FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

MSU/LSU Issue 49, March 2021

This Issue

WELCOME

As this is the first newsletter of 2021, it feels appropriate to reflect on what has happened already this year. Nationally, services have risen to the huge challenge that the second wave of COVID-19 brought, at the very beginning of the year. Teams banded together to continue protecting patients and the public, pushing themselves to the limits and working extraordinarily hard. Positively, things appear to have settled again and there is the opportunity to reflect and really take time to appreciate our peers and colleagues.

On 23 March, it was a Day of Reflection and parts of the UK's skyline was lit up in remembrance for those who lost their lives in the pandemic. Once more, a tough reflection on what has been a year-long battle with the disease. We held a minutes silence during our event on that day.

This event was focussed on See, Think, Act in the context of Trauma Informed Care and COVID-19. Following on from feedback from our members that relational security was an area they wanted to focus on, we held a full day event to discuss topics such as blurred boundaries, the impact of connecting with patients when wearing full PPE, what positive (and frustrating) changes had been made to wards over the last year.

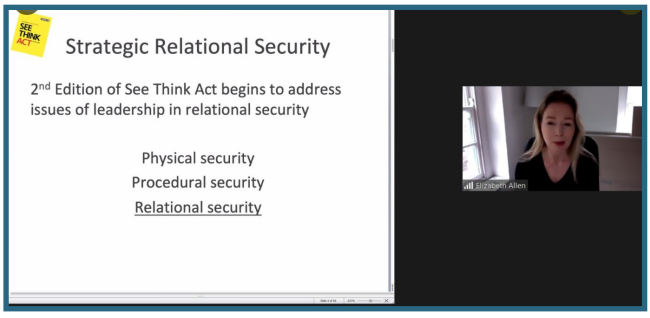
It was a really engaging day, with over 100 people in attendance. A huge thank you to Liz Allen and Jude Deacon for facilitating the day, as well as Emma Watts, Katherine Bird, Russell Bolger, Sheena Foster, Sarah Markham, Mike Lawson, Susan Denison and Ade Ajao for their tremendous input.

Towards the end of the session we spoke about the 'next steps' for See, Think, Act and what we can do to re-engage members in the approach. Certainly there seems to be a want for updating the materials, and a focus on leadership, so watch this space.

We also have a number of upcoming events, including a webinar on the newly published guidance on managing a healthy weight (29 April 2021), and a two-day event on Emerging Drug Trends (01/02 June), please look at our website for more information.

It seems to come earlier each year, but we have also opened registration for the next cycle of reviews (2021 -2022). It feels really difficult to plan ahead to a world where we might be able to travel and return to face-to-face visits. But this is what we are hoping to do from October. Although plans are still being made, we will try to prioritise this for the full reviews where possible, and COVID-19 permitting. It seems scary to believe this will be a possibility, but it's important to plan for the best case scenario (not just the worst).

Kate Townsend, Programme Manager



A Note From The Editor

By Holly Hunter-Brown, *Project Officer, QNFMHS*

In 2019 we had a newsletter on the theme of 'co-production', it was a hugely popular edition and we received over 40 articles from our members on the topic. A year on (a year during which collaboration has been so vital), we thought we would give members the chance to explore a similar theme for this edition but with a broader focus: collaboration.

Collaboration is a key element of the work we do at the Quality Network. The peer review process, all our events and of course our newsletters all rely on the sharing of expertise and experiences from patients, carers, managers and staff across all disciplines.

When putting together this newsletter, I reflected on how we collaborate with our patient and carer representatives. We have a passionate and supportive group who add so much value to the work we do. Each time I facilitate a review with one of them on my team I am thankful for their input. They never fail to ensure the patient and carer voices are lifted and their needs are discussed.

The collaboration with the group goes beyond the reviews. They are regularly involved in our events, submit articles to newsletters (see page 15 for a piece by one of our patient representatives) and engage in discussions on our online Knowledgehub (read more about how to join this on page 14). They have also helped with many of the tools we use during reviews such as the patient/carer questionnaires and patient interview script. Their input during a consultation of our standards lead to the development of the Physical Security Document (an update on this can be found on page 22).

This edition of our newsletter is full of some lovely examples of collaboration. These include but are not limited to, how our members have collaborated with other staff and patients to make service improvements, a service user's reflections on how they collaborate with the MDT as well as a reflection on how collaboration could have been better during COVID-19. I hope you enjoy reading them as much as I did!

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QNFMHS SPRING HIGHLIGHTS

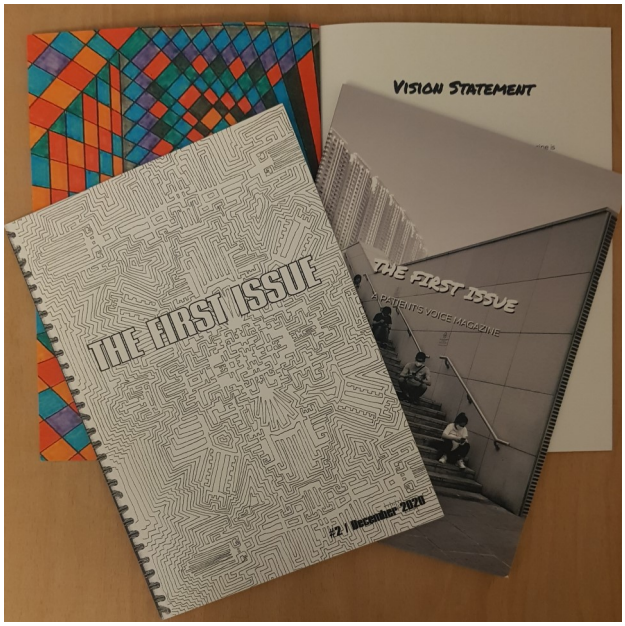
Page 12
Joint Substance Misuse Event

Page 14
QNFMHS Membership Feedback Meetings

Page 22
Physical Security Document Update

Creating a Patient Zine: a collaborative project against all odds!

Matt Knight, *Patient and Carer Experience and Involvement Lead, Forensic Service at Oxford Health*



In January 2020 I started working in the new post of patient and carer experience and involvement lead for the forensic mental health service at Oxford Health Foundation NHS Trust.

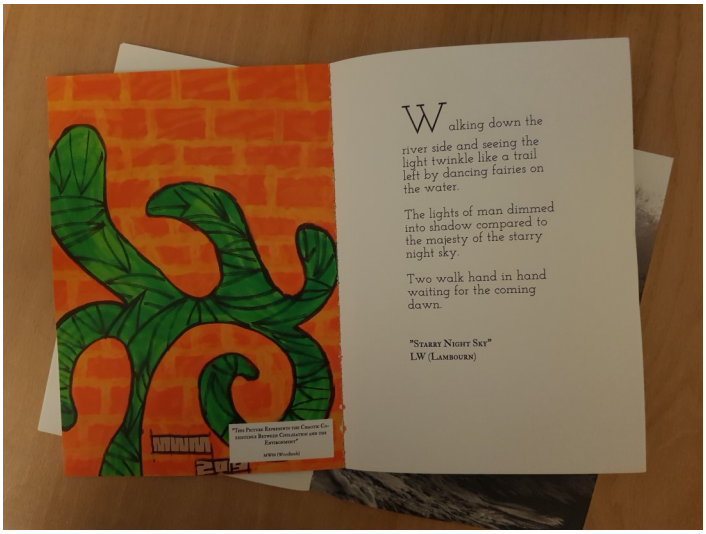
Being both new to the service, and new to forensic mental health, I had every intention of spending my first year immersing myself within every aspect of the service. My focus was going to be meeting staff and patients and getting to know the nuanced differences in routine and culture across all ten wards, over three locations across two counties. I wanted to spot areas of particularly good and effective practice, identify patients and staff with particular skills and passions as well as promote opportunities to collaborate across the service so that the service as a whole could improve and develop.

Of course, the onset of a global pandemic saw these plans severely curtailed and after just nine weeks in post I was confined to working from home. The challenge was set – how to develop opportunities for patient involvement and support the service in collaborating to share good practice, in a context where on a practical level we were all supposed to be keeping apart.

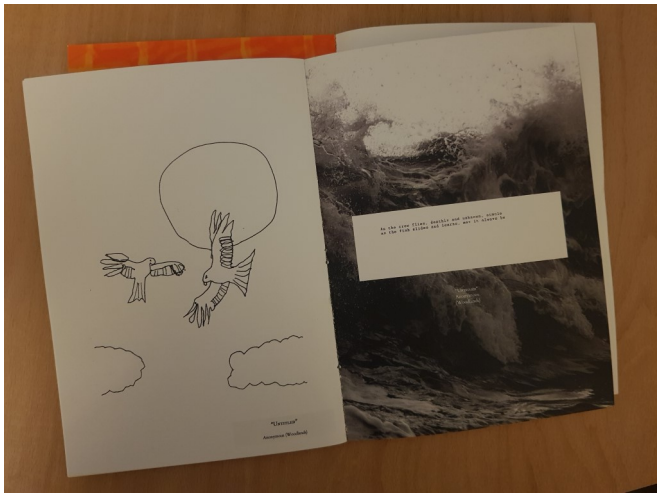
During my first patient council meeting held in February 2020 I learned that there had been a long-held interest by both patients and staff to publish a regular service wide and patient focused magazine. Having had some previous experience of designing publications for print I wondered if this might be a project that could work, against all the odds.

Having managed to arrange a number of calls with both staff and patients who were interested in the project it soon became clear that there were a range ideas as to what the magazine should look like. It also became clear that there was going to be limited opportunities to engage patients with the creative process of putting it together. I realised that what was needed was a publication that was very “raw” and required very little in terms of finer editing and design.

A conversation with an occupational therapist (OT) at the service, and an artist friend, helped me to arrive at the conclusion that a “zine” presented the best format. A zine is a publication that is produced not by professional journalists but by amateur people who share something in common. Zines have a rich history as a means of expression, collaboration and sharing ideas.



An OT support worker in the service, who was also working from home, agreed to help with the project. Using suggestions and feedback from patients we formulated some guidelines on what form the submissions should take. We were unable to actively get patients involved in the process of putting the zine together so we recognised it was important that we were as light touch as possible with submissions. We made it clear that the zine would contain no contributions from staff or the service and made the decision to avoid using any NHS branding or design elements. Our call for submissions assured patients that the zine would present "an opportunity for unrestricted expression of creativity, thoughts and ideas".



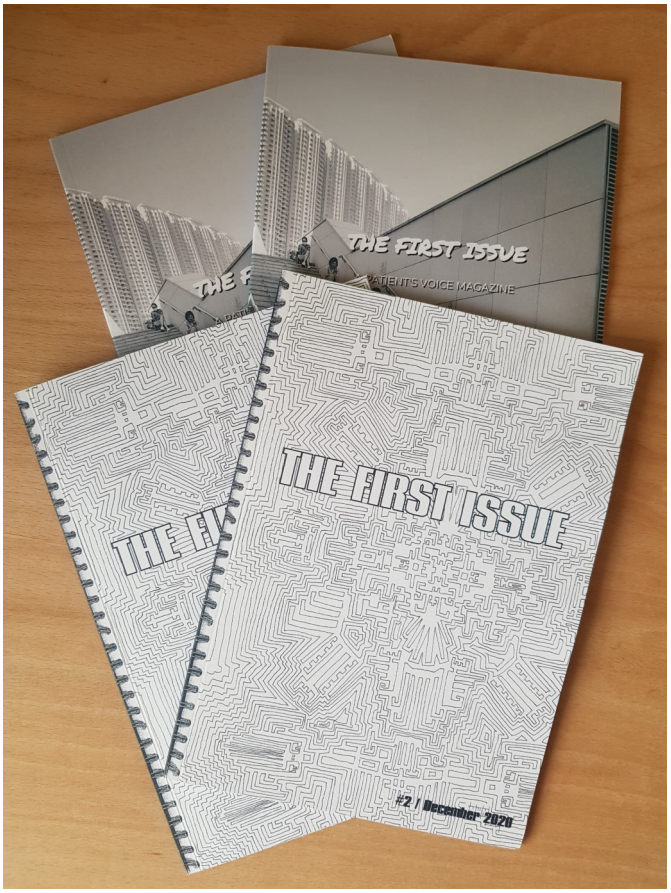
Some work was emailed directly from patients, others were scanned and sent in by ward-based colleagues. In terms of design we kept it as simple as possible. If possible work was simply dropped on to the page as it was submitted. In the case of written submissions they were typed and laid out in simple text. A grant from the Oxford Health Charity meant that we could afford to have the zine professionally printed. This resulted the finished publication having a high quality feel, despite the simplicity of the design.

Copies of the zine, which ended up being called "The First Issue" were sent to every inpatient in the service in individually addressed envelopes. It was important that, despite the challenges of involving patients as much as I would have liked, that patients felt that it was "their" publication and would have a sense of investment in it.

The result was a 24 page celebration of the creativity, talent and ideas of our patients across the service, published in July 2020. A second edition of The First Issue was published in December 2020 with a third currently in production.

A global pandemic presented a significant challenge for both collaboration and patient involvement and yet there was a desire within both the patients and wider service to see a long awaited creative project be brought to fruition. Despite the obvious barriers the creative contribution of patients was able to be harnessed and sensitively brought together in a way that preserved the integrity of their work and allowed it to speak for itself.

I have learned that a zine is a fantastic medium for promoting and developing collaboration between patients and staff across a large service set over multiple sites. Even in these times where we have all been so isolated from each other it has brought a sense of collective achievement. In times of less restriction it has the potential to do that to a far greater extent.



A reflection on my experiences of working together with the multi-disciplinary team (MDT)

***Anon**, Service User, Tatton Unit*

I have worked with many professionals across many disciplines in my twenty years as an inpatient. In my opinion, it is one-to-one meetings that mean and matter the most when meeting and working with people.

One-to-one meetings
I use one-to-one meetings with my named nurse who helps me practically. We do care plans which I enjoy. This helps keep my plans up to date and relevant, making it interesting. It is like writing a book. We work together to achieve success.

Attitude
It is absolutely vital that a patient has the right attitude not just in rehabilitation but a prolonged good attitude for life.

Cooperation and key work
Patients can build up a portfolio of cooperation and a history of effort and personal endeavour to show trying. Having a go, making a start, taking initiative. This will generally bode well for a service user. It is not rocket science.

Rehabilitation services are not geared to making things difficult or containment as many falsely view. Rehabilitation gears patients up for life in the community. It helps develop skills, giving experiences and coping devices.

Each discipline has a specific range of expertise and are very clever and considered in implementing their range of expertise. They are experts in perceiving patients' strengths and weaknesses. and knowing what to implement in their pathway.

Psychology
In the past I particularly had a difficult time working with psychology. I resented it. I disagreed with it. I strongly hated it. I felt personally bigger than that. I felt that I was above it. I felt it was a little disrespectful to my proud attitude. I thought I had built my character like a tailored suit and that they questioned my presentation. I made my sessions difficult and I resisted, often leaving my meetings early.

Then when I was in a medium secure unit, I was referred to the psychologist. I liked him instantly and I saw him weekly. I was very determined to do activities in my comfort zone, only doing what I wanted to do. I was strong minded but this made my outlook and attitude insular.

Psychologists on the other hand are by name and nature much more clinical and work directly engaging with the mind through life and thinking positively, through patient collaboration.

Occupational therapy
I have always found occupational therapists achieve a lot of poignant moments and sometimes it is quite sensory, sensitive and something to stimulate the senses. They are very clever at coupling ideas, notions and compounding these ideas with something visual.

For me, bringing my own skills and learned skills to the table makes me feel valued, positive, and successful. Occupational therapy (OT) has always been my main focus and field of personal enjoyment. There is something about OT and occupational therapists, something in their makeup and mindsets that I can relate to. Occupational therapists take the innate and make things physical and practical. The sessions are goal orientated with a view to making something remarkable and poignant.

Twelve years later, I am still in hospital but now I work well with the psychologist and all other disciplines. Now I do any courses that are offered to me across the board:

- Art therapy
- Psychology: Insight work, drugs and alcohol, relapse prevention, Cognitive Behavioural Therapy
- Working with the clinical team discussing medication, rehabilitation measures, summarising progress and planning.

Sharing Lived Experiences Framework (SLEF): a framework for mental health

Brendan J. Dunlop, *Clinical Psychologist in Training at University of Manchester*
Bethany Woods, *Assistant Psychologist,*
Jonny Lovell*, College Manager at University of York*
Alison O'Connell, *Involvement Lead for the Forensic Service*
Sally Rawcliffe-Foo, *Operational Manager*
Kerry Hinsby *Consultant Clinical and Forensic Psychologist, Newsam Centre*

Self-disclosure refers to acts of sharing personal or otherwise unknown information by mental health practitioners (Gibson, 2012; Lovell et al., 2020). By 2013, many NHS Trusts were actively recruiting individuals with lived experience of mental health difficulties to Peer Support Worker (PSW) roles, who work closely with service users to support their wellbeing (Health Education England: HEE, 2020; Lovell et al., 2020). For others, the sharing of lived experiences is perceived to violate professional boundaries and codes of conduct (Lovell et al., 2020).

Self-disclosure is not explicitly forbidden (Lovell et al., 2020) and can help foster a trusting relationship between service user and professional (Audet & Everall, 2020). Disclosure has been thought to enhance recovery by giving service users hope, providing a role model, increasing attributions of expertise and trustworthiness and reducing stigma (Lovell et al., 2020). Many clinicians view current guidelines as ambiguous and receive little training (Henretty & Levitt, 2010). Professionals fear disclosure could lead to disciplinary action. To disclose, practitioners should feel confident and should understand the advantages and disadvantages of sharing lived experience (Lovell et al., 2020).

Original research by Lovell et al. (2020) found that the 'helpfulness' of disclosure increased if the service user and practitioner shared a characteristic or identity. Disclosure was seen as humanising and provided hope for recovery and shared coping strategies. Negative effects were mainly apparent when people were considering disclosure. Barriers included being seen as unprofessional and feeling restricted by culture or Codes of Conduct.

Service users highlighted the negative impact of a lack of disclosure on relationships.

The Sharing Lived Experience Framework (SLEF) is a result of an international collaboration between academic researchers, service users, recovery workers and clinicians. A multi-method international research design was adopted, closing the gaps in the existing literature by focusing on real clinical populations. The working group wanted to create a practical and accessible framework that could be used by a range of practitioners, for a variety of disclosure scenarios. Previous research (Gutheil & Brodsky, 2011; Sadighim, 2014) has emphasised the importance of supervision when negotiating the self-disclosure process. The Seven Eyed Model (Hawkins & Shohet, 2007) and Hamilton's (2010) Boundary See-Saw work informed the creation of the SLEF. The SLEF should guide the individual through a series of prompts and reflective questions to enable an explicit and considered decision that is right for the practitioner, service user and the therapeutic relationship. The SLEF is intended as a self-reflective resource, as well as a potential supervision tool.

The SLEF spans the disclosure process and aims to take often unconscious processes and decisions and make them explicit, considered and reflected upon.

Preparedness
Practitioners should consider their own values and beliefs about sharing experiences, what they are willing to share, and in what detail.

Motivation: Confidence
The motivations for sharing information need to be reflected upon. In particular, the practitioner's level of confidence in negotiating such discussions. Motivations for sharing must be healthy or to strengthen a therapeutic relationship.

Motivation: Competence
How competent the practitioner feels negotiating a disclosure should be considered.

Impact on service user: Relevance
Practitioners should consider the relevance of disclosing and must not assume similar experiences to a service user. It is good practice to seek permission from service user's before you disclose.

Impact on service user: Comfort
When sharing lived experience, practitioners should ensure they are comfortable doing so. A key consideration is whether or not the disclosure will improve or harm the therapeutic relationship.

Supervision
If a practitioner has decided to disclose information with a service user, then a reflection upon this should take place with their supervisor. The outcome of the disclosure and the perceived impact on the client, practitioner and their relationship may be relevant in this discussion.

The SLEF formed the basis of a bespoke training package. Practitioners left training recognising the relevance of disclosure, feeling more competent, comfortable and confident doing so, and more prepared to disclose. They also could understand how to use supervision to support this. Further structured evaluation of the SLEF is needed, alongside more qualitative feedback on the acceptability of such a framework in various mental health services, for a range of practitioners.

Grounded in international research and theory, and co-created with academics, clinicians, PSWs and those that use mental health services, the SLEF extends previous guidance on this topic by considering questions and reflections for all types of disclosure and allowing the practitioner to effectively use supervision and self-guided reflective practice by considering numerous key areas of the decision-making process. This is represented visually on a framework: each component is a 'piece' of the puzzle interconnected with all others.

The SLEF has been submitted for publication, and the visual framework itself will be available as part of this publication.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

COVID-19 Rehabilitation: wellness check

Anita Attala, *Advanced Dietitian*
Joanna Brackley, *Clinical Lead Speech and Language Therapist*
James Breading, *Speech and Language Assistant*
Nikki Locke, *Clinical Lead Occupational Therapist*
Gillian Watters, *Advanced Physiotherapist, St Nicholas Hospital*

Introduction
National and International professional bodies (1, 2) have identified the need for post Covid-19 rehabilitation. The British Dietetic Association (3), Chartered Society for Physiotherapists (4, 5), Royal College of Speech and Language Therapists (6) and The Royal College Occupational Therapy (7) have provided guidance for therapists on rehabilitation post Covid-19.

Our service consists of medium and low secure learning disability and mental health forensic inpatient wards. A number of patients within the service have had Covid-19 and those who did not were impacted by restrictions made in line with the national guidance around social distancing, self-isolation and restriction of activity.

Rationale
Individuals with learning disabilities and/or mental health conditions may have difficulties in communication and interoception which could affect their ability to recognise and report their physical and emotional feelings to staff (8). Such difficulties were observed during the pandemic, with staff noticing symptoms in some individuals rather than the individuals self-reporting. This may explain why a number of patients reported being asymptomatic but did test positive. Given these challenges a 'wellbeing check' was developed by the allied health professionals (AHPs) in secure services to check on individuals following the height of the pandemic.

Method
A tool was designed in a Talking Mat format to support engagement, avoid leading people's responses and to gain meaningful information. Talking Mats are an evidence-based tool for facilitating structured conversations with individuals with communication difficulties, memory and attention difficulties

Figure 1. Example of the Talking Mat

The tool collated the key areas from the professional guidance (9, 10) that would be relevant to ask this population, noting also that individuals with learning disabilities have presented with differing/additional symptoms to those without learning disabilities (11).

These key areas were presented to individuals in a structured way. They were asked to place them according to how they felt about the topic e.g. "was it a problem or was it ok?", as per the Talking Mat process. The placement of the picture topics on the mat was recorded as were the individuals' comments. Responses were checked with the individual and they were offered the opportunity to add any more information or areas that they felt were not included.

Prior to commencement, individuals were informed of the rationale for the check-in process and were asked whether they were happy to have a conversation, by way of gaining consent to take part in the project. They were told that we would follow up any areas that they had identified as problems for them.

Results

Over 95% (n=38) patients engaged in this "check-in" with the AHP team across learning disability and mental health wards on one site of the Trust. Results were collated and common themes were extracted.

Common themes included:

- Missing family
- Being worried about family
- Not having enough to do
- General anxiety about COVID-19
- Confusion about COVID-19
- Pain, which included ears, teeth, or previous injury.

COVID-19 related themes included: (note these were post COVID-19 related symptoms)

- Headaches
- High temperature
- Body aches
- Body shakes
- Loss of sense of smell or taste

Conclusion

The Talking Mat tool works well for any population to guide a structured conversation. The conversation generated a lot of valuable qualitative information about individual experiences. The process has highlighted that individuals may not have reported this information if not asked. We have therefore considered the value of repeating a similar process at regular intervals to 'check in' with people.

The process has given information beyond a rating. There is value in the multi-disciplinary implementation of this, where some aspects identified could be supported by a number of different AHP teams. There is value in this tool for presenting information on service user views around COVID-19 to the service as part of its wider evaluation.

The conversations have allowed individuals to reflect on a broad range of topics and they have identified areas that are problematic for them.

There may be challenges in terms of AHP resource to meet the demands identified as problem areas need to be addressed with individual patients. It is intended that the tool is repeated as part of a general 'wellness' check similar to an annual health check.

TalkingMats

More information can be found on https://www.talkingmats.com/).

Secure care learning disability services: new model of care

Anne Charlton, *Model of Care Pathway Lead*
Lindsay McCallan, *Acting Ward Manager Northgate Hospital*

As a result of a project undertaken within the secure care learning disability service, it was identified that patients and staff were unable to articulate what the model of care is, due to its complexity, and how we care for people. Following this, a small working group was established to review the model of care in collaboration with patients. The result was a cyclical model which is purposefully non-linear and focuses on skills assessment.

The rationale for this being that patients struggle when they perceive they have reached the 'end' of the pathway and believe that they have no more treatment to undertake so become frustrated if further needs are identified.

The cyclical model illustrates that assessment is an ongoing process and new needs may arise due to the situation the patient finds themselves in and during the process of skill development or application. These needs will be assessed and addressed in a continuous cycle which is responsive to the individual.

Specific disciplines are not mentioned individually in order to reflect how disciplines should collaborate and flex around the patient needs, with personalisation of approach when required and a strong focus on interdisciplinary working skills development, and skills application.

Transition from a service into another or into the community may occur at any stage of the models' cycle. The cycle will continue within the new context. The model is applicable both during inpatient admission and when care is supported by the secure outreach transitions team.

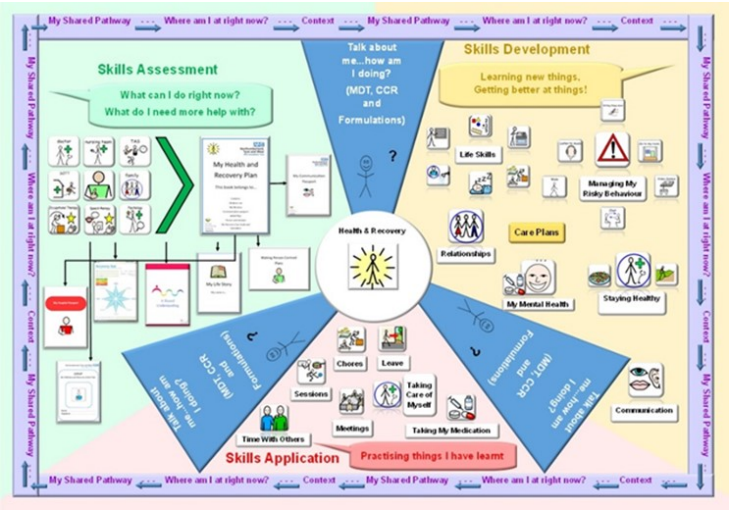
In keeping with this recovery focused approach, which the current patient population in medium and low secure are familiar with, we have developed new resources to support the process which will be used by all the patients within our service.

We have also written a whole hospital operational procedure which aims to combine the requirements we are expected to adhere to. These are as part of the national standards for secure care, NHS England standards, and CQUIN targets as well as the various processes we undertake within the service to ensure we deliver high-quality care whilst demonstrating how we engage with and work collaboratively with our patients and carers throughout these processes, from preadmission to discharge. There are a number of appendices, including checklists and guidance signposted within this procedure to support staff.

This is currently being implemented and embedded within our service and to date over 250 staff from all disciplines have received face-to-face training since June 2020. The feedback that we have received has been extremely positive. Patients and staff feel more empowered and have a greater understanding of their roles within the recovery process.

The service has appointed a designated Model of Care Pathway lead. The Pathway Lead will continue to support the embedding of the model as well as work with patients and carers to ensure they are engaged in the process, enabling co-produced & inclusive care.

The model is also being reviewed in line with a research proposal that will enable us to identify the impact of the model upon care delivery from patient, carer and staff perspectives.



Creating a brighter ward environment in the SWLSTG Forensic Service

The Forensic Occupational Therapy Team
With specific contributions from:
Melissa Chambers, *Activity Support Worker*
Sofie Grabinski, *Clinical Exercise Therapist*
Michael McManus, *Occupational Therapist*
Jessica Oglethorpe, *Senior Occupational Therapist*
Erin Shanks, *Activity Support Worker*
Service Users *from across the wards*
Shaftesbury Clinic

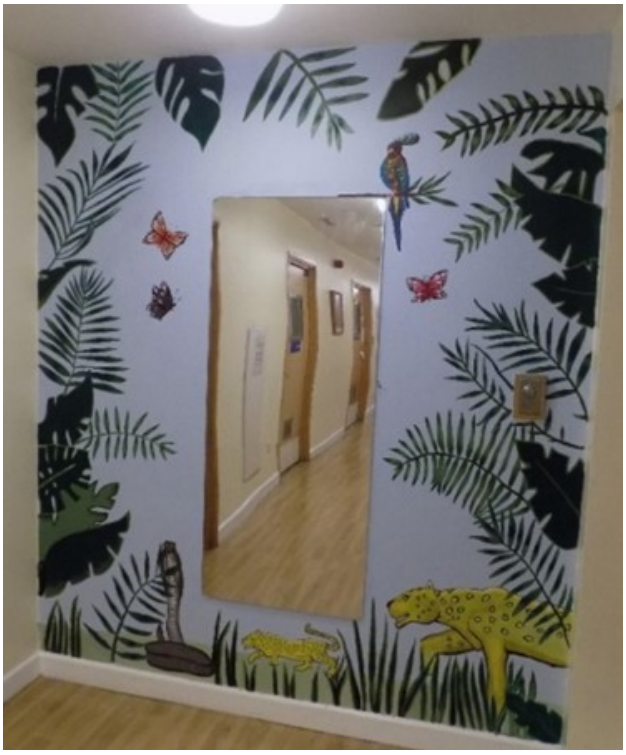
A person's immediate environment has a powerful impact on mood and motivation, and evidence suggests that incidents of violence and aggression are reduced in bright and well-designed ward environments. Through working collaboratively, we can transform these environments into engaging spaces that are conducive to service users' recovery and staff wellbeing. We developed simultaneous collaborative painting projects across our three forensic wards. The following article has also been written collaboratively, to reflect the team approach to the project.

The painting projects were developed over a few months with service users (SUs) able to contribute ideas about processes, design and equipment. They were involved in all stages of the project, and we took a step-by-step approach that encouraged people with different abilities to participate. Those that had more confidence in their skills, for example, assisted with intricate details and took on more responsibility, whilst others were able to paint small sections and still have an important role. We also worked collaboratively across professions, involving the occupational therapists, activity workers, security manager and ward managers. All wards approached the project differently: on Halswell Ward the focus was on finding an innovative way of getting SUs into thinking about future jobs and vocation. The poor condition of the walls provided an opportunity to create a painting and decorating role, collaborating with SUs by tapping into their skills and expertise. On Turner Ward, the focus was on the creative process of designing and painting murals. The therapeutic value of art-based groups within mental health services leading to improvements in SUs' mood and self-confidence. Ruby Ward focused on creativity too, SUs collaborating on designing and painting a 'Tree of Hope' on the wall to display their discharge messages and to represent the growth that can happen over admission. Staff were also able to add messages, making the project more integrated and collaborative.

A patient (K) from Halswell has previous experience of painting and decorating. We paid him a wage for the work he was doing which was important because it provided him with a sense of responsibility and value to his work. The role also eased him into a work routine while providing flexibility and support from staff working alongside.

K stated: *The project felt productive. It was a good thing to do and it took my mind off other stuff. Being here you have good moments and bad moments, but doing the project made me not think about any stress. It was nice to see everything come together.*

The vocational part of the project has set a precedent for future DIY work schemes throughout the clinic, which can support SUs back into work. Even without the paid role, however, it was clear that the sense of pride and enjoyment from having a creative impact on the environment was a positive outcome, which in turn has instilled a great sense of purpose.



Patient feedback:

I love this idea, painting is my therapy.

It brightens up the ward.

[He] looked forward to seeing it every morning.

Others noting the permanent feature of the paintings and a sense of fulfilment in changing their ward environment.

There were some challenges and drawbacks, such as the inconsistency in the projects across the wards in terms of one including a paid role and the others not. We worried that they may feel a sense of unfairness at this; however, most understood that there were different stages to each project, helped by the fact that the creative part was open to people of all levels whereas the vocational element was aimed at SUs who were closer to discharge and considering work roles in the community, giving a sense of progression. Restrictions presented other challenges, as there were a lot of potential risks that needed to be accounted for. This was why it was important to work closely with the security manager, making sure we were safe without completely restricting what we were able to achieve.

Overall, the positive impact of the projects went beyond the aesthetic transformation. Collaboration was key: it created a sense of togetherness, ensured safe practice, and promoted recovery and wellbeing. We found the most important aspect of the projects was in the process of everyone working together. Staff painting alongside SUs conveyed the message that staff were willing to 'get their hands dirty' with them, instilling a sense of equity and true collaboration within the project groups. Giving roles to SUs, paid or otherwise, was empowering and gave back a sense of control over their care through the ability to influence their environment.

JOINT EVENT!

Quality Networks, ELFT and Traverse: Emerging Drug Trends and Their Impact on Mental Health Services

We are excited to announce a two day event, in joint partnership with the Quality Networks for Forensics, Prison and PICU mental health services, with East London Foundation Trust (ELFT) and Traverse.

The emerging drugs trends and their impact on mental health service is a two day symposium on Tuesday and Wednesday, 1st and 2nd June being organised by East London Foundation Trust Forensic Services, Traverse and the Royal College of Psychiatrists CCQI. We aim to bring together national and international experts to share their work on new policy, new trends and new developments in the field of substance use and addictions. There will also be sessions dedicated for front line professionals to share their work and for service users to share their experiences. All attendees will be given the opportunity to develop discussion points within breakout rooms and share these during whole forum discussion sessions.

To book your place, please follow this link.

A first for forensic services: Peer Support Worker

Andrew Gale, *Peer Support Worker, Arnold Lodge*

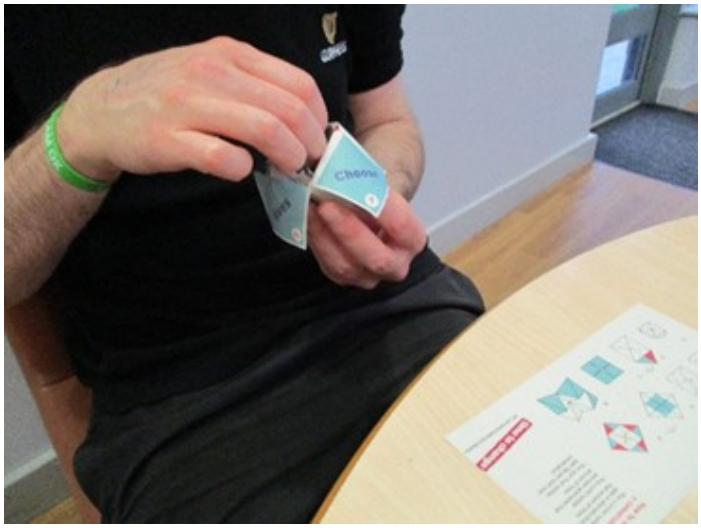
It is a great pleasure to introduce myself to you all as the first Peer Support Worker in Arnold Lodge (Medium Secure Unit). My name is Andrew and I joined the Therapy Services team at the beginning of December 2020.

I have lived with mental illness for almost 25 years, both in myself and members of my family. Therefore, I am well placed to understand what it is like to live with what can be a very debilitating illness. Having discovered the role of a Peer Support Worker, I realised I was in a great place to share my lived experience of mental health with others. This can be through co-reflection and being a supportive advocate to others who are struggling every day with their own mental health. As a result, when I saw the job advertised at Arnold Lodge, I saw a great opportunity to help others who suffer with severe mental health difficulties. I knew I could talk to the patients with real conviction and shared experience, which to me is very important. I know this resonated with the panel when I was interviewed for the role. Their feedback was that I "summed up the role of a Peer Support Worker superbly".

Having been in the role just over two months now, I feel I have embedded the role of Peer Support Worker at Arnold Lodge to a good effect. It has been a busy two months with planning, activities, Christmas, getting to know patients and staff as well as the constant adaptions due to COVID-19. There have already been many positive moments, but the main one was just how well received I have been both by staff and by patients. During December I worked my way around the wards.

> *Many patients commented on how nice it was to have someone around who has experienced trauma and mental health issues but "pulled through and come out the other side". I am now attending the community meetings on the wards to get to know all the patients within Arnold Lodge - then I'm ready to formally launch the Peer Support Service in the Hospital.*

I am now attending the community meetings on the wards to get to know all the patients within Arnold Lodge - then I'm ready to formally launch the Peer Support Service in the Hospital. As an introduction to the Peer Support worker role at Arnold Lodge, I facilitated a "Time to Talk Day" on the 4th February. This was well received by the patients and staff at Arnold Lodge and in the wider trust. Time to Talk Day aims to get the nation talking about mental health. We know that talking about mental health can feel awkward, but it doesn't have to be. We used the popular game 'Would you rather?' to help break the ice and get the conversation flowing. This generated great conversations about Mental Health and the stigma that can be attached to it.



We encouraged patients to pick four activities to complete as part of the national day of awareness, including sending letters or asking people how they were. Patients used origami to make a game from which they could choose.

If you would like to know more about the day or look at the resources, we used at Arnold Lodge then I have enclosed the link to the event.

You can find more information at: - https://www.time-to-change.org.uk/get-involved/time-talk-day

The day was a great success, and some amazing conversations were started about coping and living with a mental illness.

I have now written two articles for the carers newsletter to help connect with the patient's carers and tell them about the addition of a Peer Support Worker at Arnold Lodge. I am also in the process of creating a small notice board on each of the wards telling the patients a bit about my journey through mental health and how they can access my service as a Peer Support worker at Arnold Lodge going forward.

I have also been asked to assist with facilitating Care Opinion as a Care Opinion Volunteer, a vital platform that allows interaction between the hospital, our patients and their families and loved ones. To know how much we value and integrate the opinion of our patients and their carers is really important to me having been a patient of mental health services for over 20 years, as I feel some of the best learning can come from this vital feedback.

I hope to share much more over the coming months on my work at Arnold Lodge.

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COVID-19 outbreak on a women's secure ward

Dr Sarah Markham, *Patient Representative, College Centre for Quality Improvement*

I remember the exact moment I learned there had been an outbreak of the SARS-CoV2-19 virus on the women's secure ward. I was in the patient computer room and deeply engaged in my academic work. Without any kind of warning the door opened and suddenly the manager was talking very loudly in my right ear. "X has tested positive for COVID-19. Given the amount of time you spend with her, you should isolate in your room right now." Before I could say a single word, the door slammed shut and he was gone.

The change in the ward was almost instantaneous. X (the index patient) was in mandatory self-isolation in her room and all the other patients had also retreated to their rooms after the staff had told them that if they didn't, they would also contract the virus. To further discourage patients from venturing into the communal area, the patient telephone booth, lounge, dining room, patient computer room and were locked to shut out everyone but the staff. We were allowed to access the now locked garden, but only one at a time in spite of the grassed area being over 150 square metres. When I enquired why the ad hoc rule had been put in place, I was told that the patients weren't trusted to adhere to appropriate spatial distancing. When I tried to suggest that perhaps this could be assessed on a more individually focused basis, I was informed that this was an emergency, and no one had time to waste doing that.

I did not follow suit with the self-isolation. I hadn't tested positive for the antigen and prior to admission I had consistently tested positive for SARS-CoV2-19 antibodies. Being physically fit and as an academic engaged in medical research including aspects of the current viral outbreak, I recognised that there was a very low probability that I would fall ill. The staff didn't approve of any of this, in spite of me providing them with a clear account of my reasons. This set the stage for how I would be treated during the remainder of the outbreak.

All patients were subsequently retested for the antigen. All the tests except mine were found to be positive. From that point I was the only patient to show myself on the ward. I did however immediately start wearing the cloth mask I had made for myself prior to admission. Prior to the ward outbreak, there had been no thought given to providing patients with masks. Such protective equipment was reserved for staff alone.

Thankfully, no one suffered too badly from the virus. It was a very lonely 16 days waiting for everyone to come out of mandatory isolation in their rooms. The ward, albeit never a warm or friendly environment, now assumed the air of a post-apocalyptic disaster zone. All patient rooms (except for my own) had a stern notice in big bold red letters stuck on the door warning staff to not enter unless wearing full PPE as the inmate had tested positive for COVID-19. Discarded electronic medical equipment and metal trolleys bearing all kinds of clinical restricted items littered the corridors on a 24/7 basis: disinfectant, clinical wipes, multiple rolls of tape and bundles of plastic sheeting. I remember wryly thinking to myself that at least the staff didn't seem to regard me as 'unsafe' with such items, and perhaps I should be grateful for this back-handed acknowledgement that I wasn't by default of being a patient an inherent risk to myself or others when freely exposed to such items.

However, the ward staff still clearly viewed me as a prime source of contagion and contamination, barking the order "keep at least two metres away from me" whenever I ventured out of my room to beg for a hot drink or to access the garden for fresh air and exercise. This was not a pleasant experience to say the least.

From my perspective the outbreak demonstrated a failure of services, the MDT and care teams to seek patients' views and concerns, let alone make any attempts at collaboration with respect to tackling the outbreak together. The patients were told what to do and they complied; there was no discussion or even any interest in their experience or opinions. I found this very concerning. My experience was that right from the patients were predominately treated as being the stereotypical unreliable, inferior and dangerous 'others' and restricted to an at times disproportionate and untherapeutic extent.

Patients weren't the only ones to experience a lack of regard and due respect from the secure service. Any patient who so much as dared to raise a concern was met with a strong "everyone

is treated exactly the same on this ward!" So much for patient-centred care. The ward staff also voiced concern that they were not given any information or rationale for the operation or plan for the ward was during the outbreak. Their input wasn't solicited, and they were relegated to the role of facilitators of the MDT and management's panic plan.

In the context of the ward during more 'normal' times, regrettably this didn't come as a surprise. Similar to many other secure settings, safety and care have in practice, if not always in policy, invariably been treated as synonymous with restriction. In the context of the pandemic the patients were seen to be clinical risk entities who should neither be seen or heard.

Devon Partnership Trust

How true collaboration can lead to magic

Jody Merelle, *Psychotherapist, Langdon Hospital*

The origins of the word collaborate comes from the Latin word meaning "work together". Whilst this won't come as a surprise to most people – what *is* surprising is how easily the real meaning of the concept of true collaboration can be forgotten. Collaboration is not one person telling another what to do, or an individual informing a team of its "joint" decision in which they have actually had no say. Those may be examples of communication – but they are not collaboration. Collaboration is, as the word's origins imply, working *together*.

This means that it is only when we are able to see past banding, perceived status and struggles for power that true collaboration can ever really exist. Genuine MDT collaboration should mean all team members having an equal stake in discussions. As such all points of view should be not only listened to and considered valid but taken into consideration too. If in practice it is the consultant or other team leader making the decisions - with only a cursory check round the room to tick the obligatory collaboration box, then you are more likely to be experiencing unilateral rather than collaborative decision-making.

These ideas are even more relevant when thinking about collaboration with service users. In order for true collaboration to be possible, we need as far as possible to put to one side the power imbalances that exist and genuinely consider the service user as an equal. When this happens, it is not only hugely empowering and validating, but it also inspires and encourages the service user to take more control over his or her pathway rather than just waiting for the next decision to be imposed. Collaboration is a process of mutual learning and moving forward together. Solution focused practice and open dialogue both embrace working in partnership with clients as a central principle. Service users invariably say they feel empowered as a result.

I recently organised a workshop for service users on remembering strengths and resources. I had planned to do this alone, but quite late in the day I was asked to co-produce this with one of the people attending (I shall call him John). I must admit that initially I felt some reluctance. I already had a clear idea in my head of how to structure the workshop and didn't feel the need for new ideas or input. However, not wanting to appear rejecting of John, I agreed. As soon as we met to plan the session, I felt rather ashamed to have been reluctant in the first place. Within minutes it became obvious how much better the session was going to be with John as my partner in it.

Our session involved an exercise (Your Sparkling Moment) in which participants recall a time or event when they felt truly proud of themselves. Each person in turn tells their story and the others in the room listen and write down all the strengths and talents that they identify from what they hear. Once the story is told, the storyteller themself is asked first what strengths *they* think they must have had in order to achieve what they did. This challenges the person to recall and recognise some of their own valuable abilities, which are then written down on a flipchart. After this, we then brainstorm with the rest of the room and write down all the other strengths and qualities that we have identified together. We

end up with a whole page of each person's strengths and resources which the whole group has been witness to. Whenever I run this exercise it has a powerful effect – even when people express a little awkwardness in doing it. However, the involvement of John on this occasion took it to another level. I had asked him what role he would feel most comfortable with. John said he would like to write the words on the flipchart. When the page was full, I spontaneously asked if he would like to read them to the person who had told the story (I will call him Ray.)

John then took a long pause. He made very deliberate eye contact with Ray, who had a history of drug misuse, violent behaviour and low self-esteem. Then, pausing between each word he said "Ray you ARE.....Resilient. Brave. Caring. A warrior. A survivor....." and so on, until he had read all 30 or so words on the paper. By the end of this, there was hardly anyone in the room who was not crying with emotion. Ray had rarely in his life received praise or positive affirmation for anything. And here he was being reminded with authenticity and compassion by one of his peers just how many qualities and strengths he actually had. It was one of the most empowering moments I have ever witnessed in many years of working with all types of clients.

This moment was not planned or staged in any way; it was a magic and spontaneous one. But it came out of true collaboration. It came out of putting reservations and feeling of reluctance to one side and accepting that decisions, projects and pathways are almost always stronger and more meaningful when they are truly made together. When people – both staff and service users, feel authentically valued, listened to and part of their own destiny, that is when the magic of true collaboration can genuinely happen.

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Service user and carer involvement within New Care Models, CNTW and TEWV

Danny Cain, *Senior Peer Supporter*
Lynn Williams, *Recovery and Engagement Lead, Secure Care Service (CBU)*

Introduction and background
In 2018 Cumbria, Northumberland Tyne and Wear NHS Foundation Trust (CNTW) and Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) adult secure services joined together to become a New Care Model. Together we are known as the North East and Cumbria Specialised Services Partnership (NECSSP). This is NHS England's programme giving budget responsibility to providers enabling them to invest in the pathways that make a difference locally.

The steps we have taken towards achieving co-production
We know that historically, both organisations have a strong culture of service user and carer engagement, but we acknowledge we can and want to do better. Rather than simply involving our service users and carers or asking their opinion after the fact; we are seeking to work collaboratively as partners to ensure all our services within the North East and Cumbria footprint are co-produced.

Through consultation with service users, professionals and carer's we have identified 5 strategic aims:

1. Leadership
We will ensure involvement is supported within the Implementation Group. Key roles will be identified for service users and carers to have regular attendance within the group, and these roles will coordinate involvement within service user/carer groups to maintain communication and feedback. Current service user and carer groups will be used to ensure inclusivity is maintained. There are two of our group members who are part of the Implementation Group.

2. Recruitment, training and workforce
Service users and carers will be supported to develop and deliver training within the services, with consideration being made for all new service developments to include the recruitment of people with lived experience. Review of the

geographical area's will be made, and peer supporters will be considered to ensure inequalities and diversity is high on teams' agendas. They will support the 'hard to reach' groups trying to make our services inclusive. Our Recovery Colleges will continue to support co-production and delivery of courses by people with a 'lived experience'.

3. Communication
We will ensure we maintain robust processes for service users, carers, friends, and family to be able to contribute to the development of our services. We have service user representation within our Implementation Group and these representatives are supported by recovery leads to take an active role within the meetings. At local levels, Recovery and Outcomes Groups are well established and these forums will be used to cascade and gather information across the services to ensure inclusivity to all. Service users' representatives will chair local meetings and they will be in a position to confirm and challenge the Implementation Group. Regular attendance at local meetings by the programme leads will be welcomed. Carer involvement will be through carer peer supporters and every opportunity will be made to promote attendance at local meetings for carers.

4. Design and delivery of services
Wherever possible service users and carers will work together within the Implementation Group in the design, delivery and development of current services and new initiatives.

5. Outcomes measures
What works well and why - we will aim to constantly review and reflect on our co-production strategy with service user and carer responsive outcome measures being used to identify the impact co-production has on our services.

Hopes and achievements
The group have been responsible for the development of information leaflets as well as questionnaires to help improve the services. A repatriation questionnaire was devised by service users and the information is being used to ensure we document and acknowledge the benefits of service users returning to their home areas.

We have had to adjust how we meet to ensure we follow safe practices. We meet though Microsoft Teams once a month and the meetings are jointly chaired by service users with all members of the group receiving a payment for their attendance. The group is expanding every month with services coming on board and we are proud to have members from all wards as well as our community services. We aim to increase our carer involvement and acknowledge that this can be challenging due to the need for technology to run the meetings, but we will continue to problem solve and use innovative ways of ensuring everyone's voice is heard. The group have looked at a number of proposals including the introduction of new services, including advanced care areas within CNTW and TEWV. Suggestions from our group have been considered and actioned. We are reviewing the introduction of a New Model of Care within our learning disability services to ensure it is promoting involvement in care. We also hope to look at new technology being considered for use within seclusion and the group have asked for more information around the use of seclusion. The chair will approach the seclusion policy author to join our group.

Our Confirm and Challenge Group has only been running for a short period of time; however, we feel confident the contribution to the development of secure service will benefit from its involvement. We both support Recovery and Outcomes groups across our services and ensure cohesion between these meetings. The chair and co-chair also sit on the Implementation Group and are supported by the recovery leads as well as our senior peer supporters. This ensures effective communication between all of us is maintained. Professionals within the Implementation Group have responded positively to our involvement - they pose questions which we take back to the Confirm and Challenge Group and we in turn also pose questions to them. As a group we hope to continue being part of the New Care Models implementation process and look forward to becoming a Provider Collaborative to ensure our services are the best they can be for the people who use NE and C Specialised Services.

Senior peer supporter feedback
As one of two senior peer supporters within the Gateway Recovery College, Secure Care CNTW, we would all agree it has been a difficult twelve months due to the Covid-19 pandemic. With our lived experience, peer supporters have continued to support and inspire service users through the ethos of the recovery college. I am sure that life will eventually return to near normality slowly but surely.

Collaboration in secure services: "Reflections on 2020"- Forensic Mental Health Services in NHS Lanarkshire

Ayesha Raja, *Consultant Forensic Psychiatrist, FCMHS, NHS Lanarkshire.*

NHS Lanarkshire provides healthcare services to 650,000 people. The catchment area includes large and smaller towns but also rural areas, particularly in the south. Lanarkshire suffered significantly from de-industrialisation in the 1980s and early 1990s; today, much of the forensic caseload arises from communities that were most impacted upon by the loss of heavy industry.

Forensic mental health services are based at Beckford Lodge, a modern, purpose-built facility in the centre of Hamilton, a large town with good transport links to Glasgow and Edinburgh. Inpatient services comprise low secure and open forensic rehabilitation wards. The community team is well resourced with experienced forensic community psychiatric nurses (FCPNs), occupational therapists, support workers, psychologists and psychiatrists.

This short summary describes how our service adjusted practice during the pandemic, what we consider worked well and the challenges along with the possible benefits to longer term working.

NHS Lanarkshire Health Board
Daily staff e-briefings from the Health Board were helpful in providing succinct summaries of guidelines and cascading guidance from Scottish Government. This included various topics with guidance upon Covid-19 risk assessment for staff, PPE, infection prevention and control, third sector supports for the bereaved, video consultations, and available supports for staff e.g. the well-being service.

Inpatient low secure unit, open rehabilitation ward, Beckford Lodge.
Weekly COVID-19 steering group meetings were set up. The requirement to safely manage the service with flexibility within the roles of staff became evident, during lock down and periods of sickness amongst staff and patients. We were fortunate to have embedded forensic community support workers and together with community occupational therapists (OT), these staff temporarily assumed a role more akin to a nursing assistant. Nursing staff from other CMHT were redeployed which brought its challenges due to skill mix.

Other measures taken included forming inpatient 'bubbles' to limit social isolation whilst improving infection control. iPads were sourced to facilitate patient contact with family via Near Me, NHS Scotland's Attend Anywhere service with Wi-Fi extended to all areas of the ward. Facility of frequent telephone calls to loved ones was greatly appreciated by the inpatients.

OT garden- green space, gazebo, vegetable patch all built by service users.

Daily community OT meetings with inpatient therapy staff led to identifying unmet needs of patients e.g., shopping for patients when restrictions prevented patients leaving the unit grounds.

The forensic community OT has excellent therapeutic, vocational and recreational services

within the Beckford Lodge site for both inpatients and forensic outpatients. However, during COVID-19 restrictions procedures and protocols required adjustment to allow inpatient use of the community OT kitchens, wood workshops and the on-site green spaces. Other activities such as the woodwork and cycle workshops are now used for one-to-one sessions. A recently built gazebo was used to facilitate patient family visits. The sensory garden, poly-tunnel and the open vegetable beds have been greatly valued by service users.

Horticulture experience at allotments

Bike shed construction by service users

Community Services.
Many community placements that outpatients and inpatients in later stages of rehabilitation attended were closed for long durations. Following social distancing guidelines, OTs, forensic support workers and FCPNs met service users in the local area for walk and talk exercise – discussing concerns and providing assistance e.g., picking up prescriptions from the pharmacy for those self-isolating. Additional joint visits to allotments with service users, or bike rides and gardening at home provided much needed companionship. Some vulnerable patients were assisted with food parcel delivery.

Our nurse-led court liaison service has continued to operate utilising a mixture of virtual and face-to-face interviews.

Whilst we made some phone calls to the patients, we were also determined to maintain face-to-face reviews. Psychiatrists and FCPNs undertook home visits to ensure continuity of care and support for anxious patients. One had to follow the protocols for PPE gear. The FCPNs adjusted the timings of the depot antipsychotic medication when patients presented with symptoms of respiratory illness.

Medico-legal work continued with face-to-face interviews and mental health tribunals were held via teleconference. Some relaxations in non-essential reporting for restricted patients were permitted by Scottish Government, but we continued to hold our CPA meetings using Microsoft Teams and provided statutory reports to the Scottish Government. This has broadly worked well and has minimised build-up of a backlog of work.

We have continued our service's teaching and training commitments to medical students, foundation and core/speciality training psychiatrists.

For staff it was reassuring to have lateral flow testing equipment and COVID-19 vaccination, which allayed their anxiety about cross infection. This allowed them to work safely with vulnerable

patients. To manage staffs stress levels, designated relaxing space as dens were created for in patient and community staff and additional support meetings were held.

Summary
We understand that coronavirus has impacted on the well-being of all and that much of our experience will parallel that of other similar services.

We were fortunate that NHS Lanarkshire's forensic services have well developed recreational/ vocational OT-led services within the Beckford Lodge site. This allowed community and in patients to retain structure during the week and maintain links with staff during COVID-19 restrictions. Similarly, flexibility within the roles of the forensic support worker staff and FCPNs in the service resulted in support for our patients that might otherwise have been less guaranteed.

Our younger staff have been adept at embracing new technology with excellent support from NHS Lanarkshire IT. In the longer term some of our older staff expect to continue to improve their IT skills for online consultations. The challenge is to strike the right balance between face-to-face contact and remote working; we consider that relying on only technology to review patients would be unsatisfactory and provide suboptimal care.

Acknowledgements: Maureen Black Advance Practitioner Occupational Therapist, George Simpson Assistant Occupational Therapist, Marie Magunnigal Clerical Officer NHSL.

QNFMHS membership feedback meeting

The Quality Network team would like to invite services and trusts to feedback about their experiences of membership.

These can be arranged at a local service level, or a wider trust level. We want to hear about what you find useful about being members, and what could improve, talking through all aspects of the review process. We will then arrange for a 'Task and Finish' group to collate the feedback and make improvements to our Network.

We are specifically wanting to know member experiences of the self-review and peer-review process, the review visits and other membership benefits.

We want to identify new focusses and developmental aspects of the Network.

Please contact Kate Townsend to arrange a feedback session, either by virtual meeting or by phone call: Kate.Townsend@rcpsych.ac.uk.

PUBLICATIONS AND RESOURCES

PHYSICAL SECURITY DOCUMENT

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.

The purpose of this tool has been defined as the following:

- To act as a standardised tool that can be adapted locally to manage physical security
- To be used as an assessment and compliance tool
- To provide a consistent process of assurance
- To aid training for staff in physical security

Update:

The editable version is currently being updated and worked on to ensure usability and effectiveness. We are working with services to trial it, before it is rolled out to the wider Network. Services are **not** currently expected to complete the PSD for this cycle. It will be introduced with your self-review in cycle 14-8. There is a PDF version online if you would like to take a look and prepare for this (as the content will remain the same). The editable version will be available in the coming months. If you have any questions about this, please do get in touch.

PREVIOUS NEWSLETTERS

If you enjoyed reading this newsletter, you can click on the images below to access previous editions.

Celebrating diversity and difference

Lessons learned from COVID-19

No theme

Peer support

If you are interested in contributing to a future edition of our newsletter, 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

Knowledge Hub
www.khub.net

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

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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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