FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

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This Issue

WELCOME

Welcome to the 46th edition of the Quality Network for Forensic Mental Health Services' newsletter. The year so far has largely been dominated by COVID-19 and the challenges a pandemic brings. Forensic services have had their own set of unique challenges in handling the situation and teams have had to adapt to new ways of working. The Quality Network would like to take this opportunity to thank all of the staff working in forensic units for their efforts in managing the pandemic and keeping everyone safe.

This edition contains articles relating to COVID-19, as well as good practice on physical health/healthy living, and connecting with family and friends. In addition, we have included the entries to our artwork competition for you all to enjoy. They really are excellent and we look forward to using the winning pieces on our publications over the next year. Thank you to everyone that contributed!

As a result of COVID-19, we sadly had to cancel all peer-review visits from mid-March 2020. This resulted in over a third of our membership not receiving a visit. We are restarting the cycle and it is full steam ahead to begin visits in October. Initially, visits will occur virtually and are likely to remain this way for the rest of the cycle. We will be working closely with services to anticipate in advance any potential issues and ensure the review visits run as smoothly as possible.

Since lockdown, the Network has been hard at work to provide different forms of support. The College has been closed since mid-March and since then, we have been hosting a number of webinars and online discussion forums. These have been very well attended and well received, and have been made available on our website in case anyone would like to watch them. It has definitely been a learning process for us all! We hope you have found them useful and interesting. It has been nice to keep connected with QN members in this new way.

Finally, Megan Georgiou is stepping down as programme manager in July, having worked at the College since 2014. Kate Townsend has been appointed to take over the role and is looking forward to further developing the programme of work. Furthermore, Jude Deacon, Director of Forensic Mental Health, Oxleas NHS Foundation Trust has been appointed the new chair of the advisory group. Thank you to Quazi Haque and Megan for their tireless work over the past 6 years in developing the Network to what it is today!

Kate Townsend, Programme Manager

South West London and St Georges Mental Health Trust

Reflections on COVID-19: New Challenges and Opportunities

This March a few weeks before the official UK government lockdown began, it was necessary for our forensic clinic to go into our own imposed "lockdown" to maintain safety for service users, carers, and staff in light of COVID-19. As we all raced to understand and implement these changes, feelings of uncertainty bubbled continuously at the surface.

In some ways the atmosphere reflected that of the rest of the UK as restrictions continued to increase. There was a general fear of the unknown, along with bursts of hope and inspiration. Discussions centred around the possibility of going "back to basics" and having time to reflect on our practice.

In other ways this was entirely different. Government guidance was for the public and not tailored specifically for mental health services. The trust and other bodies put together guidance to help with this but as we have all experienced, the picture of COVID-19 was (and is) ever changing. Within our specialist forensic service adapting on the job and learning as we went, was key to coping and continuing care for our service users. However, many serious questions remained how and will we get through this? What will happen to us and our service users? How will this context influence recovery and mental health? These concerns were present throughout the service, including within our forensic occupational therapy team.

Whilst for some other disciplines it was realistic to work from home, occupational therapists continued coming into the clinic through this time. However, the way we were used to working drastically changed.

Prior to COVID-19 measures, the occupational therapy timetable relied heavily on off ward rooms where a variety of groups took place. As we went into lockdown OTs were deployed to the wards, to help nursing teams and to limit the spread of infection, off-ward groups were suspended.

As our focus turned solely to our assigned ward, there was some panic about how we would sustain motivation and engagement without varied spaces and faces to facilitate them. For example, the vocational provision "Café Connect", where service users can come to socialise with peers, take a break from the ward structure and buy confectionary items had to be suspended in line with the same social distancing measures that were being experienced throughout the country.

After a few weeks, some service users commented that having OTs on the ward consistently was "better" and that there was "more going on".

Indeed, it felt as though there was a new potential to key into the needs of specific service users - including providing more opportunities to those that found it harder to engage in the usual structured timetable. On the female ward, we began running more exercise groups such as Zumba and Yoga as many of the women had goals to improve their fitness and the ward gym had temporarily closed. One service user said she was feeling "more settled and losing weight" due to being able to engage in this daily. We have also been able to identify the need for more educational and discussion groups surrounding COVID-19, self-care and healthy relationships. With less rooms to run groups we began using the outside areas on the ward in a creative way, making the most of the warm weather. Using the garden as a location for groups has proved a motivating alternative. It has also given inspiration for fun ward-based activities, such as garden parties with games and music to mark the beginning of the weekend and promote social interaction. Feedback from the male wards have been that service users "enjoy playing sport

outside in the good weather".

We have created alternatives to valued off-ward groups. For example, "Café Connect" is now run as a "mobile café" where we facilitate the ordering and delivering of a small range of drinks and food. This has been successful and has been particularly valued due to limited shop access because of queues and leave restrictions. We have also begun developing a curriculum for our Forensic Recovery College; taking this from its previous ward existence to something that can be used off-ward to keep service users informed and empowered.

It has also been an important opportunity to work alongside the ward nursing teams, in a way that we were not doing before. The importance of being consistent and cohesive as a team is being addressed and developed more.

This is not to say everything is perfect. Whilst we strive in forensic services to have the "least restrictive practice", in a secure service there will always be some restrictions. COVID-19 measures added to these restrictions for forensic service users. Weekend and evening visits from family and friends which are often relied upon by many to stay connected were and remain no longer able to go ahead. To help this, our service had to think creatively about the use of technology and began finding ways of using applications like Skype securely which allowed service users to catch up with their families, as well as continue important psychology and psychotherapy sessions remotely. Community leave is also, at the point of writing suspended, creating further challenges in service users staying connected the world outside. Whenever this leave is resumed, there will be a need to enable service users to navigate through the ever-changing picture of COVID-19 in the community.

As lockdown eases, discussions continue around how our whole trust and, consequently our forensic OT practice will look over the next few months. As society opens again, so will the clinic in line with recommendations from the government and senior staff. We are keen to keep some of the new ways of working as well as looking forward to getting back to some of the old.

Ruby Stone-Sharp, Forensic Occupational Therapist, Shaftesbury Clinic

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Westbridge Step Down Unit COVID-19 Distraction Pack

This article is written in the midst of extreme uncertainty, recommended social distancing and a rapidly changing way of living in the unprecedented outbreak of the Corona Virus Disease 2019 (COVID-19).

The United Kingdom is under lockdown with government guidelines enforcing social distancing. To contain the diffusion of COVID-19, governments have imposed restrictions on outdoor activities or even collective quarantine on the public.

Quarantine and isolation can be very effective in protecting or restoring public health. For example, the experience of the 2003 severe acute respiratory syndrome (SARS) outbreak highlighted that infectious disease like SARS can be contained if a series of measures are implemented including the early identification of infected people, contact tracing, as well as timely quarantine and isolation measures (Hughes, 2010).

Imposed quarantine or social isolation is often an unpleasant experience for those who undergo it. Separation from loved ones, the loss of freedom, uncertainty over disease status and a departure

from usual everyday routines can, on occasions, create dramatic effects.

For people with an existing mental health condition, isolation presents more severe problems and can exacerbate feelings of anxiety and anger (Goodman et al., 2001).

Changes to the usual way of life can make people feel anxious and unsafe, feelings of being unsafe can be associated with the disease-fear contagion nexus. For example, not knowing the cause or progression of the disease and outcomes, rumours and misinformation that can lead to discrimination against or marginalism of people of specific descent (Usher et al., 2020). The need for social support is greatest in times of adverse situations and events such as the current COVID-19 pandemic; hence, severing social support as part of an imposed quarantine or isolation strategy can threaten an individual's sense of connectedness and may take considerable toll in on their mental health (Hawryluck et al, 2004).

Westbridge step down unit is a service provided in partnership between Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Tyne Housing. The service is a specialist tertiary service commissioned by local Clinical Commissioning Groups in the North East region of England. Its purpose is to contribute to reducing the risks to others posed by men and women who suffer from mental illness. This includes those who have been assessed as posing a significant risk of harm or those who are thought to do so and require further assessment of their risk. Westbridge step down unit aims to identify and meet the diverse rehabilitation needs of clients with a mental disorder who have been assessed as requiring a supported re-integration into the community.

As the situation with the COVID-19 pandemic is fluid and fast moving it was recognised that our clients were looking for alternative ways for mental stimulation, distraction from painful situations or to develop strategies to release some pressure during the lockdown. Therefore, the Westbridge step down unit COVID-19 resource pack was developed based on our client's needs and views. The pack includes mindfulness techniques, advice and suggestions about physical activities that can be performed in solitude and information about keeping connected to family, friends and the wider community.

A number of clients identified using a range of distraction techniques, however, mindfulness appeared to be the main theme as most had previously used this approach to manage pain, stress, and anxiety. Emerging literature suggests that mindfulness may also enhance occupational engagement and be related to a flow state (i.e. a state of timelessness within optimal experience of activity engagement, Elliot 2011).

Further discussions identified a number of clients regularly attend community resources to exercise such as the gym. Therefore, exercise was identified as a key strategy to maintaining good mental and physical health. Evidence suggests moderate intensity physical activities are recommended for maintaining health; that is those that raise the heart rate sufficiently for the person to feel slightly out of breath (Cole 2010). Some suggestions in the pack included walking albeit following government recommendations, active jobs around Westbridge such as participating in the job rota or leisure pursuits in addition to more structured exercises aimed at improving fitness such as Yoga or Tai Chi.

The final theme that emerged during discussions with the clients was social media, as the COVID-19 virus continues to spread so has information and misinformation also known as fake news.

Sometimes such news is reinforced by circular reasoning. The Centre for Disease Control and Prevention warns that the fear and anxiety around a disease can be overwhelming and cause strong emotions. Especially vulnerable are those who have pre-existing mental health conditions. Therefore, providing the clients with links to government websites and other trusted sources

such as faith-based websites is crucial to easing fear and anxieties during this unprecedented time. It is also important that clients are given time and space to talk about their worries, support them to process their anxiety in an uncertain time and name their fears to gain a sense of control.

Craig Searle, Specialist Occupational Therapist, Westbridge Forensic Hostel

Swansea Bay Health Board

Compassionately Working in a Medium Secure Unit During The COVID-19 Outbreak

The Caswell Clinic is a medium secure unit offering care and treatment to adult males and females detained under the Mental Health Act 2007. Most patients have complex mental health, personality and attachment needs as well as various types of offending behaviour.

Despite being a secure environment, care and treatment at the clinic is thoughtfully provided and strongly guided by our core values which include person-centred care, keeping people safe, not judging and developing staff. However, having to provide care and treatment in accordance with the government's current guidelines during the COVID-19 outbreak has posed new and complex challenges at various times.

During the 'initial stages' of the outbreak, the clinic went full speed ahead with planning and preparing for anticipated changes and participated in quick, instinctual decision making that sometimes felt as if it was too restrictive too soon, although well intentioned and undertaken to safeguard our patients from contracting COVID-19. However, a few weeks on and we as a service have now moved very much into the 'action phase' and, whilst there still remains a focus on getting things done alongside a need to consider the practical/logistical arrangements for day-to-day running of the service, there is now more time to review and reflect on some of our earlier decision making and to consider whether this is compatible with our core values.

Over time it seems that decision making is slowly becoming more considered and collaborative and importantly involving both staff and patients (where possible). It is also important to note that decision making in the current phase is becoming more underpinned by our strong value base, comprising empathy and compassion for individuals who already have many restrictions placed upon them as a result of their mental health section. For instance, decisions involving items that are normally restricted (e.g. mobile phones) have been reconsidered and introduced in most cases (i.e. following further risk assessments) in order to support patients' continued contact and connection with their families and loved ones at this difficult time when actual visits are not permitted. Furthermore, whilst all external leave that patients participated in as part of their care and rehabilitation were initially withdrawn, this decision is now being re-considered and driven by our strong moral position that patients, like members of the public, should be allowed brief time outside their place of residence for the purposes of exercise.

At both the 'initial' and 'action' phases, several principles of good leadership have been consistently demonstrated in the clinic by managers at all levels (i.e. ward managers, heads of departments, service managers and senior service managers) including the importance of being visible to staff, offering normalisation and attempting to contain people's anxieties and uncertainty in a compassionate way, alongside

offering flexibility. In particular, allowing staff to choose what level of care and patient interaction they feel most comfortable with. Lastly, ongoing and open communication achieved through daily COVID-19 meetings whereby anyone can attend also importantly features shared problem solving as well as providing a safe place for emotions to be expressed, acknowledged and validated by peers. On reflection, such principles have impacted positively on our ability to remain resilient and adaptable as a service and to continue to offer high quality care to patients at a time of great uncertainty.

At the time of writing this article, it is still unknown how long the government's lockdown conditions will continue and thus how long we as a service will have to continue to negotiate the balance between our own core values and recommended restrictions. However, amidst all of this uncertainty, the clinic is now beginning to importantly plan and prepare for what may be required post COVID-19 when entering into the 'recovery' phase. For instance, acknowledging that the clinic and people within it will require time and space to reflect and process what they have recently lived through and experienced. Furthermore, that time importantly needs to be created for such reflections and processing rather than attempting to quickly revert back to 'business as usual' no matter how tempting this position of certainty might appear.

Diagram 1: An illustration of the hierarchical nature, necessity and influence of the core values at each of the different COVID 19 stages

Diagram 1

Dr Kim Liddiard, Consultant Clinical Psychologist, Caswell Clinic

Derbyshire Healthcare NHS Foundation Trust

Keeping Motivated During COVID-19

I am the Clinical Lead at a low secure all male 20 bedded unit. I am sure we have all experienced varying issues during COVID-19, of great concern to me and the whole team was ensuring that our patients and staff stayed motivated and active during this period. Of particular concern was the high risk category advice regarding COVID-19, in regards to BMI of 40. Unfortunately we have a few patients who were on the cusp of this.

We are all painfully aware of the impact that the COVID-19 has had on everyone in our services and the dedicated staff that are continuing to keep the NHS running. With the impact of patients not being able to see their families, utilise their community leaves, be restricted on their contact with others, motivation on the unit has taken a major hit.

The questions we were all asking as well as the usual 'so what is the PPE processes' was how we can keep motivation and activities on the ward going?

As a team we have had discussions, this has included all the members of the multi-disciplinary team ranging from the area service manager, consultants, nurses, nursing assistants, OT, psychology, dieticians the list could go on. We also spoke with the patients, what did they need or want to get through this time, what ideas did they have? I particularly wanted to focus on something that could be sustainable and could be continued on past the COVID-19, something whereby social distancing could be maintained, and adhere to the government guidelines and NHSE guidelines for secure services.

A key area that some patients were struggling with was not being able to access the gym, I too am feeling their pain and my waistline is practically crying at the minute as a consequence! As we are all aware the recent CQUIN has focused on a healthy lifestyle so we have all done a lot of work in this area previously and will continue to do so.

Our solution was setting up an exercise group in the garden area, every evening including the weekends that was led by staff utilising resistance bands and weighted hula hoops. The idea of utilising the resistance bands and hula hoops allowed us the freedom to personalise the exercise to any patient or even staff that wanted to get involved, and could be easily cleaned as per the infection control procedures. This has easily allowed for social distancing to be maintained and staff wear the appropriate PPE throughout the exercising.

The resistance bands have allowed for varying exercise to occur, from low or high impact exercising, and have covered a full body workout. As with all new things initially we had only a few patients engaging with this. However, with continued staff support and encouragement this has grown to almost all patients and staff engaging with this. Hula hoop competitions have been occurring which has caused a lot of merriment. I lost my hula hoop crown to another member of staff though the other day so naturally with my competitive side I am silently fuming.

We have been gathering patient feedback on a regular basis, we have been asking if they have found it a good workout option or if there were any changes they would like to be made.

Feedback so far has been thankfully positive, patients have enjoyed this and have asked if this can be continued. The negative feedback so far has been that they would like more resistant bands to be available, which in the grand scheme of things I think is a win!

Obviously it is not all sunshine and roses literally, some days it does rain! As we are still struggling with getting some patients involved, 1:1 discussions are occurring with these patients. One key area that became apparent for one patient was that he was not engaging, as he felt self-conscious regarding his weight and did not want to exercise in front of others in a group. This has been easily rectified as we have supported the patient to have individual exercising sessions with a staff member away from others which he has been sporadically engaging with.

Others have had no interest in this so we are still brainstorming other ideas at present. As this is the first time we have trialed something like this, it will likely grow and evolve as time goes by. But I know that as a service we are not alone in trying to stay motivated and healthy and wish everyone good luck in this!

Stacey Wilson, Clinical Nurse Lead, Kedleston Unit

Royal College of Psychiatrists

Human Rights and Other Issues Experienced by Secure Psychiatric Patients During the COVID-19 Pandemic

The current COVID-19 pandemic has impacted virtually everyone's lives. The lockdown means our movement and social contact have been restricted, potentially leading to loneliness, stress, boredom, and a higher incidence of mental health symptoms. For patients in secure psychiatric hospitals this kind of confinement and isolation from the rest of the world is nothing new. It is something they have to deal with on a daily basis whilst they are detained under the MHA. Forensic patients perhaps know better than anyone how damaging such conditions can be to one's mental health and well-being, especially in the context of suffering from an ongoing mental disorder.

Secure service patients are some of the most vulnerable of psychiatric patients due to the nature and extent of the qualification of their human rights and the extraordinary degree of power that their clinical teams exercise over them. Psychiatric practice is not known for its objectivity and evidence-based decision-making. At times it may seem to patients that additional restrictions may be imposed on them without objective and grounded reasoning. Regardless of a patient's reasoning ability and eloquence, they may in practice be excluded from decisions regarding their care and well-being, and their concerns and evidence-based challenges to the curtailing of their freedoms may be discounted by default by their care teams. This is definitely my lived experience and that of far too many of my peers. I am rarely involved in decision-making with regard to my care and am routinely judged as 'lacking insight' in spite, of literally having more publications in medical journals than all the forensic psychiatric consultants in my service put together.

Carers can also face considerable barriers to enacting their rightful involvement in decision-making regarding the care of their loved ones. Carer leads may fail to respond to messages from carers, consultants may 'forget' to arrange a conference call that they had agreed to with a carer and her/his loved one's solicitor, or once set up cancel at the last minute claiming that they have a 'more pressing matter to deal with'. Nurses in charge may never seem able to answer the carer's question when they ring the ward or state that the care team needs to work separately from the carer, apparently unaware of the mandatory

involvement of carers and the contents of the Carers Toolkit. It is sad that poor practice still appears to exist within the forensic mental health sector given the excellent work of the QNFMHS and similar initiatives such as the Recovery and Outcomes Group.

One very astute and proactive parent and personal colleague within the QNFMHS reported that in her son's medium-low secure hospital, access to technology to enable much needed contact with family, friends and helpful online resources within the building was denied as a blanket restriction, and since the national lockdown was imposed all S17 leave is rescinded. This is truly tragic and according to various networks to which I belong, measures such as these exist or are being implemented throughout the mental health sector. When I challenged one general adult psychiatric hospital with regard to the blanket restrictions it was indiscriminately applying to its patients, a RMN replied rather illogically that 'desperate times required desperate remedies'. Oh dear, what ever happened to nursing ethics, duty of care and adherence to the MHA Code of Practice and the legal statute?

In the forensic sector conditions may be even worse with attention to patients being dependent on whether they are viewed reductively as risk entities or not, and the currency of care equivalent to nature and extent of restriction. This is business as usual for forensic patients, but the disregard for their actual support needs has been exacerbated since the pandemic presented.

My principal concern is that certain secure services are imposing blanket revocation of all S17 leave, so that patients even those with unescorted leave may not be allowed to exercise their right to go out for exercise (fresh air breaks within the hospital perimeter do not in general provide good opportunities for meaningful and therapeutic exercise). Such blanket restrictions may at an individual patient level constitute a potential breach of the MHA and articles 5 and 8 of the HRA.

It is definitely very bad practice for a hospital to impose a blanket ban on S17 leave given that the Government's proposed changes, to mental health legislation in England and Wales (which have yet to be activated) don't refer to the suspension or cessation of leave, admissions and/or discharges. It is also in conflict with the RCPsych's guidance on practice in the context of the pandemic which emphasises the need to consider each patient's case individually.

Thankfully however, instances of good practice do exist in the forensic sector. Dr Medhi Veisi, forensic psychiatric consultant and all round good egg, reports that the pandemic has taught him a lot and continues to do so. His trust continues to discharge patients and reduce lengths of stay in the wake of the COVID-19 epidemic. They have made the wise decision to implement an internal ethics committee (independent from management structures) to approve or reject decisions and guard against disproportionately restrictive practices during the lockdown. Dr Medhi says that the ethics committee is here to stay and certainly will continue as business as usual. I would recommend that the creation and implementation of permanent internal ethics committees should be added to the QNFMHS Quality Standards in order to support the safeguarding of patients' rights under the MHA, HRA, Equality Act and other relevant legislative frameworks it would definitely be good practice. With regard to S17 leave practice varies in London alone, from complete blanket bans in some areas to a maximum 30 minutes leave per day.

Unhappily there are also reports of patients and escorted patients being stopped by police. 'Oop north a significant number of MSU services are still facilitating external S17 leave at most once a day in line with the government's restrictions on the wider population and avoiding 'busy' places. Oxford Health also has an internal ethics committee and has also continued with S17 leave whilst working within government guidance.

The wonderful RCPsych has launched the COVID-19 Mental Health Improvement on behalf of NHS

England & Improvement. The aim is to support mental health teams to share and learn from each other to maintain and improve safety in response to the COVID-19 pandemic. Similarly, the CCQI has been considering ways to help services manage the COVID-19 outbreak and are planning on setting up weekly webinars where individuals can come together to learn and discuss certain topics.

Spatial distancing may be easier said than done on a secure hospital ward. On the QNFMHS Knowledge Hub inpatient secure services have been reporting that they are currently caring for patients with confirmed COVID-19 and reaching out to seek the advice of colleagues on how best to manage the associated challenges. This is responsible adaptive behaviour and it is good to see so many services sharing practicable ways of meeting their patients' changing needs during this time. My own service has been exploring the option of temporarily relaxing some low risk restrictions to support patient activity levels, particularly when fewer staff are available to co-ordinate therapeutic activities.

It is not only patients who are being impacted at a personal level by COVID-19. Only this morning I was talking to a paramedic who is very concerned about the impact of the pandemic, on both the short and long-term mental health of frontline healthcare workers (and the general population). He anticipates that as the pandemic continues and ultimately recedes there will be a significant increase in (undiagnosed) cases of PTSD amongst healthcare staff. Frontline workers may be exposed to the stress and trauma of their patients (and colleagues) dying, and family and friends stuck at home feeling bored and frustrated. He was very worried about this.

In short this is a testing time for us all, but not necessarily a wholly negative one if services are prepared to innovate in a rights-based fashion. Spatial-distancing doesn't necessarily entail social disconnection, if technology is deployed in a measured and individually care-planned manner in secure services. Internal ethics committee can promote reasoned, evidence-based, moral decision making. Patients, carers and staff can come together to share experiences and coping strategies in the context of exacerbated confinement. We are at our strongest and best when we think of others first, especially the most vulnerable amongst us.

Dr Sarah Markham, QNFMHS Patient Reviewer, CCQI

Nottinghamshire Healthcare NHS Foundation Trust

Patients Maintaining Contact with Family, Friends and Carers During COVID-19 Lockdown

Background

In response to the Coronavirus pandemic, Arnold Lodge stopped all planned visits to patients during the week commencing 16th March 2020. It was soon recognised that this would have a detrimental impact on the health and well-being of the patients and their families, friends and carers.

NHS Sparks

It was agreed that an alternative solution needed to be found and discussions started with the Trust's IT department. They had concerns about using the Trust network but they suggested utilising the NHS Sparks WiFi as it could be provided via the Trust's infrastructure. It was agreed that as NHS Sparks has a web filtering facility, is fully compliant on legal requirements and data protection, that this would be a good solution to the information governance concerns for the Trust, patients and the public.

Very quickly the wards now had a facility that was able to access a managed internet via WiFi that was separate to the Trust's network.

Tablet computer use
Tablets were purchased for each ward configured to access the Skype app, mitigated against the risks of inappropriate access to the internet and guidelines developed for staff to ensure their safe use. This included protecting the privacy of other patients on the ward to ensure they would not be shown on camera.

A collaborative outcome
The social work team at Arnold Lodge contacted family, friends and carers to ask if they wanted to have "virtual visits" via Skype and helped them in setting up their accounts if they needed assistance.

Clinical teams started to discuss the option for Skype visits with those patients who were not aware of how video calling technology worked and what they would experience if they wanted to have a "virtual visit".

Now patients, family, friends, and carers are able to see as well as speak, to each other throughout the day. This has proven to be beneficial at a time when the country is in lockdown and the ward activities have been affected so much by the impact of COVID-19.

Skype has been well received by our patients and the feedback from family, friends and carers has also been very positive. We are really pleased that during these difficult times we have been able to introduce something, that has had such a beneficial effect and anticipate it to continue into our futures.

Ian Mawer, Security and Support Services Manager, Arnold Lodge

Knowledgehub

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

Joining Knowledge Hub will allow you to:

- **Share best practice and quality improvement initiatives**
- **Seek advice and network with other members**
- **Share policies, procedures or research papers**
- **Advertise upcoming events and conferences**

We will be using Knowledge Hub as our main way of communicating with our members, so in order to keep up to date with the Quality Network, ensure you sign up!

Email **'join Knowledge Hub'** to forensics@rcpsych.ac.uk

QNFMHS Open Discussion Summaries

We have been holding open discussion forums for services. Here is a summary of the themes of each discussion. The full summaries can be found in the forum section of our Knowledge Hub.

Restoration and Recovery

What is the current situation with COVID-19 in services?
Most services have fewer cases and restrictions are easing.

Key challenges
The main challenges for services were discussed. These included increase in incidents, the limitations of staff wearing facemasks and adhering to government restrictions.

Use of technology
It was reported that COVID-19 has allowed services to develop technology use.

Easing restrictions
Following the government guidance, some services have been slowly easing out of lockdown. Many staff are returning to work, leave is being gradually reintroduced.

Carer experiences
Patients are starting to receive visits with family on the grounds. The increase in opportunities ot contact their loved ones via mobiles on the wards has been positive for carers.

Staff support and wellbeing
Services are continuing to check in on staff. There are anxieties around a second wave happening and concerns around the wellbeing of ward managers.

Least Restrictive Practice

What is the current situation with COVID-19 in services?
Most services are beginning to ease restrictive lockdown measures. Many patients have struggles with these. In all services staff have adapted the way they work e.g. face coverings, good hygiene.

Service perspectives and actions
There was a discussion around what different services are doing. E.g. easing restrictions, reviewing restrictive practices, hygiene and infection prevention.

Positive outcomes
The improvement in use of technology has been a big positive for services. There has also been a strong focus on physical health.

Communication
The importance of communication to patients and cares during lockdown was highlighted. Services discussed how they have been addressing this.

Carer Experiences
There has been mixed experiences for carers during the pandemic, not all have seen the restrictions reduced for their loves ones.

S17 leave
Facilitating leave has been a big challenge. There was a discussion around what different services have been doing.

Staff and Patient Safety and Wellbeing

Communication
There was a discussion around MDT support to nursing staff and challenges with communication,

Use of technology
The use of Microsoft Teams was reported as being helpful. Virtual ward rounds have gone well and feel more productive for services. There have been challenges with the introduction of technology, including patient access.

Easing restrictions
Some wards have designated occupational therapists. However, others activities initially dropped during lockdown. There are plans for some service to increase psychology programmes on the wards.

Lessons learned
Staff expressed that they would have liked to see more senior staff members visible and more present on wards.

Upcoming initiatives

Open forum discussion sessions

We recently hosted three open discussion sessions with members, to discuss common issues arising from working within forensic mental health. Each forum has a particular theme and is facilitated by the Quality Network group.

The sessions are for individuals to engage in conversations about particular issues and to learn and share good practice. As the initial sessions were well attended and we received positive feedback, we are pleased to announce some additional sessions, which are:

- **24 August 2020, 12:30-11:30: Use of technology in forensic services**
- **10 September 2020, 13:00-14:00: Managing risk and patient pathways**
- **28 September 2020, 16:00-17:00: Lessons learned from COVID-19, what we want to keep**

To join a session, please complete this booking form. Please share this widely within your teams.

Please note: There is an expectation that those that join the call actively participate to ensure the discussions are as productive as possible. We suggest that attendees prepare a couple of questions or scenarios in advance that could encourage discussion on the topic.

If you are interested in viewing any of our previous webinars, please visit our website. For any questions, please get in touch with us on forensics@rcpsych.ac.uk.

Peer-reviewer training

As we are entering a cycle of virtual reviews, we have amended our reviewer training package to cover the process of virtual reviews and the responsibilities of peer-reviewers. We have condensed the session to 1-hour and these will be delivered on MS Teams. The following training sessions are:

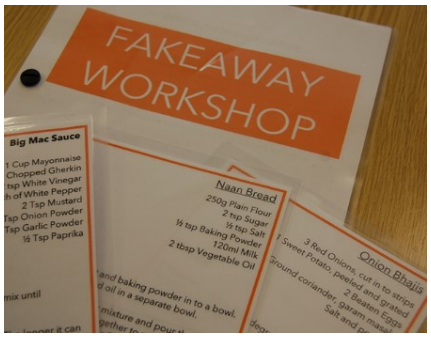
- 26 August (14:00—15:00)
- 3 September (10:00—11:00)
- 15 September (15:00—16:00)
- 30 September (12:00—13:00)
- 6 October (10:00—11:00)

If you are interested in attending, please complete this booking form.

Riverside Healthcare Ltd

Fakeaway Vs. Takeaway: A Recovery College Success Story

Over a year ago, we were approached by a patient's relative with an idea to run a course within the hospital to educate our Cheswold Park Recovery College students about healthy eating and living on a budget whilst still enjoying their favourite foods. A relative with years of teaching experience and a passion for working with those living with mental health conditions, the perfect person to make this work. After much deliberation, many emails going back and forth and several meetings, we were proud to present our very first "Fakeaway Vs. Takeaway" course. With the support of our occupational therapy team, we created a seven-week course, planned the lessons and created a course guide for students to keep. The goal was to top this off with a Cheswold Park-style showcase event that gave the students the opportunity to show the hospital what they had achieved during the course, and to generate interest across the hospital for future courses.



Four students were selected to road test the content, format and supporting material of the course. Four students who were seen as competent in a kitchen setting and enough creative flair and enthusiasm to create a Hollywood blockbuster. Four students from different backgrounds with varying culinary tastes and a few dietary requirements thrown into the mix for good measure.

Our first session was an introduction to the teacher and facilitating staff. We discussed the course aims, the plan for the future sessions and our goal of hosting a showcase event. We discussed our favourite takeaways and to say that it made us hungry would be an understatement! From lamb madras to fillet steak Cantonese style, the ideas were flowing, and from there, we decided that the first week of practical work would be recreating the good old Indian takeaway.

We created a feast fit for a king. Lamb madras, chicken korma, sag aloo, bhajis and samosas. Recipes were sourced that focused on healthy eating without losing any of the taste or flavour of these dishes. The table was heaving under the weight of the fabulous dishes we had created from scratch. We ate, we enjoyed, we ate some more. Then came our review. We discussed what we had created, compared cost and calorie content to that of a "real" takeaway and we were all shocked with the difference. This inspired us to create a number of different takeaways during our future sessions, including Chinese, Pizza and KFC! Week after week, we cooked a number of dishes and compared them to the real thing, examined the calorie content and cost. Everything was cooked from scratch and the aroma of all this fresh food filled the corridors every Monday evening. It tempted passers-by to pop their head in to find out what we were making, all in the hope of being lucky enough to be offered a free sample of our work. Word soon got out about what we were doing, and soon we had requests for take-outs and people asking to sign up to future courses. All before we had even started planning and advertising our showcase event!

After 5 weeks of cooking, we took a seat and set about reviewing and evaluating our work. It felt strange not to be cooking together, but we remained enthusiastic and energised. We evaluated the course (100% of course participants would recommend the course to other students...just saying!) and started planning this great showcase event that we all had in our minds.

Showcase day was upon us (well, the day before!) We met on a Sunday afternoon, which is usually reserved for some well earned R&R here at Cheswold Park, and we prepared what we could to make sure we could provide everybody who walked through that door with a sample of our creations. On the day, we donned our best shirts and whipped up a storm in that kitchen. We created a menu that would satisfy all tastes and really show what we had learnt during the course. Chicken curry, sweet & sour chicken, vegetable spring rolls (with homemade sweet chilli sauce for good measure), fresh burgers and lasagne. We opened the door at 3:30pm, nervous that people wouldn't show up or that people wouldn't enjoy what we made. Those worries were short lived. People flocked into the dining room, tempted by the smells that flooded the Cheswold Park corridors. People came back for seconds, people were interested in the course and spoke to the students about what they gained from the course, people were asking to sign up to the next course. Our students were presented with their certificates of achievement, our teacher was presented with a bouquet of flowers to say thank you for her support and this was topped off by a visit from the Chief Executive of Cheswold Park, Tony, who congratulated the students on a successful event. The feedback we received was 100% positive and everybody left with a smile on their face and a belly full of food.

So what next...? Will we do this again? Will we continue to educate those who want to learn? The answer to that question is a definitive YES! Having received such positive feedback from our students and those who attended our showcase, we wouldn't change a thing. Our students are keen to return to the kitchen to impart their wisdom on the students of tomorrow and support in facilitating future courses. We actively encourage this, and it is this kind of passion and enthusiasm that is at the heart of what the Cheswold Park Recovery College stands for.

One question that needs answering is "What's next for these students" and that's a great question. One of the big focus points of Cheswold Park's Recovery College is "what's next?". With the support of our original four students, we want to launch an enterprise. An enterprise that truly showcases the talents and skills of these amazing students. We want our students to be involved in areas of the hospital that have previously been reserved exclusively for staff. We want to be catering events, we want to host theme nights, we want to raise money from our creations and skills, and eventually take this out in to the community. What that looks like right now is being kept under wraps, but we assure you that it will be spectacular, unlike anything ever seen at Cheswold Park before. We will add to this skills base with every course we complete, growing our enterprise further and further.

Richard Mason, Recovery College Lead, Cheswold Park Hospital

Cumbria, Northumberland,Tyne & Wear NHS Foundation Trust

The Journey to Becoming an Artist in Secure Services

If one is fortunate in life, one may encounter a good teacher who inspires and influences and sets a person on a course in life with confidence, self-belief and inner strength. Perhaps many people can remember someone saying something good about a talent, a personal quality or an ability they have. Words never to be forgotten, something to forge and form character. A touchstone of who we are to ourselves and, hopefully, to the outer world. Why should it be any different for someone living in secure services? In this article, with the input and reflections of a remarkable and talented young man, I hope to demonstrate just that. And it so happens that the young man is a patient within secure services.

"That was the beginning" said Charles, of a day in 2015 when Hannah Whitlock from the Sussex-based organisation 'Outside In' held an Artist Surgery Day in a nearby town. Outside In supports artists who, for reasons of health or social exclusion, find barriers to accessing the arts. Surgery days are held nationally to raise awareness of the opportunities available.

Charles was nervous that day, when, with other patient artists, we went to meet Hannah. Everyone clutching their portfolios, wondering how the work would be received; shy about exposing their artwork for gaze and possible criticism but also intrigued and excited. "This stayed with me a lot" Charles said of the day. "She said my work was brilliant and she showed us how to photograph, crop and upload pictures of our artwork onto the Gallery site". "I knew this could be a bigger chance". Charles Truman now has a virtual gallery of his artwork which can be reached on the Outside In website. The national website offers a platform for artists to display and receive feedback on their work. Each Outside In artist uses a pseudonym (as in the case of Charles, not his real name) and curates their own virtual exhibition space. Staff at Arts Project, Secure Care Services CNTW, help facilitate this process for a number of patients. Outside In also organise real-space exhibitions, take work to International Art Fairs and collaborate with other organisations, for joint projects open to members, with a selection process based on artistic merit.

Charles produces elaborate and very detailed pen drawings; collisions of imagery full of symbolism and energy, referencing urban culture. He has developed and honed his

technique over years. He also paints powerful, expressive, landscapes which are as much about an interior as an exterior world. Turneresque, sometimes apocalyptic, vivid paintings; as if the paint has been imbued by the artist with a wild life of its own. Intense landscapes are evoked and marvellous creatures such as fireflies burst out of blackness. There are self-portraits, angels, wrestlers, packs of cards (the Ace of Spades figures often).

I asked Charles if he remembered when his interest in art first started and when he began to express creativity. He spoke about doing a lot of graffiti around his home area, significantly in scrapyards, tagging abandoned cars. This early influence seems to have filtered through, in drawings such as 'Industrial Playground' and 'Psychogeography'.

Whilst in secure care services, Charles has attended sessions with the arts team at Arts Project. He credits this experience as being instrumental to his development as an artist. Of the Art Studio he says "it is much more than just a room" and cites the education he received in painting from two tutors, themselves professional artists. "I did a lot with Ted, he was a key to me".

Charles said he makes art about life as he sees it, often influenced by the news, truth and untruth. Body-building features in Charles' art, symbolising strength and protection. "It's the mind as well as the body", defeating weakness and injury; carrying on, overcoming. Women are depicted in Charles' work as mothers, angels, body-builders: strong, powerful and positive influences.

Charles has a take on the experience of prison and secure services, depicting time in the form of clocks "time that you've done; time that could have happened", round and round, endlessly. I asked Charles why he depicts contraband such as weapons. "Because it's the scariest stuff" he said. However, it was clear that this is not a celebration but a critique. We also touched on the role of humour in his art "humour is a different strategy".

I felt privileged that Charles discussed his wonderful art with me. What of the future for Charles and art?
"To have a studio...Maybe teaching?"
"Now that I've reached the point that I know I am capable of it, I think it will always be there".

Charles has exhibited in Koestler UK exhibitions at the Southbank, London and in 'LOUD!' the Koestler Exhibition for the Northeast at BALTIC Centre for Contemporary Art, Gateshead.

Jane Akhurst, Arts Project Manager and Charles Truman, Artist and Service User, Northgate Hospital

Cumbria, Northumberland, Tyne and Wear NHS Trust

Education Service at Cumbria, Northumberland, Tyne and Wear

The Education Team in Secure Services was established in 2016 and consists of a small team of dedicated staff - 2 qualified teachers and an assistant practitioner who support patients on a one-to-one and group basis. We work across two sites offering sessions based on the adult curriculums which is offered in the community. We have centre approval from two awarding bodies to offer qualifications: OCR, One Awards/ NOCN and have direct claims status for the majority of qualifications we offer.

Patients can earn vocationally recognised qualifications based on the functional skills syllabus, English and maths based awards, IT and online safety, budgeting, employability, peer support, mentoring and volunteering. We have also completed a number of qualifications in the following vocational areas – sports, art and woodwork. We also help to facilitate distance learning and e-learning sessions with the emphasis on self-development and wellbeing.

We work in partnership with the Recovery College and run accredited sessions in the evening concentrating on recovery focused skills – volunteering, peer support and mentoring. In addition, we offer creative sessions in poetry and creative writing. We support developing the collation of this patient work into anthologies and booklets as a record of the positive and recovery-focused work across the sites. We also run a library service which offers DVDs/video games and books to patients on the main site and the KDU at Northgate and at the Bamburgh Clinic. As part of this service, we work in collaboration with the Head of Library Services who has helped to facilitate a Book Club along with education staff at The Bamburgh Clinic and has supplied reading materials for self-help and personal wellness to the sites.

At regular intervals we run competitions with the Recovery College to encourage participation in themed events. For example, coast and castles writing competition, Easter poetry competition, VE day written word celebration and publicise topical events following the educational calendar e.g. National Poetry Day, National Adult Literacy Day, online safety, world book night.

The education team firmly believe in supporting the patients to access the opportunities and benefits that educational activities can have. We also encourage them to participate and contribute to their own learning whilst in our care. With the encouragement of staff, it is our belief that patients can build up a positive rapport that is built on trust. In turn, this can support their recovery in a safe and constructive environment.

Achievement Comparison 2016-2019

Years	Success Rate %	Total Enrolled	Total Passed	Total Failed
2016	91	67	61	6
2017	91	81	74	7
2018	96	47	45	2
2019	95	58	55	3

Our achievement rates demonstrate the overall successful participation of candidates who achieve a qualification which in 2019 was 95% of those who undertook a qualification achieved it. In terms of the feedback we have received, we collate the student perception of course (SPOCs) forms and report this back to staff and patients every December. The feedback has been exceptionally positive and supportive and identifies the value that the patients place on the sessions. Figure 1 on the next page illustrates this.

Helen Sonnenfeld, Education Lead and Specialist Teacher, St Nicolas Hospital

Figure 1.

2016-2020 Comparison: Curriculum Questions

Question	2019 Results	2018 Results	2017 Results	2016 Results
I have discussed my course and the topics with my tutor	100%	94%	97%	96.5%
I can clearly see my progress through my course	97%	88%	97%	90%
I feel that my skills have improved since I started the education course	94%	83%	91%	93%
The tutor works at a pace which is comfortable for me	100%	100%	97%	100%
I feel comfortable asking my tutor for help if I need it	100%	100%	100%	97%
The planned activities and resources help me to learn	100%	94%	97%	90%
Would you recommend this course to others	100%	94%	97%	90%
*Have you achieved a qualification? *	NA	72%	57.5%	59%

*(In 2019 we removed this question from the SPOC)

Royal College of Psychiatrists

Implementation of the Carers Toolkit: involving families in secure services

Opportunities for family involvement in secure services have been developing in recent years in recognition of the fact that carers have skills, knowledge and experience that can make a positive impact on their loved one's care and treatment. The involvement of carers is now regarded as vital to their loved one's recovery. Since the publication of The Carers Toolkit in 2018 the involvement of carers is now mandatory in secure services.

As the mother of a man who has been a user of mental health services of all types for 19 years, including inpatient secure services for almost the past 4 years, I regard this as a welcome and necessary improvement. Here I will describe some of the adverse experiences I have had as a carer over the years, outline some new initiatives that have provided involvement opportunities for me, share my thoughts about the limitations to family involvement in care planning and delivery and barriers to implementation of the requirements of the Toolkit and lastly offer some thoughts on how these can be overcome.

Adverse experiences

To date, my son has been under the care of in excess of 30 different mental health teams and more than 40 different consultant psychiatrists have been involved in assessing him. It is important to me that I have good communication with those working with my son and to be involved in any way that might be helpful. My son supports this and has always given his consent. As you can see it involves trying to establish rapport with a large and shifting population of mental health professionals.

For the first 15 years of my son's involvement with services all of my contact with treatment teams was initiated by me and otherwise would not have occurred. I felt I was not regarded as having any relevance to my son's treatment and that my attempts at involvement were an irritant rather than seen as having any value

On several occasions when my son was in the community I experienced being ignored when I expressed concern about him being in crisis, appropriate action then being delayed until after the crisis had escalated, with avoidable dire consequences for my son and for me. At times I have not been informed when my son had statutory mental health assessments, nor when he was transferred from one hospital to another. I have never been informed nor consulted on decisions about medication. I have had the experience of consultants declining to speak to me, citing confidentiality as a bogus issue. Numerous letters, emails and telephone calls from me to consultants have not been responded to. Lack of response to communications continues to happen and I am still mostly excluded from decision making in relation to care plans, medication and risk assessments.

New initiatives providing involvement opportunities

Within the past 4 years, through the appointment of a carer and service user involvement coordinator and a carer lead at the secure hospital where my son is an inpatient, I have attended a bimonthly carer support group, a bimonthly carer focus group, I have been trained as a trainer and as an interviewer, I have contributed to staff induction, staff recruitment, academic meetings, I have spoken at a regional conference and I have been a member of a variety of specific stakeholder groups. I am now a peer reviewer at the College's QNFMHS and a family representative on the QNFMHS Advisory Group.

Barriers to family involvement in clinical practice

Despite the involvement opportunities described above, there is a significant dissonance between this type of family involvement and family involvement in clinical practice.

The local trust's Carers' Charter reads 'We will value the experience and expertise you have and we will work with you as equal and expert partners to give the best possible care' and 'we will recognise that you are integral to the whole care plan, initial assessment, risk assessment, reviews, discharge and recovery planning'. However, opportunities to be involved in this way do not exist as a matter of course. It is still rare for anyone involved in my son's care to contact me spontaneously nor to ask me questions about my son; any involvement on my part is still largely initiated by me. I have received mixed messages about whether or not I am welcome to attend ward rounds. If I do it is a matter of being present for around 10 minutes at a meeting where discussions are held and decisions made when my son and I are not present. These attendances involve a 30 mile round trip for me, a small amount of travel compared with that involved for many families. The only other regular opportunities for family involvement are the six monthly CPA, annual hospital managers' hearings and 3-yearly tribunals, which is hardly satisfactory. At my request, I have established, in theory, a regular weekly phone contact with one member of the current team. In principle this is good but in practice the contact is unreliable and has failed to take place more than 60% of the time and I continue to be informed of decisions made about my son's care rather than being involved in making them. As a result of my persistence I have very recently started to have occasional direct communication with the consultant which is very welcome.

However, generally, there is clearly not a culture of valuing family involvement. Attempts to include families seem half-hearted, there is little knowledge amongst staff of the requirements of the Carers Toolkit and little real appreciation of the benefits of carer involvement.

How can we understand and overcome these barriers?

Last month I had a conversation with a nurse on my son's ward about my struggle to have a voice in my son's care, particularly important as I am the only person who can explain the events that give meaning to his problems. I gave her examples of how it is evident to me that, despite

my efforts and even though my son has been in their care for almost 4 years, key members of the team still do not have this crucial knowledge and understanding. She told me that the team needs to be able to work independently of carers, just as a medical team would not expect carers to be involved in their work.

Therein lies the problem. In forensic inpatient services, mental health problems are still regarded primarily as biological illnesses and treatment teams are structured hierarchically, along the lines of medical teams. All patients have a psychiatric diagnosis and for the vast majority the primary intervention is medication, usually prescribed long term. These psychiatric diagnoses are believed to explain what is wrong with patients in terms of underlying illness resulting from neurochemical imbalance that drugs purport to correct and insufficient attention is paid to what has happened to patients in their lives that has led to their problems. There is much debate about the validity of this paradigm and alternatives are gaining attention such as those outlined in Trauma-informed Care, Open Dialogue, and the Power Threat Meaning framework. There is a more obvious and natural role for family members in these approaches, particularly in Open Dialogue teams where hierarchies are flattened, families are fully included, all voices have equal validity and all decision making involves the patient and their family. Studies show superior clinical outcomes for Open Dialogue, as well as increased job satisfaction for staff and improved staff retention rates.

A huge shift in the way services are organised will be required to move away from the predominant biomedical model towards the primacy of these alternative paradigms. This will enable meaningful family involvement as well as bringing great benefit to all.

Nuala Sheehan, QNFMHS Family and Friends Representative, CCQI

Birmingham and Solihull Mental Health Foundation Trust

Meeting the Diverse Needs of our Service Users

The Tamarind Centre is a medium secure hospital for male service users in the East of the City of Birmingham, with a culturally diverse population. To meet the needs of the service users there are a number of events and initiatives to support them

During the COVID-19 pandemic, occupational therapy (OT), psychology and nursing staff have worked with service users on various wards to hold roots and culture-based activities. These consisted of a quiz, food, music and discussions between staff and service users

The Elders Project - Promoting Inclusion in Forensic Services for African and Caribbean men

There is documented evidence that black men are overrepresented within the secure service patient population. They have longer lengths of stay and are more likely to be involved in restraints etc. The aim of the Elders Project is to address the needs of black African Caribbean males in secure care who have lost their

connection with their families and in turn, their community. The importance of social support is recognised as being very important in supporting service users in their recovery journey, especially for people who feel disconnected from their culture and community.

Progress so far...

In February 2018, an event was held at the Tamarind Centre to introduce the Elders Project to the service users. During the event we were joined by the Lighthouse Group, a theatre company who highlight issues that affect the men in our service.

To date

- We have successfully recruited 13 Volunteers
- DBS checks are nearing completion
- Six of the volunteers have received training on: Introduction to Forensic Services, Professional Boundaries, Mental Health Awareness (diagnosis, medication and sections)
- Training for the remaining seven was halted due to the COVID-19 pandemic but will resume shortly using our new ways of working. Once the training has been completed then the next stage is to match the identified service users with the volunteers

The recruited volunteers will bring a wealth of professional, personal and life skills to the programme. They will have strong family ties and individual skills and influence in their respective communities. They will be given ongoing support in the form of one-to-one and group supervision once they have started to work with our service users.

Cultural Events

For the third year running a Black History event was held at the Tamarind Centre in October 2019, with the theme 'Diversity in Action'. This event was enjoyed by staff, service users, carers and senior members of the Trust. The sports hall was decorated with photos and quotes of inspirational black leaders. This was complemented by a selection of flags and African print table clothes.

The event was compered by Steven Brown (Co-Founder of Wellbeing SOS). He got the afternoon off to the perfect start with an interactive session that dismantled some misconceptions and stereotypes about black people, celebrated the contributions of influential people and highlighted that as a diverse society we have more similarities than we may consider. Steven also challenged us to look at any beliefs that hinder us from accepting cultural differences. Steven explained the importance of embracing and recognising black history as it is a part of all our histories!

A service user devised and facilitated a quiz which focused on influential black figures and facts from history which generated enthusiastic participation from the crowd.

Some of the entertainment was facilitated by Calvert with his selection of African drums with service users and staff actively participating. A reggae band also provided entertainment, again this was enjoyed by the audience who were able to take part by singing and rocking along which really solidified the aim of the day - to collectively celebrate the rich heritage of black history and culture.

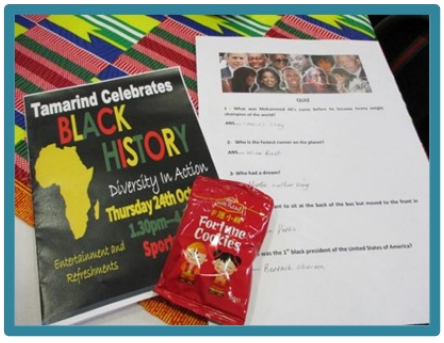
For lunch was a selection of hot Caribbean dishes and Indian snacks prepared by our in-house catering department.

Feedback from service users', carers and staff was very positive; everyone said that they had a wonderful time.

The above is just two examples of what we are doing as a service to meet the diverse cultural needs of the service users in our care. This event is in addition to the three friends and family events that are held at the Tamarind each year. Invitations are sent out to all the approved friends and family of our service users inviting them to these events.

Due to the current COVID-19 pandemic it is very unlikely that we will be holding a Black History event this year, but throughout the pandemic we have kept families and carers informed about what we are doing as a service to keep their loved ones safe whilst keeping in line with government guidance.

Dawn Sutherland, Advanced Nurse Practitioner, Tamarind Centre



Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Delivering Pain Neuroscience Education to Clinicians Improves Pain Catastrophising

Introduction

Persistent pain affects more than two fifths of the UK population meaning more than 28 million adults are living with pain that has lasted for more than three months (The British Pain Society, 2016). Given the complex interactions between pain and mental health it is understood that a lot of clients seen in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust will have experienced or be experiencing persistent pain.

Over the past 20 years there has been a growing understanding of the science of pain, including the neurobiological and immune changes which occur and begin to become drivers in persistent pain and associated symptoms. This understanding has helped us to recognise that tissue-based damage is often not the main driver for medically unexplained persistent symptoms, but instead other biological, psychological and social factors can combine to create neurobiological and immune changes which keep these complex conditions going (Moseley and Butler, 2015).

There has been plenty of research which looks at pain education being delivered to patients and the benefits associated with this, including a decrease in catastrophising; an increase in self-efficacy; a decrease in fear avoidance; and a decrease in total health care costs (Lorig et al, 1993). However, research is lacking into the role pain education plays on clinician knowledge, attitudes and beliefs despite there being an understanding of the association between clinician held attitudes and beliefs and the advice and care they deliver to service users (Darlow et al, 2012; Houben et al, 2005).

The purpose of this pilot study was to see if a single, two-hour pain education session delivered to clinicians working into an adult secure care service reduced clinician pain catastrophising levels.

Methods

Twenty-five clinicians working into the adult secure care services at Cumbia, Northumberland, Tyne and Wear NHS Foundation Trust were invited to attend a two-hour pain education seminar and fill out a Pain Catastrophizing Scale (PCS) questionnaire before and after the seminar. The questionnaire totals and the subcategories of catastrophising (rumination, magnification and helplessness) were analysed for change.

Distribution of data was checked and where it was normal the paired t-test was used to check for statistical significance. Where distribution was not normal the Wilcoxon signed-rank test was used to check for statistical significance.

Significance was set at $p = 0.005$

Results

Following a two-hour pain education seminar, significant improvements were found in total PCS scores ($p=0.001$), and sub-categories of rumination ($p=0.000$) and helplessness ($p=0.002$). A notable improvement in magnification was found but this was not significant ($p=0.280$).

Discussion

In line with research around the impact of pain education on patients, this study demonstrates that a one-off pain education seminar can reduce clinician pain catastrophizing levels.

Research has shown that clinician attitudes and beliefs impact on the advice and care they give to patients, so improving their knowledge and understanding of the complexities of persistent pain conditions reduces the likelihood of catastrophic thoughts around pain being passed on or picked up by people in their care. This is especially important in inpatient mental health care settings where service users with severe mental illnesses and complex biopsychosocial factors have an increased likelihood of experiencing long-term persistent symptoms

compared to the general population (Vigo et al, 2016).

It is also recognised that inpatients in mental healthcare settings face multiple barriers to attending mainstream services, including pain management services. These barriers include but are not limited to lower levels of recognition of physical health needs; barriers to seeking and accessing primary care services; increased levels of fear and mistrust of services; diagnostic overshadowing; and lower intervention rates (Disability Rights Commission, 2006). Further barriers specific to secure care settings might include issues linked to section 17 leave, escort status and staffing levels. This means a lot of initial physical health advice and care is delivered by staff within the mental health secure care setting so improving the knowledge and understanding of clinicians around the management of long-term conditions will positively impact on the care being delivered to patients.

This small study suggests that delivering pain education to staff improves their catastrophising levels so in theory should change the way they approach the subject of persistent pain in clients who experience this. However, this study did not have the size or design to look at whether this reduction results in improved patient care.

Conclusion

Pain catastrophising levels of clinicians working in a male secure care service improved following their attendance at a two-hour pain education seminar. Further research with a larger sample size, a control group and other associated metrics (e.g. clinician knowledge of pain science, clinician attitudes and beliefs on managing pain conditions and clinician fear avoidance levels) would be helpful to further understand the impact of clinicians receiving pain education on patient care.

Gillian Watters, Advanced Physiotherapist, St Nicholas Hospital

Oxford Health NHS Foundation Trust

FoVOx: a novel and scalable violence risk assessment tool based on the largest forensic sample to date

Assessment of risk towards others is a key issue in forensic psychiatry and informs admission, management and discharge planning. While re-offending rates in patients discharged from forensic psychiatric units are lower than those in released prisoners, they remain significant with a recent meta-analysis reporting a crude re-offending rate of 4484 per 100 000 person-years. This can be interpreted as around 4-5% per year in the community, although this will change over time and is lower in those with restriction orders. One UK based study has found a re-conviction rate of one in three in men and one in seven in women in the six years after discharge. As such a significant part of the clinical focus is on accurately assessing and reducing risk of violence.

The approaches used for this purpose can be broadly divided into three categories: unstructured clinical (based solely on clinical judgement); actuarial, which use statistical methods to achieve a numerical probability about risk; and structured professional judgement, which aims to combine clinical judgement after considering some sort of list of risk and management factors. The latter category is extensively employed in forensic settings and is often used as a performance indicator, despite having low to moderate validity in real world studies, being based on dated and limited evidence on risk factors, having cut-offs that do mean different things depending on the assessor

and little correspondence with the actual risk on discharge, and typically requiring a significant amount of time to complete. There has been very limited innovation in this field in the past decade and given the increased time pressures most clinicians work under, there is a clear need for more accurate efficient and easy to use tools.

The forensic psychiatry research team at the University of Oxford, led by Professor Seena Fazel, have developed a free online tool FoVOx (Forensic Psychiatry and Violence tool Oxford), based on a study with the largest forensic sample to date and developed using the latest methods in the field of prognostic medicine. The tool is based on a longitudinal cohort study of 2,248 forensic psychiatric patients from Sweden, who were discharged to community settings over 14 years. All patients were followed up for 24 months. Data from several national registers provided information on identified risk factors, and survival analyses were used to generate a predictive model that was tested for predicting violent crime (defined as any interpersonal violence, which included ABH, GBH, attempted murder, manslaughter, murder, contact sexual offences, and arson to endanger life) at 12 and 24 months after discharge from hospital. The tool can be used via categories: which are pre-set as: low < 5%, medium 5-20% and high >20%; or can give a probability score (e.g. 8% likelihood of violent reoffending within 1 year of discharge, and 14% within 2 years).

The total sample of 2,248 patients had 2,933 discharges into the community. 6.9% of the sample committed a violent offence within 12 months and 10.9% within 24 months. 86% of the sample were male and the median age at discharge was 36. The final prediction model included 12 risk factors: age at discharge, male sex, previous violent crime, previous serious violent crime, primary diagnosis at discharge, alcohol use at hospitalization or discharge, personality disorder at discharge, employment before admission, five or more previous inpatient episodes, drug use disorder at hospitalization or discharge, lifetime drug use disorder, and a length of stay of over one year. The model had an AUC of 0.77, indicating good overall measure discrimination; calibration was also good (meaning the predicted risk was close to the actual risk). Using the 5% cut-off at 24 months, sensitivity was 96% and specificity was 21%, and positive and negative predictive values were 19% and 97% respectively. For a 20% cut-off sensitivity was 55%, specificity 83%, with positive and negative predictive values of 37% and 91% respectively.

Prior to implementing a new tool its potential clinical impact needs to be assessed. The FoVOx tool has been tested in a feasibility study, in which its acceptability, practicality and demand for its use was assessed in the Thames Valley Forensic Mental Health Service for 90 consecutive discharges. Consultant psychiatrists in the service found the FoVOx tool practical and very easy to employ, owing to the reliance of the tool on routinely collected data (i.e. not requiring extra interviewing). For the lead clinicians familiar with their patient, completion of the tool took around one minute. 7 of the 11 consultants respondents stated they would use the tool routinely in their future clinical practice. The study also highlighted the fact that probability scores generated can potentially be used to support clinical decision-making for outside bodies, such as Tribunals. The tool has attracted significant international interest and there are currently several feasibility studies being undertaken in Finland, China and Sweden alongside a 5-country EU funded study involving Germany, Italy, Austria, Poland and the UK.

The tool is available for use here and the original FoVOx study here.

If you are interested in a collaborative project involving the use of FoVOx please contact Seena.Fazel@psych.ox.ac.uk.

Dr Oana Ciobanasu. ST5 Forensic Psychiatry, Dr Robert Cornish, Forensic Psychiatry Consultant, Oxford Clinic, Professor Seena Fazel, University of Oxford & Wellcome Trust Senior Research Fellow in Clinical Science and Honorary Consultant Forensic Psychiatrist, Oxford Clinic

Cumbria Northumberland Tyne and Wear NHS Foundation Trust

The Development of a New 'Boxercise' Intervention for Cumbria Northumberland Tyne and Wear NHS Foundation Trust Adult Medium Secure Mental Health Service

Background

The current Commissioning for Quality and Innovation (CQUIN) target for adult medium and low secure care services is around managing a healthy weight. With this in mind it was felt that a new group was required to promote service user engagement in physical activity, while potentially increasing inclusion for individuals who had previously been reluctant to participate in the fitness activities already available on the units.

After consulting with service users, it became apparent that a number of them were interested in boxing. However, boxing has previously been unavailable to service users on medium and low secure units due to the risk of injuries associated with boxing and the perceived increase in risk of violent and aggressive behaviours towards staff and peers associated with this training approach.

Following discussions with relevant stakeholders including sports instructors, consultant psychiatrists, psychologists, nurses and service users it was agreed that a pilot exercise class based on the principles of boxing training but without physical contact could be supported if properly risk assessed and managed. On the back of these discussions the 'Boxercise' intervention was developed with the aim to promote physical activity and its benefits whilst limiting the risks associated with hitting or being hit by others which had previously been a barrier to any facilitation of boxing related activities.

Intervention

- A sports instructor completed the official 'Boxercise' qualification.
- A programme of six sessions was created, each having a detailed outline of the weekly content. It is a closed group with a maximum number of six participants.
- Service users are required to sign a contract stating they agree to follow the rules and mutual expectations of the group and understand the consequences if they are breached.
- Qualitative outcome measures were taken to help assess the impact it had on participants

Results

The first programme ran for six consecutive weeks with a maximum capacity of six participants. Although some participants missed a session, all completed the programme with a satisfactory attendance.

At the end of the intervention qualitative feedback from the participants included:
"Over the last six weeks my physical and metal heath has improved"
"I have learnt new exercises and had have enjoyed the social side of the group"
"I don't really like to attend the cardio gym, but this has gave me the opportunity to try something new and fun outdoors"
"Boxercise was something I had never done before but now has made me want to continue this in the future"

Feedback from other stakeholders include:
"The introduction of the boxercise intervention has been a welcome addition to the Oswin Personality Disorder therapeutic regime with an emphasis on facilitators and patients being able to challenge the use of the body – that of the perpetrator's and the victim's - to manage core feeling of tension and tolerance of frustration" (Dr Ravi Lingam, Consultant Forensic Psychiatrist)
"Appears good for mind and body" (Dr James Stoddart, Consultant Forensic Psychiatrist)
"Taking a positive therapeutic risk, supported by the multidisciplinary team, the sessions have demonstrated positive changes in levels of motivation, physical health and individuals have only used the skills in a socially responsible way." (Rhona MacLeod, Professional Lead Occupational Therapist)

Discussion
Boxing based exercises have been shown to meet the American College of Sports Medicine criteria for intensity of exercise to maintain and improve cardiorespiratory fitness (Kravitz et al, 2003) and the combined elements of aerobic and resistance training have been shown to be more effective in improving body composition, metabolic profile, inflammatory markers and intra-abdominal fat than aerobic training alone (Damaso et al, 2014). This means that the 'Boxercise' class is a helpful resource for service users in line with the 'Managing a Healthy Weight' CQUIN target.

However, barriers to setting up the group included a historic reluctance to have boxing related activity on the unit. Whilst boxing is a competitive contact sport, Boxercise is a high intensity interval training programme based on the principles of boxing training which specifically omits the contact, sparring and competitive elements included in boxing. As a result, it is hoped that the aerobic and resistant elements of the training will help individuals manage mood rather than antagonise it.

To help manage risk, the participants with their multidisciplinary team completed risk assessments, care plans, exercise agreements and the Boxercise contract prior to commencement of the intervention. No incidents of violent or aggressive behaviours were recorded for any of the participants during the course of the programme.

Feedback from participants indicates that the Boxercise intervention appears to be impacting on various elements of the Recovery Star Secure, the outcome measure favoured by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust Secure Care Services. This links with research done by Hefferon et al (2013) who looked at a boxercise intervention and how it mapped onto a similar conceptualisation of mental health recovery (Davidson et al, 2005).

Conclusion
In conclusion the introduction of a Boxercise

intervention was a success. By setting up the programme an intervention was developed which was responsive to service user wants, was an appropriate resource in line with the current CQUIN target and managed risk appropriately. Feedback from participants and other stakeholders has been positive and there are plans to run the programme again with another cohort of participants.

Mark Downey, Sports Instructor, Mark Hennessey, Sports Instructor, Andy Murray, Sports and Fitness Lead, Gillian Watters, Advanced Physiotherapist, St Nicholas Hospital

QNFMHS Physical Security Document
E-Consultation

During the consultation process for the third edition of low and medium secure standards (2019), we received feedback that these standards would be more useful in a physical security document that can be adapted locally.

As a result, we have devised a **Physical Security Document** using the physical security standards as a framework. It should be utilised as a 'live' document that is subject to continual review. Some elements are mandatory for all services; however, each area provides you with the opportunity to define how this practice occurs locally.

E-consultation with member services:
The next stage of developing this tool requires comments and feedback from members services. The comments received as part of this consultation phase will inform the next stage of the document's development. The document will 'go live' in spring/summer 2021 on publication of the next edition of QNFMHS standards.

We are looking for feedback on the draft, specifically focusing on:

- Clarity and grammar
- Suggested additions and deletions
- Practical application of using the document
- Training and key learning areas
- Using the audit and review tool

To help you in commenting on the draft, please read the following information:

- The PSD has been developed using the current standards. The standards themselves have not changed. The standards will be included as part of the next standards revision in 2021.
- A physical security index document, referencing all security policies, should form part of the PSID which is included as part of the appendix of the end of this document.
- The PSD should be held at a local level and not sent or stored outside of your organisation.
- Photographs should be included to enhance training or understanding of a specific item.

The deadline for providing comments is **3 August 2020**. Please send your feedback to **forensics@rcpsych.ac.uk**

Cygnet Healthcare

Management of vitamin D status in the secure mental health setting

Vitamin D in brief

Vitamin D is known as the 'sunshine vitamin' for very good reason: cutaneous exposure to UVB light is the best natural source of colecalciferol (vitamin D3). The colecalciferol is synthesised from 7-dehydrocholestrol (the cholesterol precursor) and it undergoes a number of changes along the pathway, that produces the vitamin D active metabolite 1, 25-dihydroxyvitamin D3. This hormone helps control absorption of calcium and phosphate, the main minerals that make up bone. The presence of vitamin D receptors (VDR) in numerous tissues in our body (including brain), indicates that it does more than prevent rickets or osteomalacia. Might it make a difference to mental health? Is the association between vitamin D deficiency and depression simply a classic example of reverse causality? Or is the relationship bi-directional?

Vitamin D is associated with prevention and treatment of various diseases, and population-based studies show a strong association between vitamin D status and defence against respiratory pathogens [1]. A 2017 systematic review concluded that vitamin D supplementation protected against acute respiratory tract infection [2]. There has been recent interest in the effect that vitamin D status might have on protection against COVID-19 – intervention trials will be needed to answer this question.

Vitamin D status

The prevalence of vitamin D deficiency among service users in secure hospitals is markedly higher, across the seasons and regardless of skin colour, than it is in the general population. This has been observed at various sites in mental health hospital trusts where I have provided a service. Several years ago, before the prevalence of vitamin D deficiency was fully appreciated, it was noted that >90% of service users on a low-secure male ward were vitamin D-deficient – serum 25(OH)D concentration below 25nmol/L.

Dietary sources of vitamin D

The only naturally-rich food sources of vitamin D are oily fish (around 200IU - 600IU vitamin D per 140g serving) and egg (50IU - 150IU per egg). Dietary information resources often cite red meat (4IU - 40IU of vitamin D per 100g) and fortified margarine (around 15IU vitamin D per teaspoon) as sources of vitamin D, but each of these makes only a very small contribution to our daily intake of vitamin D. A daily serving of oily fish would get us close to (or exceed) the RNI for vitamin D (400IU = 10ug a day), but for most people consuming oily fish on a daily basis is very unlikely, unless you're a seal! The RNI for vitamin D is considerably lower than the dose of vitamin D (~31ug a day) required by sun-avoiders, if they are to achieve vitamin D sufficiency – a serum 25OHD concentration above 50nmol/L) [3].

Vitamin D supplementation

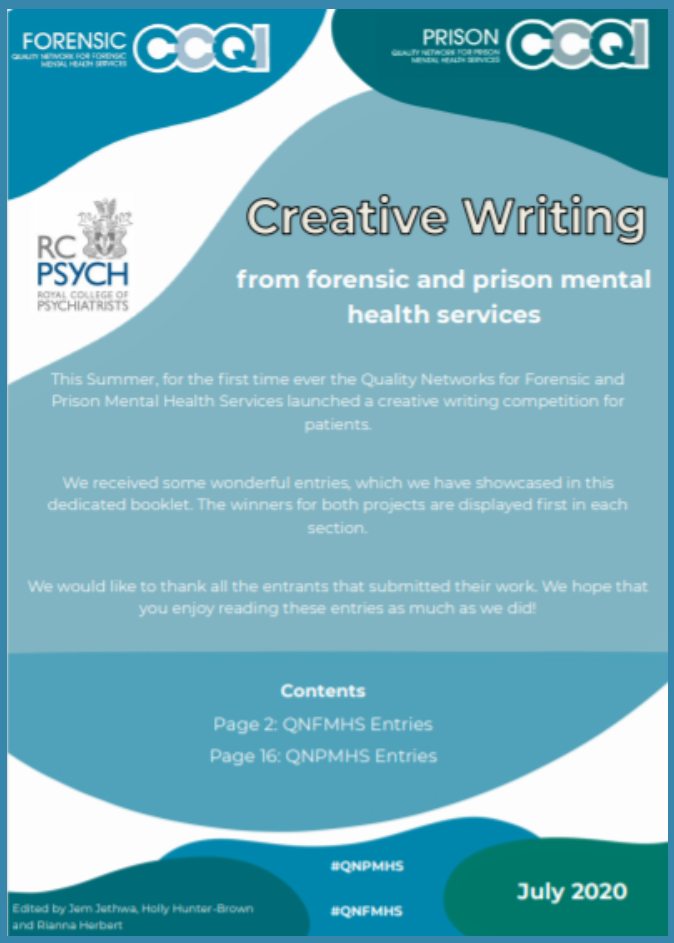
The recommendation in NICE guidance for treating vitamin D deficiency is to administer a loading dose of up to 300,000IU (7,500ug) of vitamin D as either weekly or daily split doses e.g. 50,000IU once a week for 6 weeks [4]. The vitamin D loading regimen should then be followed by an appropriate maintenance dose of vitamin D. Some clinicians favour delivery of large single-doses of vitamin D (300,000IU – 500,000IU) in order to address poor compliance when treating vitamin D deficiency, but some studies on the elderly found increased risk of falls when

large single-doses of vitamin D were administered [5]. Interestingly, the 2017 systematic review found that for those who were vitamin D deficient, daily or weekly doses of vitamin D protected against acute respiratory tract infection, whereas one or more large-bolus doses did not [2]. Vieth has proposed that the unnaturally high concentration of serum 25OHD that follows administration of a large bolus dose, may dysregulate the enzyme system responsible for the synthesis and catabolism of 1, 25-dihydroxyvitamin D, resulting in lower concentrations of this vitamin D active metabolite in extra-renal tissues [6].

Spending sufficient, and safe time in the sun between April and September is by far the best way to optimise vitamin D status, but this is not always feasible, for a variety of reasons in secure mental health care settings. A pragmatic approach to managing the vitamin D status of service users is to routinely offer a weekly dose of 10,000IU (250ug) of vitamin D3. This dose should meet the daily requirement for vitamin D for service users who do not get adequate exposure to sunlight. Additionally, weekly dosing of vitamin D is less burdensome than is taking it daily, both for the service user and dispensing staff. People who have obesity may require a larger daily or weekly dose of vitamin D [7].

Tony Hirving, RD, MRes(Clin), Dietitian, Cygnet Hospital Stevenage

Creative Writing Competition Booklet



This summer, we ran our first creative writing competition alongside our annual artwork competition. We received some brilliant entries which can be found in our dedicated booklet, with the winners and entries from our sister project's competition (the Quality Network for Prison Mental Health Services).

The booklet can be found on our website in the publications section:

https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/forensic-mental-health-services/publications-and-resources

QNFMHS Artwork Competition

We hold an annual QNFMHS artwork competition for patients in secure services. Every year we receive an exciting range of artworks, all using different mediums and styles. The winners are used on our publications, such as our reports and guidance documents. We are pleased to display this years fantastic winners below. All other entrants can be found on pages 32 to 36.

This year, we also opened it up to creative writing entries. These will be displayed in a separate edition of all the entries, along with the creative writing entries from our sister project (Quality Network for prison mental health services), so keep a lookout for this.

Untitled 1, T. Young, Ash Ward

Flowers on a Black Background, a patient at Northgate Hospital (The Arts Project)

Flowers on a Pink Background, a patient at Northgate Hospital (The Arts Project)

The Coven, A. J Willian, Edenfield Centre

London Bridge, a patient at Northgate Hospital (The Arts Project)

Acrylics 1, A. Sudha, Chadwick Lodge

Acrylics 2, A. Sudha, Chadwick Lodge

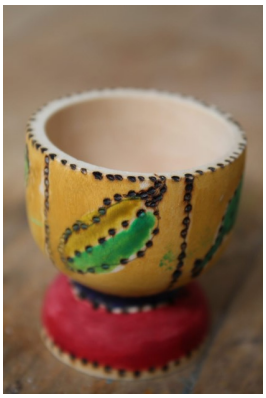
Daffodils, a patient at Northgate Hospital (The Arts Project)

NHS Angels, Patients and OT staff at Brockfield House

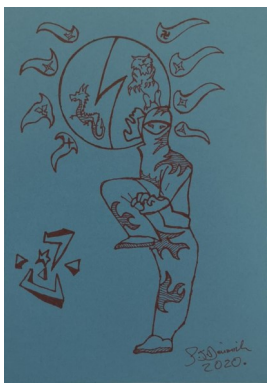




Monica

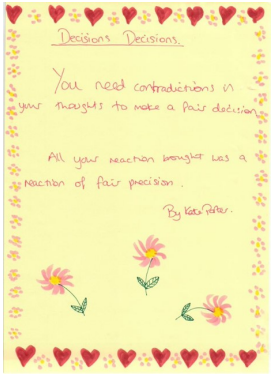







2020.



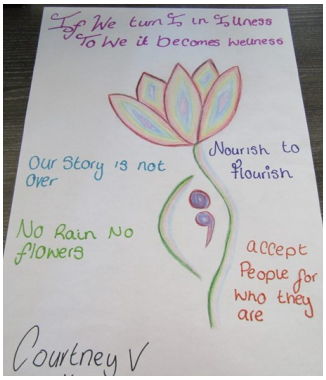

Kawazaki
Ninja
1000

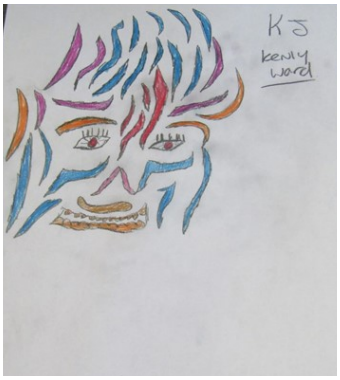

Decisions Decisions
You need contradictions in your thoughts to make a fair decision
All your reaction brought has a reaction of fair precision.
By Kate Potter.


SPARKLE
THE SUPER HERO


What to protect?
Fauna
Foliage
Plants
Flowers


YOU
NHS
COVID
19

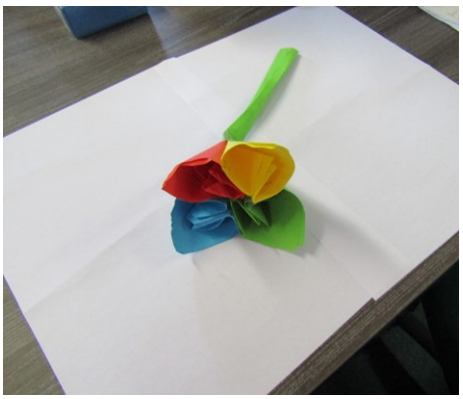

If We turn In Illness To We it becomes Wellness
Our Story is not over
Nourish to flourish
No Rain No flowers
accept People for who they are
Courtney V


KJ
kenny ward


NHS
BEE
Forest
Tree

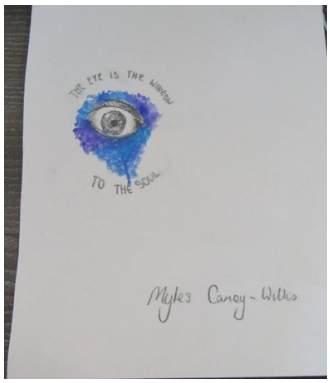

Morgan X

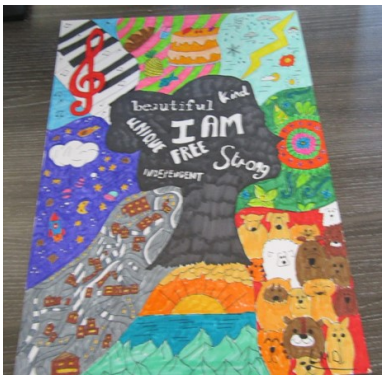

TOY STORY
COCO
WALL·E
DREAM
MARVEL
STAR WARS

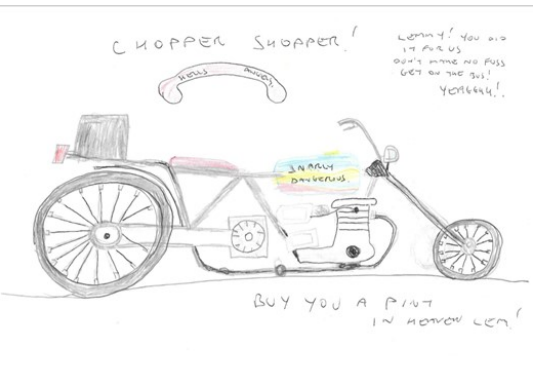


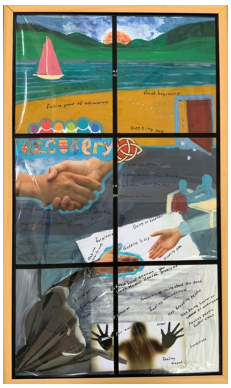

PEARS


BIG-DOG MISSING YOU

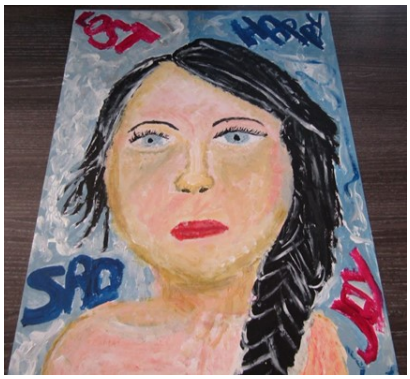

THE EYE IS THE WINDOW TO THE SOUL
Myles Canoy-Witts

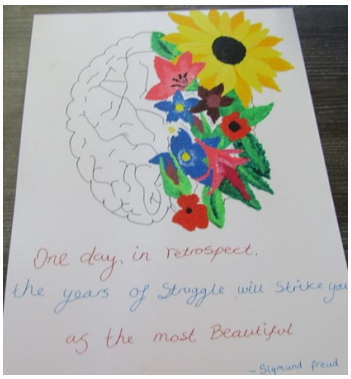

beautiful kind
I AM
FREE Strong

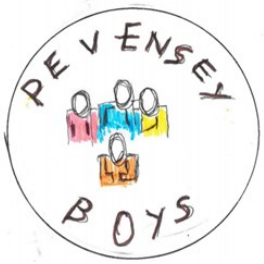

CHOPPER SHOPPER!
BUY YOU A PINT




I WANT TO BE FREE

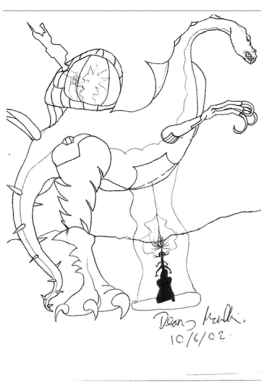

SAD
JOY


One day, in retrospect,
the years of Struggle will Strike you
as the most Beautiful
- Sigmund Freud

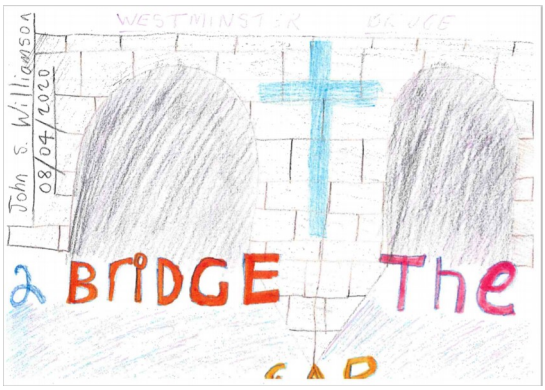

PEVENSEY
BOYS


(METROPLEX)
(WACKING CITY
OF THE FUTURE)


STRIVE FOR PROGRESS NOT PERFECTION
NEVER GIVE UP
CENATION
KEEP CALM NEVER GIVE UP
WINNING IS NOT EVERYTHING BUT MAKING THE EFFORT TO WIN IS.
NEVER GIVE UP
CENATION

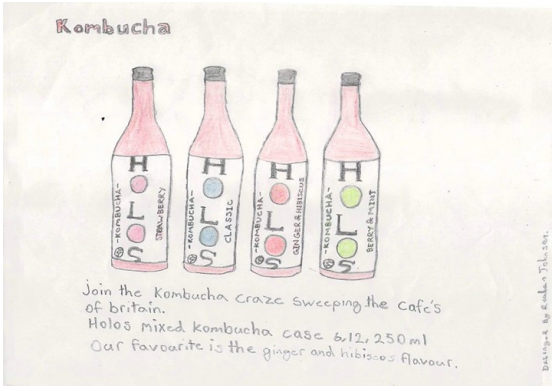


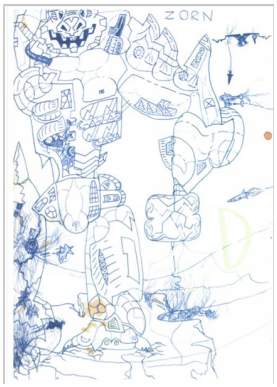

If you do this.....
Or like painting
GREEN PAINT
...Please Scrub your dirty mits before entering the kitchen
DON'T MAKE OTHER PEOPLE EAT YOUR
"GREENS"


WESTMINSTER BRIDGE
John S. Williamson
08/04/2020
A BRIDGE The

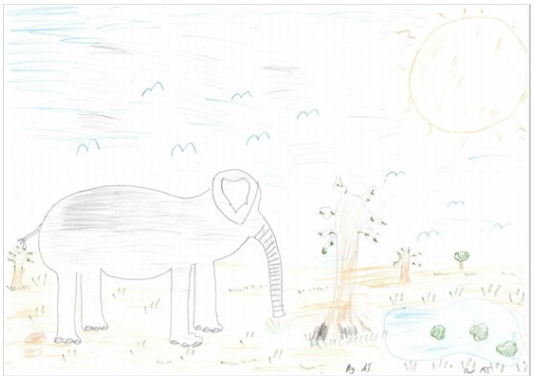

PROTECT OUR BEE'S

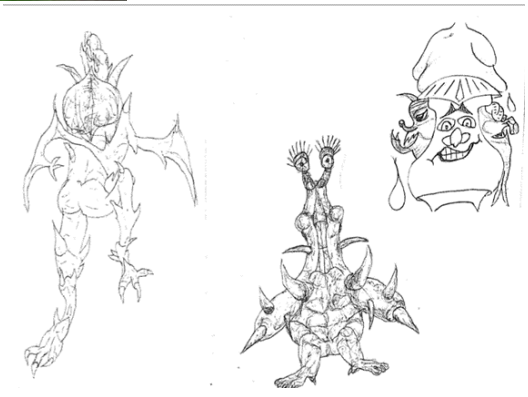

LOVE IS THE ANSWER
Rain forest...
MUSIC...
PRAYER....
RESCUE
War- Times...
Pollution...
protecting peace till surroundings...


Kombucha
Join the Kombucha craze sweeping the cafe's of britain.
Holos mixed kombucha case 6.12, 250ml
Our favourite is the ginger and hibiscus flavour.


ZORN


spiritual state






WE ARE #1
PEVENSEY
PEVENSEY

Changes to the QNFMHS review process following COVID-19

As we are sure you are aware, COVID-19 has impacted our ability to deliver a normal service. Therefore, we just wanted to update our member services on the upcoming changes and options as we try to determine new ways of working.

We recently opened member recruitment/registration for the next cycle (cycle 13-7 part 2). Services that did not receive a review visit last cycle are eligible for discounted membership rates for the next cycle.

For the upcoming cycle you will have two options:

1. **Full review:** for services who are at a settled stage where they would benefit from reviewing their service against all standards.
2. **Developmental review:** for services who are due a developmental visit and those who feel they are not at a stage where a full review would be beneficial. This will be discussion based.

Both options will be conducted remotely, via Microsoft Teams, for the foreseeable future. For the remainder of 2020, we do not expect to be conducting visits to services in person. This will be reviewed later this year.

For services that do not have access to the necessary technology, please let us know and we can consider other options.

What will a virtual review look like?

The self-review will be done as normal, over a period of two months. The peer-review 'visit' can be completed in either of two ways:

- Over the usual time allocated to your service, depending on the number of wards and whether your service consists of one type of security or both (between 1-3 days)
- Over a week period (for example, 1-2 meetings per day).

A member of the Quality Network team will be in contact with you over the coming weeks with more details about this.

We will be guided by you on the best ways to conduct the reviews/meetings and we will be as flexible as possible.

If you have any questions about the upcoming cycle, please contact us on forensics@rcpsych.ac.uk

Useful Links

Care Quality Commission
www.cqc.org.uk

Centre for Mental Health
www.centreformentalhealth.org.uk

Department of Health
www.doh.gov.uk

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

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

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

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

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

NHS England
www.england.nhs.uk

Offender Health Research Network
www.ohrn.nhs.uk

Revolving Doors
www.revolving-doors.org.uk

Royal College of Psychiatrists' College Centre for Quality Improvement
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

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

QNFMHS Knowledge Hub Group
www.khub.net/group/quality-network-for-forensic-mental-health-services-discussion-forum

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