practice for all.

**Dr Sarah Markham, Patient Reviewer,  
QNFMS**

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## Personality Disorder Training

Patients within Caswell Clinic present with complex vulnerabilities and needs, including serious mental illness, personality difficulties and offending behaviour. Complex trauma, attachment difficulties and adverse childhood experiences feature in the majority of patients' early lives and beyond. Consequently, many individuals demonstrate relational, emotional and behavioural difficulties, which could be considered to meet criteria for personality disorders (PD).

It has been highlighted that retention of a skilled workforce is crucial for the delivery of high quality services (Crawford et al., 2010). Burnout is believed to be particularly common amongst care staff working with patients with a diagnosis of PD (Perseus et al., 2007; Chandler et al., 2017). Moreover, training and support, such as clinical supervision, is important to minimise the risk of staff burnout within this client population (Crawford et al., 2010). Consequently, a PD training strategy was implemented to enhance skills and knowledge amongst the workforce.

**Personality disorder awareness training**  
Historically, staff from Caswell Clinic attended PD awareness training delivered centrally within the health board. This training evolved from the Knowledge and Understanding Framework (KUF), which was commissioned by the Department of Health and Ministry of Justice in 2007. This aimed to support people to work more effectively with individuals with a diagnosis of PD.

Whilst feedback from the training was generally positive, due to a decline in available facilitators, the training was often oversubscribed. Due to natural attrition of staff, it became increasingly evident that the majority of Caswell Clinic staff had not accessed this training. Consequently, a decision was made to locate the training within Caswell Clinic.

The training was reviewed internally and adapted to suit the needs of staff working within specialist forensic services. Four one-day PD awareness sessions are planned for 2019. To date, two sessions have run, with 33 staff in attendance. The current PD awareness training includes didactic teaching, videos, case vignettes and experiential exercises to enhance understanding of the following areas:

- Theories of personality, including the five factor model
- The importance of attachment theory and trauma
- An overview of PD diagnoses, using information adapted from 'NOMS working with offenders with PDs: a practitioner's guide'
- The Impact and stigma of PD diagnoses
- Challenges to working with this group, including concepts such as boundaries and splitting
- Managing challenging situations
- Staff wellbeing
- Helpful and unhelpful features of PD services

### The development of enhanced training

Feedback from the training has been overwhelmingly positive, with attendees noting that the training improved their understanding of the causes of the difficulties and distress individuals may experience, for example, "*Understanding that the patient doesn't behave negatively on purpose and that they have adapted the way their brain works due to trauma*".

Attendees were asked what they would like to see delivered in further training. Many indicated a desire to learn more practical skills to increase confidence when supporting individuals with such complex needs, for example "*how to deal with patients in crisis, best approaches*"; "*to get more out of interactions*" and "*interested in DBT skills*". Accordingly, a one-day enhanced PD training session was developed.

A self-selection model has been implemented. Attendees of the awareness session can indicate interest in the second 'enhanced' session. At present, 41% of individuals who attended the 2019 awareness sessions have indicated an interest in attending the enhanced session, which will take place in November 2019.

The enhanced session focuses on areas outlined below:

- Livesley's integrated model of PD
- Core therapeutic skills central to working with individuals with a diagnosis of PD
- An overview of Dialectical Behaviour Therapy
- An overview of Cognitive Analytic Therapy
- Self-care and staff wellbeing

A range of teaching methods are used, including group discussion, skills illustration and practice, and a focus on service user experiences. Attendees are informed that the session does not provide sufficient training to undertake such therapies with clients. The session aims to increase the confidence and skills of staff providing therapeutic care and support to individuals, particularly at times of acute distress and emotional arousal.

### **Training evaluation**

Perceived confidence and competence of working with individuals with a diagnosis of PD will be assessed before and after the session.

Future evaluation may include assessing levels of staff burnout, and feedback from patients about their experiences of care and support following the training. The training sits within the overall clinic strategy for supporting patients with a diagnosis of PD, which includes the use of staff CAT consultations, regular reflective practice, individual and group therapies including CAT, and multidisciplinary scaffolding teams working closely with wards to support staff at a ward level.

**Leigh Gale, Clinical Psychologist, Caswell Clinic**

## **Northumberland, Tyne and Wear NHS Foundation Trust**

### **Supporting Staff to be Mindful in a Secure Setting – Service Evaluation of a Training Course**

At the Bamburgh Clinic we have provided and evaluated a mindfulness training package for staff. The aim was for this to enhance staff wellbeing, while also promoting relational security and reflective practice. We would view this as being linked to the Quality Network's standards, for well-governed staff support and a compassionate approach to patient relations.

Mindfulness aims to teach people to purposefully pay attention, in the present moment and non-judgmentally (Siegel, 2007), and to internal experiences, such as your body sensations, thoughts and emotions (Groves, 2016). Working in clinical environments with high rates of aggressive and violent behaviour can have serious consequences for staff wellbeing. While mindfulness is recognised as having positive effects on wellbeing it is also proposed that training in mindfulness may enhance the therapeutic relationship between staff and patient and thus benefit clinical outcomes (Groves, 2016). We were keen to undertake a pilot study (PreARMed: Pre-incident Anticipatory Resilience and Mindfulness Education) to evaluate whether the introduction of a mindfulness course could increase staff resilience and wellbeing, and whether there would be an impact upon ward based violence. This evaluation formed part of our Trust's restraint reduction strategy 'Positive and Safe'. A fuller account will be published in the proceedings of European

Violence in Psychiatry Research Group, Oslo 2019.

The PreARMed training was delivered over three 90 minute sessions across a 6 month period. The training was a combination of didactic teaching, group tasks and discussions. It was intended that staff would attend all three of the sessions, although we found that attrition for the 3rd session was high. Staff who attended the training worked in a range of direct clinical roles within secure services: nurses, support workers, activity workers, and occupational therapy staff.

We asked staff who attended the sessions to complete pre and post measures for wellbeing (General Health Questionnaire) and use of mindfulness (Five Facet Mindfulness Questionnaire). Staff were also asked to complete an evaluative questionnaire to rate their experience of the sessions.

While quantitative analysis of our outcome data suggested no significant change in staff use of mindfulness or wellbeing, the qualitative feedback from staff who attended was positive and three main themes could be informally summarised:

**Benefit of shared experiences:** *"really helpful to sit in a room with other people who are feeling the same about their jobs – the pressures and stresses. Don't feel like it's just you!"*

**Reflection:** *"helped to focus on what's important and also why I'm in the job in the first place", "relevant and beneficial to job role, helping me to reflect and improve well-being when work life is demanding."*

**Enjoyment of the course:** *"well presented and engaging, made me intrigued to know more", "I have really enjoyed this training, looking forward to part 2."*

Preliminary analysis of ward based violence showed that incidents of patient violence against staff, was higher for those staff who attended the training in the three weeks, before the course and then lower in the six weeks following the training (when compared to a matched sample of staff within the service). While the sample was underpowered, the result indicates an interesting trend which demonstrates a potential impact, of mindfulness and resilience training for staff on patient violence. We have wondered if increased mindfulness in staff might promote a 'calm attention' that supports staff to increasingly deescalate situations that might

typically lead to violent behaviours. We are planning to undertake a multi-site research study to test our hypothesis further. Providers who are interested in joining a multicentre trial can contact the authors KR or HC below.

Challenges for the training related to maintaining staff attendance across the three sessions, which was felt to be a consequence of staff moving jobs and high clinical activity. In future we would consider condensing the content into two sessions in order to make it more accessible for staff.

**Kerry McCubbin, Assistant Psychologist,  
Dr Keith Reid, Consultant Forensic  
Psychiatrist AMD for Positive and Safe  
Care & Dr Helen Clothier, Consultant  
Clinical Psychologist, Bamburgh Clinic**

## **Derbyshire Healthcare NHS Foundation Trust**

### **Staff Training and Development on See, Think, Act**



The Kedleston Low Secure Unit like any other Service have its challenges. One of the difficulties we have faced is around See Think Act and being consistent with boundaries. Until this year we did not have any external training on Security, we delivered an in house e-learning package on induction and completed a face-to-face talk about procedures and ward specific information as part of the induction process.

We have found that our biggest challenge is on being consistent with boundaries with patients, which can lead to splitting in the team and inconsistencies. We sourced some external training on See Think Act and held a team away day to facilitate delivery. The training was attended by 35 staff and was very well received. Some of the feedback from the team was that it had made them realise

just how different the opinions were within the team, and also that we didn't often focus enough on our patient mix/dynamic and how that impacts on the ward. As part of the training package we purchased a developmental workbook in order to continue to learn and develop as a team.

We identified two security link workers and put together a 12 month plan to work through the sections in the book, in a variety of different ways to keep the team engaged and to ensure that we capture the teams' views when seeking clarity on issues raised. We decided to start with the topic around boundaries, as this has caused significant divides within the team. We asked the team to complete a survey to get their views on procedural and relational boundaries, as well as negotiable and non-negotiable boundaries.

We are currently compiling the results of the survey, however what is clear at first glance is that there are massive differences, in opinion over lots of the items on the surveys. This was not completely unexpected, and we have planned to have a couple of listening sessions to gain some narrative behind people's views prior to writing and issuing some guidance on the consensus of opinion on each item of the survey with a rationale.

This is just the first part of our training and development journey and we fully expect that we will have further hurdles to overcome, but what is really important is that we learn and develop as a team, including and respecting

each person's opinions and offering a clear rationale for how we should be managing boundaries. We are hoping to continue to work collaboratively as a team and develop our knowledge in this area. The team are aiming to present a poster at next year's annual LSU forum to share our journey and to help

support other services who may be experiencing the same issues as we have.

**Rebecca Mace, Senior Nurse and Service Manager, Kedleston Unit**

## Swansea Bay Health Board

### Staff Wellbeing

The National Health Service (NHS) is widely reported to face many challenges (see Lafond *et al.* 2016), with staff wellbeing identified as one of several factors affecting the quality of healthcare provision (Robertson *et al.* 2017). The promotion of staff health, wellbeing and engagement can lead to high-quality patient care, service improvements and increased staff retention rates (Francis, 2013; NHS Wales, 2014; Welsh Government 2011). Supporting staff wellbeing can also lead to improvements to patient safety, experience and treatment (Department of Health, 2009). Employment can promote wellbeing and resilience with benefits to personal and social areas of functioning, such as income, identity, achievements and relationships (MIND, 2016; National Institute for Health and Clinical Excellence [NICE], 2009). Improving staff wellbeing can also have organisational benefits, including reduced staff absenteeism and presenteeism (British Psychological Society, 2017; Stevenson & Farmer, 2017). Furthermore, employment within a forensic mental health context may have specific challenges for staff wellbeing compared to other services (Chandler *et al.*, 2017).

Accordingly, the Staff Wellbeing Group (SWG) was formed at a medium secure hospital to increase awareness about the wellbeing needs of staff. Through monthly meetings, the multi-disciplinary group developed an overall strategy to identify levels of wellbeing across the clinic and to support initiatives.

An anonymous online staff survey was developed and sent by email to explore staff wellbeing levels and needs. The findings indicated that a high proportion of participants reported positive wellbeing and that there was good awareness of some of the support services available. Despite most respondents reporting high levels of confidence with accessing the wellbeing resources, a proportion stated that further improvements

could be made. Currently, there are staff based at the clinic who have completed the health board's 'Wellbeing Champion' training and their roles are to signpost staff to the resources available. The SWG, as a forum, could help to co-ordinate and embed these roles further at the clinic. Furthermore, having a designated figure to offer specific wellbeing support and regular individual / group-based interventions may help to integrate the wellbeing strategy further. As such, funding was secured for a fixed-term staff counsellor post for a 12-month period. It is planned that there will be ongoing monitoring of staff wellbeing through anonymous surveys to inform service development and also evaluation of the interventions initiated (e.g. through the staff counsellor post).

To build upon the information gathered from the staff surveys, focus groups with ward-based staff and clinical team members were completed. Four themes emerged from the data collected: *team-working*; *designated support figure*; *wellbeing resource awareness and provision*; and *forensic context challenges*. A number of recommendations were made from these themes. The importance of effective team-working repeatedly emerged, with a number of good practices identified. Ways to improve this aspect further were suggested and consistent clinical team members, have been allocated to specific wards to improve communication between ward-staff and clinical teams. Having wider representation at weekly clinical meetings has also been implemented on one of the wards.

Staff were supportive of having a designated staff counsellor and it will be important for the post-holder to clearly outline their role and responsibilities to staff to overcome any potential barriers to access, such as concerns related to stigma, privacy and confidentiality. Currently, staff training on wellbeing and resilience is available for new employees, as part of their induction and this will be extended to existing staff members also.

There were a number of aspects specific to the

impact of working in forensic services on wellbeing that were raised (e.g. working with individuals with known histories of committing serious acts of violence). This can have implications for staff wellbeing, as well as for ongoing risk management. Regular formal support through reflective practice, team meetings, consultation and supervision are provided. These forums are also an opportunity to consider good practice rather than adverse events or 'near misses'. A clear protocol for responding to adverse incidents has been developed and a group of senior clinicians to review such incidents has also been established. It is important that any

pertinent findings and recommendations are clearly communicated across the workforce to maintain transparency and engagement.

In summary, working in a forensic inpatient service can be challenging. The SWG is a multi-disciplinary group focused on understanding and developing the wellbeing of staff within a medium secure hospital. Through regular meetings, online surveys, focus groups and designated support figures it is planned that further initiatives are embedded and evaluated to further promote a positive working culture.

**Dr Chris Stamatakis, Clinical Psychologist,  
Caswell Clinic**

### **Leeds and York Partnership NHS Foundation Trust**

## **Staff Training and Support in Keeping with the Trauma Informed Clinical Model**

The Leeds and York Partnership NHS Foundation Trusts Forensic Service have recently been implementing a trauma-informed care approach as the model understands a person's difficulties and behaviours as a response to traumatic experiences, and attempts to limit the potential of mental health services to re-traumatise. Our service has successfully embedded Trauma Informed Care (TIC) by shifting the way in which we think about the care we offer. We ask what has happened to you rather than thinking what is wrong with you. We recognise that the majority of our service users have experienced trauma at some point in their lifetime (Trauma review, 2019) and therefore ensure that we integrate knowledge about trauma into our practice. We ensure that we minimise the potential for re-traumatisation and think about how trauma can impact recovery pathways. As part of embedding the trauma informed clinical model, the service has introduced a range of staff training and support.

Alongside our changes to service user care, staff wellbeing is also at the forefront of our minds. Previous literature has illustrated a correlation between staff wellbeing and the quality of mental health services delivered (Hall et al., 2016), hence it is important to explore our staff members' professional quality of life in order to minimise any detrimental effects towards our service users and staff wellbeing. Therefore using the Professional

Quality of Life Scale (ProQOL) (Stamm, 2010) we explored both positive and negative effects that staff members may experience when working with service users who have experienced trauma or historical stressful events. Our findings indicated that our staff teams showed compassion but did experience low to average levels of burnout and secondary traumatic stress. We recognise that staff wellbeing can be impacted by the type of healthcare we work in, and therefore we have implemented more opportunities for open dialogue amongst teams, and with managers and supported more training on wellbeing and coaching.

Further to the acknowledgement that our staff work in challenging environments, we have also embedded trauma awareness within our training package. This has been developed to support our staffing teams with working alongside trauma, in regards to both service user's experiences and possible re-traumatising situations. The trauma awareness training aims to create an understanding of what trauma is and encourages attendees, to reflect on how working with trauma impacts job roles and responses to others. It is hoped that these, combined with basic knowledge of strategies, enhance confidence of talking about trauma and better equip staff to deal with difficult or re-traumatising situations. The feedback received from attendees suggests that the majority (98%) felt the course was useful and were complimentary of the training. The evaluations show that attendees thought the training had been beneficial for reflecting on how trauma impacts our service-users mental health, and thinking about how staff wellbeing can impact care.

Effective and regular supervision is also a necessity for ensuring the wellbeing of staff

members is considered. Supervision training has been developed to improve knowledge about, the purpose of supervision; the differences between clinical and managerial supervision; and introduce the seven eyed supervision model (Hawkins & Shoet, 2012) to use within clinical supervision. The seven eyed model allows for the supervisee and supervisor to pay attention, to various perspectives of interactions or situations which the supervisee identifies. It allows reflection from the service users' perspective, the staff member's viewpoint, and an observer's insight whilst also exploring the relationships. It also takes into account reflections on whether the interventions used were trauma informed and appropriate to the recipient, as well as paying consideration to the wider context such as cultural or organisational factors. This training has promoted honest and open dialogue, between supervisees and supervisors and provided an alternative trauma informed method, of thinking about the way in which we work professionally.

Both the Newsam Centre and Clifton House have appeared to benefit from the implementation of the trauma informed clinical model and the adaptations it has brought. The additions to the training package

have resulted in staff members, having more resources to rely upon when supporting those who have experienced trauma and promoted supervision as a safe space to reflect on what our staff experience. We have taken steps to challenge secondary traumatic stress and burnout which results from the nature of work we do. It is hoped that the follow-up ProQOL and continued feedback from training will exhibit positive changes as a result of considering staff wellbeing as a priority and thinking about trauma in all aspects of our forensic service.



**Gemma Robinson, Assistant Clinical Psychologist, Newsam Centre**

## **Avon & Wiltshire Mental Health Partnership Trust**

### **The Life of Co-developing Training and Support**

Here at AWP secure services everyone has worked together to look at how we can train and support our staff, service users and carers. With support from the involvement coordinator service users and carers have been involved in receiving, developing and delivering tailor made training sessions.

We are Luisa Suarez (involvement coordinator) and Anthony B (service user representative) and have co-written this article to highlight some of the great work we have been part of.

#### **Monthly staff induction**

Every month new staff members receive training on our local induction. What started as two sessions being co-delivered has now extended to five including; customer care and

involvement/working with families. These sessions have been developed from visitor and staff feedback, working with families was co-developed with a carer from a staff survey that had identified the need for more training on this topic.

We always get great feedback from staff on the co-facilitated sessions "great to have a service user and carer come to share their experience, inspiring and reflective". Most staff say that this is the most helpful part of the induction and really value hearing lived experience.

#### **Community meeting training**

In a support meeting ward, representatives (reps) identified that community meetings were not working so well. They came together with the involvement coordinator to make a brochure and training session around what people should expect and what staff should do in these meetings. This was presented to all ward managers and supported by the lead of operations. Having senior management meant that ward managers were more engaged and things improved quickly.

## Co-production training

This was developed by the local co-production group (a current, a discharged service user, 2 carers and 3 staff members). Learning how we could all work together, we delivered to senior clinical teams so they could see how AWP are doing in co-production. This training has supported to get more involvement and now everyone wants to be part of the team.

## Train the trainers

Giving people skills and confidence to co-develop and co-deliver training this session is open to staff, carers and service users. Once someone has finished the training they can go on to bigger things like delivering on the induction. As a service user I have co-delivered this training to a group of staff and service users and really enjoyed it.

## Supporting everyone

In Kennet ward, staff and service users support each other, they run a monthly bring and share lunch. This lunch is a great way for service users and staff to break down the barriers and informally support each other. As a service user it is great to be involved, everyone shows appreciation of each other and you learn new things.

Here at AWP, we have been looking at how we can support staff, service users and carers when involved in co-producing. We want to make sure everyone feels confident and safe to work together. We have both been attending groups to develop a mutual expectations charter. This is important work so everyone gets a better understanding of each other and what is expected.

## Anthony's lived experience

My involvement with training and support has meant that I can talk about what has worked (or not). I feel that everyone working together can help so much, different professionals can see it from different angles. You need to feel safe and relaxed to do the roles but to get that you need to do positive risk taking. It is very

scary and can take a while to build your confidence, but if you want to change it is the only way and the more positive you feel, the more positive the outcome will be. I feel the quality of training has changed so much as we have a wide variety of expertise from staff, carers and service users.

Staff support is also big because they are part of our care and you can't keep thinking it's 'us against them'. I feel when service users are not involved it takes away the actual lived experience of us. When we are involved we have good and positive feedback.

All service users and carers involved receive training for the roles, this means that we get a better understanding of life and how people see things differently. It helps you get a better view on getting people well and improving life in hospital and outside.

## Final thoughts

We would both like to thank all the staff, service users and carers that have supported with the work. We have been coming together, building therapeutic relationships and learning new skills.

*Anthony:* One male staff member in particular has helped me so much I am now able to talk to other males which was an issue before. He spent a lot of time with me, helping me get to groups and noticing any changes in me. If this hadn't happened then I would not have got through this.

Staff are so important to support co-production, without having staff on board then none of this would have been possible. Thank you Fromeside and Wickham staff.

## Anthony B, Service User & Luisa Suarez, Involvement Coordinator, Fromeside and Wickham Unit



## **Perspectives of Training and Support from Staff Members/ Staff Support and Wellbeing Initiatives**

### **Ward staff experiences of group supervision**

The Care Quality Commission (2013) suggests that clinical supervision gives staff an opportunity to reflect on their practice, discuss cases, identify and make changes necessary to provide care and support in line with best practice. The benefits of creating space for reflection and learning for staff, service users and service providers has been noted in the research. As a women's blended secure service (WBSS), it is essential for staff to access appropriate and timely supervision. It is also vital for staff to have the opportunity to contribute to the development of supervision practices within the service, to ensure staff members are supported in accordance with their needs and in line with best practice.

### **So what did we do about this?**

In early 2019, a member of the psychology team developed a service evaluation project titled '*ward staff experiences of psychology facilitated communication and learning in practice (CLIP) supervision groups*'. The overall aim of the service evaluation was to improve the supervision sessions within Ardenleigh Women's Service, delivered by the psychology department for ward staff. Upon development, the following objectives were established:

- To gain an understanding of staff experience of engaging in the psychology facilitated CLIP supervision groups and to identify any barriers to attendance/engagement, with a view to inform future group planning/development
- To provide staff with an opportunity to present feedback on their experience of participating in the psychology facilitated CLIP supervision groups
- To facilitate and promote collaborative working practices

Three focus groups facilitated by two members of the psychology team were undertaken with ward staff across the three wards within

Ardenleigh women's service (2 acute in-patient and 1 rehabilitation). The focus groups were carried out using semi-structured interviews, with open ended questions enabling staff the opportunity to respond as broadly as possible.

### **What did we find?**

A number of broad themes emerged from the focus groups:

#### What staff found helpful:

- Opportunities to broaden views regarding service user needs/behaviours
- Being able to offload and share difficult experiences and challenges
- Shared formulation/making links and gaining deeper understanding
- Getting to know members of the psychology team and gaining an understanding of what they do
- Being able to have time to stop and think

#### What staff found unhelpful:

- Communication issues re the timing/content/facilitating of sessions
- Lack of structure to sessions

#### Barriers to attendance/engagement:

- Confidence issues – can prevent staff contributing
- Staff feeling they may be blamed/targeted by others for sharing
- Frustration – what's the point in going/saying anything? Nothing changes
- Timing/day of CLIP group means some staff unlikely to attend due to shifts
- Some staff unaware of the group/not invited to attend

### **Going forward**

The CLIP groups are currently being reviewed, and this service evaluation is contributing specifically, to the development of the psychology facilitated CLIP supervision sessions and the new programme beginning in September 2019. Structural changes to the delivery of the sessions have been incorporated to widen access, with supervision sessions scheduled for delivery at various

times on different days of the week. This has necessitated more active communication to teams to ensure staff, are aware when and where groups can be accessed and additional support from the wider service, in order to ensure wards, remain adequately staffed while the supervision sessions occur. Facilitators will have prepared material and have formulation

tasks available but remain responsive to the needs of the group on the day, allowing space to reflect on and share experiences as well as to work together to develop understanding of the women admitted to the service.

**Donna Doherty, Forensic and Clinical Psychologist in Training, Ardenleigh**

## *Swansea Bay Health Board*

### **Development of a Bespoke Module Highlighting Contemporary Issues in Forensic Health Care**

The complexity and challenges of working in this field of mental health nursing is well recognised and as such, our organisation has always worked hard to provide suitable and accessible training and development for all of its staff. After we became a fully commissioned service from 2004, it became evident that our Band 5 staff nurses required ongoing access to specialised training and development, in effect focusing on work based learning, to empower our colleagues to provide safe and effective care in challenging conditions.

Throughout monthly CPD meetings it was agreed that we would commission an in house staff nurse development course. This course was designed to run along similar lines to stand alone university modules, but the focus would be on identifying and developing clinical based skills, with sessions being facilitated by expert staff. These sessions included effective report writing, improving the role of a primary nurse, effective communication skills etc. This model of training was planned to be repeated on a yearly basis in order to support the development of our workforce.

In 2008 due to a boundary change, a new health board was created, ABMU, which immediately included alignment to Swansea University for academic support and access. In time communication and networking across our sites developed and we sought the help of Swansea University in developing our staff nurse development course into an academically supported module. Thus the contemporary issues in forensic nursing module was developed.

The module has evolved every year, it

wouldn't be contemporary otherwise, and in 2016 we changed the title to that of contemporary issues in forensic health care, dropping nursing from the title. This allowed our qualified Allied Health Professional colleagues to be eligible for attendance to the course, providing essential multi-disciplinary discussion and learning.

Apart from ensuring the clinical content remains relevant, we have also looked at how formative and summative work is used to work towards academic success. Candidates are required to complete an academic essay based upon the current care of a patient in their areas, adhering to NMC and associated codes of conduct regarding confidentiality and patient anonymity, alongside having to produce and deliver a 10 minute presentation or lead a discussion on one care intervention aimed at promoting patient safety. There have been some remarkable projects developed which as an organisation we are using to improve areas of care. A recent example is how we can better use our shift handovers to improve patient care and safety.

Since inception, the course has been hosted and facilitated by staff from both Caswell Clinic and Swansea University. This allows some learning to be based in the actual clinical environments with access to specialist nurses for clinical support and via the university campus allowing access to academic support. We have also agreed that the module can be undertaken academically at both Level 6 and Level 7. This supports ongoing professional development for our registrants and the academic credits can be used towards a full qualification with Swansea University if required.

To date, we have had staff from a multitude of work areas attend, medium and low secure forensic units, prison in-reach teams, community and locked rehabilitation wards from both ABMU and other health boards.

The feedback continues to be positive and we

strive to take on board suggestions for content and context wherever possible as we have a continued passion to deliver the very best in academic theory whilst upskilling our staff and colleagues in necessary requirements to work effectively, safely and always in a patient centred way.

**Student feedback from 2019 module:**

*What aspect of the module did you find most effective?*

- Risk assessment training, substance misuse, aggression and challenging behaviour.
- I enjoyed the content of the course and found each topic very stimulating.

- Looking at offending behaviour and CBT. This has been helpful in understanding patient's behaviour better in my every day work.
- I particularly enjoyed and found intellectually stimulating the open discussions about contemporary issues. I found lecturers were approachable, knowledgeable and offer continuous support.
- Through this course I have recognised my own strengths in practice and areas for improvement and development.

**John Griffiths, Lecturer Practitioner, Caswell Clinic**

*Elysium Healthcare*

**Assuring Staff Consistency and the Provision of Quality Services:  
Competence Based 'Bite-size Training' in Positive Behaviour Support and Functional Communication**



One of the biggest barriers is consistency in the implementation of complex communication and behaviour support plans in secure settings. Challenges to this include; clinician to front-line staff ratio, case loads of qualified staff, releasing staff for training and training not being personalised to the individual. Plans are often technically well written but fail to make a difference as staff don't get a chance to read them or explore how they practically work, with opportunities to ask questions in a safe space and often staff have not seen the plans in practice.

This dilemma prompted the introduction of weekly bite-size trainings that were held on the ward focusing on individual plans or parts of plans that required targeted training led by the primary clinician.

In practice, this was a small group training

session of four to five people in thirty-minute blocks, held over two hours every Friday. In order to release front line staff from their observations to attend the training, senior managers and off-ward clinicians would support on the ward.

The format of the sessions would begin with clinicians talking through the plan. Staff would then role play the interactions. This helped them to get used to the plan, problem solve and address any concerns they had around implementing this with the individual and then be assessed in practice. This is an evidence/competency-based training approach that increases effective implementation of plans.

Staff feedback was very positive, and staff felt more confident and involved in implementing complex behaviour/communication plans. Adherence checks following training improved by 44% within a one month follow up.

In conclusion, this competency-based training supplemented mandatory generic training packages currently provided in PBS and communication. The training was unique in that it was provided in the natural environment and allowed staff to explore the plan in detail. Focusing on individual outcomes and providing different ways to think about the plan in terms of verbal, model and implementation, meant it captured all the learning needs/styles of frontline staff.

**Laura Higgins, Board Certified Behaviour Analyst and Ward Manager and Charlotte Litherland, Lead Speech and Language Therapist, St Mary's Hospital**

## **The Delivery of Professional Boundary Training within the Tamarind Centre**

The boundary training that we carry out at the Tamarind is based on one element of relational security as set out in the See, Think, Act booklet (2<sup>nd</sup> edition).

### **Context**

We have an increasing number of service users with personality disorder and challenging behaviour in our service. This can cause significant anxiety, stress, and splitting among staff. Service users spend a long time in our care and this can result in inappropriate relationships developing between staff and service users. Therefore, by carrying out boundary training with staff we are able to support the nursing team in providing the best care for our service users. These boundary breaches have also undermined wider nursing team's confidence and morale.

We found that boundary breaches can occur by all grades and disciplines of staff working in our services. Therefore, the training was offered to all staff groups including domestics and estate staff. The training was delivered at a level which enabled the entire staff group to see how it related to them. Examples of potential or actual boundary breaches were used to highlight that these issues can affect all disciplines. The training also gave nursing staff an opportunity to discuss possible sensitive issues around boundaries in a safe open environment, sharing experiences and discussing challenges.

### **Contents of the training**

A brief overview of relational security was given. This was used as a means of introducing the main boundary training elements. We invited the group to consider the expectation of a professional relationship in comparison to the relationship between friends. This is a very useful way of getting the staff to think about their interaction with service users. The limits to the relationship, rules that govern and the power imbalances between staff and service-users were also explored.

Other areas the training considered were boundary crossing and boundary violations. Examples of these occurring in daily work was

discussed and analysed. Case examples were found to be a useful method of explaining these areas.

Next, we discussed the elements of boundaries as outlined in the See, Think, Act booklet. Group participation was encouraged which generated a lively conversation. The conversations raised issues around confidence in speaking up when someone observes boundary breaches. This may be to the individual concerned, the ward manager or at staff meetings. The reason for speaking up is to keep staff and service users safe and not to get people in trouble.

The training also addresses sexual boundaries. Case examples that featured in national and local news involving real life healthcare workers were explored. The experience of staff and service-users anxieties were discussed. Possible signs of sexual attraction towards service-users and sexualised behaviour in healthcare professional were explored. This section generated an increased level of debate and concern by attendees.

The steps to be taken when sexualised boundaries becomes a cause for concern were highlighted. The need for proper supervision and reflective practice sessions were emphasised.

The training then concentrated on the Boundary Seesaw model (Hamilton 2010). Scenarios and work-related examples were used to expand on and explain the model.

The session recapped the elements involved in boundary breaches and how staff can reduce or eliminate areas of concerns. This can be achieved by staff teams having reflective practice and staff meetings to discuss their concerns. The relevance to the service was highlighted with suggestions from the attendees. Areas identified included staff supporting each other, creating a culture of openness, and being on guard for team splitting or isolation of members. Areas of work involving the service-users identified the benefit of including the use of therapeutic contracts, thus allowing boundary crossing to be raised and discussed. The need for consistency and agreeing a shared and unified response was highlighted along with the importance of developing a formulation of boundary breaches to contribute to care planning and risk management.

Staff were asked to complete an evaluation form at the end of the session. Feedback has

shown that attendees find case studies and group discussions very helpful and feel team-based refreshers would be beneficial.

**Patrick Bennett, Advanced Nurse Practitioner for ICU & Dawn Sutherland Advanced Nurse Practitioner, Carer Involvement Lead, Tamarind Centre.**

## *Northumberland, Tyne and Wear Foundation NHS Trust*

### **An Exemplar of Service Specific CPD: The Oswin Unit Medium Secure Offender Personality Disorder Service**

#### **About our service**

The Oswin Unit is a medium secure ward co-commissioned by NHS England and HM Prison & Probation Service (HMPPS) as part of the Offender Personality Disorder (OPD) pathway; a partnership provision of services to broadly improve the psychological well-being of individuals sentenced for offences and reduce risks associated with serious violent or sexual offending. Our service model is underpinned by provision of a psychologically-informed environment, which in summation addresses:

- The need for a strong value base to inform relational work with service users.
- Awareness of the psychological and emotional needs of service users on the OPD pathway.
- Development of structured and evidence-derived psychological practices to explore the complex treatment needs, risks and related personality difficulties (PD) of our service users.

From an organisational level, implementation of the service model requires investment and support of our staff team, of which Continued Professional Development (CPD) is crucial to ensuring essential core skills, understanding and motivation within our multi-disciplinary team (MDT).

#### **Training needs and planning**

We complete a service-specific annual training needs plan using information within a thematic analysis from a range of stakeholders, including service users, our MDT, senior managers and national commissioning standards. Three levels of

training needs were identified; core, enhanced and specialist. Some of the emergent clinical themes were also relevant across secure care services, enabling us to integrate core knowledge and skills into a wider CPD programme. It was hypothesised that the Bamburgh CPD programme would meet the following service-specific aims:

1. To deliver accessible, core knowledge and skills directly linked to clinical practice by a wider range of MDT specialists.
2. To ensure all staff working into PD services, including those cross deployed, have a fundamental understanding of the service user group.
3. To enable the Oswin Unit to focus resources on developing a complimentary service specific programme of training relating to our service model and with our OPD pathway partners (HMPPS), while increasing enhanced and specialist training.

#### **Developing a service specific programme**

In developing a service-specific model of training, we initially devised a graded/stepped programme underpinned by core skills and knowledge, and which would provide our staff continued opportunities to enhance their clinical skills within PD.

#### **Feedback and reflections**

A clear positive outcome of the developing training package is the structure and increased accessibility for staff of all grades and disciplines. With core skills training now firmly embedded within the Bamburgh CPD programme, we have had the capacity to adapt our established modular programme to focus on enhanced exploration and relationally working with PD. Furthermore, we have recently added structured clinical management (SCM) to our model to increase staff confidence and competence within their key worker sessions (Level 2: Enhanced Skills) in a joint training enterprise with our OPD partnerships based in community and prison-based services.

Concurrent to the Bamburgh CPD programme, our evaluation strategy gathers both

qualitative and quantitative feedback on training quality. Evaluations have been positively linked with the clinical relevance, to our service model and we are further developing our methods to ensure the efficacy of training is impacting on clinical practice and used in job planning through follow-up evaluation. We will continue to utilise feedback within our annual training needs analyses to determine what themes and service-specific CPD areas are important to invest in within our team.

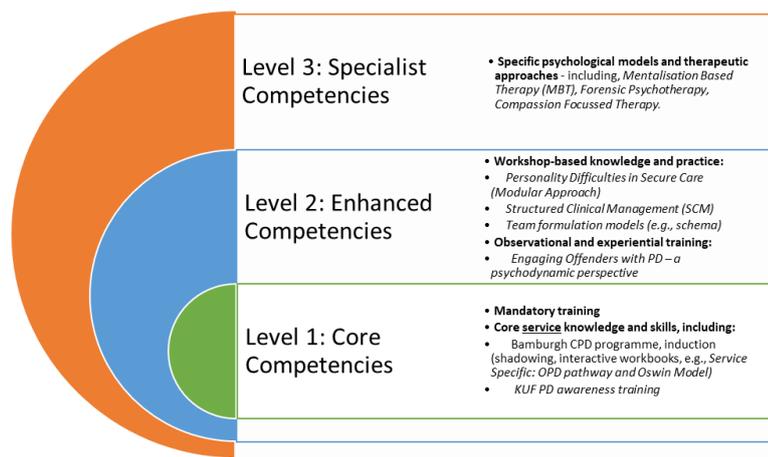
### Next steps

We are currently developing an enhanced induction programme, to fit with the learning needs of new staff to the ward, to increase co-production/co-delivered training provision with our service users and to increase accessibility. This will include a series of workbooks providing both an educational resource that can be consulted while working on the ward and which highlights the main

competencies required in staff working on to the ward through a series of exercises and activities to be completed at an individual's pace. Similar to the Bamburgh CPD programme, clinical supervision and reflective practice are central features with exercises embedding learning through experience and testing out these features within clinical practice.

We are also developing our experiential learning opportunities, using peer supervision and mentoring through cross-discipline working and through utilising a group observation model of one of our core interventions (Reflective Understanding of Personality Difficulties and Offending Risk, RUPDOR) to consolidate knowledge gained through our modular programme.

**Dr Rachel Woodward, Clinical Psychologist, Bamburgh Clinic**



## Greater Manchester Mental Health NHS Foundation Trust

### Staff Training and Support

#### Introduction

The adult forensic service (AFS) within Greater Manchester Mental Health NHS Foundation Trust comprises of medium (Edenfield Centre) and low (The Lowry Unit) secure care for 226 service users. The medium secure service houses the recovery academy Edenfield campus (RAEC) and it has been operational in its current form for over three years. The RAEC is affiliated to the Trusts recovery academy and is accessible for all service users within AFS.

The RAEC have a monthly commitment to provide an induction session at the Edenfield Centre. The session provides staff training and support to new starters as part of the service induction. The aim of the session is to promote the RAEC and highlight the 'service users' perspective of their experiences living within a medium secure setting. The session also highlights the importance of service user engagement.

In these sessions, the RAEC team promotes the importance of supporting service users through their individual recovery journeys. The RAEC team promote the Trust recovery academy and their prospectus. In recognition of the specific needs of the service users, the RAEC prospectus focuses on sessions for

service users without leave.

The RAEC team also promotes sessions aimed at AFS service users. Copies of the prospectus are handed out and sessions within the weekly programme, that are available to all service users, staff and students, are highlighted. An explanation is given about how the sessions have been developed and facilitated in collaboration with service users, highlighting the lived experience of the service users in secure care.

Everyone is welcome to attend the RAEC, share experiences and learn from each other. This relaxed approach allows service users to be themselves and provides the opportunity for staff and service users to build therapeutic relationships. The aim is to work together to gain knowledge and skills that will equip service users to prepare for their life beyond secure services.

Within the induction session, four topics are covered.

- What it is like being here
- What makes a good member of staff
- Patients engaging within recovery
- Preparation for discharge, aftercare and moving on

These sessions represent the views that the service users have shared within RAEC sessions, focus groups and denote key messages to staff to help them understand what it is like to be a service user in a secure care setting. Service users present this themselves or feature in a video talking about their experiences.

Staff are encouraged to ask questions throughout the discussion and once again at the end of the session to provide the opportunity for further learning and to also provide feedback about what they have learned about the RAEC and a service user's perspective of their experiences within a medium secure setting.

This session is supported by a facilitator from the independent mental health advocacy service who also play an important role in highlighting the importance of all staff understanding service user's experiences and points of view.

The staff attendees are required to complete an evaluation of each session on the induction programme. The session on the service user's perspective consistently receives a high satisfaction rating from participants which is positive feedback for RAEC staff and the service users involved.

**Michele Morgan, Programme Facilitator,  
Recovery Academy Edenfield Centre**

## *Swansea Bay Health Board*

### **Implementing Sexual Health Training**

Working with sexual behaviours that challenge (SBC's) is common within forensic mental health (Hughes & Hebb, 2005). The impact on staff working with service users that display such behaviours can be distressing, disruptive and disturbing (Stubbs, 2011). Clinical experience has taught us that people who display SBCs within healthcare institutions do not always have previous sexual convictions. Burnout rates in professionals caring for and treating sexual offenders ranges from 29% (Edmunds, 1997) to 80% (Bengis, 1997). Recent studies however, have revealed low levels of vicarious trauma and low to moderate levels of burnout (Hatcher & Noakes, 2010).

There have been numerous suggestions to reduce the impact of working with individuals that display SBCs. These include cultural change through training staff about sexuality and SBCs, encouraging staff to question their own views, and to consider the impact that their beliefs, attitudes and experiences of sexuality and SBC's could have on their work (Heywood, 2009). Recommendations also include reflective spaces such as supervision to support practice.

In 2015 a sexual health forum was established within Caswell Clinic. The aim was to develop a care pathway based on a positive, strengths based approach for sexual violence risk. Considering the literature, a service evaluation was undertaken to explore staff perceptions of sexual offending and SBCs across the clinic. Of the findings from the survey, there was a desire from the staff to receive training in this area.

A training package was developed that aimed to:

- Raise awareness of attachment
- Reflect on 'healthy' sexual development
- Introduce models of sexual offending
- Consider what practices exist in Caswell Clinic to assess and manage sexual harm

The training explored healthy sexual development in an attachment context. We encouraged staff to reflect on normative sexual development/behaviour within our culture and how the secure environment impacts this; as sexual expression/relationships are often blocked or limited. We asked staff to think about a person they have/were currently working with to consider their sexual development and attachment histories, and how this may have influenced their relationships/sexual behaviours.

The training then introduced Finkelhor's model (1984), Ward and Siegert's pathways model (2002) and the Good Lives Model (Ward and Brown, 2004). We encouraged staff to formulate the same individual's sexual offending/behaviours using one of these models. Whilst we recognised that the Finkelhor model is increasingly obsolete, the model fits with some of the perceptions and intuitive models that staff described in our initial survey. By starting with Finkelhor, we were then able to guide staff to thinking more in terms of more recent developmental and strengths based models.

We then went on to outline how sexual violence is predicted using actuarial tools, such as the Risk Matrix 2000 (2000) and how structured professional judgement tools such as the Risk of Sexual Violence Protocol (2003) are used to formulate sexual risk. We then introduced risk management planning. When discussing treatments/ interventions,

there was an emphasis on the treatment needs addressed through the wide-ranging multi-disciplinary interventions offered at the clinic, in contrast to sex offender treatment programmes in prison, and the rationale for our individually focused approaches.

The final part of the training focused on the challenges of working with this population. We asked people to reflect on the personal impact and the personal resources they draw upon; with signposting to safe spaces to discuss this (i.e. supervision, reflective practice).

We have delivered this training to members of staff that were identified as sexual health champions'. These people were the link between the wards and the sexual health forum for whom other members of staff could approach with queries about sexual health across the spectrum and spread knowledge through clinical teams. The training has also become part of the forensic mental health module delivered at Swansea University. We have adapted the training to use as part of the handover of a patient who was stepping down to a community placement where the receiving team was keen to have training in sexual offending. The training has been delivered to a cohort of trainee clinical psychologists, where we encouraged them to think more broadly about sexual health within the various contexts they were placed. The feedback from this training has, overall, been very positive. The impact of this training within our service is currently being evaluated through a repeated sexual health survey. It is hoped that knowledge of sexual health from development through to sexual offending would have improved, and that myths have been dispelled.

**Dr Sara Morgan, Dr Leigh Gale & Dr Ruth Bagshaw, Clinical Psychologists, Caswell Clinic**

**Do you have an area of good practice you would like to share with other secure services?**

If you would like to contribute to the next edition of the QNFMHS newsletter, head to our website for more information and future themes for newsletters.

[www.qnfmhs.co.uk](http://www.qnfmhs.co.uk)

## Avon & Wiltshire Mental Health Partnership Trust

### Group Supervision for Ward-Based Staff in Fromeside and Wickham, AWP Secure Services

A group supervision pilot was set up by two arts psychotherapists working within AWP secure services from September 2017 to July 2018. Reflective practice had been offered previously by the psychology and arts psychotherapies teams in both units and was co-ordinated by the principal psychotherapist. When this psychotherapist was relocated to another unit this provision was difficult to maintain consistently across the service and was impacted further by falling attendance in the sessions.

QNFMHS states in the Standards for Forensic Mental Health Services: Low and Medium Secure Care (2019) that:

*'All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body'* (Standard 112, p.30).

*'All staff members have access to monthly formal reflective practice sessions. Guidance: This forum provides staff members with the opportunity to reflect on their own actions and the actions of others. It can also be used to discuss concerns and issues of relational security. Reflection is a conscious effort to think about an activity or incident that allows the individual and/or group to consider what was positive or challenging, and if appropriate, plan how it might be enhanced, improved or done differently in the future'* (Standard 124, p.30).

The pilot was devised to deliver these requirements.

The aim of the pilot was to apply the central elements of supervision: learning, reflection and support to promote confidence in proactive reflection. This approach works to build open communication encouraging individuals to contribute to group discussion. The intention is that teams become a resource of ideas and experience for each other in terms of their clinical practice.

Short questionnaires were given to both supervisors and supervisees to evaluate the pilot and it was evident, that the service was valued by the staff attending group supervision.

In the qualitative feedback from the supervisees some of the comments were:

'[Group Supervision] is a brilliant way to talk about problems and situations [in the clinical work]'

'Very helpful during difficult times on the ward'

'A valuable resource'

'Helpful to discuss things as a team'

'[Group Supervision] is vital to feel better and empathise with others'

'Promotes team work and decision making'

'Empowers everyone'

Supervisors' feedback included:

'Regular attendance deepened understanding of the role of the supervisor - understanding [that] the supervisor facilitates an open and safe space to explore and process thoughts and feelings around the impact of their work'

'Staff grasped the notion of it being a serious forum to discuss work, outside of informal conversation with colleagues'

Phase two of the group supervision staff support service began in January 2019 to all wards in Fromeside Medium Secure Unit and Wickham Low Secure Unit, running until October 2019

Group supervision covers ten wards and is facilitated by experienced MDT clinical staff and consists of: senior nursing practitioners, arts psychotherapists, psychologists, occupational therapists and medics. The criteria for being a Supervisor is committing to completing the duration of each phase of group supervision, band 6 or above and committing to attending monthly supervision-for-supervisors meeting. A brief training is provided for Supervisors focusing on the supervisors' understanding of the theory of the unconscious and the parallel process, their understanding of learning in supervision and their willingness to engage in honest questioning of personal beliefs and

prejudices. Gibb's 'reflective cycle' and Hawkins and Shoheit's 'seven eyed supervision model' were also offered as theoretical frameworks for the supervisors to refer to. The training also looked at setting up a supervision contract and keeping supervision records.

Each supervisor takes responsibility for setting up group supervision on the ward they supervise and meet with the ward manager and the staff to arrange the day of the group supervision. The supervisor and ward manager prepare a contract including a date to review group supervision three months after the start date. Group supervision is offered at the time of afternoon handover 2.00 – 3.00pm, to enable more staff to attend and allow cover.

Group supervision is coordinated by two Arts Psychotherapists. They oversee the provision of group supervision across the service, liaise with senior management and facilitate the

monthly supervision-for-supervisors meeting.

The group supervision intervention works to maintain and improve interest and curiosity in our working practice and support all staff in providing a thoughtful and empathic service. This is indicated in the NHS Workforce Health and Wellbeing Framework (2018).

*'Investments and wellbeing programmes should improve both the local work culture and the wider organisation's performance...'* (Understanding staff wellbeing, its impact on patient experience and healthcare quality, Picker Institute, 2015).

**Cathy Goodwin, Dramatherapist & Tristram Cox, Lead for Arts Psychotherapies, Fromeside and Wickham Unit**

## Birmingham and Solihull Mental Health Trust

### Staff Training and Support When Developing a Trauma-Informed Service

Within forensic services the prevalence of trauma is high. In one study 91% of women in a forensic facility reported experiencing both child and adult trauma (Karatzias et al, 2018).

Increasing evidence suggests significant social, emotional and health consequences on the direct victim of trauma (Brennan, Bush, Trickey, Levene & Watsona; adversity and trauma-informed practice, a short guide for professionals working on the frontline).

A secondary, and possibly more overlooked, consequence of trauma is that of vicarious trauma. Vicarious trauma is when helpers (people involved in the support of service users) 'take on the clients trauma', affecting services and those working within these systems. Vicarious Trauma leaves people to feel burnt out, helpless, shamed and emotionally exhausted (Bennett, 2017). Consequently, understanding trauma and meeting the needs that trauma presents is a priority for service development, with staff training and support at the forefront.

### What is a trauma-informed care model (TICM) and how might it apply to staff?

A trauma-informed care model (TICM) discussed in the last issue, considers the impact of trauma and incorporates this thinking in all aspects of the service. A TICM moves the focus from symptoms or risk behaviours associated with trauma, towards healing the trauma history behind the behaviour.

An essential component of trauma-informed settings is that they implement the values of trauma-informed services in relation to staff members as well as to the people they serve. It is unrealistic to expect staff members to employ these values in their work if this does not occur (Fallot & Harris, 2006).

Thus, the key principles in trauma-informed care apply to staff too:

<b>Safety</b>	<ul style="list-style-type: none"> <li>• People who have suffered physical or emotional trauma are often hyper aware of possible danger</li> <li>• Hospital environments can remind people of previous risk scenarios</li> <li>• Safety in the workplace, is opposite to danger</li> </ul>
<b>Choice</b>	<ul style="list-style-type: none"> <li>• Trauma can prompt powerlessness and lack of choice as a result of on-going threat</li> <li>• When choice is taken away anyone could believe their needs are not important</li> <li>• Choice is the opposite to coercion</li> </ul>
<b>Empowerment</b>	<ul style="list-style-type: none"> <li>• Trauma can lead to feelings of helplessness</li> <li>• Empowerment involves helping and encouraging people to do what they can for themselves, being active and involved in service design.</li> <li>• Empowerment is the opposite of helplessness</li> </ul>
<b>Trust</b>	<ul style="list-style-type: none"> <li>• People who have been harmed are likely to find it hard to trust others</li> <li>• Recovery involves providing relationships that are safe</li> <li>• This service values honesty and openness, communicating decision making</li> </ul>
<b>Collaboration</b>	<ul style="list-style-type: none"> <li>• Traumatised individuals have likely experienced relationships where they have been "done to".</li> <li>• Collaboration involves working together where ever we can.</li> </ul>

## What are the benefits to staff of using a Trauma informed care model?

- Creating a proactive approach to safety
- Creating safer physical and emotional environments for all
- Reducing the possibility of re-traumatization or triggering
- Creating environments that care for and support staff
- Increasing the quality of services, reducing unnecessary interventions, reducing costs
- Reducing the number and types of negative encounters and events
- Reducing aggression towards staff

## What are we doing to support staff?

- We aim to offer 100% of staff training in trauma-informed care principles. This includes a tiered approach of bespoke face-to-face training and development of an online training package. Learning objectives include:
  - ◇ To understand what a trauma-informed environment is and why adopting a trauma-informed approach is appropriate in health services.
  - ◇ To understand the impact of trauma.
  - ◇ To develop a vision of what being trauma-informed might look like.
  - ◇ To explore how to practically implement a trauma-informed approach.
  - ◇ To understand what secondary or vicarious trauma is and to explore strategies for self-care.
  - ◇ To have clear signposts for support available both from the Trust and externally if traumatic experiences have occurred directly or vicariously in the workplace.
- Service users have been part of the development of this training and have contributed some art work to depict their experience of trauma and its impact (please see figure 1)
- Staff group supervisions have been evaluated and redesigned incorporating staff choice and preferences.
- A tiered group debrief model is designed to promote the recovery of individuals to mitigate stress-related responses to incidents and prevent potential long-term

effects.

- TRiM training is occurring in the Trust with representatives from this service attending.

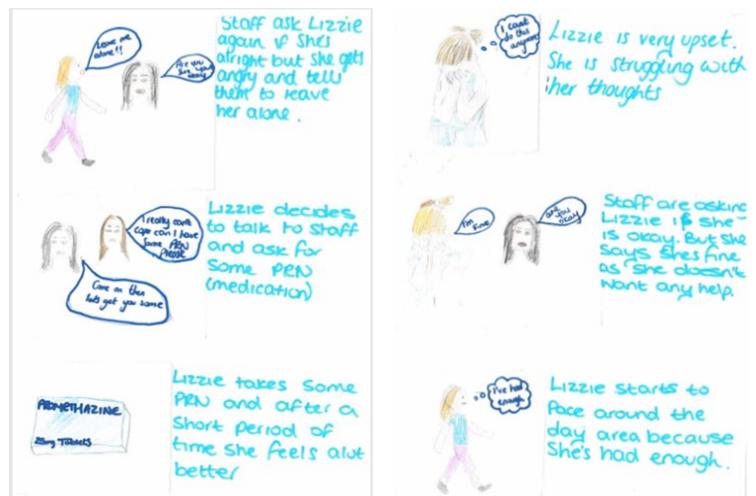


Figure 1

TRiM is a trauma-focused peer support system that focuses on providing advice and support to staff following a potentially traumatic event, identifying staff who may be struggling, accessing further support for staff as required, and ensuring the organisation is better prepared to fulfil its duty of care to staff in relation to the challenges they face in fulfilling their roles at work.

## What we anticipate?

As a service, we routinely monitor changes of ward environment with use of the EssenCES. We hope this will indicate the TICM and training will create a yet safer environment for service users and staff; with an emphasis on empowerment, least restrictive practice and person-centered care. We hope to monitor burnout and absence levels as staff complete training and revised supervision structures take hold. We hope these values, in relation to all our staff as well as the women admitted to the service, helps improve job satisfaction and improve staff retention rates. Other service evaluations are underway, as a pilot blended secure service, we shall also be monitored externally, including qualitative interviews of staff to monitor the impact these changes have.

**Katrina Chapman, Specialist Psychological Practitioner & Dr Ruth Fountain, Clinical Psychologist, Ardenleigh Women's Blended Secure Service**

## **Developing a Continued Professional Development (CPD) Programme for Staff within Secure Care Services**

Continued Professional Development (CPD) is an integral task in developing staff skill and knowledge in line with evidence-based practice and is essential for enhancing competence, confidence and commitment to work within a service. More so, it is an investment in the on-going workforce and is a major influencing factor in retaining valuable members of staff. In addition, all health regulation authorities for clinical staff endorse CPD as a requirement for registration and continued clinical practice.

### **Our previous programme**

For a number of years, our service has held protected CPD time for staff across the clinic, the content of which was largely based on requests or ideas from staff. However, over time the content became more reactive than strategic, and often served the purpose of being an opportunity, to meet statutory and mandatory training needs rather than developing staff knowledge, skill and interest in subjects that felt more clinically relevant and so, consequently attendance declined.

### **The new Bamburgh Clinic CPD programme**

We were keen to develop a CPD programme that felt more responsive to emergent clinical themes across our service and that would be offered in a more planned way so that staff would know in advance when particular sessions were planned and, therefore, make arrangements to attend. As part of NTW NHS Foundation Trust's, and specifically secure care services, commitment to staff CPD, our aim was to promote a reflective, outcome-based approach to CPD that enhances staff capacity to evaluate their learning and its application to their clinical work to benefit the individual, teams and ultimately our service users. We also aimed to place reflective practice and clinical supervision at the heart of quality care by ensuring all training could be utilised clinically and then reflectively within individual or team based supervisory forums.

### **Programme content**

The sessions were planned across three clinically relevant themes based upon the knowledge and skills that staff and teams

would need to have to enable them to provide safe, purposeful and well-led services.

The three themes are as follows:

#### **Clinical Presentations**

•Sessions aimed at ensuring our service users are understood and the complexity of their needs are at the forefront of our service delivery.

#### **Relational Thinking**

•Sessions which focused on enhancing principles of relational security, understanding therapeutic relationships and using the notion of 'every interaction is an intervention'.

#### **Looking After Ourselves**

•Sessions which explored how the system looks after itself to ensure quality care. This would include staff support, well-being and a focus on whole system working.

While there are three overarching themes within the CPD programme, each theme is made up of four distinct sessions. While staff are encouraged to attend as many CPD sessions as they can, there are no requirements to attend other sessions within that theme, ensuring a level of flexibility that encourages continued attendance. By developing the timetable of sessions on a rolling programme across the whole year, line managers and staff could link attendance at CPD sessions to developmental objectives identified in individual staff appraisal processes. The programme also retains space for service specific CPD sessions which might be arranged within particular clinical areas or professional groups depending upon need, an example of which is outlined in the article on page 24 'An Exemplar of Service Specific CPD: The Oswin Unit Medium Secure Offender Personality Disorder Service'.

A major consideration in developing the themes and content of individual sessions was to ensure the clinical relevance across a range of different professional backgrounds. This included consulting staff from different disciplines and teams and encouraging session facilitation by specialists in those disciplines.

### **Feedback and Reflections**

An evaluation strategy was devised prior to the programme roll out to enable us to gain both qualitative and quantitative feedback on session quality and clinical relevance. Furthermore, we feedback attendance figures to each ward to encourage individual teams to consider what enables and prevents their staff members from attending. Thus far, session evaluations have been positive and managerial support has increased staff attendance. We

are currently developing further evaluation methods to include the efficacy of training is being brought into clinical practice and in job planning.

At the end of this year the third wave of sessions will have come to an end. We will complete a further training needs analysis to determine what themes and CPD areas

continue to feel important to staff across the clinic. We would also like to look for ways for service users to be more involved in the development and facilitation of sessions.

**Dr Helen Clothier, Consultant Clinical Psychologist & Dr Rachel Woodward, Clinical Psychologist, Bamburgh Clinic**

## *Riverside Healthcare Ltd*

### **Involvement of Patients in Delivering Staff Training**

At Cheswold Park Hospital (CPH) over the last 2 years we have been looking at ways that we can incorporate involving patients within the hospital induction process. The idea behind this was to involve patients as soon as possible in meeting the new employees at CPH, but also helping the inductees to put their minds at ease, as many new starters are now younger people entering the care profession with little knowledge or understanding around forensic services.

By involving patients during their first couple of days of employment, on the induction process in an off ward environment, this would hopefully help the new starters understand and realise what these patients, can achieve with correct support and care within this setting.

Prior to patients being given the job of tour guides, the learning and development department (L&D) took time out of their job to go through what is expected of the patients whilst carrying out this task. We walk through the tour with them offering advice around areas of discussion, highlighting areas within the hospital where patients and staff work collaboratively together, to provide a better healthy environment for all.

We have four patients currently from different pathways across the hospital who take it in turns to be the tour guides during the induction programmes. If we have a large group on induction these will be split into two groups and we will involve two patients on one induction.

On the first day the new starters are shown around the hospital the patients take great care in their appearance and pride in what they are doing whilst undertaking this role. We supply them with identification badges with the title of hospital tour guide on, so

everyone knows who they are and the role they are undertaking. They are supported by the L&D team during the whole process, and they will openly ask the new starters to ask questions as the tour is taking place. They will take the inductees into different rooms within the hospital and on occasions will ask if some sessions are taking place or rooms have staff in whether they can come in and talk and involve other patients and staff in the tour.

Another session on the induction in which we involve patients is, on the delivery of therapeutic observations. We have two patients who were members of the committee that sat on the reducing restrictive practice group at CPH who have had a big input into the development of the therapeutic observations policy. The patients take it in turns to deliver their own designed PowerPoint presentation to the new starters, talking about the different levels of observations, how observation can be reduced or increased and talk about their own life experiences around the different levels and how different it is in relation to carrying out observations during the day compared to the night in relation to the inconvenience and disruptions in sleep patterns. These patients are also open to questions being asked and again supported by a member of the L&D team during the session.

The new starters are given feedback forms to fill in around the sessions delivered by the patients. One patient is close to being discharged from section, and is applying to be a service user representative on the peer review teams and keeping his feedback forms, as evidence in relation to the work he has carried out whilst at CPH which we think will stand him in good stead going forward.

The next project being undertaken at this moment in time by the L&D team is incorporating a patient to co-deliver the equality & diversity training on induction.

**John Foster, Head of Learning & Development, Cheswold Park Hospital**

## **Supporting Staff via Forensic Staff Nurse Mentorship and Resilience Program**



### **FORENSIC NURSE MENTORSHIP**

TO SUPPORT YOUR GROWTH & WELL-BEING AS A CLINICIAN

•  
Policy & Strategy Awareness  
Peer Support & Networking  
Group Reflective Practice  
Workshop Based Sessions  
•

### **Aims**

In 2014, the forensic services of Greater Manchester Mental Health NHS Trust embarked on a project to implement a forensic mentorship program for newly qualified staff, with a view to contribute to the shaping of a positive and proactive workforce who will use restrictive practice as a last resort (DOH, 2014). Nationally, strategic development of the workforce was deemed a necessary measure in terms of reducing restrictive interventions (DOH, 2014). However locally, amid a multitude of strategies to reduce such interventions, there was limited evidence of work being undertaken locally to support the workforce, or consideration of what specific factors contribute to the likelihood that a restrictive practice would be undertaken.

Literature suggests that problems with staff retention and high staff turnover, impacts on the collective skills (Huckshorn, 2004), and confidence of the workforce (Mental Health Council of Tasmania, 2014). Findings of Powers (1990) and Bowers (2006), also support the notion that high staff turnover leads to a lack of experience in a core staff group. It is also noted that lack of effective leadership and supervision (Thyer, 2003) and

exposure to high levels of workload stress (Clarke, 2013), correlate with high incidence of more restrictive practices and alongside burnout in staff.

### **Development of a program**

A proposal was put forward in 2014 for the service to support a cohort of 4 x 4 hour protected sessions for all band 5 qualified new to forensic services. The content would be based on the evidence base of supporting staff by providing supervision, structured reflection and skills development, to mitigate burn-out and stress using an emotional intelligence model.

Facilitation by members of senior nursing, with experience and inpatient clinical contact as a core element of their roles. Facilitators were also experienced in offering robust clinical supervision, across a range of modalities within a variety of healthcare settings and had an active working interest in developing the nursing workforce to benefit and raise the standards of inpatient care.

### **What the program offered**

*Stress recognition, management and emotional intelligence*

Huckshorn (2004) suggested that high staff turn-over increases perceived stress on staff, and this in turn has been associated with increased use of restrictive practices in health care (Powers et al. 1990; Curran, 2007; Goetz and Taylor-Trujillo, 2012). The content included stress awareness and recognition in self and colleagues, emotional intelligence theory, mindfulness techniques, learning sessions for working with defence mechanisms in complex patients and personality disorder, and group based reflective supervision. The content also placed emphasis on structured table-top exploration of events and situations brought forth by attendees, to benefit from not only self-reflection and appraisal of skills, but for face-to-face discussion with senior clinicians as facilitators and supervisors.

*Access to supervision and reflective time*

Michie and Williams (2003) suggests that levels of psychological ill-health are significantly higher in healthcare workers. The King's Fund (2012) suggested that a stressed workforce had a significant part to play in abusive use of restrictive practice at Winterbourne View. Clarke (2013) and Lolk and Arnetz (1997), suggest access to clinical supervision and reflective space corresponds directly to levels of perceived stress and job

satisfaction in healthcare settings. The program delivered a minimum of one hour peer-based supervision per session. This focused on exposure to several potential models of clinical based supervision and reflective practice to consolidate skills and abilities to reflect, with a view to offering the foundation of embedding this into practice going forwards for the individual attendees.

### Recruitment and retention in mind

Trossman (2002) and Jokelainen et al (2011) suggest that availability of structured post qualification role modelling and mentorship can attract new recruits to a service. Furthermore, Greene and Puetzer (2002), suggest that mentoring and role-modelling opportunities improve staff satisfaction and retention rates. Nursing recruitment drives embraced and advertised the mentorship program to prospective employees, emphasising the contents of the program and the many facets.

### Present day

Present day the program is now running regularly as 3 cohorts per year, coinciding with the main recruitment of staff nurses as our future workforce and leaders. The program continues to receive positive feedback from attendees, managers and service leads and has greatly informed the wider trust approach, to preceptorship support for our largest discipline in the workforce. The current program has also been widened to include secure and non-secure adolescent services staff nurses.

### Where we are now and looking forward

- Working closely with our local Practice development nurse to synthesise and bolster use of reflective practice and supervision, during staff nurse and nurse associate preceptorship.

- Maintain programs responsivity to feedback from cohorts, in terms of planning content.
- Potentially evaluate corresponding measures for attendees and non-attendees, such as retention, sickness, supervision attendance, and job satisfaction.



*Acknowledgments: Lauren Worthington, Senior Nurse, Nicky Stott, Practice Development Nurse, Jonathan Reeve, Advanced Practitioner*

**Sherilyn Magee, Advanced Practitioner, Edenfield Centre**



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information

## *Swansea Bay Health Board*

### **Reflective Practice at the Caswell Clinic: A way of Offering Staff Support, Improved Well-being and Continued Professional Development**

The Caswell Clinic is a 61 bedded medium secure hospital for both male and female patients who have complex mental health needs alongside a history of serious offending. As a result, frontline staff, which are largely from the discipline of nursing, are exposed daily to extremely difficult situations including acute emotional and psychological distress and/or episodes of self-injury or violence/aggression. Challenging working conditions such as these have been shown to have an adverse effect on nursing staffs' wellbeing and lead to increased likelihood of burnout. Therefore, it is essential to safeguard forensic mental health nursing staff from physical harm and/or psychological burnout and one way that the Caswell Clinic aims to do so is through regular ward based reflective practice sessions which were first introduced in 2009.

The reflective sessions themselves are facilitated to nursing staff by members of the psychotherapy co-ordination group which comprises Psychologists, clinical nurse specialists, a nurse practitioner and a senior occupational therapist. The reflective sessions themselves loosely follow Gibbs' reflective cycle (1988) which encourages systemic thinking around a particular event, including any feelings linked to this event, an analysis and evaluation of the event, identification of other options that could have been made available, and an action plan requiring consideration of how/what could be improved next time should the event re-occur once more. Nonetheless, despite this structure, the topics brought for discussion to the reflective sessions are very much the raw, real life lived experiences of the nursing staff involved.

An internal evaluation of staffs' perceptions of reflective practice took place in 2013, whereby semi structured interviews were undertaken with 10 nurses to uncover their ideas in relation to the reflective session offered. The findings of this study revealed that the benefits associated with engaging in reflective sessions identified by the participants included: being able to remain an objective and reflective practitioner, improved decision making and team working, enhanced

communication and a way of obtaining support from peers when needed. A greater awareness of the wards potential 'blind spots' and remaining solution-focused were also identified as a valuable outcome.

Whilst a follow up study to evaluate the effectiveness of reflective practice sessions offered has not yet taken place, it is undoubtedly valued by the service and staff within it and is very much firmly embedded in the culture of the Caswell Clinic. Evidence to support this notion comes from its continued use and recent expansion within the service to include reflective practice/consultation with multi-disciplinary clinical teams whereby they are encouraged to focus on their work with select patients as well as attend to team dynamics. Separate reflective practice sessions for unqualified members of nursing staff were also set up in 2014 in order to support and develop these members of our clinical workforce due to an acknowledgement that such individuals may be less able to attend formal continued professional development programmes as a result of their roles and responsibilities. In addition, informal feedback from nursing staff to facilitators post sessions about learning and increased capacity alongside sustained investment by the wards in terms of promotion and attendance also suggests that the very people who engage in reflective sessions still consider them to be of benefit.

Staff development is ultimately a matter of considerable importance in forensic mental health in order to ensure the safety and highest standards of care delivery to our patients. However, staff wellbeing and resilience is also of vital importance. In our experience, reflective practice therefore offers a way of attending to both in equal proportions through careful examination of the undercurrents that can threaten good practice, undermine staffs' functioning and wellbeing, and prevent staff and service development.

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

## Humber Teaching NHS Foundation Trust

### Foundations in Forensic Care Training Programme at the Humber Centre

*"Good buildings come from good people, and all problems are solved by good design."*  
**Stephen Gardiner, Architect**

#### Good People

A strong and stable structure begins with firm foundations. The introduction of associate practitioner roles of different disciplines into the Humber Centre, combined with the enthusiasm of existing staff to develop their knowledge, offered opportunity to ensure individuals were prepared with the appropriate foundations to build their roles. It was a chance to invest in our good people, providing more training and education to help them build on the fantastic care they provide for our patients. The result was the five day Foundations in forensic care training programme.

#### Good design; developing the blueprint

To understand more about the design needed for the training, the needs and aims of individual roles were assessed, with consideration of existing knowledge levels and the needs of the service. The structure was created from this and included a range of different training topics as the essential materials for our building.

#### Our construction team

All building sites need a solid team of professionals from different trades. The training construction team, led by the psychology department, comprises SLT, OT and experts by experience; service users who create and deliver some of the content. We are always looking for new service user team members to join us 'on site'! Organisational support behind the scenes enables staff to attend the week long course.

#### Construction materials

Training materials were assembled from expertise within different disciplines, and developing training packages and exercises, using our blueprint needs analysis as a guide. The training encourages participants to focus on the potential impact of different experiences on our service users, which leads to interesting and reflective discussions about topics such as power dynamics, detention, boundaries, and self-reflection. Participants

get the opportunity to practice some of the skills covered, think about how they may apply them, and increase understanding of service users they work with. The training uses a mixture of 'education', roleplay, skills practice and discussions. One key material is the introduction of a fictitious 'service user' who the group follow through the week, considering his experiences in relation to each topic covered, and developing their understanding of the likely experiences of a service user.

Alongside the right materials and construction team, from the outset we recognised the need to ensure our foundations last when facing the various pressures and challenges, of working in a busy service. So, after four days of thinking about our service users and how we can work with them, the final day focuses on thinking about ourselves; how we can use supervision effectively and how we can take care of ourselves; including reenergising ourselves in different ways.

#### Foundations in Forensic Care Training Programme: Content

Key Concepts and Theories	Applying Skills	Looking after us
<ul style="list-style-type: none"><li>• Part 3 of MHA</li><li>• Social Learning Theory</li><li>• Attachment</li><li>• Trauma</li><li>• The role of cognition and attention</li><li>• Introduction to occupation</li><li>• Working with sensory needs</li></ul>	<ul style="list-style-type: none"><li>• Working with different presentations (e.g. ASD, unshared beliefs, paranoia, communication difficulties, emotional dysregulation)</li><li>• Key Therapeutic Skills</li><li>• Motivational Interviewing</li><li>• Healthy Boundaries</li></ul>	<ul style="list-style-type: none"><li>• Unique challenges</li><li>• Finding our reward at work</li><li>• Effective use of supervision</li><li>• Staying healthy at work</li><li>• Ways to re-energise</li><li>• Team work/support</li></ul>

#### Breaking ground

With the final design in place, the team ready to go, and the materials assembled, it was time to start to dig our Foundations. Since the first course in 2016, we have run 5 courses, training over 70 people. Most of the participants have been associate practitioners and healthcare assistants, but qualified staff who have attended have identified it as being useful, in particular those new to forensics.

#### Location, location, location

The three most important considerations for any house, according to Kirsty and Phil! Learning from our first course which ran in the Humber Centre building, was recognising staff need time and space away from the usual work environment to really benefit from the learning experience. Moving the course location has allowed staff to focus on the training, they have reflected this has helped them to return to their jobs refreshed and re-energised.

## Ongoing maintenance

Feedback from training participants has been overwhelmingly positive. The detailed training evaluations completed by participants are analysed and used to shape future courses. Quantitative analysis has reflected the high relevance of the topics to the day to day job of providing care to our patient group and consistently and reliably increased people's knowledge in the different areas.

Even the most high specification building needs maintenance. The training has developed and evolved over time using the detailed training evaluations completed by participants, informal feedback, and our own reflections. Some areas have had a full refurbishment, whilst others just a bit of a spruce-up! Our intentions are to continue renewing and investing in our good people and good design to maintain that good building.

*"A building is not just a place to be but a way to be."*

**Frank Lloyd Wright**

Learning: "Don't take behaviour on face value— always ask 'why?'"

"Best thing was being able to discuss feelings around work in a

I'd recommend all staff to attend this and gain some knowledge

Learning: "To be more mindful of what I bring to every interaction"

"Really enjoyed this week. Learnt a lot and this will positively influence my practice"

**Sarah Rockliff, Consultant Forensic Psychologist & Carolyn Scott, Professional Lead for Forensic Services, Humber Centre**

## Greater Manchester Mental Health NHS Foundation Trust

### Rethinking Support of Preceptorship Nurses in Adult Forensic Services: Reflection on Pilot of Practice Development Nurse Role

#### What: Rationale for the role of practice development nurse

Within adult forensic services (AFS) it was recognised that there was a need to provide increased opportunities for support and supervision for preceptorship nurses. It was recognised that for a multitude of reasons, clinical supervision specifically geared for preceptor nurses was often provided by ward managers and team leaders, as an add-on to general line management supervision. It was felt that this often depleted the quality and engagement in effective preceptorship support.

In addition and in terms of quality standards, whilst a trust-wide and local Preceptorship framework was in situ to guide supervisors; it appeared preceptor experience and quality of portfolio massively varied and was largely

dependent on supervisor's interpretation of the framework itself. For example, individual interpretation of the framework by the supervisor led to variation as to what evidence was requested to support progress and achievements.

#### What now: The proposed role of practice development nurse

The remit of the pilot role was to engage the preceptorship nurse in one-to-one reflection and group reflective practice, compliant with the Nursing and Midwifery Council (Code of conduct & Revalidation) and fostering the need to develop individuals working within a challenging environment, dealing with complex forensic inpatients. Supplementary aims were to contribute to an overall local initiative of maintaining a resilient and skillful workforce, against a national backdrop of financially compromised staffing levels and local staff retention concerns.

#### Core aims of supporting preceptorship nurses

To support nurses deliver collaborative, service user centered care that has a positive impact on service user experience.

To treat service users, carers and family with understanding, kindness and respect to

ensure their experience and quality of care is exceptional.

Deliver evidence-based care and treatment along the continuum of the pathways, from admission to discharge.

To meet the needs and manage the risks of service users, in the least restrictive manner possible.

To support individual members of staff progress and develop within their nursing career, by providing opportunities for learning, education, supervision and reflection.

The ability for staff nurses to access bespoke supervision and coaching as necessary by a senior experienced clinician, guided by referral or self-referral.

### **Consideration of skills, experience and supervision for the individual undertaking the role**

The practice development nurse had a wealth of both clinical and managerial experience and was recruited as an existing, established well-respected practitioner within an inpatient forensic setting. The role benefitted from an individual with effective working relationships with both clinical, operational and corporate nursing. The individual was able to work flexibly in terms of hours, in order to be responsive to the shift patterns of those the role was aimed to support, e.g., to offer ward based shadow and co-working opportunities. This was deemed both necessary and important in terms of working in partnership with both preceptors and their ward based supervisors.

Line management and clinical supervision for the role was provided by an advanced practitioner working within the existing local resilience initiative, as part of a wider senior clinical nursing team. This was closely partnered with support from the operational service manager, to ensure consistency in terms of service wide approach to the development of new staff nurses.

### **Achievements of the pilot**

Standardised 'How to guide' produced for ward based supervisors, to address issues relating to interpretation of the preceptorship framework.

Establishment of practice development nurse as link person to support and supervise, supervisors with issues arising with preceptorship nurses and to support

supervisors with their own training and development in terms of supporting preceptorship nurses.

Ward based medications management training by practice development nurse, including safe administration of medication assessment

Embedding of 'mutual supervision contract' for preceptorship nurses identifying areas for development to meet their preceptorship portfolio aims, access to mentoring support, shadowing and training.

Regular and protected individual support meetings with preceptorship nurses and ward based supervisors to progress learning aims.

Online educational and information resource folder access for preceptorship nurses in collaboration with senior clinical nursing team.

Synthesised and consolidated preceptorship objectives with local resilience, staff nurse mentorship sessions, and clinical skills training, offering exposure to national initiative in practice, emotional intelligence, stress management, self-awareness, working in a trauma informed way with defense mechanisms and personality disorder, within a preceptorships first year of practice.

Contributed to wider service aims of maintaining quality care standards by providing access to opportunities for clinical supervision and training.

Succeeded in completing all outstanding preceptorships within service and devised projection database of up and coming preceptorships.

Embedded active involvement with service recruitment and liaison with students as potential new recruits.

A comprehensive and regularly updated service database of clinical supervisor availability, by specialty and skill set accessible to all staff nurses.

### **Now What**

1. Development of the new trainee nurse associate role within AFS will be a key aspect of the practice development nurse role, in terms of working towards a realistic and effective job description and equivalent preceptorship framework; to ensure a future registered nurse associate is skilled to support staff nurses in their role.
2. It is noted that the implementation of the

role worked in partnership with the pre-existing local resilience, staff nurse mentorship sessions, and clinical skills training, which offered exposure to national initiative in practice, emotional intelligence, stress management, self-awareness, working in a trauma informed way with defense mechanisms and personality disorder. Continued involvement in the facilitation of this program and communication of the necessity of this program both operationally and clinically within the service is a crucial remit of the role going forwards in terms of supporting progressive development of our new staff nurses.

3. Service wide oversight and organisation of a system for monitoring preceptorship progress and experience is imperative to the role, in terms of both staff retention

and recruitment, and quality of care. It is envisioned that this will be the primary role the practice development nurse going forwards.

4. Multidisciplinary liaison to raise awareness of preceptorship needs such as responsiveness to feedback requests and learning opportunities, with allied health professionals and other disciplines. Also factoring in the responsibilities of the new NMC practice assessor's role and team mentorship remits of that role.
5. Continued contact with students as student link and to support recruitment opportunities

**Nicky Stott, Practice Development Nurse & Sherilyn Magee, Advanced Practitioner, Edenfield Centre**

## *Belfast Health & Social Care Trust*

### **The New 2 Forensic Programme for all Staff in the Shannon Clinic**

#### **Introduction**

The introduction of the New to Forensic Programme (N2F) for all staff (clinical and non-clinical) working in the Shannon Clinic, which is the medium secure unit for Northern Ireland.

Shannon Clinic is a 34 bedded inpatient facility which opened in 2005 and forensic services are a relatively new concept in Northern Ireland. At the beginning, staff had little qualifications or experience working in forensic healthcare settings. From the outset, we were very aware that an adequate and competent workforce is fundamental to the success of a new and developing service.

#### **Background**

The N2F teaching programme was developed by the School of Forensic Mental Health Scotland (SoFMH) and adapted for use in Northern Ireland. It's a multidisciplinary team, a multiagency practice-based learning approach to developing staff's skills and enhances the quality of care for the patients. All staff complete the programme as part of their induction and linked to a personal professional development profile.

#### **New to forensic mental health teaching programme (N2F)**

The education programme is for clinical and non-clinical staff. The programme is designed to promote self-directed learning and is multi-disciplinary and multi-agency in approach. The programme student will be supported throughout their period of study (recommended six months to one year depending on previous experience) by a mentor who is an experienced forensic mental health care worker.

#### **Chapters**

The programme has fourteen chapters, each of which (excluding chapter one) includes case scenarios of patients in various settings, from the community to high secure psychiatric care:

1. Aims and teaching methods
2. Understanding mental disorder
3. Definitions, principles and policy for mentally disordered offenders
4. Civil mental health legislation
5. Forensic mental health services
6. Attitudes to mentally disordered offenders
7. Forensic mental health services and the criminal justice system: understanding the relationship
8. Psychiatric defences and legislation for mentally disordered offenders
9. Assessment, treatment and management of mentally disordered offenders
10. Multidisciplinary working, communication and managing difference

11. Safety of staff, patients and public including risk assessment and management
12. Taking account of the views of users and carers
13. Forensic Learning Disability Services
14. Mental Health in Prison

The patients and carers advocates were involved in the development of the programme and deliver the training to staff. There is a specific chapter allocated to the user and carer perspective. It is envisaged that patients who have a lived experience of forensic settings could also deliver on the programme.

Staff progress through the programme at their own pace, supported by a mentor which can take 3 to 12 months to complete. The mentor is a competent practitioner familiar to the practice setting and to the service user group.

It's a self-directed, problem-based learning approach, challenging participants to seek solutions to real and actual problems.

Case studies are used in context to stimulate curiosity and promote learning of the subject matter.

The participant keeps a reflective diary which promotes planning and achieving learning goals.

An RQIA Inspection (2016) reported:

'Staff who met with inspectors reflected positively about their experience of the training that they had received'.

'Patients stated they were treated with dignity and respect, and that staff were considerate and responded compassionately when help was needed'.

'Nursing staff in all three wards felt the nursing management within the ward was effective and supportive'.

An evaluation of the N2F Programme carried out by Walker et al (2018) highlighted that practice based learning had a positive impact for both staff and the service user. The following comments were fed back from staff that completed the N2F Programme.

*"Before the programme I had a negative view of mentally disordered offenders. Then I did the programme and it helped me to see the person as a person, not the offence."*

*"I felt that I had been thrown in at the deep end and then doing the programme my confidence grew."*

*"It supplemented what you were learning on the ground. I felt more knowledgeable and skilled"*

*"I found the case studies were very good in making you reflect on your practice, attitude and views."*

*"We have a multidisciplinary and multiagency approach to care, specifically related to the course, these roles were further explored and this was very useful in appreciating the wide range of disciplines."*

*"It develops your practice and understanding and as a result makes you a more effective practitioner."*

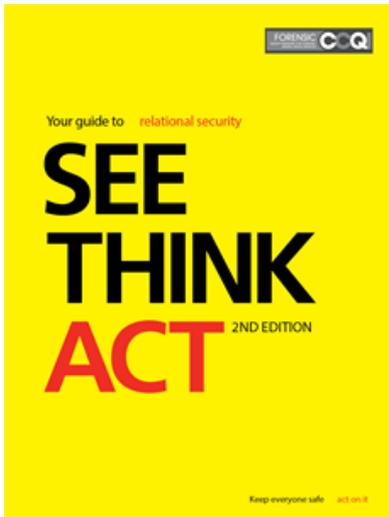
The N2F programme does not only educate staff but also encourages positive multidisciplinary team working. Staff feel valued and gives them a greater understanding of what forensic healthcare is and provides them with skills in order to deliver a high quality of care to the service users. It also provides a platform for some staff who wish to further their knowledge specific to forensic healthcare with the local Universities.

**Noel Mc Donald, Forensic Network Manager, Shannon Clinic**

## QNFMHS Artwork Competition

We are delighted to share with you all the wonderful artwork entries we received from patients at secure services for our annual artwork competition. We received over 300 pieces of artwork this year and we have displayed these on pages 40 to 47.

## Supporting Staff to Develop Their Relational Security Skills



Most readers will be familiar with the College's publication See, Think, Act, our guide to relational security for secure mental health services. It's been part of our narrative for almost ten years now and informed the development of many of our current standards.

Since the first launch in 2010 I've run See, Think, Act training and development events with staff right across the UK and now Canada and The Netherlands have adopted our work too.

People seem to get a lot out of the sessions. Not because I'm an especially great speaker - because the sessions provide staff with a *space* to talk together (sometimes for the first time) about patient care, care planning, boundaries, patient mix, spotting the signs of an incident, and so on.

These are really important issues, but staff understandably don't often get the opportunity to stop for long enough to talk together about how they can improve their practice in these areas.

Feedback from the training sessions reassures me staff are overwhelmingly leaving inspired and energised, validated as practitioners and optimistic about the future. Everyone goes away motivated and I feel like I did a great job.

So why then, recently, when I revisited one service did I find that not that much had changed? I left them so fired up!

Well, when anyone leaves any kind of training session there's a small window of time in which it's more likely we'll instigate a change of practice before the reality of our workload and the comfort of established practice obscures that once urgent motivation for change. Ideas we planned on coming back to get shelved and suddenly it's six months down the road, CQC are on the doorstep and we're kicking ourselves wishing we'd done what we said we'd do.

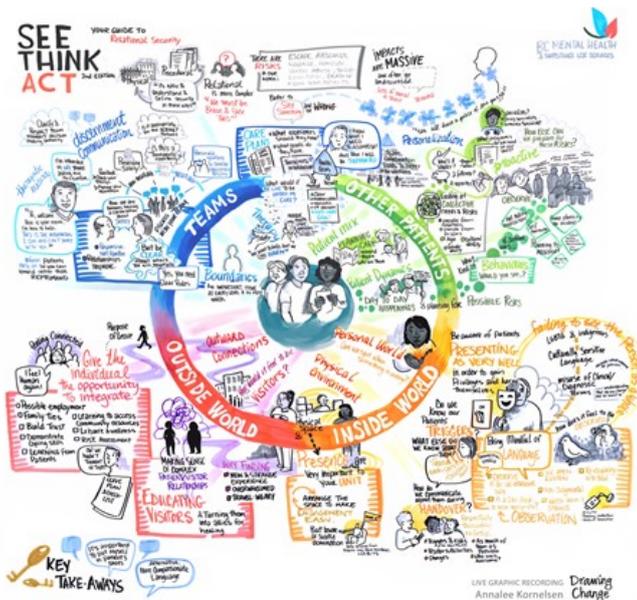
There are two important things I've discovered about relational security training over the years that can help keep the momentum you generated:

Firstly, **train your team together**. It's not easy to organise, but staff appear to be far more likely to adopt a new attitude to care or a new practice if they've shared the same training experience and are on the same journey together.

It just makes sense that a group of people together with a shared vision for their own service can make more of an impact that one lone voice.

Staff repeatedly feed back how much they appreciate talking about *their* issues in training rather than feeling part of a generic programme.

Secondly, **know what you're going to follow training up with**. Don't view the relational security 'induction' as having



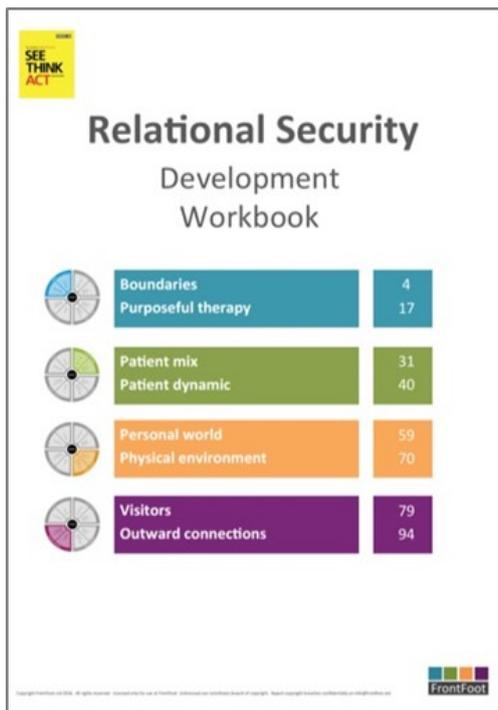
Visual output from British Columbia training session

'trained' your staff. Relational security is a continued process of preparing, learning, reflecting and modifying practice. Induction really should just cover the basics and prepare staff to commence a career-long process of refining their relational security knowledge and skill. You'll have noticed a change to the Network's relational security standards this year. It suggests a development plan for staff, recognising that you can't teach your staff everything in a classroom – they have to learn through experience and over time.



This issue of training came up at the relational security conference the Quality Network ran in 2017 and so we set about developing something that responded to what services asked for - more practical support in the workplace, more recognition of healthcare worker training needs and more support for building leadership capability.

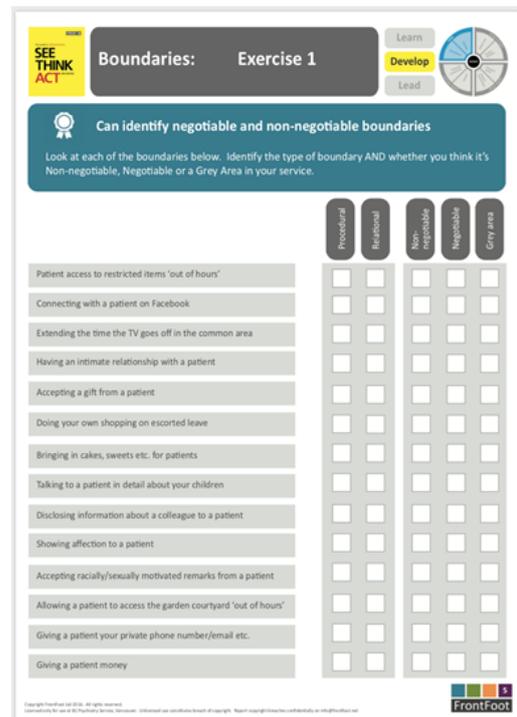
So, we've published the Relational Security Development Workbook.



This is a comprehensive suite of work-based learning exercise drawing on that ten years of experience delivering See Think Act training to clinical teams, here and abroad.

This is the next step from induction; ensuring staff can take the enthusiasm they've built in their relational security training immediately back to the workplace where they can continue to develop their practice with the support of their colleagues and leaders.

**Who's it aimed at?** It's aimed at anyone directly involved in providing secure mental healthcare, particularly healthcare workers, therapists, nurses and service manager.



**Example of exercise**

**What does it do?** At over 100 pages, this framework helps staff:

- Learn/recap the theory of relational security
- Develop therapeutic maturity at every level of practice
- Develop expertise and confidence in all staff
- Reflect on how personal practice can be continually improved
- Plan actions to be a better **leader** of relational security through specific sections for leaders

- 
- Evaluate skills against competency measures at the conclusion of each section.

that means better health outcomes for patients.

**How do I get it?** Workbooks are issued to services at a small cost per site directly from FrontFoot. Licenses are issued without limits on time or on the number of users at that site. This way, each hospital site can use the material with as many staff as they want to without incurring unreasonable cost. That means we're able to reach every member of staff that would benefit from the material; and

There's also a free sample of one section available online at <http://www.frontfoot.net/relational-security-resources>

If you're Interested in using the workbooks at your site, contact [info@frontfoot.net](mailto:info@frontfoot.net)

**Elizabeth Allen, Author of See Think Act,**  
[www.frontfoot.net](http://www.frontfoot.net)

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## Upcoming Events

### Trauma-informed care within forensic and prison mental health services - SOLD OUT

Date: 21 November 2019

Venue: Royal College of Psychiatrists, London, E1 8BB

### Special interest day (topic TBC) - Save the date!

Date: Tuesday 3 March 2020

### PICU 2nd Annual Forum

Date: Tuesday 15 October 2019

Venue: Royal College of Psychiatrists, London, E1 8BB

**For more information and to see the programme for the day please visit the QNPICU website or contact:** [Holly.Hunter-Brown@rcpsych.ac.uk](mailto:Holly.Hunter-Brown@rcpsych.ac.uk).

### Reviewer Training

Our reviewer training is suitable for staff from our member services from any discipline, with an interest in being a part of external peer-reviews for forensic mental health services. The training is free and is a great learning experience. It gives potential reviewers the opportunity to gain practical knowledge about how to conduct a peer-review visit. The days involve presentation, discussion and workshops created to develop the skills of a reviewer.

Date: 28 October 2019, 14:00 to 17:00

Venue: Royal College of Psychiatrists, London, E1 8BB

Unfortunately this is **sold out** but you can be added to the waiting list. Please do let us know if you are booked but unable to attend so someone else can take your place

There will also be sessions available early next year so do look out for these to be advertised over the next few months.

**Booking forms for events and reviewer training can be found on our website.**

[www.qnfmhs.ac.uk](http://www.qnfmhs.ac.uk)

## Artwork Competition Winners!

Each year we hold an artwork competition, open to all patients in secure services. We always receive lots of amazing work to be used on our posters and publications. This year in particular we received an impressive amount of submissions, with an exciting range of styles. You can find all these entries on pages 42-47.

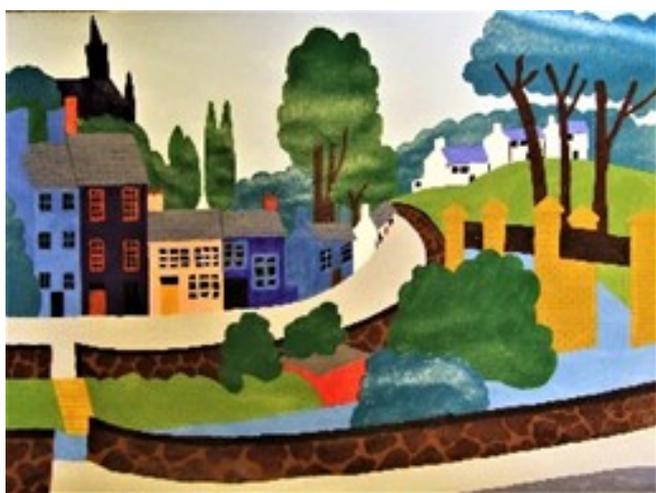
On this page we are pleased to showcase our ten winners! Look out for these wonderful pieces of work on our posters, postcards and reports over the coming year.



**Patient, The Spinney**



**S Taylor, Kemple View**



**Patient, The Spinney**



**Meg Barret, Heatherwood Court**



**Patient, Northgate Hospital**



**Patient, The Spinney**



**D Carty, St Andrew's**



**Patient, River House**

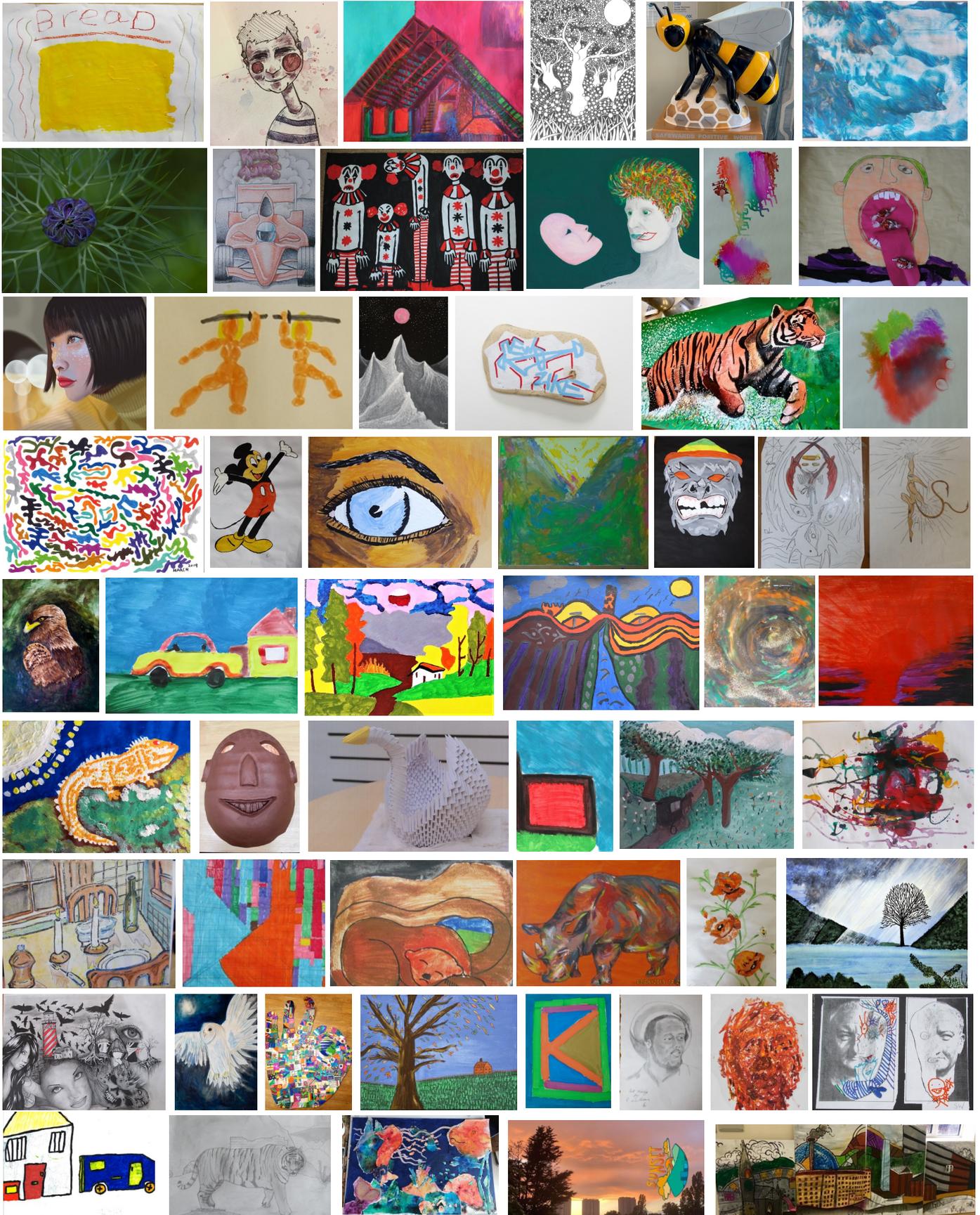


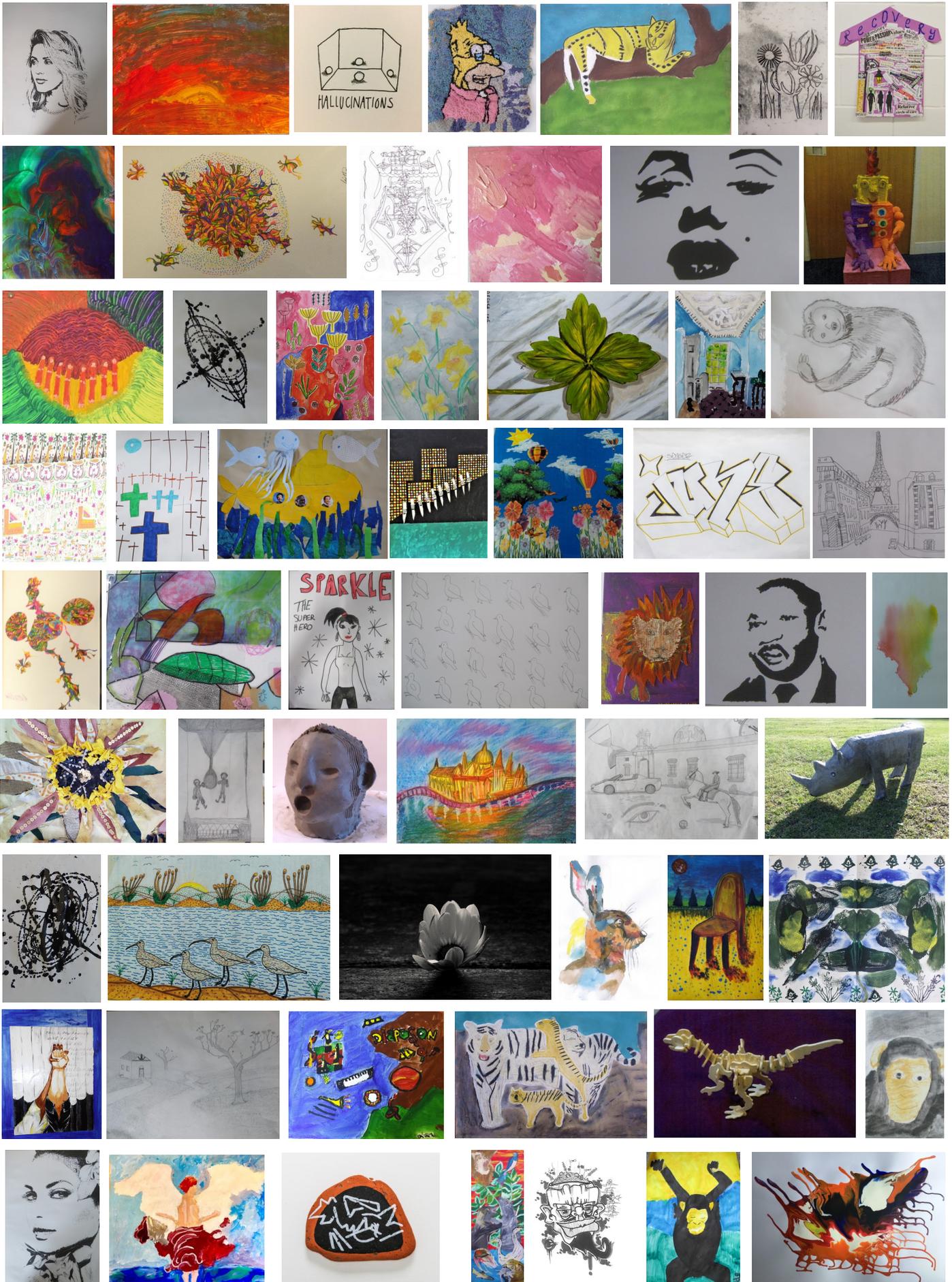
**Ashford Unit Patients,  
Ashford Unit**

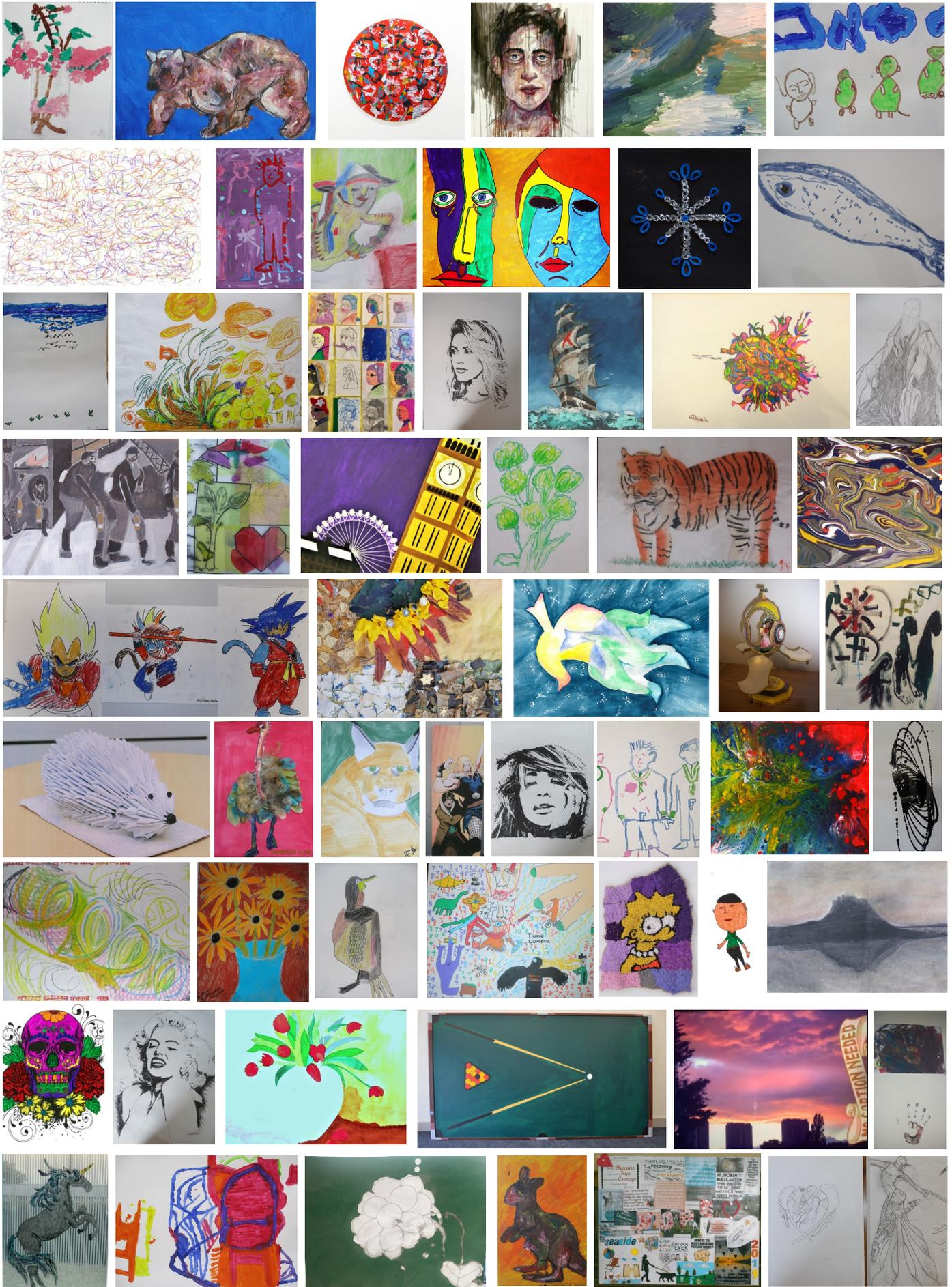


**N.G, Cheswold Park Hospital**

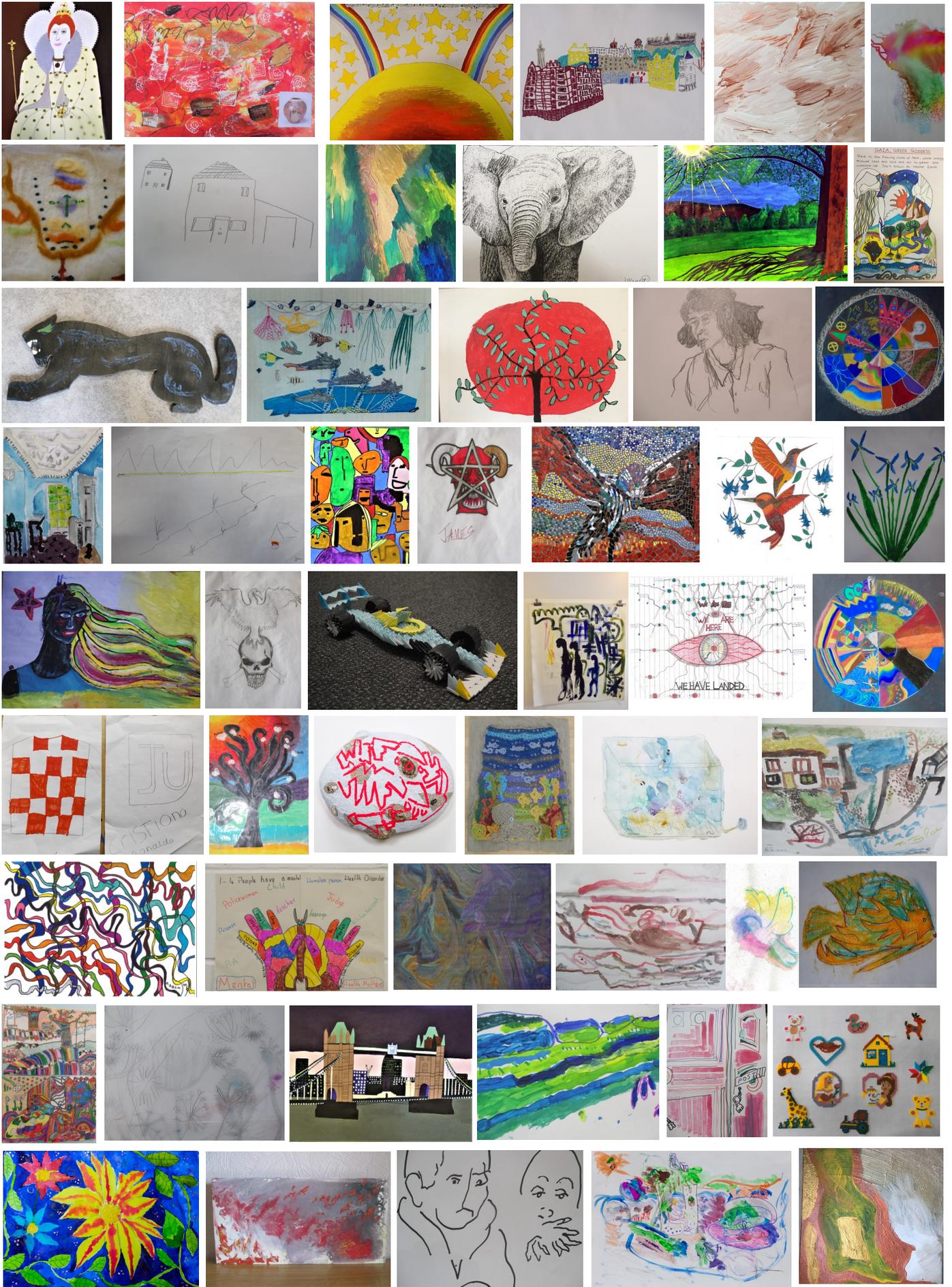
# Artwork Competition Entries

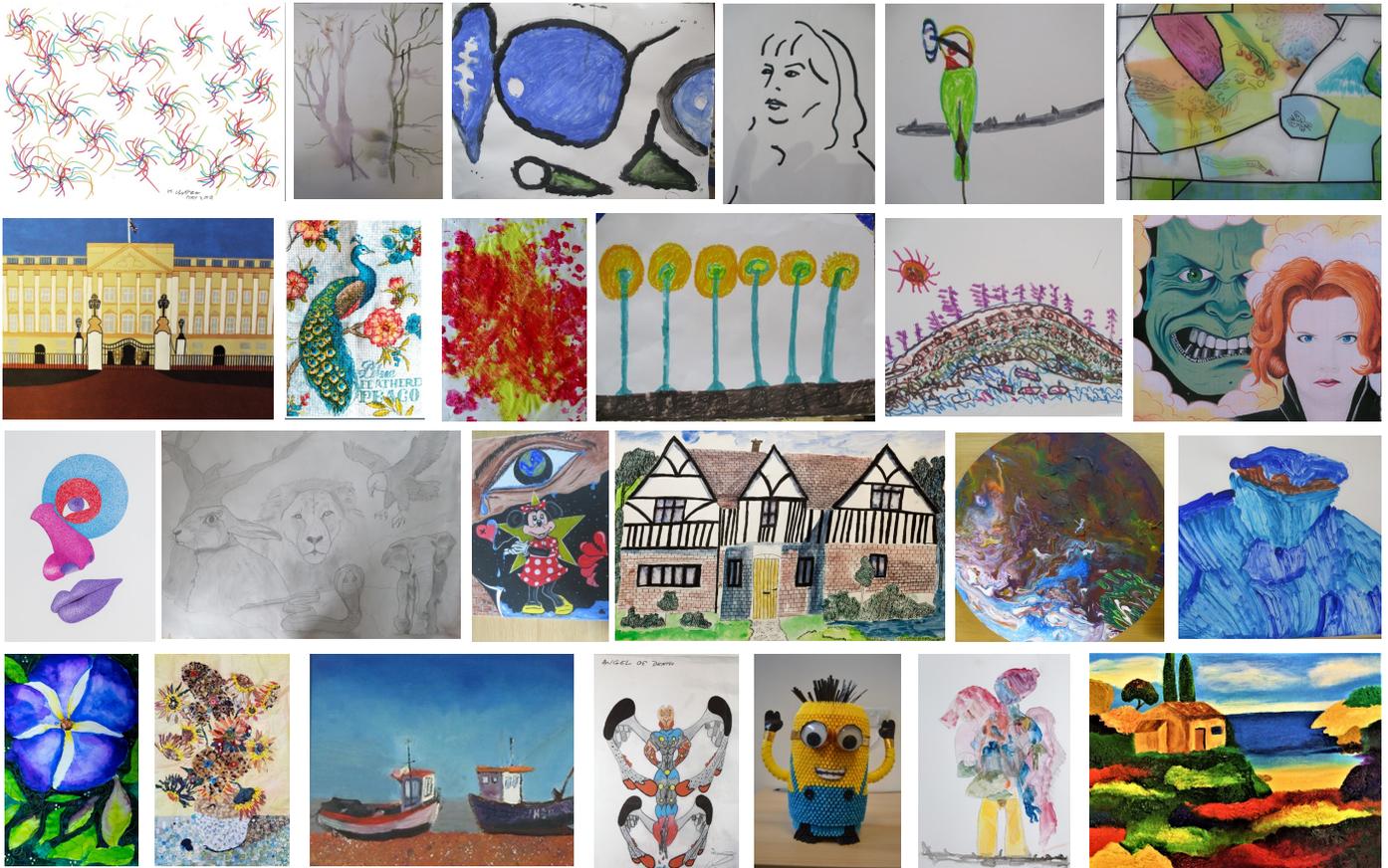












## External Art Events

### Outsider Gallery: Winter Exhibition Private View

**Date and Time:** Friday 11 October 2019, 6-10pm  
**Venue:** Clarendon Recovery College, London, N8 0DJ

Outsider Gallery is a mental health gallery dedicated to NHS mental health and other secure settings. They invite you to celebrate their annual winter exhibition. The collection of works on show will come from the C.R.E.W and arts and wellbeing programmes, submissions from secure units, prisons, people with lived experience and CAMHS. Live music from community patients and individuals engaging in mental health services may also occur on the evening.

**For more information contact via  
 Facebook/Instagram: @OutsiderGalleryLondon**

### Koestler Arts Annual UK Exhibition: AnotherMe

**Date:** 19 September – 3 November 2019  
**Venue:** Southbank Centre, London SE1 8XX

Koestler Arts is the UK's best-known prison arts charity. They encourage people in the criminal justice system to change their lives by participating in the arts. Another Me, is their annual UK exhibition at Southbank Centre, curated by award-winning musician Soweto Kinch

**For more information visit: <https://www.koestlerarts.org.uk/exhibitions/another-me/>**

## Useful Links

**Care Quality Commission**

[www.cqc.org.uk](http://www.cqc.org.uk)

**Centre for Mental Health**

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

**Department of Health**

[www.doh.gov.uk](http://www.doh.gov.uk)

**Health and Social Care Advisory Service**

[www.hascas.org.uk](http://www.hascas.org.uk)

**Institute of Psychiatry**

[www.iop.kcl.ac.uk](http://www.iop.kcl.ac.uk)

**Ministry of Justice**

[www.gov.uk/government/organisations/ministry-of-justice](http://www.gov.uk/government/organisations/ministry-of-justice)

**National Forensic Mental Health R&D Programme**

[www.nfmhp.org.uk](http://www.nfmhp.org.uk)

**National Institute for Health and Care Excellence**

[www.nice.org.uk](http://www.nice.org.uk)

**NHS England**

[www.england.nhs.uk](http://www.england.nhs.uk)

**Offender Health Research Network**

[www.ohrn.nhs.uk](http://www.ohrn.nhs.uk)

**Revolving Doors**

[www.revolving-doors.org.uk](http://www.revolving-doors.org.uk)

**Royal College of Psychiatrists' College Centre for Quality Improvement**

<https://www.rcpsych.ac.uk/improving-care/ccqi>

**Royal College of Psychiatrists' Training**

<https://www.rcpsych.ac.uk/training>

**See Think Act (2nd Edition)**

<https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services/see-think-act>

## Contact the Network

**Megan Georgiou, Programme Manager**

Megan.Georgiou@rcpsych.ac.uk  
020 3701 2701

**Matt Oultram, Deputy Programme Manager**

Matthew.Oultram@rcpsych.ac.uk  
020 3701 2736

**Holly Hunter-Brown, Project Worker**

Holly.Hunter-Brown@rcpsych.ac.uk  
020 3701 2671

**Twitter**

Follow us: @rcpsych @ccqi\_  
And use #qnfms for up-to-date information

**QNFMS Knowledge Hub Group**

[www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum](http://www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum)

**Royal College of Psychiatrists' Centre for Quality for Improvement**

21 Prescott Street, London, E1 8BB

[www.qnfms.co.uk](http://www.qnfms.co.uk)