WELCOME

Welcome to the 10th edition of the Quality Network for Low Secure Forensic Mental Health Services’ Newsletter, a themed edition addressing the Physical Environment in Low Secure Services. There are a range of articles written by patients and members of staff from low secure services across the UK which explore initiatives that are in place around the physical environment of low secure services and how this affects patient’s care. Many thanks to all those who contributed to this edition and we hope you find the articles both interesting and useful.

Since the last edition, we successfully ran both the MSU and LSU Annual Forums which were held at the Royal Society of Medicine. We are in the process of finalising both the MSU and LSU Annual Reports which will be sent out to all member services shortly. We are due to commence Cycle 4 of peer-reviews this month and have recruited 10 new member services.

Dr Quazi Haque
Chair of the Advisory Group

St Andrews Healthcare
Graffiti as a Therapeutic Intervention

Background
For many years graffiti art has been a prominent feature in most big cities around the world, and in some respect has a bad reputation, in some cases for valid reasons. However the important thing to remember is that many artists who use graffiti styles, are just that, artists.

We identified a suitable space, which would be visible to all and large enough to complete a large mural on.
Graffiti art originated in New York in the 1970s and played a huge part in the hip hop movement. It started off with kids writing their names/nicknames and street numbers all over the city, over time the city of New York was covered in various people’s names and initials. The need for your piece to ‘stand out’ became huge. This is when individuals started experimenting with bright colours, bold shapes and pictures and the growth of the graffiti art movement really began.

**Research evidence**

The idea that creative expression can make a powerful contribution to the healing process has been embraced in many different cultures. Throughout recorded history, people have used pictures, stories, dances, and chants as healing rituals. Nevertheless, we have seen positive outcomes for the potential of using art to promote healing.

Art can be a refuge from the intense emotions associated with illness. There are no limits to the imagination in finding creative ways of expressing grief and other emotions.

From ‘*The Arts and Mental Health: Creativity and Inclusion*’ – Parr, University of Dundee

I have always considered art to be of huge therapeutic value, whether or not you are a talented painter, musician or sketcher. Over the years of working in mental health I have had the privilege of meeting patients with varying talents; some published authors, some artists and musicians alike. One thing they all had in common was that they found the arts therapeutic. In the UK particularly, graffiti art can be seen as a form of vandalism or anti-social

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**NEXT EDITION**

**Providing High Quality Meals in Low Secure Services**

For more information or to submit articles please contact Amy Lawson at the Quality Network

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Some areas that could be covered:

- The environmental design of low secure services and maintaining patient’s safety
- Challenges faced with the environmental design of low secure services
- How these challenges have been overcome
behaviour, with artists trespassing at times to paint their masterpieces. Working within a low secure unit, many of my patients have had experience of inner-city living and the challenges that come with this. Over time patients showed an interest in graffiti as a form of art, in ward based art and crafts group. As the Lead Occupational Therapist, I am responsible for organising various projects and initiatives and I felt that graffiti being something the patients already showed an interest in, could be a great project to embark upon.

Once we identified the derelict wall we would use, we then went on to identify the patients who were passionate and wanted to be involved. After some research I came across a company named Brave Arts, who are a wonderful team of artists who have worked within many secure units, hospitals, schools and within the prison service.

For me it was very important for patients to understand the history of graffiti art, where it originated from and how it can be seen as a productive art form when done in legal ways as opposed to trespassing and painting illegally. Brave Arts came along to our unit and completed a half day workshop which our patients loved. Within this they explored various forms of graffiti art and how it has evolved over the years. The patients came up with a concept with the help of the Brave Arts team. Their concept was around their recovery journey within mental health and they were keen to present a positive image.

**The project**
The project itself took two days of painting and 18 patients were involved from various wards within the low secure unit. There was a huge buzz within the unit when it was going on, and patients who had previously shown no interest in art were keen to come along, if only to fill in one small section. The Occupational Therapy team all got to be involved as well and we all loved being part of such an exciting project and being able to, along with our patients, leave our mark on the unit we work in.

**Feedback from patients**
Patients who were involved in the project had nothing but positive feedback on the experience; here are some of their words below.

'It was really significant for me to be part of something which will be here in the future, for others to see, that there is a way out even if you have mental health issues’

'I have loved taking part in this and leaving my mark’

'It’s been an amazing day, I’ve loved the whole experience’

'It looks so good, I’m so happy I did this’

'This was a great idea and thanks to the OT team for putting this together’
I would like to acknowledge the entire Occupational Therapy team for their hard work and support in helping pull together this amazing project for our patients. (Team: Glenn Ellison, Liam Huntingford, George Hambley, Frederick O’Brien, Emily Courtier, Georgina Atkins, Ciara Mitchell, Narinder Sangha, Natasha Dillow and Emma Tillbrook).

I remember the day I, as an inpatient of Medium Secure Services, went with a bunch of fellow patients to look around the new Low Secure Unit (our Trust’s first low secure service). It seemed smaller and more compact than the medium secure unit with a more open plan layout which made it seem airier and friendlier. I sensed at once I would be less isolated there.

Through the far door opposite the main entry point to the ward I could see the garden, smaller than the garden area in the medium secure unit, but with a noticeably lower fence which made it seem far less forbidding than the 5.2m fence around the unit in which I was a resident. This felt like a great relief; a more normal sized boundary felt less stigmatizing and more homely.

The bedrooms were smaller but somehow cosier and more attractive looking, although some didn’t have an ensuite shower alcove which was rather disappointing. For someone whose first instinct of waking up is to head for the shower, it is not good to have to pad around the ward in a towel/dressing gown and bottle of shower gel in hand, looking for a staff member to unlock the communal shower room for you. This has the potential to compromise dignity and privacy and could be quite stressful, particularly when the staff are especially busy and don’t have the time to follow you back down the corridor and apply the necessary key action to the locked barrier between you and physical freshness.

In my, however subjective, experience of being an inpatient on locked units, the relational...
dynamics between staff and patients positivity can go a long way to making up for any deficiencies or disadvantages of the physical environment. Even the stress of so many doors being locked (shower room, ADL kitchen, quiet room, etc.) can be ameliorated to some extent by staff who are aware and responsive to patient needs and who don’t express impatience and irritation when politely asked if rooms could be unlocked. However, if you are someone who doesn’t and perhaps has never needed such environmental constraints, the long term effect of being an inpatient in such locked environments can be one of lower self-esteem and a lessening in your confidence in secure services to see you as you are.

This is especially a problem on a women’s ward where you may find a wide spectrum of vulnerabilities of varying degrees. For instance, you might find a patient who has never presented risk around the use of a kettle or cooker, together with patients who may at times seek to use such devices to harm themselves and/or others. For financial reasons it is (currently) rarely viable to have more than one women’s ward on a low secure unit especially as the female patient population in forensic services tends to be smaller than the male population. Therefore, it is rarely possible to segregate patients who present a risk in normal living environments from those who don’t. In an ideal world patients would be restricted only with regard to the specific areas of risk which pertain to them as individuals and I think this should be kept in mind in an aspirational sense by secure and forensic services.

I remember the ‘key issue’ of the locked doors impacted harshly on me during that visit to the low secure unit to which I was to be transferred.

I was horrified that there seemed to be no distinction between medium and low secure environments with regard to which doors were and weren’t locked on the ward. At the time during that visit my disappointment and sense of dread that this locked environment was to become my new ‘home’ was so acutely painful that I found it hard to hold back tears. I felt it an indicator of the extent to which services devalued their more adaptive patients, that they subjected them to inappropriate levels and forms of environmental restriction.

Fortunately for me, my next step after the secure unit was to a ‘step down’ facility in which I lived in a single-occupancy bungalow flat to which I held the key. Yes, it was within fenced and locked boundaries, but the flat itself was my own little sanctuary where I could cook for myself and lead (on a domestic level at least) a normal existence. The only issue around showering was if the night staffs’ early morning checks coincided with me having a shower leading to one or two of them bursting into my flat whilst I was in the shower. Thankfully that didn’t happen too often!

I think it is important for low secure services to realise and acknowledge the impact an inappropriate level of environmental restriction can have on a patient’s recovery. Even if there is little they can do to reduce overly restrictive protocols, to say to patients that they understand how onerous and degrading it can feel to be subjected to such constraints can help to restore a little of patients’ confidence in services.

Dr Sarah Markham
Patient Reviewer
QNFMHS
Partnerships in Care
Introducing a Mobile Phone Policy on Byron Ward: The Challenges and Benefits

As a Low Secure Unit within a Medium Secure Building it can be difficult for the staff and patients of Byron Ward at the North London Clinic (NLC) to distinguish their lower security status. Many things are more restricted due to the nature of the hospital design and layout of the facilities. As a result, the members of the MDT have actively attempted to introduce ways for patients to differentiate themselves and be able to recognise their progress along individual care pathways. To support this, a policy was drafted to support patient access to mobile phones on the ward.

An area that staff at NLC promotes strongly is contact with external support such as family and friends. This communication is vital to maintain external links to the community and reduce social exclusion. According to Killsapy et al (2010, p.88) “Efforts to counteract social exclusion and to promote socially inclusive practice are necessary and beneficial both to the individual user of mental health services and to the wider society”. Visits are arranged regularly and patients are offered access to Skype to maintain contact with family and friends. Many patients, however, are placed far away from their families, or do not feel that Skype is feasible. For these patients, the ward telephone is the main source of communication. Through access to mobile phones, it was suggested that patients could develop more independence in the way they choose to communicate with the outside world.

All patients on the ward have access to the ward payphone. They can also request to use the office phone for legal or professional calls to support their progression. This can, at times, be difficult to manage as patients may want the phone at the same time, as well as wanting more privacy. This consideration was cited as an additional reason to suggest the plan to introduce mobile phones. It was thought that the increased independence and need for responsibility for the phones would help the patients develop skills that would support their eventual transition back to the community.

The process that was used to develop the policy followed several steps and was designed to include input from all staff and patients that would be affected with the introduction of mobile phones. The first step was to consult with patients to see how they felt about the idea. The issue was raised in a series of community meetings on the ward and patients were invited to make suggestions as to how they felt about access to mobile phones on the ward. The majority of the feedback was positive. Comments included:

“Having phones would improve things, it would mean I could text my Mum”
“I think it’s a great idea”
“How can we get them straight away?”

Interestingly, one patient made the following comment:

“I’ve been away for a long time and have never had a mobile phone, so I’m not desperate to have one. I’d have to learn how to use it, so I’d need some help.”

The next stage of the process was to ask the patients to suggest how they thought the introduction of the phones could be managed within a ward environment. They came up with ideas including time limited access, ensuring that the phones do not interfere with therapeutic activities, limiting access to others’ phones and suggestions related to the suspension or withdrawal of access. These ideas were brought to staff Reflective Practice meetings to encourage RMNs and Healthcare Workers to consider and develop. This was an important stage as the MDT were aware that it would be the ward staff that would be in charge of the day to day management of the mobile phones. The ward staffs were in agreement with a lot of what the patients had suggested and helped confirm how these steps would be factored into the policy development.

Following this, the MDT structured the protocol focussing on the day to day management to make sure there would be enough checks, bearing in mind the ward (Byron) is within a medium secure building. Most of our discussions
were about meeting the expectation of the patients as well as addressing any security concerns. The final draft by the MDT was circulated to the Unit Manager and the Security Lead who made some useful suggestions.

The next stage was the presentation of the Protocol to the Security Committee for consideration. Some suggestions and amendments were made and the protocol was then ratified. It was agreed that the phone would be a normal basic mobile phone with no camera or videoing capabilities.

Mobile phones are audited and issued to patients at 10:15 each day and signed back into the ward safe. There is the possibility of allowing patients to keep their mobile phones for 24 hours when the protocol is reviewed after three months. We will however, have to put measures in place to monitor its use in order to reduce the impact 24 hours use may have on therapeutic engagement.

The Mobile Phone policy has now been in place on Byron Ward for 3 months. Patients have adhered well to the procedures that it details and staffs have commented that its introduction has been successful. The patients have demonstrated good levels of responsibility and with increased contact with family, friends and carers, have been able to maintain communication and minimise social isolation.

Over the trial period, there has been noticeably less conflict with the ward pay phone with most patients choosing to acquire their personal mobile phone. This has given the patients responsibility and independence. The introduction of mobile phone use has also improved their privacy and dignity since most of them prefer to use their phones in the comfort of their bedrooms.

It has also helped in the development of their functional skills since most of the patients are at the stage of their recovery journey to be either discharged or stepped down to a lower level of security. The process of introducing mobile phones to the Low Secure Unit has presented several challenges and the process has taken collaboration and negotiation between staff and patients. This process has been beneficial, however, as it has helped evidence to the patient group the benefits of working productively with the MDT towards a desirable goal.

James P. Cooper, Charge Nurse
Richard Hewett, Occupational Therapist
North London Clinic

References

Why Should I Join the LSU Discussion Group?

The Quality Network run a discussion group to enable any member of staff from a member service to post questions to the Network and receive responses and suggestions from other units. This might include OT’s, frontline nursing staff, security staff and hospital managers.

This facility is only available to Quality Network members and is a great way to receive advise and share good practice across low secure sites.

“A very useful service, which helps with a wide variety of tasks ranging from policy information to ethical issues”

If you would like to join the eLSU discussion group, please email ‘Join’ to: lsu@rcpsych.ac.uk
eLSU Patient Artwork
This year we received over 130 entries for the Cycle 3 Low Secure Patient Artwork Competition and you can see all the entries on these pages. We would like to thank all of the patients that entered the competition and the winning entries can be found on the website, www.qnfmhs.co.uk. The five winning pieces will be used on the front cover of our Cycle 3 Annual Report, Cycle 4 Local Reports and our other publications.
Quality Network for Forensic Mental Health Services

Stagnant Space, Frustrated Mind

Detained behind fences and locked behind doors
Trapped and living with strangers, pent up frustration out pours
Little space to find serenity, peace and some calm
I try to switch off but again someone activates the alarm!

Not a home but the temporary place where I’m forced to reside
A ward, with functional rooms, little comfort or communal pride
White washed walls look tired, chipped paint and damaged pictures
Drab curtains, musky duvet, wonky tables and no positive features.

Does this place reflect the attitude and the care that I deserve?
Every hour in every week I’m surfing urges to self-preserve
Walking poorly lit corridors towards spaces I genuinely feel fear
Bullied in corners out of sight, but staff don’t have time to hear.

Notice boards are out of date, uninspiring and irrelevant
The nursing office looks a shambles, lacks confidentiality and is stagnant
Perhaps this is a reflection of staff recognising this as merely their workplace
But for me this is all I have, I want to relax and live in a clean and safe space.

On the hour the doors to the courtyard are briefly unlocked
But the air I crave is taken hostage and I am mocked

Shared sofa’s bare the scars of battles over years gone by
My bed, a lumpy mattress and a misshapen pillow in which so many will have cried
No privacy, no dignity, so no choice but to just accept
A living space, so neglected it provides no motivation (or self-respect).
As I stare with despair at the fag ends, litter and weeds dominating this space
I am finding it difficult to envisage anything but my current life status and consequent disgrace.

As frustrated as I’ve become, perhaps institutionalised beyond repair
I do my best to get through each day, clean my room – but others just don’t care
Take the opportunity to change attitudes and for patient’s scenery to be improved

It wouldn’t take much to consider our environment and for fears to be removed.

Install some cameras, paint the walls and let more daylight seep in
Encourage patients to take responsibility and put their rubbish in the bin
Start by scattering captivating images, perhaps landscapes to motivate with natural beauty
A place where ‘care’ can flourish without conditions or an impression of a mere duty.

Let decisions of an improved environment be openly discussed and jointly agreed
Freshen up the atmosphere, improve the lighting, brighten furnishing, plant some seeds
Let my home be a space where I am inspired and I can learn
An improved environment might not seem important but as my home it’s what I yearn.

Suzanne Harrison
Patient Reviewer
QNFMHS

Priory Group
Reality, Risk and Reactions

For most patients a low secure unit can be the last stop before the community. On the other hand it can just be the last stop. Although low secure units promote moving out, it can be common practice for a low secure to have a long stay ward of five years and up. This occurs in NHS and private hospitals. Going to a low secure unit usually means you’re on your way out or it could mean you’re no nearer to that than you were in a medium secure unit. However, you have a better quality of life. It is not unknown for units to have ‘beds’ in low secure for quality of life purpose.

Risks in a low secure unit
‘Snowmen’ have been built next to perimeter fences to assist escape for those not on leave, brisk trading in drugs, alcohol, tobacco and any other banned items can and are common risk issues in some low secure units. It is related to camaraderie amongst those with unescorted leave and those without, even though getting caught is an automatic suspension, an unthinkable loyalty, the ‘us and them’ factor stays strong. An interesting point is, a 37/41 patient may require reapplication for lost leave. A section 3, 37n patient may only have leave suspended between ward rounds. This was a common occurrence at a low secure I was in. What patients gained by using unescorted leave to smuggle in items outweighed a two week suspension. Legal highs have always been and will probably continue to be an issue. There is a lack of testing for its usage. One low secure attempted to solve this by implementing a home grown test. If anyone returned from unescorted leave with glazed eyes, looking lethargic, sweaty or unsteady were caught out. Whether they had taken highs or not.

Low secure units close to or in a large city tend to replicate social problems associated with that
community. For example, if the low secure is within or close to a large ‘drug using area’ it would be reasonable to expect that the low secure will have a more than normal population of ex and current ‘drug users’ who will eventually be on unescorted leave in that same community. Multi-disciplinary teams may say that they believe the patient has changed and been rehabilitated to keep away from drugs. I have no doubt that the patient will also believe this. However, the memories of the drug buzz, the culture and of course their friends in the community who are unlikely to stigmatise them. These will all be a big push to start taking drugs again.

A patient I knew who was out every day on unescorted leave told me he felt incredibly lonely on his leave because while he was still a patient, he wasn’t allowed to fully connect with the community, they could not go on dates, nights out with mates, stay out late etc. Having to be in by 8pm restricts that connection. Alcohol may be a way of coping and may become a strategy used when the patient goes to live in the community especially when stigma comes calling.

Professionals in low secure do see a lot and manage a lot of risks associated with managing patients on unescorted leave. I believe they also miss a lot. I knew a patient who had a formula for beating the alcohol test on unescorted leave. If he knew he would be out from 9am-8pm he would calculate that if he drank a certain amount containing a measurable alcohol content as soon as he got out on leave, he would not be picked up by an alcohol test on a late return. He was never busted for a drink.

I get the impression that the reality of being a patient in a low secure is not within the low secure at all. They’re probably a relaxed environment for most people. The reality is the bridging between low secure and community. From ‘patient’ to citizen. From the role you played pre patient to the place you’re at post patient. From having a readymade group around you who accept you for what you are and don’t judge you, to a community who doesn’t know you and will definitely judge you. From relatively low stigma to the reality of it and its impact. From sharing deep, personal information as a common practice to having to keep your past a secret to most people. Finding out by trial and error what you say in the community can’t be unsaid. I remember one I was in a bar, drinking tonic water, with charity shop worker colleagues and they started talking about mental health issues, I had so much to say, I wanted to join in. I knew if I did then I would be revealing what I was, a patient on leave from a unit. The reality is a low secure is limited to how it can prepare people to be in the community. They do offer a reasonable quality of life and usually give lots of unescorted leave but is that in itself creating a situation where it impacts on the ‘bridging’. A patient may become reliant in being in the community under the protection of the low secure.

Reactions
From my experience and seeing similar effects on other patients, staff in low securities tend to over react to minor infringements. It is always as if the minor issue is the tip of the iceberg they cannot see but must be there. I am not saying all low secure staff react this way. I am talking from what I have experienced and seen.

It seems that while you’re in a low secure you come under the daily monitoring and checks that keep ward staff and MDTs assured that they have a good grasp on the handle of every conceivable situation. Institutions sleep better when they have knowns such as a fence, locks, and drugs. Unescorted leave creates a very big unknown and from experience if staff sense that anything seems wrong, you could say a wrong word or crack a joke then it is automatically an interrogation.

It could be said “well the patient should have faith in his team as they are the professionals” that maybe but the staff at the units understand unit life they don’t understand the mind set of patients when they are out on unescorted leave. How much of the community mind set of a patients do they understand?

A community CPN once told me that staff in a low secure see things differently from community psychiatric staff. When it comes to risk this might be true.

Alex Sunyata
Patient
Thornford Park Hospital
Quality Network for Forensic Mental Health Services
Improving your Ward’s Physical Environment

Patients who are detained, are living in secure environments that they are essentially legally bound to live within. 168 hours a week 24/7, of the same confined space, unless of course you have managed to gain some community access. Needless to say that even if you have leave, you will still return to the same environment day in, day out. For those of you reading this who are not patients, I feel sure that your home environment gets a facelift, or furniture change around on a regular basis. I am sure that you also look to make your home as comfortable, appealing, colourful and reflective of your personality or interests as you possibly can. It’s probably a space that you take great pride in caring for. It’s somewhere you feel safe and somewhere you feel you are able to relax in.

Now take a moment to consider that the wards that patients are forced to live on are to put it bluntly – ‘their temporary homes’. ‘Home’ itself is a word that captures feeling of comfort and security – but if we are honest and take a good look at the environment that patients are living in – they are on the whole bland, cold in presentation and far from homely – in fact in many places they are simply ‘wards’ and no more than that! Yet in order to ‘Recover’ and to develop individuals self worth and pride, they firstly need to feel comfortable with their environment.

On my travels working for the Quality Network Review Panels, I have seen some fabulous efforts made by wards to give them a feel of comfort and homeliness.

It’s time to do away with whitewashed walls, colourless curtains, bland pictures and tatty noticeboards. The ward environment needs to be inviting, educational and inspirational. They also need to consider the possibilities for patients to apply Mindfulness skills – through captivating photography, stunning landscapes or restful images, so patients can sit peacefully in the comfort of a carefully considered environment – which is of course safe!

I have listed below a top 10 list - agreed by my fellow patients - as the key elements to providing a positive ‘Temporary Home’. Staff have understandably got the judgement call on key safety issues – and these are fine as long as the judgement is communicated openly with patients.

1. **Do away with white washed walls!** Introduce (therapeutic) **mood enhancing colours**, and include patients in the choice of colour.

2. **Ensure that the ward is kept immaculately clean**, and patients are encouraged to clean up after themselves. (Fellow patients commented - that a poorly deep cleaned ward, invites laziness, and a negative attitude to the environment). It is also important that patients respect and their outside spaces including courtyards and gardens. – Group ‘clean up’s’ and/or ‘Face lifts’ can be carried out in an encouraging and rewarding manner as patient based projects.

3. **Choose furniture** that allows all patients to be able to sit down in communal areas – to avoid the dominance of certain individuals. Engage patients in the choice of furnishings – provide them with visual examples of the types of furniture your organisation selects from. Where necessary communicate why some options would not be possible for reasons of safety etc.

4. **Actively encourage patients to choose matching furnishings** including carpets/ laminates’, cushions and curtains by letting them browse swatches, even if the choice...
presented to them is limited because of safety or sensibility!

5. **Provide a quiet space / or a room** for patients who struggle to interact, or who want time away from 24/7 TV or music. These rooms can be designed in such a way as to be restful places, perhaps considering sensory resources. Positive quotes and enchanting pictures can be displayed. One ward I visited had an Aquarium which formed part of the wall. Or you could integrate a type of lava lamp again within a casing in the room. Here a bookshelf could be placed and appropriate restful or inspirational reading could be supplied.

6. **Display patients work** (anonymously if agreed), acknowledge their efforts, preferably behind lockable screens, so work is not damaged. (Pictures surrounding this article are all photos taken and then blown up into glossy prints and stuck directly onto the walls. Patients take great pride in knowing their work will remain there after they have moved on.)

7. **Choose ‘Themes’ for the ward** – whether it be ‘Christmas’, or as simple as the ‘Fairview Ward’s ‘Springtime’ theme – where patients decorated the insides of internal and external windows on the ward. The Christmas theme has been a running competition at my hospital for a number of years with a first prize for the best decorated ward of £150, to be spent on activity resources for the ward. Other themes could include – World Cup, Charity promotion, Mindfulness, Where’s Wally! Sensitive consideration for patients when it comes to possible conflict with cultures and religion – especially Easter and Halloween.

8. **Notice boards** – where possible these should always be enclosed, so that notices do not simply get ‘slapped up’ – of course there is always going to be key information that must be available for patients i.e. Advocacy Services, information about the Quality Network Review or a CQC inspection, or perhaps ward protocols / agreed rules etc. These boards are however a real opportunity to Inspire and promote opportunities for increased engagement – as you can see from the images of the Notice board promoting a ‘Recovery Fair’. Daily Mindfulness techniques, positive quotes or themes such as Smoking Cessation, or the importance of exercise can take centre stage! One male ward I visited had put together a fantastic display on Testicular Cancer – so important and very informative! As patients we generally appreciate informative displays – these are especially helpful if they are followed up with discussion groups, where Q&A is actively encouraged.

9. In Low Secure units – patients should be
actively encouraged to **personalise their bedrooms**, and have open access to them – This is for many the only area that patients feel real safety and sanctity, and the more it feels ‘ours’ the happier we are and the prouder we are to look after it. Needless to say that there may be occasions where ‘Risk control’ is prioritised for certain individuals.

10. **Lighting** – some wards can be very dark and dingy, which immediately generates low mood and apathy. Some in contrast are too bright and overwhelming preventing some from getting a decent night’s sleep, even when dimmer switches are used. A balance is needed, and where possible natural light to be encouraged. Coloured therapeutic lighting in certain areas could also be considered.

We could have added many other issues to the list such as space, noise and resources available on the ward (i.e. books on bookshelves) but the above were agreed to be of key importance to us, and that at all points, decision making should be shared, joint and transparent with patients. Where ideas cannot work either due to cost or safety these should be explained clearly.

Good luck in your quest to develop more inspirational, educational, informative, comfortable and ‘homely’ environments!!

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**Membership Resources**

The LSU network are updating the ‘membership resources’ section of their website with up-to-date policies.

If anybody has any policies that they are prepared to share then we would be very grateful to receive them.

Any policies that are submitted will be put onto the Quality Network website in a password protected members area to enable the sharing of resources.

For more information contact the LSU Team at

lsu@rcpsych.ac.uk

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**Suzanne Harrison**

Patient Reviewer

QNFMHS

**FAIRVIEW AT CHRISTMAS**
Useful links

Department of Health
www.doh.gov.uk

Health and Social Care Advisory Service
www.hascas.org.uk
An evidence based service development organisation working in all spect of mental health and older people’s services across the health and social care contiuum

Institute of Psychiatry
www.iop.kcl.ac.uk
The largest academic community in Europe devoted to the study and prevention of mental health problems.

National Forensic Mental Health R&D Programme
www.nfmhp.org.uk
Recently completed programme of research funding to support the provision of mental health services for people with mental health disorders who are offenders/ risk of offending.

National Institute for Health and Clinical Excellence
www.nice.org.uk
An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Includes the National Collaborating Centre for Mental Health (NCCMH), a partnership between the RCP and BPS.

National Offender Management Service (NOMS)
www.justice.gov.uk/about/noms
Brings together the work of the correctional services.

Prison Health
www.dh.gov.uk/health/category/policy-areas/social-care/offender-health
A partnership between the PrisonService and the Department of Health working to improve the standard of health care in prisons.

Offender Health Research Network
www.ohrn.nhs.uk

The Offender Health Research Network
www.ohrn.nhs.uk
The Offender Health Research Network is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester.

Centre for Mental Health
www.scmh.org.uk
An independent charity that seeks to influence mental health policy and practice and enables the development of excellent mental health services through a programme of research, training and development.

QIPP
www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp

College Centre for Quality Improvement
www.rcpsych.ac.uk/quality.aspx

College Training
www.rcpsych.ac.uk/rainingpsychiatry/eventsandcurses.aspx
Offers courses for professional development in mental health care.

Contact the LSU FORENSIC team

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