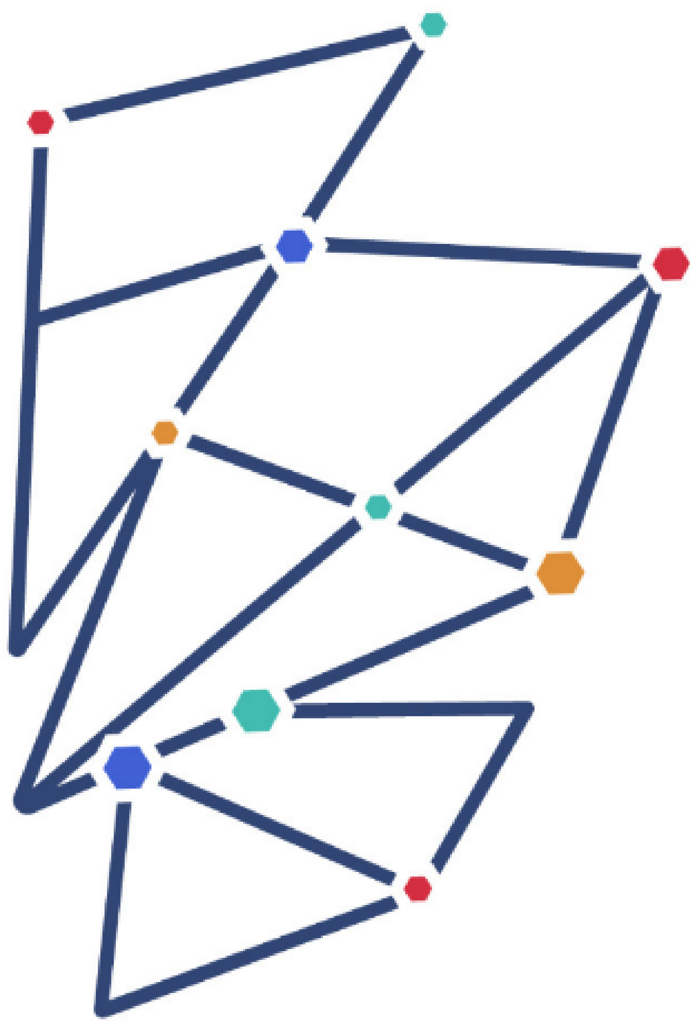


Forensic Network

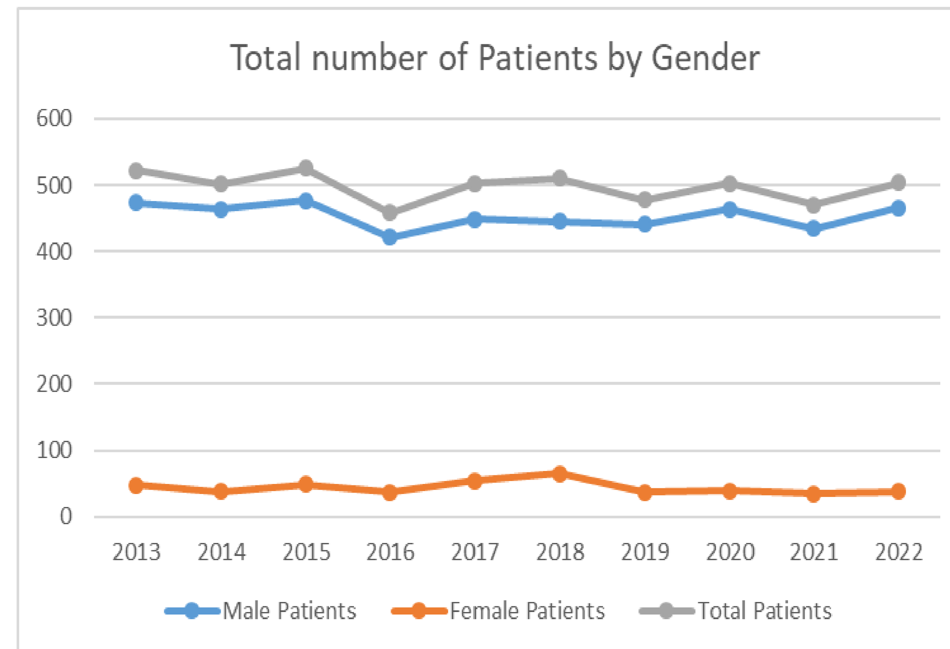
Celebrating 20 Years

10 Years of the Forensic Network Census - 2013-2022

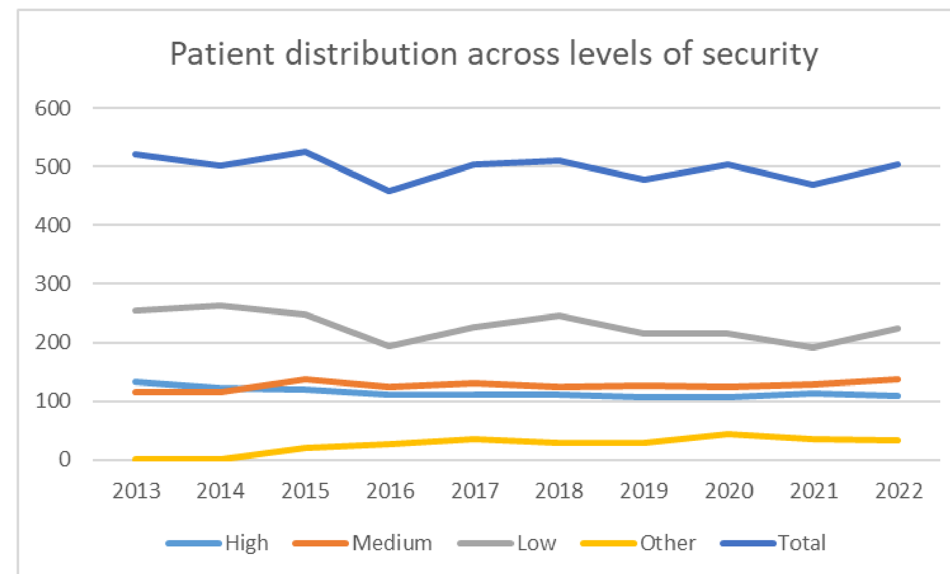
Forensic Network

The Forensic Network started collecting data through the annual Census at the end of 2013. The census was designed as a Point Prevalence exercise, collating data on all Forensic Inpatients in FN sites on the 26th of November each year. The initial Census in 2013 gathered a huge range of data which has been used to inform a number of research studies, and form the basis for the ongoing development of the of the FN Inpatient database. Subsequent iterations of the Census have gathered a more limited data set including site, level of security, gender, age, diagnostic category, date of admission and source of admission. The criteria for inclusion within the FN Census are clearly defined, and are noted the right under FN Census Inclusion Criteria. The poster provides details of the FN Inpatient population over 10 years between 2013 and 2022.

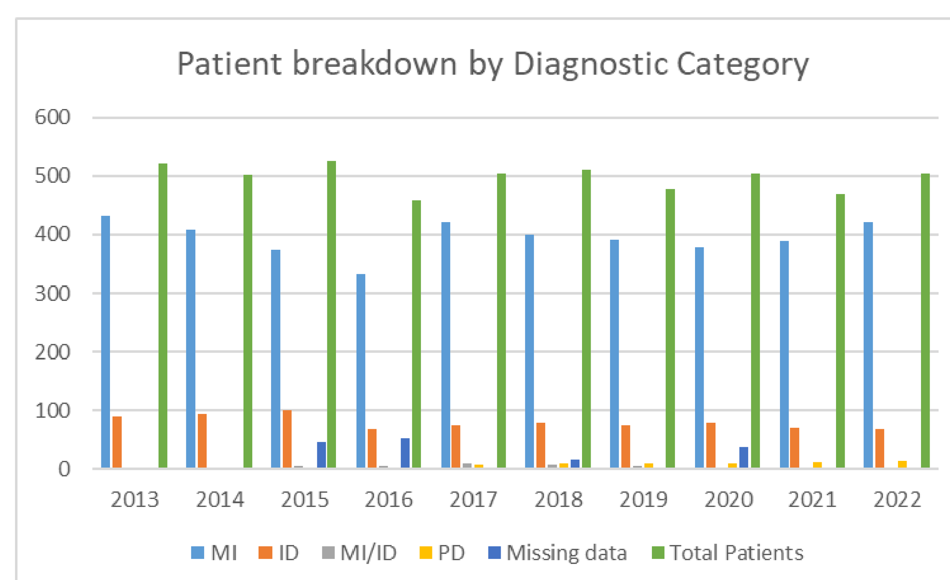
FN Inpatient Population
The FN inpatient population has remained remarkably consistent over the 10 years of the Census, despite some issues with data collection: see FN Census Limitations. The population has ranged from 522 in 2013 to a peak of 526 in 2015, and on the last Census date of 26th November 2022 sat at 504. Female patients numbers have ranged from 35 to 65 with a percentage range from 7.4% to a peak of 12.7% in 2018. 2022 data shows a total population of 504 patients; 38 women (7.5%) and 466 men (92.5%). The Census data has only reported one Transgender patient in the 2013 Census.



Patient Distribution across Levels of Security
The chart to the right shows the distribution of patients across the different levels of secure care. Initial submissions to the Census team reported patients as solely residing in High, Medium or Low security; however since 2015 sites have noted patients being cared for under a far wider range of security options. The additional categories noted by sites and referred to as Other in the chart to the right include: IPCU, Locked Ward, Locked ID ward and Open.

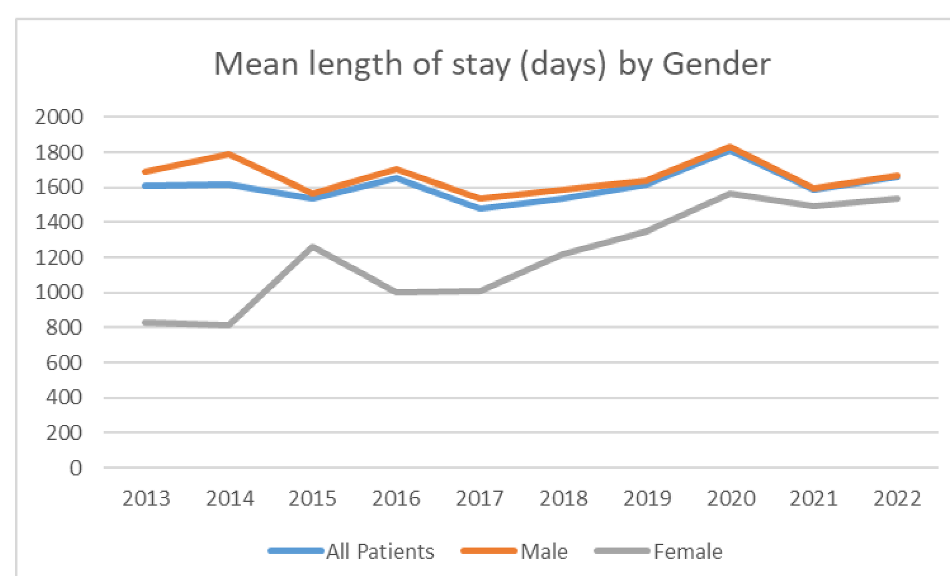


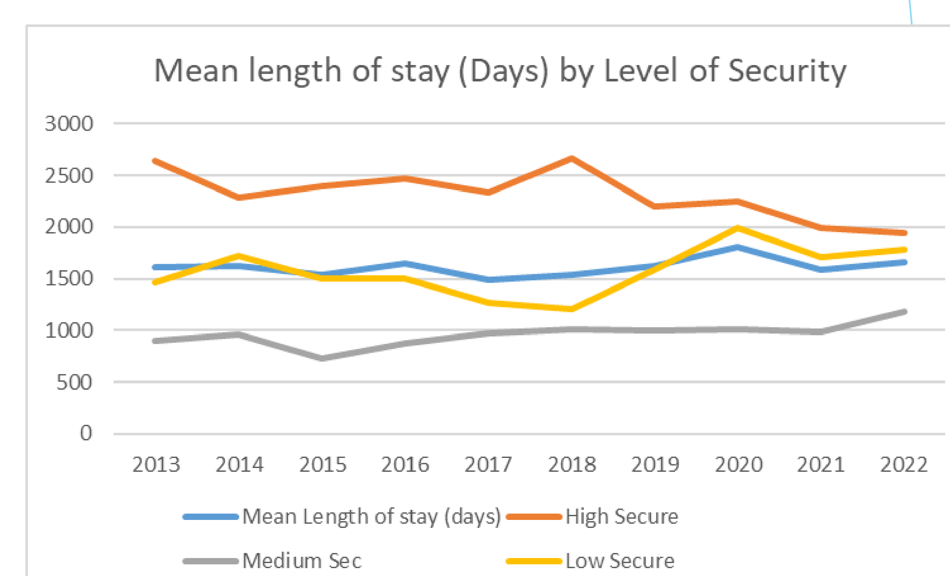
Distribution by Diagnostic Category
The census collects data on the diagnostic category of all patients. The proportion of patients identified as ID peaked at 19% in 2015 and has since steadily decreased down to the current 2022 level of 13.7%. Responses in early years of the Census where limited to patients being either Mental Illness (MI) of Intellectual Disability (ID) patients, however since 2017 an increasing number of patients have been identified as having the primary diagnostic category of Personality Disorder (PD). The most recent 2022 Census saw the highest number of patients identified as PD with 14, which represents 2.8% of the 2022 population.



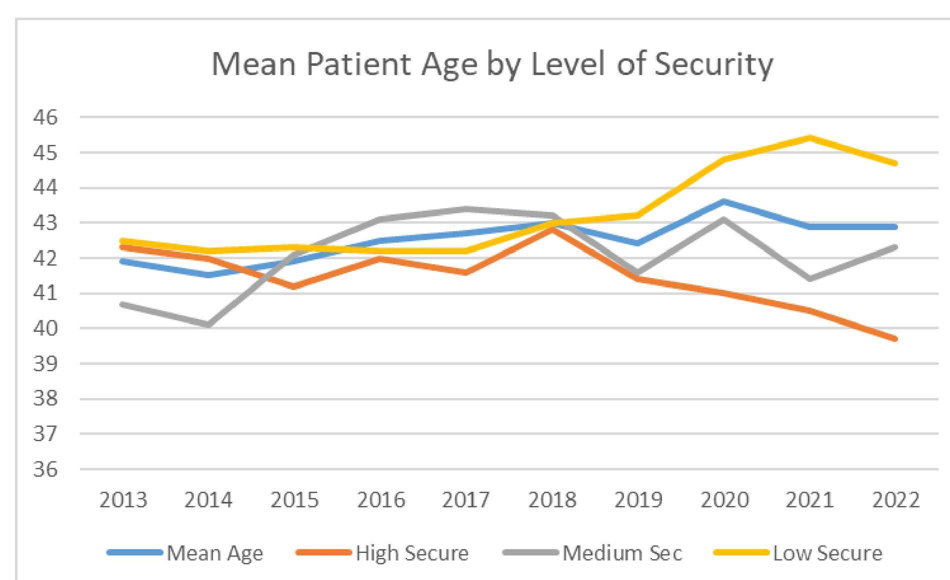
Patient Length of Stay (Days)
The mean length of patient stay during their current admission has remained fairly consistent across the whole FN inpatient population throughout the Census period. However changes in the mean length of stay for our Female patients has been relatively significant, steadily increasing from 826 days in 2013 to 1534 days in the most recent 2022 Census.

Mean length of stay has also changed over time based on patient level of security. High secure mean length of stay has reduced from 2643 days in 2013 to 1947 in 2022, whereas Low and Medium secure have seen a gradual increase in their patients mean length of stay.

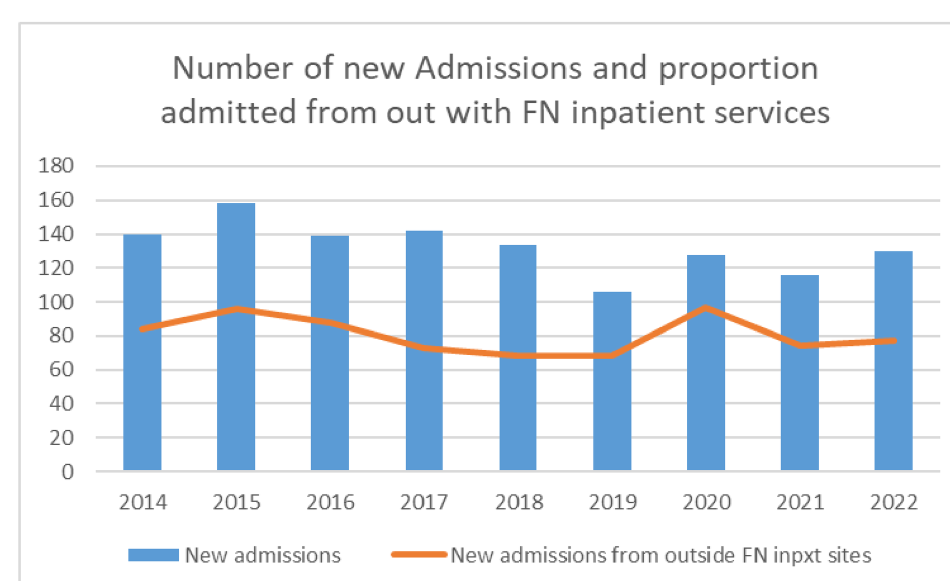




Patient Age
The mean age of patients reported through the Census has increased slightly over the 10 period from 41,9 yrs in 2013 up to 42.9 yrs in 2022. This rate of change has been relatively consistent for both Male patients (41.9 - 42.9) and Female patients (41.9 – 42.6). However change in mean age has been seen more clearly across level of security, with High secure decreasing from 42.3 to 39.7 yrs, but Medium secure increasing from 40.7 to 42.3 yrs; and Low secure increasing from 42.5 to 44.7 yrs. These changes may partially reflect the increased Mean Length of Stay at these levels of security.



FN Admissions
Any changes to the data over the 10 year period of the FN Census, as reflected in this poster, will relate directly to the level and nature of admissions into FN inpatient beds. The number of new admissions in each year of the Census peaked at 158 in 2015, before gradually reducing to the 130 new admissions in 2022. The proportion of these new admissions who have come from outside FN sites has remained consistent at approximately 60%, with exceptions being 2018 when it fell to 50% and 2020 when it peaked at 75%. The analysis of FN admissions through the Census data is an important mechanism to support the monitoring of patient progression through FN services



FN Census Inclusion Criteria

The Forensic Network Inpatient census will include **all** patients from high and medium security establishments. For other establishments which employ lower levels of security provision, the following definition has been provided in order for clinicians to identify which of their patients are defined as mentally disordered offenders and will therefore be included in the census.

The Scottish Office policy on *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland* describes mentally disordered offenders as those who are: ***"Considered to suffer from a mental disorder as defined in the Mental Health (Care and Treatment) (Scotland) Act 2003, whether or not they are, or may be, managed under its provisions and come to the attention of the criminal justice system or whose behaviour poses a risk of such contact"*** (Scottish Office, 1999 – with update for 2003 Act)

This includes **everyone** currently being treated and detained under a criminal section of mental health legislation, namely:

- Assessment Orders
- Treatment Orders
- Compulsion Orders
- Interim-Compulsion Orders
- Restriction Orders
- Hospital Directions
- Transferred Prisoners
- Temporary Hospital Orders

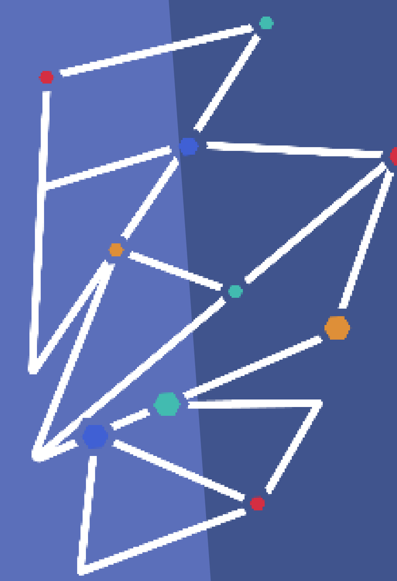
FN Census Limitations
The collation of the Census data is a considerable task for both the FN Office and also the sites submitting data. Unfortunately data collection issues have affected the Census in 2016, 2019 and 2021, despite all efforts to ensure full submission of data on all patients who meet the Census Inclusion Criteria. Given the analysis of FN Census data is limited to descriptive statistics, and the level of data collection error being limited to <10%, the Census remains a useful tool for monitoring fluctuations or changes in the distribution or nature of the FN Inpatient population.

Conclusions
The FN Census is a useful data collection and collation process. The 10 year data shows a considerable level of consistency across a number of markers, but also highlights some changes in the data that may require further investigation. These areas would include the significant increase in the mean length of stay for female patients, and the convergence of length of stay for patients in different levels of security. While the reducing length of stay for High secure patients is to be welcomed, the increases seen in Low and Medium secure should be investigated in relation to sources of admission. The gradually increasing proportion of the patient population deemed to be in a primary diagnostic category of Personality Disorder may also warrant further analysis.

Given the Census has been in operation for 10 years, there may also now be an opportunity to review the range of data collated, and to better align this to the needs of the FN office and key research priorities identified within the revised FN Research Strategy to be finalised in 2024.

Acknowledgements
The FN Census team would like to note our appreciation for the support from staff across the FN for taking the time to collate and submit patient data as part of the Census process. We always aim to ensure the process is made as easy as possible, and would be happy to provide Census data to support planning.

Clinical Forum: Victims and Trauma
10 Years On



Recent speakers and topics

- *"National Confidential Forum - Time to listen"* - Dr Aileen Blower, Prof Kate Davidson and Jamie Malcolm
- *"Introduction to Trauma and Homelessness"* -Dr Laura Barrie, Principal Clinical Psychologist and Julie Jackson, Art Psychotherapist,
- *"Development of a Trauma Informed Service in Custodial Settings"* Lisa Thomson, & David Pitt, SPS HMYOI Polmont

10 Clinical Fora delivered to date

"The presentation was educational, informative and relevant to the issues that I currently face with patients"

"Excellent day and speakers. It's great that the Forensic Network is recognising the huge relevance of trauma to forensic settings."

> 250 Attendees

The Victims & Trauma Clinical Forum events have spread the word and encouraged discussion to help embed trauma-focussed working across the Forensic Network.

"The forum allows you the opportunity to get knowledge/access to research, ideas which you can share with your colleagues and put in to practice."

"Great to be involved in this forum it enables you to look at the Forensic Network resources for the day and for the future support and treatment of patients."

Conflict Resolution Process

Forensic Network

Background

The Forensic Network developed a process for resolving clinical conflicts between forensic mental health services in 2005. This became Scottish Government Policy in HDL (2006) 48, Annex C. The process aims to assist services in Scotland to find a suitable resolution within a reasonable timeframe.

The process is managed by the Conflict Resolution Group (CRG) which is chaired by the Lead Clinician of the Forensic Network and involves three stages:

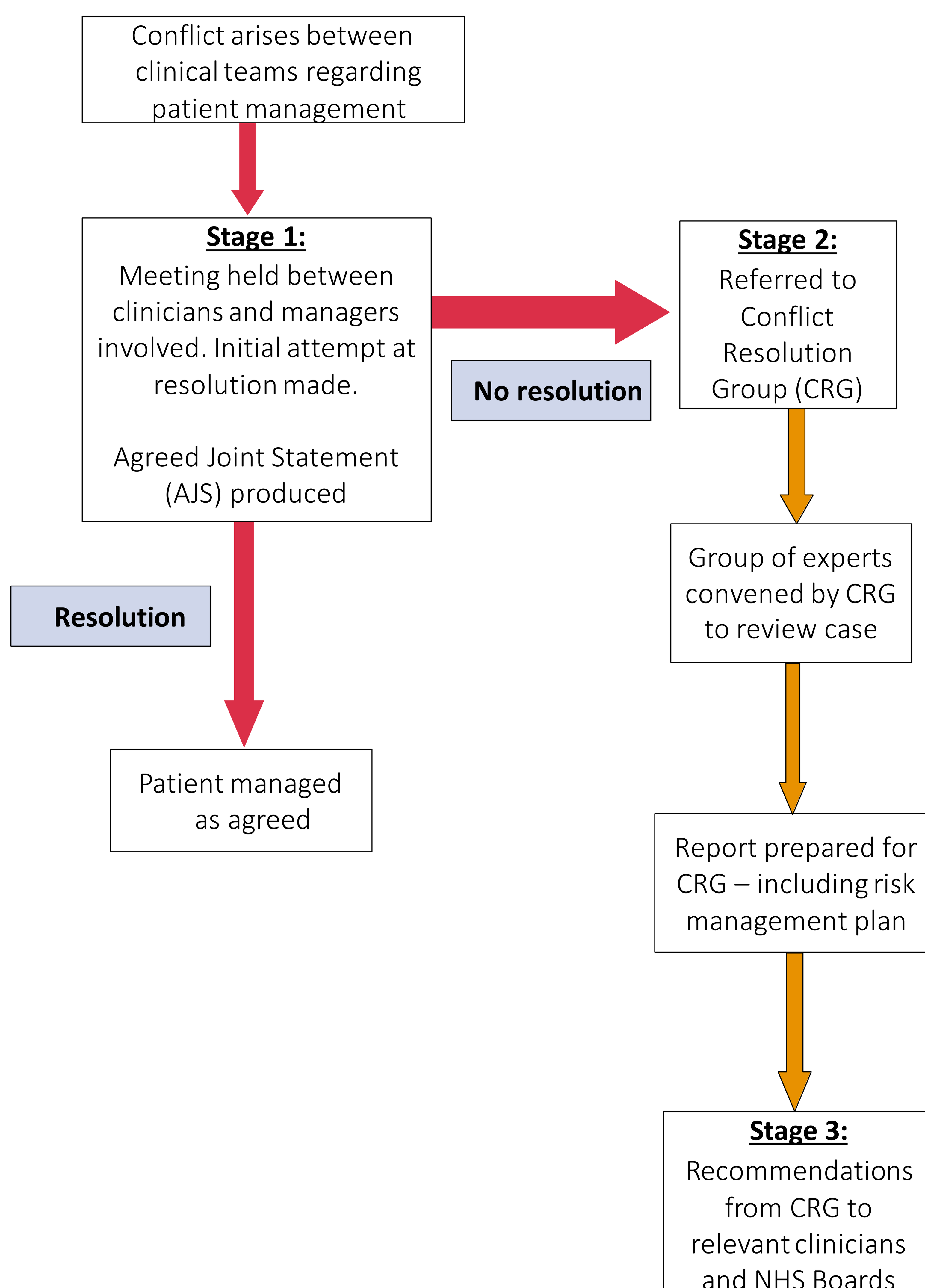
- Initial Resolution
- Referral to Conflict Resolution Group and
- Judgement

Conflict Resolution Model

The conflict resolution model takes into account that Responsible Medical Officers (RMO) cannot be obliged to accept a patient whom, in their professional judgement:

- does not meet the criteria for compulsory detention under current mental health legislation; or
- would be inappropriately managed at their level of security – either that the level of security is excessive for the risks posed or insufficient to ensure safe care and treatment; or
- would be inappropriate in terms of the treatment available in their facility.

In the case of an upheld tribunal as a result of the Mental Health (Care and Treatment) (Scotland) Act 2003 the responsibility to find a suitable location for a patient's treatment lies with the Health Board and not any particular RMO.



An expedited version of the model also exists, involving an expert report prepared by one clinician (Consultant Psychiatrist). Recommendations made within this report will be reviewed by the CRG and accepted as the outcome of the process. As such, all parties involved are required to indicate their agreement at the outset to the use of the expedited process.

Conflict Resolution Group

The Conflict Resolution Group (CRG) manages the conflict resolution process. The group consists of a number of experts and multi-disciplinary practitioners. Any member of the Group with a conflict of interest will not participate in any decisions relating to such a case.

Role:

- Allocate experts to cases
- Instruct experts
- Decide who convenes expects
- Receive report
- Question experts or agree report

Membership:

- Network Lead Clinician (Chair)
- Regional Clinical Leads
- Senior Social Worker
- Psychologist
- Nurse
- Occupational Therapist
- First Ministers Psychiatric Advisor (In attendance)
- Chair of the RCPsych Forensic Faculty (In attendance)
- Forensic Network Manager (Secretariat)

Use to date

Since 2005:

- Nine referrals to the process to date
- Five cases withdrawn or resolved part way through the process
- Four progressed through the process to resolution

Impact

Whilst the process has been rarely used over the past 18 years, having a mechanism to resolve conflicts between Health Boards in a neutral manner has proven to be highly valuable. Central to the process is the assurance that patient care remains of paramount importance.

As of 2023, the process will also be extended to include conflicts between Foxgrove, the National Secure Adolescent Inpatient Service, and other NHS Boards and services who provide care for adolescents in contact with the criminal justice system.

For further information on the Conflict Resolution process, please refer to the full document available on the Forensic Network website, or email the team to discuss with the Forensic Network Manager (tsh.forensicnetwork@nhs.scot)

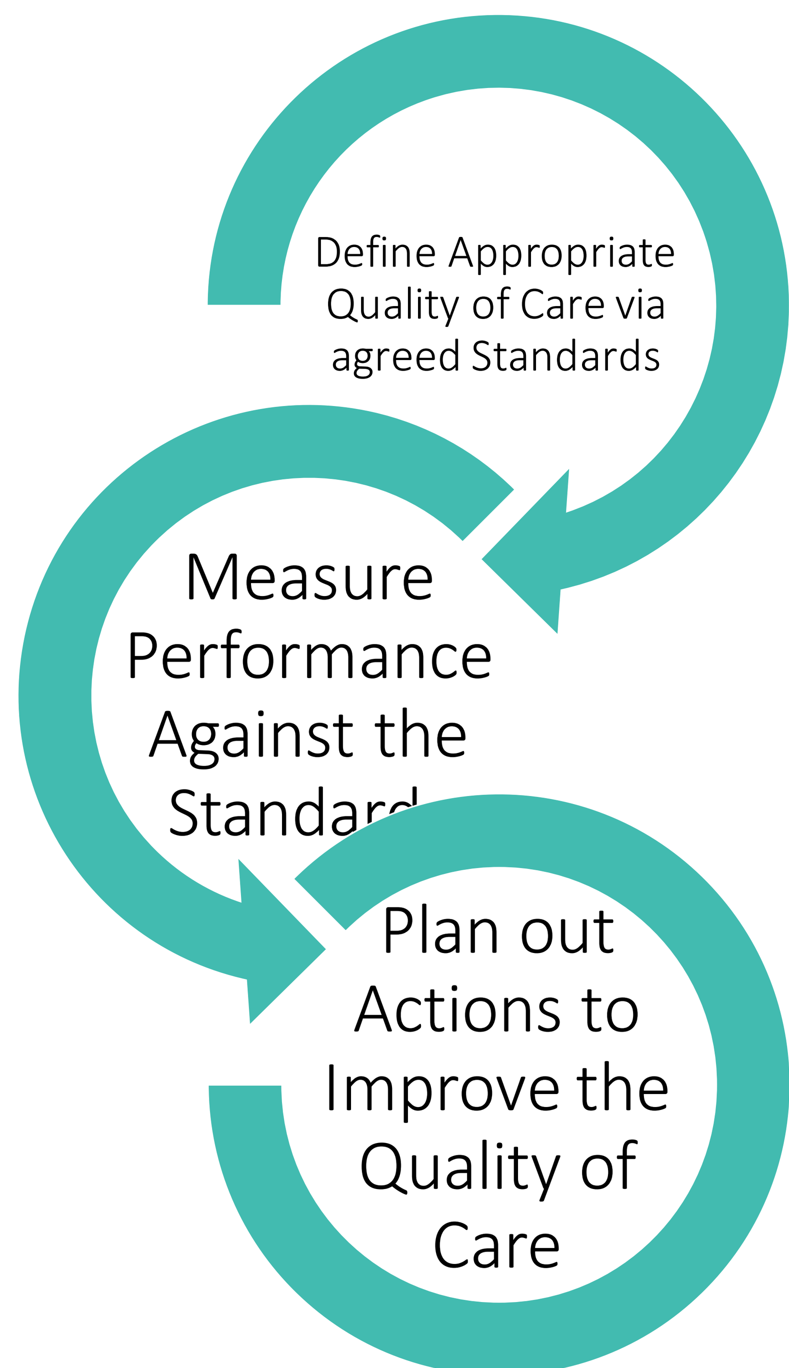
Continuous Quality Improvement Framework (CQIF) Reviews

Forensic Network

The Continuous Quality Improvement Framework was developed in conjunction with Healthcare Improvement Scotland (HIS) in order to support forensic mental health services in the development of a quality agenda. The framework provides services with an opportunity to be involved in a consistent, estate-wide approach to service development, allowing for benchmarking across the estate and a clear way of meeting the requirements of NHS CEL (2007). The framework covers the full range of levels of security (high, medium, low and community) and Forensic Learning Disabilities Services.

Aim: to use a multi-disciplinary approach to share good practice and support learning across the Forensic Network, through a culture of openness and facilitated enquiry. The review process is not about finding fault, but rather working with services to identify any potential gaps in practice and support the service's work to improve their delivery of care and achieve their identified aims.

Methodology



The CQIF Reviews are conducted across the estate on a three-year cycle and the process involves definition of appropriate quality standards, measurement of performance against these standards (via self-assessment and peer review) and the development of an agreed action plan by the service to further increase quality of care.

Each review cycle is followed with a national conference to share good practice, spread learning and provide opportunities for further professional development.

First Round: 2011 - 2013

Second Round: 2016 – 2019

Quality Improvement Scale

Reviewing
- Clear evidence of a mature implementation process
- Well developed processes with clear evidence of learning, measurement and spread
- Evidence that these processes are used for quality improvement

Developing
- Systems in place but are not fully operating
- Implementation at planning stage only
- Very early stage of implementation

Implementing
- Clear evidence of implementation of standards

Clear evidence of roll out/spread across service

Evidence of operational reports discussed by multi-disciplinary team

Monitoring
- Clear evidence of a measurement process
- Clear evidence of a measurement process used for feedback
- Clear evidence of a measurement process used for learning

Within each round of CQIF Reviews, opinions are sought on the delivery of care from patients and also their family and friends

'Person-Centred Care'

Feedback

To date, CQIF Reviews have been very well received and the general view is that they are important in providing an opportunity for services to identify areas of good practice and areas of improvement through a supported process. Over the years, services have provided valuable feedback on ways in which the process could be streamlined and we have worked to act on this feedback as each round progresses.

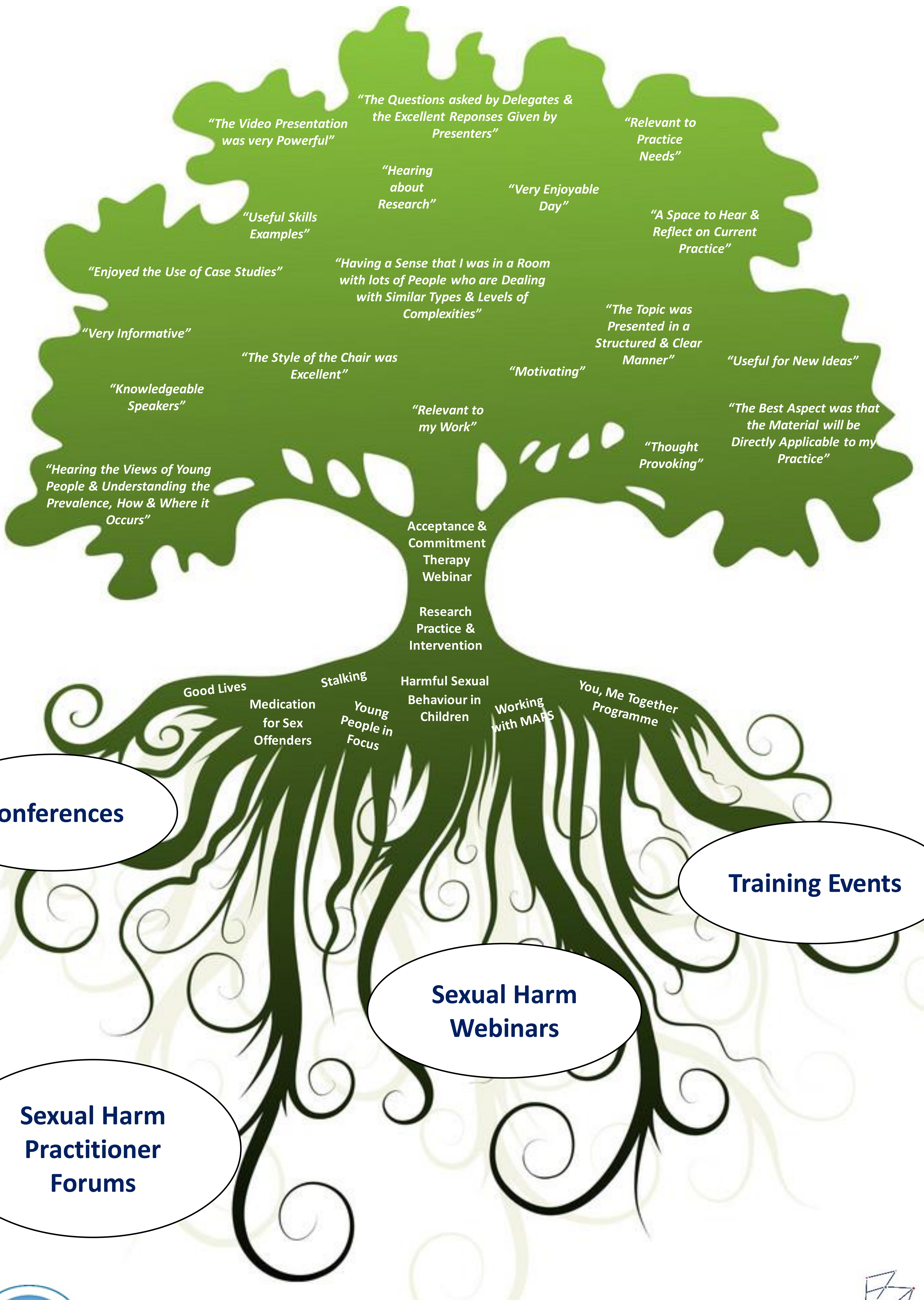
"An opportunity to learn about how other services at the same level of security deliver care"

"Fantastic way to observe other services and see positive initiatives for forensic patients"

"Great experience being a volunteer reviewer – really helped me to think critically about the care we deliver!"

Next Steps

- In 2023, the Forensic Network began to review and refresh the Care Quality Standards for the next round of the Reviews.
- Once finalised, engagement with stakeholders across the forensic estate will begin to invite services to participate in future reviews.
- A call for volunteer reviewers and report writers will be issued to facilitate reviews over the next 3 year period.



NOTA
Supporting Professionals to Prevent Sexual Abuse
SCOTLAND BRANCH

NOTA & Forensic Network
Celebrating our Partnership since 2009

Forensic Network

The CORE-OM in a high secure forensic population

Psychometric properties and test structure

Lindsey G McIntosh[1,2] Kerr Hartop[2] Natasha Purcell[1] Lindsay D G Thomson[1,2]

1. The State Hospital, Carstairs; 2. University of Edinburgh, Division of Psychiatry

Background

Psychological therapy services should be subject to ongoing monitoring and evaluation [1]. The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) was developed for this purpose [2]. The Scottish Government has recommended all adult psychological therapy services use the CORE-OM to standardise outcome measurement in an effort to benchmark services [3]. Forensic mental health services across Scotland, including the State Hospital (TSH), Scotland's high security hospital, have incorporated the CORE-OM into their service evaluation and clinical outcomes monitoring. There is much evidence for the CORE-OM's validity and sound psychometric properties in general adult mental health populations [4]. However, to date no study has assessed whether these properties can be safely generalised to a forensic psychiatric sample.

Clinical Outcomes in Routine Evaluation (CORE-OM)

- Part of a suite of measures, as well as versions for GP offices, young people, intellectual disabilities, and short forms for research and clinical monitoring
- Likert responses 0-4 with respect to frequency they have had that thought or experience over previous week
- Items designed to map onto conceptual domains : wellbeing, symptoms, functioning, and risk to self and others

Research Aims

- Establish reliability of the CORE-OM (and embedded short forms) for high secure forensic psychiatric patients
- Examine TSH sample score distribution and compare to established clinical and non-clinical normative CORE-OM data
- Determine underlying factor structure of the CORE-OM for high secure forensic psychiatric patients

Setting and sample

State Hospital

144-bed high secure forensic hospital service Scotland and Northern Ireland. Patients are admitted from court, prison, or other psychiatric units and detained for treatment under Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995. All patients are male and average length of stay was 6.8 years at the time of this study [5].

Sample

Retrospective analysis of CORE-OM data collected from TSH patients (*n*=188) as part of their case reviews 2012-2017. Patients in the sample were on average 39.6 years old (*SD* 11.6), and had been detained in TSH a mean 4.5 years (*SD* 7.4). The sample is predominantly white British (80%) and diagnosed with schizophrenia (71%). Common secondary diagnoses included substance misuse (51%) and personality disorders (30%). Most common index offences included homicide (36%), other physical violence (40%), and sexual violence (11%).

Methods

- Calculated Cronbach's alpha [6] for CORE-OM total score and conceptual domains, and embedded short forms for TSH sample.
- Used *t*-tests to compare TSH patients' scores to normative clinical (*n*=338) and non-clinical scores (*n*=471) in CORE-OM manual. Population mean differences quantified using Cohen's *d* effect size [7].
- First used confirmatory factor analysis (CFA) to test fit of two previously proposed models to TSH sample data: (a) four factors corresponding to the four conceptual domains of wellbeing, functioning, problems, and risk [2] (b) three factors of positively-worded items, negatively worded items, and risk items [4]. Because fit of both models was poor, CFA was followed by post hoc principal components analysis with oblique rotation.

Research Approvals

NHS Research Ethics Service confirmed study met exemption from REC review as limited to secondary use of existing anonymised clinical data. TSH research committee provided managerial approval.

Results

Reliability of CORE suite for forensic patients

	CORE-OM					Embedded short forms			
	Wellbeing	Problems	Functioning	Risk	Global	CORE-SF A	CORE-SF B	CORE-10	CORE-5
Original	.77	.90	.86	.79	.94	.93	.92	.82	.81
TSH	.68	.86	.80	.58	.92	.88	.86	.83	.79

Cronbach Alpha [6]	
α ≥ .90	Excellent
.90 > α ≥ .80	Good
.80 > α ≥ .70	Acceptable
.70 > α ≥ .60	Questionable
.60 > α ≥ .50	Poor
.50 > α	Unacceptable

CORE-OM global score had excellent internal consistency. Alpha coefficients for Wellbeing and Risk domains substantially lower than those published by Evans et al [4].

Internal consistency of embedded short forms broadly similar to those published for non-clinical samples [8-10].

Forensic patients' vs. normative sample scores

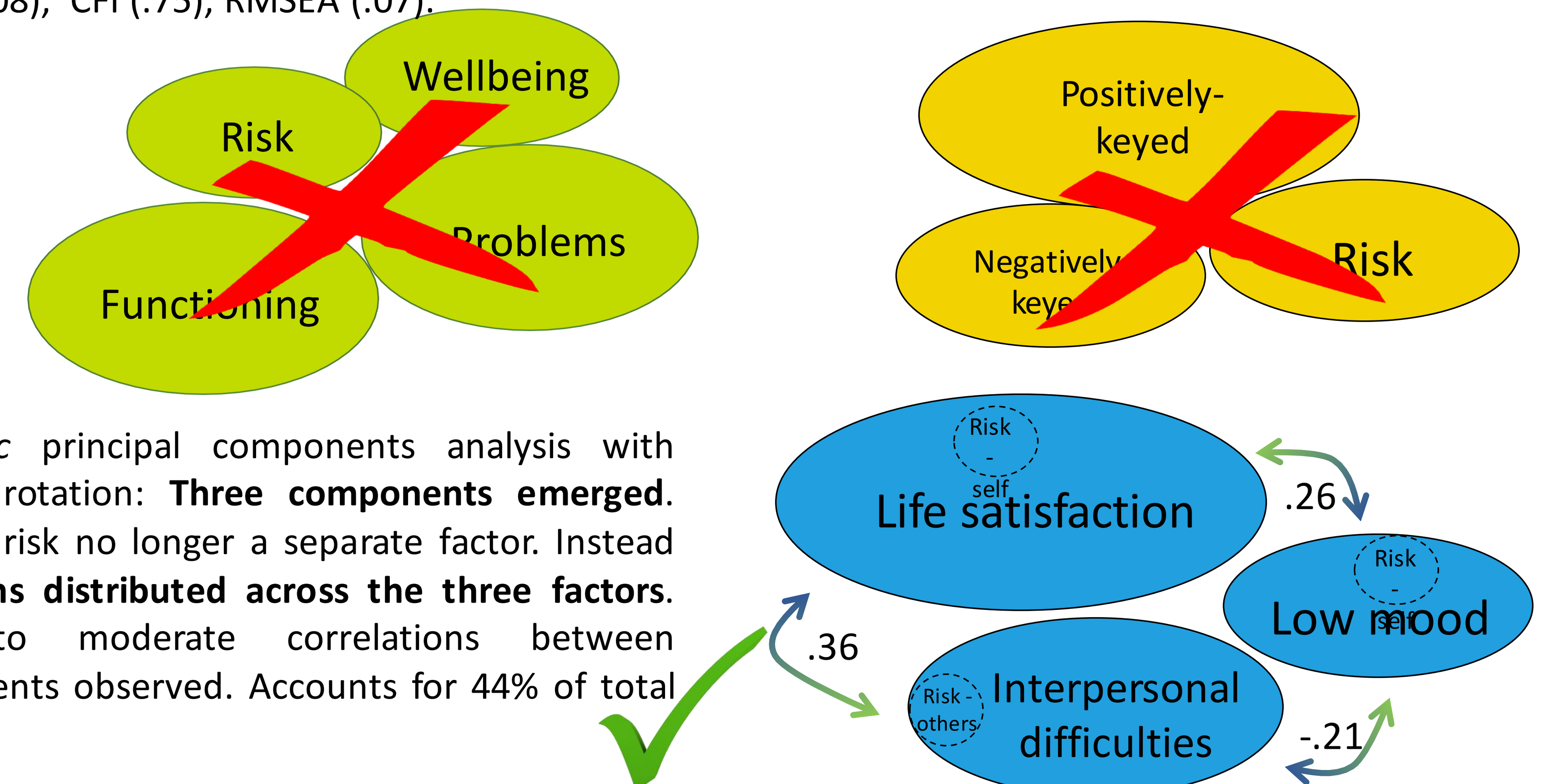
On the CORE-OM ***global score****, TSH sample mean fell between normative means from non-clinical and clinical sample. Only 30% of TSH sample had a "clinically significant" level of distress, using cut-off scores derived from normative data* [4].

On the CORE-OM ***risk items*** *(harm to self & others), TSH sample mean sig. lower than normative clinical sample, and similar to non-clinical sample.*

Differences in underlying factor structure

Model 1 | Four conceptual domains: originally proposed item structure, current scoring structure. No empirical support for this structure in any sample to date. Fit indices in TSH sample: SRMR (.08), CFI (.75), RMSEA (.07).

Model 2 | Two 'method' factors and a factor for risk. Supported in non-clinical and clinical samples of adults [4] (and older adults [11]). Fit indices in TSH sample: SRMR (.08), CFI (.79), RMSEA (.07).



Post hoc principal components analysis with oblique rotation: **Three components emerged**. Notably, risk no longer a separate factor. Instead **risk items distributed across the three factors**. Small to moderate correlations between components observed. Accounts for 44% of total variance.

Study limitations

- Some patients too unwell to complete the CORE-OM – did we miss some of the most distressed?
- Forensic patients may be motivated to mask or minimise distress. Requires study of validity in this population.
- Limits to generalizability – males in high security care. Future studies should utilise CORE-OM data combined across high, medium, and low secure units and female forensic patients.

Conclusions

- The CORE-OM is reliable self-report distress tool for high secure patients. This study found no support for using currently recommended four conceptual domain framework to score and interpret patients' responses.
- Clinical cut-offs, used to identify individuals in significant distress, were relevant for only small number of TSH patients. This indicates a separate set of forensic norms would be useful.
- Unique dimensions of variation in CORE-OM scores for high secure patients suggests distress conceptually different for this population, particularly as it relates to risk of harming self and others.

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CORE OM forensic

THE UNIVERSITY of EDINBURGH

NHS Health Scotland

Patient reflections on recovery: Living in the community, 20 Years on from high secure care

Cheryl Rees, Research Assistant, University of Edinburgh
Professor Lindsay Thomson, Professor of Forensic Psychiatry, University of Edinburgh & Medical Director, The State Hospital and Forensic Network

INTRODUCTION

The Recovery Model for Patients within a High Secure Setting: A 20 year Follow Up is a mixed methods study with a longitudinal design created by repurposing previously collected information. The data relate to a specific cohort of 241 high secure patients first interviewed in 1992/3[1]. and those with a diagnosis of schizophrenia (N=169) followed up in 2000/1[2]. The 20 year Follow Up centres upon subjective recovery and this poster explores data from the qualitative aspect.

AIM

- Analyse patients' understanding and thoughts on their own recovery and determine the main factors which affect their recovery.
- To prompt discuss regarding how this data could be developed to promote recovery among a new group of high secure psychiatric patients.

METHODS

Ten participants who were living within the **community** were included in this analysis. 9 male and 1 female, average age 57.1 years (range 44.9 to 66.8 years), A diversity of diagnosis were reflected including one person with learning disability. Consented participants were interviewed using a semi structured schedule based on the 7 elements of the recovery model. Within this model the following are considered elements of recovery: Hope, Secure base, Sense of self, Supportive relationships, Empowerment and inclusion, Coping strategies, Meaning and purpose. The interviews were audio recorded and transcribed verbatim. Thematic analysis was conducted with data familiarisation and analysis undertaken according to Braun and Clarke[3]. An Inductive Interpretative Constructionist method was adopted and reflexively interpretation was through an informed non clinical lens.

Figure 1. schematic of main codes/themes interpreted and flow

CONCLUSIONS

These findings represent the subjective experience of individuals successfully negotiating the forensic inpatient system and developing lives within the community.

- These were emotionally charged interviews and they highlight the impact of staff interaction and feedback to patients. These interactions, positive and negative are reflected upon and undoubtedly impact upon recovery.
- Multiple barriers to recovery were reported with most affecting early stages of recovery.
- Participants engaged in self protective behaviours to avoid stigma in the community.

We need to reflect upon how these experiences can inform the recovery of new generations of forensic inpatients.

RESULTS

Figure1. provides an overview of codes/themes interpreted with a focus on the journey from State Hospital inpatient to living in the community. More specifically 6 themes and 8 subthemes were identified relating to that journey.

1.**The 'aha!' moment**: a strong theme running through these interviews was the 'aha' moment when everything fell into place and a sense of clarity regarding how to move on from the State Hospital appeared. "I was sitting watching big [fellow patient] and somebody else one day an ***that's when it hit me*** and I thought ***that's how the staff and the doctors must see us!***"

2.**Treatment**, subthemes: medication, *"I was put on Clozapine 21 years ago and I've never looked back, all my problems just went out the window"*. Psychological therapies and life skills: *"I went on the R&R course, **and that totally got a grip of me that."***

3. **Progression**, subthemes: Battles fought, "I don't know, I don't know how I kept going". Staff feedback, *"When people are telling you … it gives you a bit of self praise, as if to say, "well I am doing something right, I am moving on" but people are noticing, it's noticed, its getting recognized."* Self-reflection, *"look at me walking up the street on my own, where was I 20 year ago to where I am now!"*

4.**Identity**, subthemes: Past Identity, *"I see myself in the State and prison if you like, as a stupid wee boy who thought he was clever,"* Current Identity, *"if I am looking at myself now, I see a much more mature person, an adult, grown up."* Identity Staff, *"Classed insane by 5 doctors, I remember it being said and it wasn't a nice feeling, let me tell you,"*

5.**Self-protection**: *"I could meet someone now and chat away to them but …for to become friends, I don't really commit myself… that far."*

6. **Previous behaviour**: *"You know I was being very offensive…"*

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Forensic Community Mental Health Team
Physical Health & Well-being Initiatives

Statistics show that those who suffer from mental illness are also more likely an increase in obesity, diabetes, cardiovascular complications, hypertension and this adversely affects their lives. It is recognised that mental health patients are unlikely to be physically active. Barriers to physical activity include lack of motivation, stress, fatigue, lack of support, and the weather. Research shows that people with a diagnosis of schizophrenia or bipolar disorder would prefer to be supervised by a professional when engaging in physical activity. The WHO (2020) guidelines on physical activity indicates "some activity is better than none."

The initiatives below were commenced and so far are having excellent success

"It's not us and them anymore"

"I can get most of my health checks done when I come to see my nurse, saves me going to the GP"

Challenge Group

- Walking group with patients planning the routes
- Main focus – Patient partnership
- Aims to meet individuals physical fitness & recover goals
- Walking improves improved cognition, mood, fitness and reduced anxiety

Physical Health and Wellbeing Clinic

- "One Stop Shop" for High Dose Monitoring, Annual Physicals, serum monitoring etc.
- Weekly clinic run at time when patients are most likely to be at the premises
- Staff trained in venipuncture and ECG
- Core group to continue to develop service
- Learned that incidental findings can save lives

"Excellent, great for your mental health. The people that take part are lovely"

Mountain Biking Group

- Jointly run with OT & Nursing staff in partnership with Developing Mountain Biking Scotland
- Staff & patients now trained as Qualified Bike Leaders
- Weekly group using local outdoor spaces
- Celebratory events 2/3 times per year to experience the challenges of dedicated mountain biking trails further afield

Recovery - Using trail therapy to accelerate and sustain recovery from mental ill-health https://www.youtube.com/watch?v=XFD335d-4HE

FCMHT Lanarkshire, October 2023

L.Mackie

How to 'Get On and Get Out': High secure patients peer support plan for recovery

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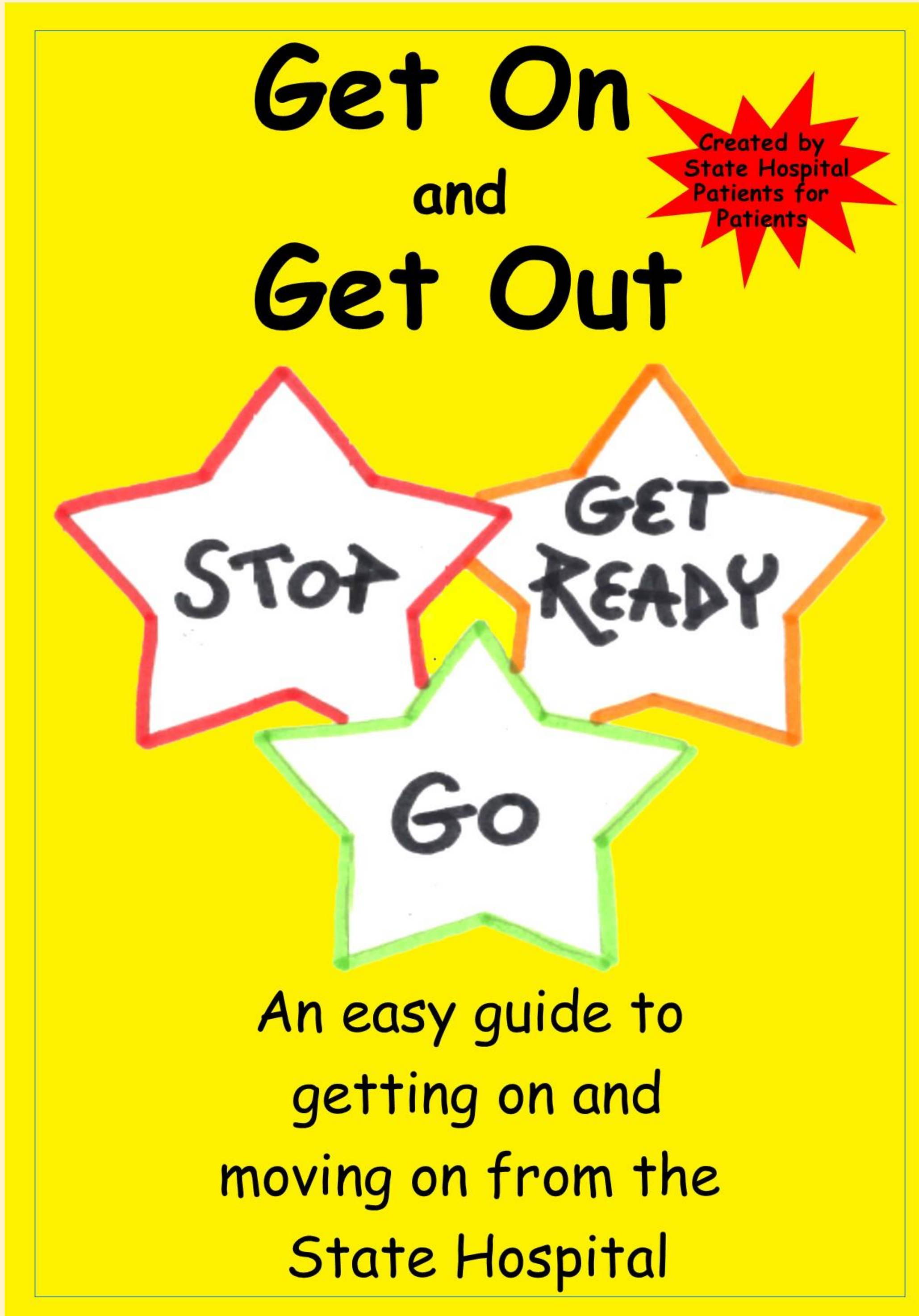

Introduction

Quantitative and qualitative data from previous work exploring recovery through follow up of a cohort who were in high secure care during 1992/93 (20+ year follow up recovery study) indicated that cohort members remaining within the State Hospital did not consider themselves to part of a community. They were therefore removed from the benefits that community dwelling offers in terms of connectedness and social support. To address this, it was proposed that Participatory Action Research (PAR) involving patients be undertaken which built on the previous recovery research.

The aim of this new piece of work was to create a piece of peer to peer introductory material based on newly collected qualitative interview data and the qualitative data gathered during the 20+ year recovery study. PAR is a research framework which recognizes the knowledge and experience of community members (patients) as equal to those of stakeholders (staff) and researchers. The three main goals of PAR are: to produce practical knowledge, to take action to make that knowledge available and to be transformative both socially and for the individuals that take part. These goals are achieved by bringing together the diversity of knowledge systems available and through a flattening of power hierarchies by not privileging specific knowledge and empowering the voice of communities, encourage action through combined knowledge.

It was reinforced that the collaborators were **experts by experience,** that was central to the PAR approach, they held valuable knowledge that was essential to the success of the project.

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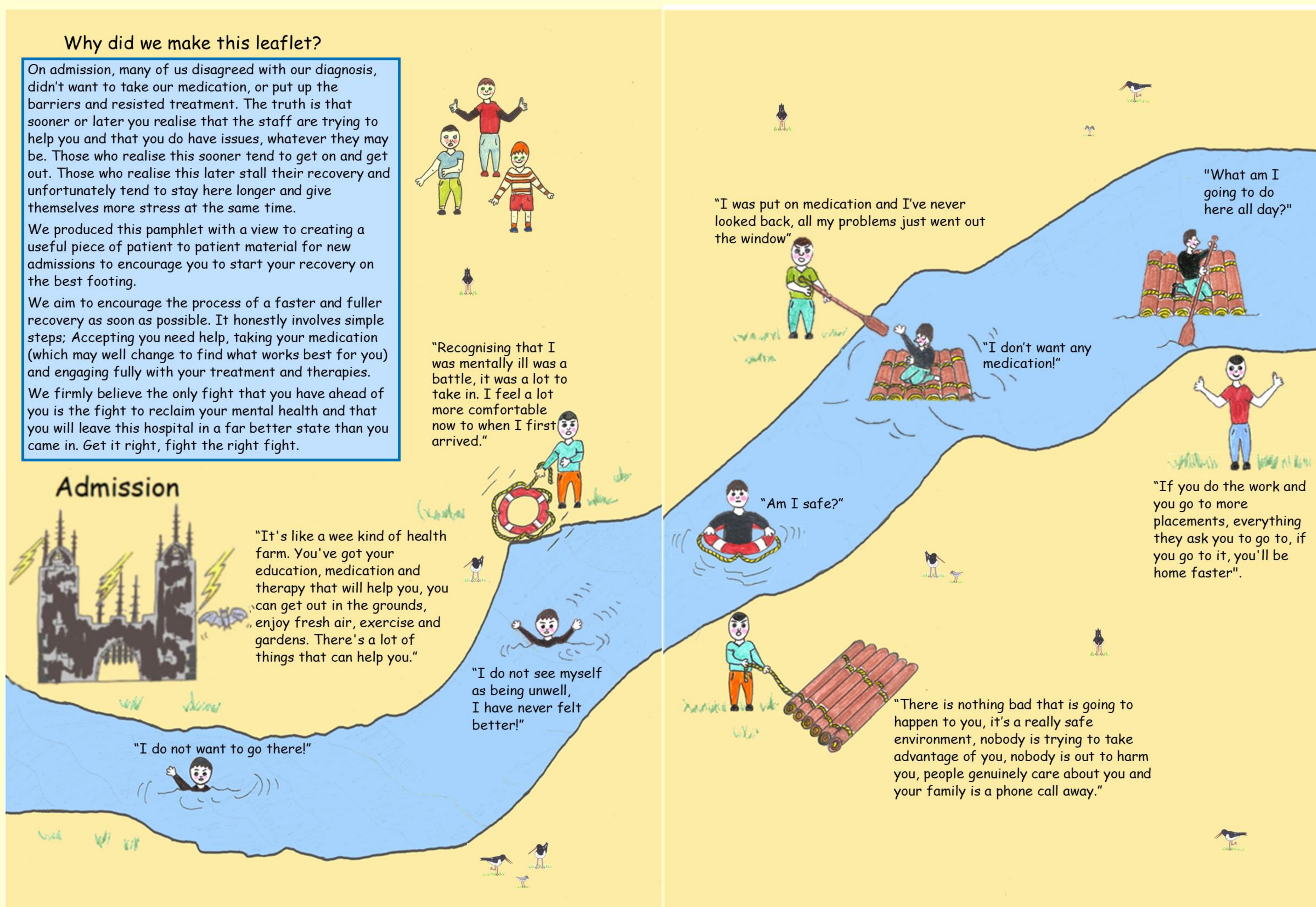


'Get On and Get Out' pages 1 & 2.

Method

- Using their experience and when they could, by speaking with their peers, three collaborators developed a semi-structured interview topic guide.
- For confidentiality the researcher conducted the patient interviews and processed the transcript into quotes.
- The collaborators then considered both the quotes from the 20 year follow up recovery study and new patient interviews and decided how best to use them.
- The collaborators curated the quotes into the recovery journey & patient story,
- Created the introductory paragraph to explain why they had put together the booklet and what they hoped those reading it would get out of it.
- They also created the visual theme and illustrated the booklet.

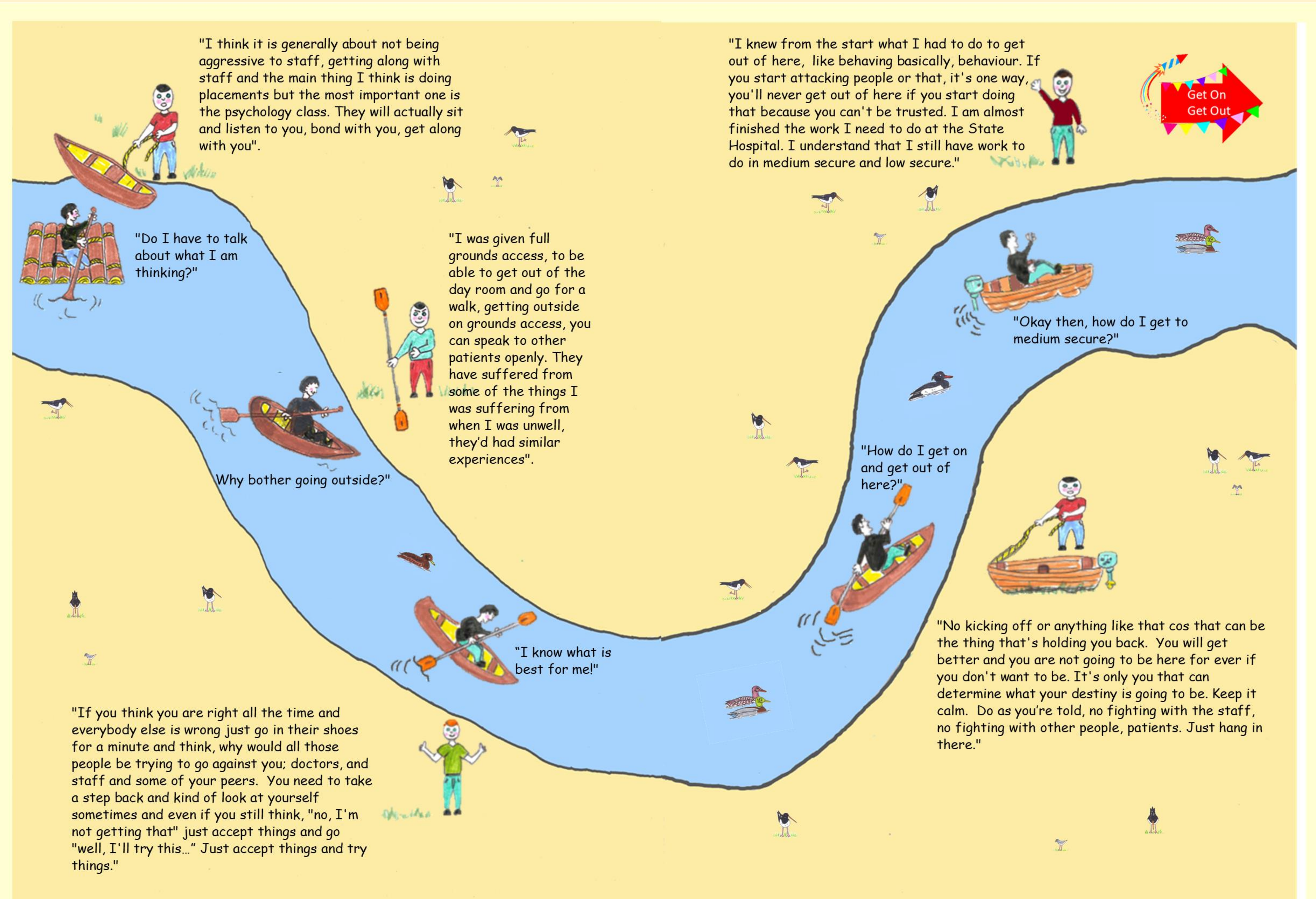
All the text within the 6 page booklet came from patient interviews and the visuals and journey ideas came from the collaborators.

Development

- During patient interviews there was comment of 'going with the flow' which lead to the river metaphor (pages 1&2) for the journey; being swept along, having no control over what could happen.
- It was important that there shouldn't be the provision of new items at every step, sometimes support and encouragement is what is needed to keep going forward.
- The longer more in-depth quotes (pages 3&4) address the work the individual needs to put in to progress beyond high secure care
- There was a need to maintain that sense of effort but that they had been provided with the tools to journey onwards with greater ease with scope to continue building their resources, this was not the end of the journey but how to move on and out from high secure care.

Conclusion

These are the words of wisdom patients would like to pass on to those embarking on their recovery journey. Peer to peer deliver to new admissions is being planned at the State Hospital.



'Get On and Get Out' pages 3 & 4.