Regional Forensic Involvement Strategy

(YORKSHIRE AND THE HUMBER):

Reaching Joint Solutions

2007–2010

Involvement is a bit like spinach:

no one is against it in principle

because it is good for you,

but not everyone eats it

(Anon)

Acknowledgements

Rosie Ayub and Joanna Wright have jointly led the development of this involvement strategy. They have worked across 7 secure units in Yorkshire; and would like to recognise, with thanks, some people who have been central to the work so far.

Rosie has worked for many years with individuals and organisations developing innovative and empowering processes to involvement. After gaining her Law degree she worked for a Mental Health Advocacy organisation and studied for a management qualification where she gained an interest in organisational development. Rosie has been studying Sociodrama for the last 3 years which has inspired her to continually develop new ways to explore how we all operate within groups and organisations and what we can learn from each other. She views involvement as a key approach to organisational development.

Joanna comes from a long background of using and working in mental health services. She has undergone training in mental health nursing, project management and service improvement. Joanna believes this has given her a greater insight into understanding, developing and improving services in relation to involvement. She has worked in forensic mental health settings for 7 years — locally, regionally and nationally. She is passionate and committed to working with service users and organisations to work creatively together to reach joint solutions and lead improvements together, in a transparent way.

We would like to thank all those people who have been committed to attending the Involvement Strategy Group. This has been an invaluable part of the strategy development process. We especially would like to thank, Balbeer, Jolene, Julie, Alan, Clare and Andy who have shown real commitment, energy and shared their personal experiences which supported us all to move on.

We would also like to acknowledge all those people who have been involved in the project groups across the various units. They have acted as key reference points as well as developing key themes within the strategy. They have always been warm and welcoming groups to be part of.

We would like to acknowledge service users and staff from Newton Lodge, Humber Services and Stockton Hall for producing the displays for the "Collage of involvement" conference. Pictures of these displays are included in this strategy.

Thank you to Cloverleaf Advocacy who were part of the initial stages of the strategy and who also organised at the "Collage of involvement" Conference.

Finally thank you to all service users and staff who have shared their views and ideas at workshops at the "Collage of involvement" Conference.

Contents

Section 1 – Background

1 INTRODUCTION

This strategy sets out the values and principles of involvement in Medium, Low Secure and Community services within the Yorkshire Forensic Catchment Group Region. It has been developed with involvement from service users and staff from all the units in the region who have shared their ideas and experiences, given their time, enthusiasm and energy and ensured that there was opportunity to model the values and principles in this process.

This strategy is not an end but a starting point and sets out the broad direction and planning framework for the further development of involvement across forensic services.

Involvement should be at the heart of all individual care and service developments. The culture of involvement in most units needs to shift from being an add on which is mainly driven by a few committed and enthusiastic staff to an integrated service driven process which understands that involvement is the only way to ensure a truly equitable and value for money service which meets the needs, wishes, preferences and choices of the individuals that it serves.

"We need to find ways to support people to think outside of the box"

What will it look like — the vision

At present although there are some involvement groups, meetings and committees, within some units. There is still a long way to go reach the point where involvement shifts from 'hearing the views of service users' to 'involvement in decision making and reaching joint solutions'. A metaphor has been developed to help people see the future vision interpreted in a different, and perhaps more striking way:

There was a small village of people who lived on one side of the river. They had lived there for a long time, with no real challenges as everyone did things as they and those before them, had always done. It was only when one man came back from a trip to the next village that he had found out that the quality of the land and the food which was available was much better. He suggested that the village folk should think about moving across the river.

A bunch of people thought it would be exciting to set off in this new adventure, and went together to the river. The river was fast flowing and quite deep. This put some of the people off making the move and so went back home. A couple of strong swimmers said that they were going to jump right in and swim straight across. And that is exactly what they did. However, the majority of others felt this would be too risky and that they did not feel they would be strong enough to reach the other side.

This left these villagers with the challenge to find their way towards a more fulfilling life. Two people walked down the riverside, and saw that there was a shallower part of the river with stepping stones — which would allow them to get to their new life. So that is what they did. However still many people did not feel able to take the risk of crossing that way because the stones looked wet and slippy.

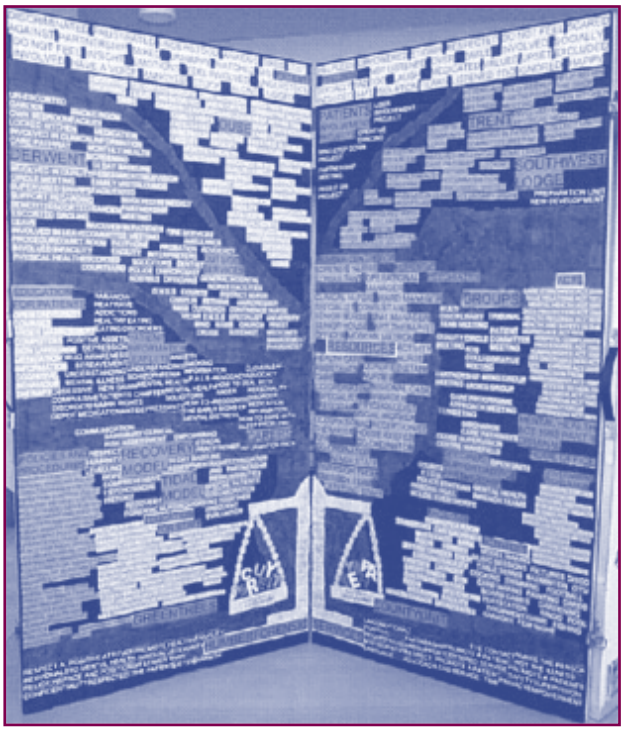
So off the remainder of the villagers went looking to cross the river on their journey. As you may have predicted, there was some old wood on the river bank down the field. Some of these people worked together day and night to build a bridge which would be sturdy enough to allow people to move across safely. They set off with this mission, and a week later they made it. And off they went to make a start on their new life.

A couple of the people decided to go to the village they had come from originally, and tell people about the rich and beautiful land they had recently moved to. They told the remaining villagers to go with them, and everyone agreed — including those who had first gone to cross the river, but retreated back when they saw that the task may be too challenging.

When people got to the river, they stopped and asked how would they get across. One man told the tale of the range of ways the first people had crossed. Each of them had there benefits and varied in risk and challenges posed. People chose the way that suited themselves the best — many of them choosing to go over the bridge though!

That evening everyone was celebrating, and talking about what they had learnt and how their new lives would be different. To summarize people said:

- …that they would remember that people do things differently, and that this allows creativity in the process, where people can support each other to achieve goals, both individually and together.
- …by working together you are much more likely to solve problems and reach shared solutions.
- …through involving people, people take ownership and responsibility to make a difference — benefiting everybody.
- …there are more choices which become apparent through allowing the process to evolve.
- …do not assume that one approach "fits all".



2 LITRATURE REVIEW

2.1 THE NATIONAL PATIENT AND PUBLIC INVOLVEMENT PERSPECTIVE

As part of the Governments agenda to improve the level of involvement that the public have in Health Services, they emphasize the importance of how much the general population should have in the development of services and local policy.

The following legislation and guidance describes the Governments recent drive to put local people in the centre of NHS improvements.

Section 7 of the Health and Social Care Act (2001) requires NHS trusts to consult the local Overview and Scrutiny Committee on any proposal for a substantial variation of the health service. What constitutes a "substantial development or variation" is not defined in the legislation.

Further in this document in Section 11, it stated there is now a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities — "to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes."

This statutory duty, outlined areas for consultation and involvement in:

- Ongoing service planning
- In development of new proposals
- In general service delivery — not just major changes

A Stronger Local Voice (DoH, 2006) sets out a framework for improving involvement, which includes strengthening the duty to involve and consult.

Later in 'A Stronger Local Voice' the government says it intends to replace the Patient and Public Involvement Forum (PPIF) with Local Involvement Networks (LINks). These will have the power to refer matters to the Overview and Scrutiny Committee. Proposals on how these will work are currently being developed. Details of how people using forensic services need to be considered to ensure that any processes are inclusive.

Health and Social Care (Community Health and Standards) Act (2003), established Foundation Trusts. These new bodies are accountable through local members of the Foundation Trust and an elected board of user governers. However the majority of forensic service users will be excluded from these positions.

In 'Building on the Best: Choice, responsiveness and equity in the NHS (2003) (Chapter 2, section 9)' they outline the patient experience definition. It states:

"We want an NHS that meets not only our physical needs but our emotional ones too. This means:

- Getting good treatment in a comfortable, caring and safe environment, delivered in a calm reassuring way;
- Having information to make choices, to feel confident and to feel in control;
- Being talked to and listened to as an equal;
- Being treated with honesty, respect and dignity.

Analysis of the survey data reveals that the emotional experience is a key driver for the overall patient satisfaction. We now plan to use the definition to improve the patient experience."

2.2 SERVICE USER INVOLVEMENT IN MENTAL HEALTH

Many lessons have been learned from the Survivor Movement in England, from people with the experience of mental health distress. This movement has been a key part of policy making in this country and has the strongest network of service users and survivors than many other countries (Rush 2004).

At the macro level of policy making their influence has not always been as successful as some would have wished. This is evident in the Mental Health Bill which focuses clearly on risk (Mental Health Bill 2006).

Despite the recent governmental policy directives towards stronger professional collaborations, increased service user involvement and the framework for mental health services in the UK; the prevailing mental health care culture continues to focus on control and compliance and professional expertise (Warne & Stark 2004).

When considering the impact of service user involvement in policy, the research evidence points to a continued struggle to influence service and individual agenda, which appears to be even more so in forensic settings. Faulkner and Morris (2004) found disappointingly low levels of involvement in individuals own care plans.

For service user involvement to move forward there needs to be a shift in clinicians practice to embrace involvement to its full and necessary potential.

Repper & Perkins (2003) assert "It is not the case that professionals lack expertise, rather they do not have monopoly on wisdom. The real challenge we face as practitioners involves placing the expertise at the disposal of those with mental health problems rather than making decisions for them."

Debates exist around the value of the terms and meanings of 'experts by experience' and 'experts by practice'. The former phrase is used to describe people who have some personal experience of mental health distress and this is recognised to add extra value to the planning, development and evaluation of services. On the other hand those described by the phrase 'experts by practice' are people who work to provide services and are skilled through qualifications.

Assumptions still exist within health care that people with the most knowledge have the most power. Experience and evidence says that Consultant Psychiatrists are consistently seen as the most powerful member of the team by both staff and service users (Warne & Stark 2004).

Literature informs that patient satisfaction is closely linked to how people experience relationships in services, rather than what professionals may believe is important. A study showed that "in relation to the most important tasks carried out by the Mental Health Nurse, service users rated personal skills such as 'listening' highly. Paradoxically, the service professionals themselves rated professional skills such as 'assessment' higher, perhaps reflecting the 'doing aspects' of the nursing role rather than the 'being aspects' " (Brown et al 1998, Warne & Stark 2001).

In this same study Health Care Assistants were said to provide much of the informal contact which led to higher patient satisfaction (Stark and Warne 2004). This suggests that it is not always professional expertise which people value, and remember, which led to turning points in their care — instead it can be suggested that it is how people experience the action of these skills to be important.

2.3 SERVICE USER INVOLVEMENT IN FORENSIC MENTAL HEALTH

The literature and research in this area is limited and focuses mainly on involvement in research or research on patient perceptions in secure environments.

In an Expert Paper: User Involvement in Forensic Mental Health Research and Development (Faulkner & Morris 2004), the following issues were explored and recognised:

- Security is a profound issue in user involvement
- Traditional Patient's councils were not working well in High Secure Hospitals
- Reports of low involvement in individual's own care plans
- User involvement in forensic mental health research is currently limited to small scale consultations and audits
- There has been some work to identify the strengths, weaknesses, successes and failures of user involvement (Crawford et al 2001) but little has been written from a user perspective.

However, the Forensic Mental Health Research & Development Programme has made some significant steps which include current forensic service users in the research commissioning process. Guidelines for the involvement of service users in research has been promoted and published by INVOLVE. There has also been a number of good practice guidelines published through SURGE. Although service user involvement in forensic mental health is in it's infancy, new opportunities are developing (Spiers et al, 2005).

A further review of the literature showed that the potential of satisfaction surveys in forensic mental health has yet to be realised, and efforts should be made when considering such an approach to involve participants in determining a shared meaning of the concept (Avis et al 1995, Coffey 2006).

Drawing the key messages from this literature review are that once a baseline of involvement is sought then there needs to be an effort to promote involvement owned in partnership — rather than being implicitly for service users. This will nurture and support the culture of 'being together' in a way that values diverse roles.

3 THE PROCESS

3.1 DEVELOPING THE STRATEGY

It has been important that in the writing of this strategy emerging values and principles which underpin the practice and attitudes of involvement were modelled. From the outset a partnership approach including both service users and staff together was fundamental. The aim was to involve as many people as possible, in guiding the direction of the strategy, and allowing it to evolve based on shared experiences and ideas of both service users and providers.

"If staff are not involved they will be unlikely and unable to support service users to get involved"

The commitment, time and enthusiasm that service users and staff have given to the development of this strategy has been heart warming. The process would not have arrived at this point without everyone's **involvement**.

The process allowed for continual exploration of creative and innovative methods of involvement, with the understanding that service users who presently use forensic services may not engage in "meeting cultures," or be unable to meet off the ward. By listening to service users express that the most significant level of involvement is at an individual level; this then supports and nurtures involvement at a more strategic level. The approach developed was to explore involvement in its widest term, which includes both 'formal' and 'informal' approaches, activities and structures. Finally there has been acknowledgement that the process of writing this strategy has been as important as the outcome of having the written document. The processes that were followed built the momentum for change within each organisation, and celebrated good practice — which was then shared across various units.

3.2 INVOLVEMENT STRATEGY GROUP

Setting up a joint group across community, low and medium secure settings involving both staff and service users, has been crucial to the development of the strategy. People have been keen to share and support the process. Involving service users in the group was important but took some time. However when people were able to attend the group, many more benefits were achieved and this was evident in the enhancement and quality of the discussions.

Members of the group from various units soon took on the lead role in their organisations giving priority to different aspects of the strategy, and project groups across the units began to emerge. It was envisaged that these groups would not only be instrumental in developing the various topic areas but could also play a big part in the implementation of the strategy.

3.3 LISTENING WORKSHOPS

In May and June 2006 a number of listening workshops took place across the medium secure units. These were structured to meet the various needs of the individual units and took the form of sessions on wards and staff and service user workshops off the ward. The aims of these workshops were two fold. Firstly they were to listen to service user's and staff's experiences of involvement and ideas of what they would like to see in the future. These views would support the planning of a conference in October 2006 which would also feed into the strategy. Secondly the workshops gave people who may be unable to attend the conference an opportunity to have a voice. The outcomes from these workshops supported the planning of the conference and the topic areas for the strategy. However they also raised the profile of involvement and were the beginning of a relationship with the units.

Prior to the conference in October all three medium secure units developed creative displays depicting service user's views around involvement. These were another way of people being able to express their views and also provided a wonderful backdrop for the conference.
After the conference similar workshops were set up to engage with the low secure services in the region, again listening to the views of both service users and service providers.

"Warmth and humanity are key to successful involvement"

3.4 THE CONFERENCE

The conference was planned to raise the profile of involvement, bringing service users, staff and commissioners together from community forensic services, low and medium secure units, to support the development of the strategy. It aimed to be creative and fun as well as informative.

The greatest success of the day was that about 35 service users from all 7 forensic settings were able to attend; several of those took part in facilitating workshops and presenting information from their experiences. This gave a very rich mix of information and ideas for the next steps.

"The conference made us all concentrate our minds on how to involve people and support them in going to the conference"
A staff member

The conference was a key turning point for many units who started from a position that it would be very hard to practically arrange for service users to attend. This proved to be the very opposite in the end, and has been valued by service users.

"At the conference I met up with people from another unit I had been in, it was really good to see them again. People really listened to me and the lunch was great"
A service user

"Playback theatre was excellent!! All was fantastic — full of admiration for the speakers and organisers. Very professional and great things (I feel) were accomplished."

3.5 PROJECT GROUPS

During the process the different units began to take a lead on the development of the themes in the strategy. As each individual unit was visited, different needs and interests within the various units began to emerge. The development of the project groups within each unit was seen as a useful way forward to involve service users and providers in these developments. Many of the project groups were linked to present involvement structures (e.g. patients committees and ward representatives meeting). The project groups will also give continuity to the implementation of the strategy.

"My confidence has picked up lots so I feel I can speak to anyone for anything. I feel like I can approach people for things big or small."

3.6 MOTIVATION TO GET INVOLVED

It has been delightful and inspiring that there has been so much enthusiasm from people to support the development of the strategy. All of the units have been happy to develop project groups, and this action learning process is invaluable to eventually achieve core standards in the next phase of involvement.

Payment has not proved to be a major motivation to involvement in this instance. However to ensure that we recognise and value people's involvement we have made payments for involvement in the Involvement Strategy Group and in the various project groups. (See briefing paper on Supporting and Valuing Involvement — available on request).

"I wasn't sure where I was going when I first started to be a ward rep. It helped me share things because when I began it was for selfish reasons — but then I realised what it could mean to other people on the ward."

"Payments are good but not necessarily the only reason that people get involved"

3.7 THE FUTURE

This strategy is merely a starting point and no doubt the strategy itself will evolve. Continued involvement is the key to implementing the strategy.

The launch event in 2007 will raise the profile of the strategy and celebrate people's involvement. This hopes to build momentum for the future and encourage even more people to engage and be part of the service improvements within their organisations.

Individual units need to consider their commitment to involvement and contemplate how they intend to resource and support the implementation of the action plans — ensuring the focus which will be required is sustained, and not sidelined.

The project groups within the individual units will continue to evolve and will be a crucial support to the implementation of the strategy within the individual units.

The Specialist Forensic Commissioning Team will provide leadership and practical resources to support the implementation of the strategy.

The Involvement Strategy group will be a vehicle for the implementation of the strategy.

"There needs to be clarity on what people want to change and there needs to be commitment from the whole organisation."

"Becoming a ward rep was really nerve racking. I was outspoken speaking for myself on the ward, but when representing others I felt scared and my voice showed I was nervous. But I feel more confident now. I have got a lot out of being involved."

Key Messages

- The process is just as important as the outcomes and gives an opportunity to model the values and principles of involvement
- Start with a vision but being prepared to shift and change that vision if a new collaborative vision emerges
- Be prepared to be "unsure" of next steps, and allow group processes to evolve and feed the process
- Keep going back — feeding back and updating people are key steps to maintaining involvement
- Listen, Listen, Listen!!

4 DEFINITIONS

4.1 OUR DEFINITION OF INVOLVEMENT

Throughout this document involvement is meant in its widest sense as ***'any attitude, action, activity, approach, policy or structure which supports people who use forensic services to have a voice, exert influence and be part of joint solutions within their own care and the development of services.'***

4.2 DIRECT AND INDIRECT

'Direct Involvement' means involvement in development of services by those people who are directly affected by the change.

'Indirect involvement' is often used as the next best thing to 'direct involvement' and refers to 'user led' initiatives being undertaken by user led organisations or groups.

4.3 FORMAL AND INFORMAL INVOLVEMENT

'Informal involvement' is often unplanned and refers to attitudes, approaches and activities which nurture involvement. This often occurs at the grass routes level of service delivery.

'Formal involvement' is usually planned and refers to structures and meetings, which again support involvement.

4.4 INVOLVEMENT AND ADVOCACY

To clarify the difference, this document suggests that involvement and advocacy are distinguished by their boundaries.

Advocacy, and in turn advocacy workers come completely from the service user's perspective. This will be the case whether working with individuals or groups. Advocates must not have or offer their own opinions.

Involvement, and in turn involvement workers, are supporting joint working and dialogue. They will try to ensure that the different perspectives are heard. They may have, and at times offer, their own perspectives.

4.5 ARNSTEIN'S LADDER OF PARTICIPATION

Arnstein's ladder of participation (Arnstein, 1969 — later adapted by Wilcox) is one example of a model of involvement, and is valuable in identifying, describing and debating involvement opportunities in a transparent way.

Arnstein's original model

8	Citizen control	
7	Delegated Power	6–8 Degree of citizen power
6	Partnership	
5	Placation	
4	Consultation	3–5 Degree of Tokenism
3	Informing	
2	Therapy	1–2 Non participation
1	Manipulation	

5 VALUES AND PRINCIPLES

Underpinning these values and principles there are some key values and principles which need to be in place.

How valued people feel as human beings has a great impact on people's willingness or ability to get involved at all levels. If people feel that their basic human rights are not being listened to and met either individually or as a group they are unlikely to or should not be expected to engage in wider strategic involvement.

There are some fundamental needs which need to be addressed for effective involvement to take place:–

- Environment, including safety, dignity and privacy
- Food, of good quality, choice and appropriate portion sizes

Further values and principles are:–

- Equal value needs to be given to the experiences and roles people have and share.
- Everyone's involvement needs to be recognised, valued and rewarded.
- The process of involvement is just as valuable as the outcomes.
- Partnership and collaborative working with service users and staff is valued as a way of shifting ward and service cultures.
- Involvement is everyone's role and involvement processes should be nurtured by everyone at all levels.
- All involvement is valued. This includes ideas and opinions passed on to staff in informal interactions through to experiences, views and ideas shared within strategic formal structures.
- Service developments should be influenced by those people who have direct experience of using those services.
- Collective involvement and ownership (although there may be specific involvement worker posts, involvement and it's achievements are owned by everyone involved).

6 AIMS

Drawing from the key messages of the literature review, the process and the definitions these are the aims of the strategy that we have come to.

- To develop active service user involvement in Strategic Planning
- To establish core standards of user involvement across medium and low secure settings
- To outline good practice and develop service user led Audits and Evaluations
- To ensure that user defined outcomes are sought and included at the point of commissioning
- To establish a Yorkshire/Humberside wide involvement network
- To establish greater service user access to information including the internet
- Establish a policy on "Supporting and Valuing" involvement
- To develop and implement a training programme for staff and service users about involvement principles and practice
- Identify support mechanisms to support and sustain involvement

7 MAPPING INVOLVEMENT AND GOOD PRACTICE

Within Yorkshire and the Humber area there are three medium secure services and four low secure services that have been engaged in the development of this strategy. These services are:

Medium secure

- Newton Lodge — Wakefield
- Humber Services — Hull
- Stockton Hall (Independent sector) — York

Low secure

- Clifton House — York
- Castle Hill Unit and Newhaven — Huddersfield
- Newsam Centre — Leeds
- Moorlands View — Bradford

Over a period of six months a mapping exercise to establish what 'involvement' was presently happening in the area was undertaken. This has also given opportunities for sharing learning and good practice. Many services were surprised at the amount of involvement which was happening within their services — as they had previously not thought of including more informal approaches.

Below is a summary of the feedback from the mapping exercise. Examples of good practice have been chosen to show the breadth of activity and approaches, as many units have similar structures, activities and approaches.

7.1 ACHIEVEMENTS

7.1.1 Creating the right environment

- Social events actively planned with service–users and staff together (Newton Lodge).
- The underpinning Person Centred Planning philosophy (Newhaven).
- Commencing a service user's forum and communication 'tree' to maximise the voice of every service user through a number of means; notice boards, suggestion boxes, key and co–workers, the newsletter (Clifton House).
- An information strategy which lets people know how to become involved in patient/staff involvement and how decisions are made (Humber services).
- Recovery Worker employed to work alongside volunteers to bring culture of Recovery Groups to clinical areas (Newsam Centre).
- A weekly patient activity schedule where the patients choose and hopefully follow a therapeutic activity / engagement plan. This includes choosing from a list of nurse led therapeutic group activities held on the ward and available am and pm (Mon–Fri), along with any Occupational Therapy engagement they choose to participate in, any participation in community projects such as day centres or specific groups (drug counselling etc). Additionally the patient can choose to include individual activities they are interested in participating in — such as access to the gym, kitchen and music room (Castle Hill Unit).

7.1.2 Supporting involvement at an individual level

- Involvement of more established service users e.g. ward representatives, assist with induction of new service users onto the ward in parallel to the support they receive from professionals. This could include a summary of user involvement structures and daily routines. (Stockton Hall).
- There is a specific section for service user perspective within nursing reports. Service users are also involved in developing and evaluating care plans (Newhaven).
- Care Pathways — this is a recently reviewed version of a system running parallel to the CPA. It consists of a number of areas, specifically questionnaires including one for the service users to complete (with or without support) and is designed to identify the service users desires in conjunction with their areas of need (Clifton House).
- Each service user is supported to record their own views prior to CPA's and these are treated as very important within the CPA process and alongside the other professional reports. CPA's are designed so that a whole range of care issues are discussed that are important to service users rather than just medication/behaviour issues important to staff (Bradford).
- The patients have been given the choice of engaging with staff trained or undergoing PSI training (Castle Hill).

7.1.3 Involvement structures

Ward level

- Weekly community meetings on all wards where the agenda is set between Ward Representative and the charge nurse or other senior clinician, and minutes are taken in accordance with the terms of reference. On some wards the Ward representative chairs the meeting (Stockton Hall).
- Regular meetings held by and for service users on the Women's Service (Newton Lodge).
- Women's Involvement Group — facilitated by service users (Newsam Centre).
- Potential for service users to be offered paid work within the unit, structured weekly tasks with a job description, responsibilities and the opportunity to 'earn' therapeutic earnings (Clifton House).

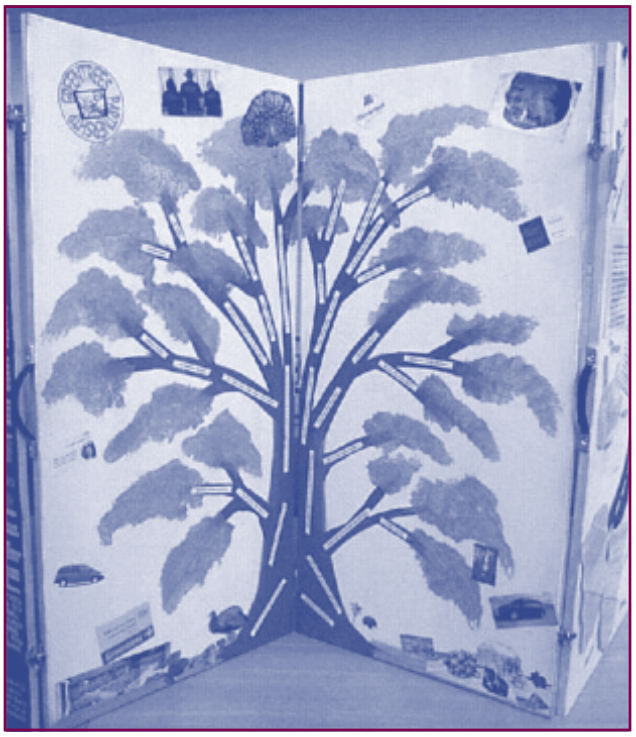
Unit level

- Fortnightly Ward Representatives Meetings which are attended by Ward Reps, Deputy Ward Reps, link workers who are either Occupational Therapists or Nurses, and senior managers. The Ward Reps have a role profile which, along with arrangements for electing both Ward Reps and Deputies, is summarised in the handbook. The Chair is a Ward Representative. Roles of Ward Representatives and other roles are outlined in a handbook (Stockton Hall).
- Involvement Project Group of staff and service users exploring the involvement structures which might be most appropriate for Newton Lodge. This group is also looking at how to involve the people from the other wards (Newton Lodge).
- Service Users Forum — a monthly meeting where service users from both wards meet to discuss items relating to their care and the running of the unit. Service users were strategic in designing the rules and boundaries of the meeting and play a participative role in maintaining minutes and running the meetings with support where appropriate (Clifton House).
- Working Towards Recovery / Working Towards Discovery Groups — In–patient and community involvement groups — membership at both include service users and staff. Chaired and minutes taken by service users, and supported by the Service User Involvement Facilitator (Newsam Centre).
- The Patient Committee — There is representation from each ward, and the patient committee is held once a month on an evening, each meeting is

recorded and all minutes are shared with all patients, and key influential others. The patient partnership meetings held on the wards weekly, are the main forum that feeds in to the patient committee, and patients who attend the patient committee feedback to the wards any discussion/actions agreed by the patient committee. The Committee also produce a seasonal magazine outlining issues relating to the service (Humber Centre & Greentrees).

Wider strategic involvement

- There has been service user participation within the interview process for specific disciplines, e.g. Social Work, Occupational Therapy and Advocacy (Stockton Hall).
- A Ward Representative, supported by an OT, attends a monthly Catering Working Group and ensures that relevant issues are discussed at the Ward Representatives Meeting (Stockton Hall).
- Active involvement in Involvement Strategy planning meetings and participation in planning for and attendance at conference (Newton Lodge).
- Learning Disability user and carer groups (Newton Lodge).
- Service User Involvement and Recovery Strategy developed — in collaboration with the Working Towards Recovery Group. Some service users leading on objectives for improvements (Newsam Centre).
- Collaborative Patient Meeting — Due to some senior staff being unable to attend the out of hour's patient committee, it has been agreed by the MDT to introduce into the Humber Centre ICP a Collaborative Patient Meeting during working hours. The Humber Centre MDT advocates that no single person or profession holds all the skills, knowledge or expertise required to address all concerns expressed by the patient group. Therefore it has been agreed to hold a quarterly meeting where all the senior staff can meet with the Patient Committee, with the aim of answering concerns direct, without having to go through a third party, the minutes from this meeting are published in the patient seasonal magazine (Humber Services).
- Service user involvement in training e.g. self harm workshops (Clifton House).
- The Trust has a user involvement strategy that we are part of. We are working to improve user involvement in many areas such as user led audits, employment of service users and users involved in interviewing as well as present at wider decision making forums. We are working to ensure that we copy all information to users (Bradford).
- Planning around service development / unit relocation (Castle Hill).



7.1.4 Process used to set up structures

- A User Involvement Steering Group, comprised of staff from SW, OT and Nursing, coordinated a scoping exercise that gained information from 20 patients across all the wards which resulted in creation of the Ward Representatives Group in 2004 (Stockton Hall).
- Service users already involved at planning level can positively influence other areas of the unit by showing what they are already achieving. Social events can incorporate service user information (Newton Lodge).
- Community Social Group was identified by the community team as relevant for those service users who are more independent but without regular social contacts, predominantly established by community OT and CPN with support from Community Social Worker. An initial questionnaire to determine venues, times, etc. Occurs monthly, personal invitations dispatched 1–2 weeks before, transportation offered but only two request it, 1st meal out = 4 service users, 2nd meal out = 8 service users, 3rd meal out = 9 service users. Due for review after 6 months (May 2007) — (Clifton House).
- Patients have chosen to be involved in patient experience groups. This was developed by OT and psychology department and followed a questionnaire / suggestion format.

7.1.5 Other things which support involvement

- Volunteers work with service users to increase the range of activities available. Service users make decisions about which activities they want — and volunteers are matched to meet these requests (Newsam Centre).
- There is great emphasis on the importance of the link worker role. The functions of the link worker includes providing regular support to the Ward Representatives in the Community Meetings, and the Ward Representatives Meetings. When this role is undertaken effectively service users are able to develop their abilities to become functional Ward Representatives, and in encouraging all members of the ward community to participate in the structures that have been established (Stockton Hall).
- Involvement in planning and implementation of Social Events which can also act as a catalyst for wider involvement (Newton Lodge).
- Alternative environments/venues are explored to encourage those service users who do not regularly participate in the service user forum — and to promote the opportunities to contribute through engagement meaningful for them, i.e. may be seeing OT informally away from the unit on neutral ground (Clifton House).
- Patients supporting and fund raising for well known national charity days such as the BBC's Children in Need Appeal (Castle Hill Unit).

7.1.6 Plans or next steps for involvement in the future

- Confidence building group — 'Moving on'. This has been identified through Care Pathway Meetings that a number of service users were experiencing similar anxieties with regard to the next progressive stage of their rehabilitation (Clifton House).

- Further patient involvement consultation around relocation to another hospital site (Castle Hill).
- Attendance at regional involvement strategy groups.

7.2 CHALLENGES IDENTIFIED IN THE MAPPING

- Entrenched attitudes of staff, including some doctors and senior clinicians, and traditional patterns of working.
- Culture of forensic/psychiatric care is changing positively however the concept of involvement can be difficult/feel threatening to some staff. This may also be a consideration for service users who do not wish to be 'part of the system'.
- Recognising that there may be physical and/or emotional barriers to service user's involvement. This is rectified to some degree through facilitating a number of opportunities in different settings, with different staff to promote involvement on an individual basis.
- There is a need for real leadership to push this forward within the forensic setting and to be more radical in the way we see user involvement.
- The main barrier to overcome is the social inclusion of our patient group into mainstream services which may include;
  - Housing
  - Employment
  - Education
- Limited resources, and conflicting professional demands on staff.
- Inconsistent communication between staff on different wards.
- Lack of regular attendance of senior clinicians at Community Meetings.
- Positive and negative symptoms of mental disorder experienced by service users.
- Security of environment and restrictions of detention can act as barriers to individual involvement though it has to be considered that levels of involvement should reflect this.
- Changing patient populations.

Section 2 — Involvement Activity

8 THEMES

The themes below have been developed from the listening workshops and the conference. They are the areas that service users and staff felt were the most important things when thinking about involvement. These themes have been further developed with the support of the project groups within the different units. Some of the themes which include a national and international perspective, user led audits and to some extent the use of "Confluence" have been collated from national events and papers which have been explored and presented in this document for discussion.

8.1 ENVIRONMENT

Environment in this context is seen as the physical and attitudinal aspects which can potentially nurture or block involvement. For example, the way rooms are set out can facilitate more formal or less formal environments. This section also explores the opportunities for involvement in any given environment.

8.1.1 Individual care

How involved people feel within their own individual care is pivotal to the extent people choose to engage in further involvement activities. Involvement in one's own care can be either formal through Ward Round, CPA's or tribunals or more informal through relationships with ward staff, how helpful staff are when approached etc. Throughout the process of developing the strategy there have been key areas which people have felt would improve involvement at this level.

"Involvement to me is all about honesty and openness"

Key messages for improvement

- People said that they still saw the RMO as the decision maker and would therefore like opportunities to see their RMO more often.
- People sometimes felt that their wishes were not listened to, especially in respect of treatments and approaches. The development and use of advanced directives would enable people to have more control over this.
- People told us that they do not feel that their views are taken into account in relation to risk, and their old behaviours and actions continuously get brought up. The development and use of service user led Safety plans would enable people to become more involved in areas of risk.
- When decisions are made by one member of staff(s) on duty this is not always communicated to the next shift, therefore people are restricted in doing something that has already been decided. One suggestion to resolve this has been staff and service user joint communication books on wards which would support continuity.
- Many people told us that they still do not feel part of their CPA and feel unable to contribute. The use of self assessment forms for CPA meetings would help ensure people felt involved.
- People told us that they felt some CPA's were a waste of time as the people who they felt were important were unable to attend. This included RMOs and people from out of area. Service users having greater involvement in how CPA's are run and who attends (moving towards chairing them) would help this.
- Many people told us that they get invited into ward rounds or CPA meetings only once everything has been decided. Having people in at the beginning of meetings would help and would ensure that people are aware and can influence all the options.
- People told us how important it was to spend time with staff just talking and doing activities. This helped build trust and relationships.
- People said that they feel intimidated by formal meetings and prefer to meet in less formal ways.

8.1.2 Ward level

Again involvement at a ward level can be formal or informal. Formal activities may be Ward Community Meetings and organised activities. Informal involvement may include having a seating area in a way which facilitates staff and service users to sit together and talk about what's been happening.

"At first when I was doing community meetings I wondered what others thought of me. But when things started to get better it felt good."

"Community meetings are a crucial part of patients week if we could

generate that belief across all staff then we would get more patients to come along"

"Developing a mural as a group was really good and really supported us to think and work as a group".

Key messages for improvement

- People said how important it was to have decision makers attending community meetings and other meetings. These included RMOs and ward managers.
- People told us how important it was to have Information from community meetings recorded and revisited and any action fedback.
- Some people told us that they felt that Ward based meetings should be chaired/ facilitated by a service user with staff support. This helps ensure that it is a user led meeting.
- People told us about how they value opportunities to get together in more sociable ways.

8.1.3 Unit level and structures

Involvement structures are more formally planned involvement activities such as meetings and pathways which involve service users and take place regularly. Some units have more developed structures than others. Most units in the region do have a ward based community meeting as a minimum within their units. Structures beyond this vary for some this takes the form of ward representatives meeting, Patients Committee meetings and Working towards Recovery Meetings. Most involvement in the region does not go beyond this point e.g. most units do not have involvement in more senior management/decision making meetings.

"As a representative I have a role other than just a patient. That is important to me"

"I was asked to become ward rep and didn't want to do it at first. Then other people said for me to do it, and I gave it a try. I try my best to improve things for the lads on the ward — and I think I do!"

"Things have to change or people lose faith. There are some things we constantly bring up which never change"

Key messages for improvement

- Many people felt that involvement comes down to a few committed individuals and feel that other people need to get involved. All opportunities for involvement within the unit need to be clearly publicised to enable all service users the opportunity to get involved if they choose to.
- It was important to people if they were representing people's views that this was clear to everyone about how they were elected.
- Meetings that had service user chairs felt that this was very important. Having a service user chair for meetings sends a clear message of where the power lies within the meeting; this may take steps, time, support and training.
- Units where there are not formal involvement structures are exploring other formats which are more open and may not rely on representatives (e.g. Open panel where all service users are invited and can raise issues).
- The role of representatives can be hard and those in this role are aware that not everyone will want to talk to them. Consider how all views and ideas from other service users can be raised at the meeting without having to go through a representative.
- In one unit link workers are used to support representatives. The service users really value this role and support. Support needs to be considered for any service users taking on any roles within involvement meetings/structures.
- Many staff that are supporting involvement activities are doing so on top of other roles. These activities can take up quite a lot of time and this can become difficult for people. There needs to be someone with an identified role and dedicated time to support involvement activities within units
- All units should have a clear Involvement action plan (developed with service users).

8.1.4 Regional

Opportunities for involvement in regional activities have vastly grown from the development of this strategy. The Strategy Steering Group which supports the processes used to explore involvement practice across Yorkshire includes service users from several of the units in the area.

In the terms of reference for this group, it is clear that all members of the group have equal responsibility and respect for comments and ideas discussed in meetings. Agreeing terms of reference was difficult in the development of them, but as the group has grown and developed it has become wholly supportive and appreciative of everyone's opinions. Complicated language and abbreviations are used as little as possible; as a result of creating clarity, transparency and breaking down imbalances of power through language.

As described earlier in the document, a number of Project Groups have been set up in the different units. Although they are attended in the individual units, the work completed in them is information which is being used for the purpose of sharing regionally. Therefore this type of involvement is valued for its regional impact. The wealth of information, knowledge and experience from all work completed has been exceptional. The content of the information gathered directly feeds the recommendations of the draft strategy, and therefore comments made between units is encouraged. Any minutes of Project Groups can be given upon request. When the communication networks have been practised and developed, all minutes will be posted on there for access of anybody wishing to become involved. Roles of members in the above two involvement activities have been discussed and described. This also helps people keep focussed.

Another regional involvement activity has been the Women's Involvement Project which was a year long project with the aim of all recommendations and learning arising from personal experiences of women from Yorkshire, to inform the development of a new service model. A lot of attention was paid to the experience of involvement for each woman taking part in the project. The type and intensity of involvement was led by the interest and motivation of those choosing to be involved. A variety of methods were used, and people had the choice of how directly they wanted to be placed in the process. A number of recommendations were made, and they range from practice starting with

first contact people have with the system, right through to moving on from services in the recovery processes.

Key messages for improvement

- People have said that they value opportunities for listening and sharing developments between units.
- The Involvement Strategy Steering Group can steer the implementation of the strategy.
- Development of the Regional Network will give opportunities for continued sharing and act as an advisory panel for future developments.
- Unit based project groups will support the implementation of the strategy.

8.1.5 National

In terms of influence and opportunities to have a say in national initiatives, service users in forensic services have a good chance to impact service improvement whilst being supported through networks and resources described in this strategy.

Already service users have contributed to the consultation about the CPA (Care Programme Approach) process being carried out by the Department of Health. People across Yorkshire commented about the practicalities and experiences of CPA, and reflected together to discuss if the realities they have encountered actually match their personal experience with those set out as achievable good practice guidance described in the consultation.

Another example of national involvement was that some service users took part in a review of their experience being transferred from prison to mental health care in the medium secure units. This was with the intention to understand and improve the experiences for people moving from prison to hospital, and what needs to be monitored during future evaluation of this same process.

With any type of involvement or consultation it is extremely important for people who have taken part to get feedback. The larger the target audience of those the activity is aimed towards, the harder it is to give individual feedback. However those facilitating the involvement should actively seek solutions to make this happen.

Key messages for improvement

Through the strategy group, network and project groups will:

- Influence national policy and developments
- Respond to national and regional consultations
- Make links to the Home Office
- Continue to feedback on developments

8.1.6 International

Different countries have different systems for managing and caring for people who fit into what we would describe as our forensic populations. Some concentrate on prevention and early intervention and some concentrate on reactive interventions.

It would be interesting to investigate and map out alternative models, and discuss these with service users, providers and commissioners together — to consider different and more empowering ways for services to be designed and delivered.

Key message for improvement

- Sharing and learning from different involvement approaches used in different countries

8.2 DEVELOPING A NETWORK

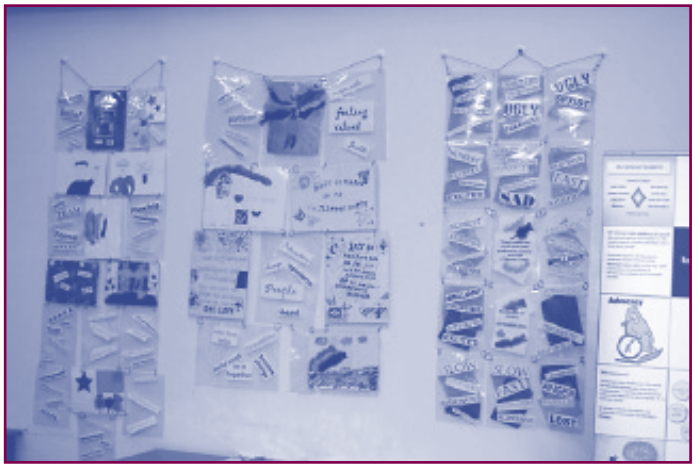
An aim of the strategy was to develop a Regional Forensic Reference Group which would ensure that there was service user involvement in future developments within Forensic Services.

An IT software package called "confluence," which is a secure space on the internet where people can post papers, edit and make comments about papers, email about issues which can be followed by everyone, post news and bulletins and have conversations is being developed for this use. This will support a "network" across all of the medium and low secure settings within the Yorkshire Catchment Group Region.

Key messages for improvement

Through using confluence it will:

- Bring people together who have restricted leave.
- Widen the scope for involving more people.
- Ensure continuity.
- Address access to information issues.
- Make involvement and information as accessible as possible.
- Support people to be able to express views and engage in dialogue in ways and times that most suit them.
- Support services to share ideas.
- Support service users being moved to different units in the region to access information and communicate with other units about that unit.
- Overcome barriers to access the internet.



8.3 TRAINING

There has been a lot of work done looking at the training needs of service users around involvement. This training is often to support service users to "fit in" to present structures and meetings and ensure they feel able to contribute to "professionals meetings". This approach does little to challenge and shift the power dynamics between service users and service providers. As part of this strategy it has been important to not only look at opportunities for involvement but also look at the opportunities to challenge and shift present structures and the training needs which will support this.

As part of the development of this strategy one of the project group's are exploring the issues around training. There have been some key messages which have evolved from within this group, and discussions with others.

Key messages for improvement

- All training when ever possible should be delivered and received by joint groups of staff and service users ensuring joint opportunities for dialogue and shared messages.
- Joint training will support the culture shift within units.
- Rather than training service users to fit in, opportunities for changing structures and meetings should be explored.

- Training should cover three key areas
  – Individual level through CPA, advanced directives and safety plans training.
  – Unit level through training & supporting representative roles.
  – Management and decision making levels through negotiation, influencing and leadership training.

8.4 INVOLVEMENT IN RECRUITMENT & SELECTION

Staff and their skills and attitudes are the key component to ensuring a good quality service, which respects and values the views of the service users. It is therefore crucial that service users play a central part within the recruitment process. There is evidence that this happens within some units for recruitment of some disciplines. These pockets of good practice need to be shared and widened to include recruitment at every level of the organisations. This will require recruitment and selection training to include service users.

8.5 INFORMATION

Access to information is key to effective involvement at all levels. The internet is a wide and varied source of information which people can use to ensure effective involvement in their own care e.g. information about diagnosis and treatments and also support engagement in the wider debates including legal and political issues.

There are at present many restrictions on service users accessing the internet in many units. This is an area which needs to be explored and step by step process made to achieve the use of the internet.

Accessible information is also an issue. How people choose to engage with information is very individual. A leaflet even translated or with pictures added does not mean that it will be accessible to certain individuals.

A system which explores being linked up to the "confluence space" encouraging and supporting people to adapt the information on that site, and possibly other sites, to develop individually accessible information is being considered. This may include larger print, colour of back ground and font, pictures, wordbank (explaining difficult words) audio recordings, different languages etc.

Different units are also adapting different forms of information e.g. rights leaflets for people with learning difficulties. This information could be shared via confluencing.

Key messages for improvement

- People have said that their Trust policy bans service users from using the internet. The barriers of internet access need to be overcome to ensure access to information and involvement
- Different people want information in different formats; however it is important that people have the opportunity to have information provided in ways which support their own identified needs without assumptions being made by service providers. Confluence will work towards ensuring information on the site is accessible for all
- Units are designing information in a variety of formats. This information could be shared across units which would support more standardised information.

8.6 USER LED AUDITS AND EVALUATION

"Mental health Services look very different according to one's position in relation to them: the perspective of those who provide them is poles apart from that of people who are on the receiving end of their ministrations, and differs again from the perspective of their relatives and friends" (Kotecha et al 2007)

Having service users involved and leading audits and evaluations is crucial to ensuring providers and commissioners are measuring what is important to service users and that this is reported back in a way that truly reflects the issues, values and concerns.

There have been several examples of user led monitoring/audits across the country (Birmingham & Bradford), however most are examples of indirect user involvement / led monitoring, i.e. using non forensic user led organisations to lead the process and interview service users.

In Yorkshire the model being aimed towards would be direct user led/collaborative monitoring. This would mean that those people presently using services within medium and low secure forensic services would be involved. A model being considered would be to offer training and support to a group of staff and service users from one unit to audit specific parts of the service in another unit. This would ensure that people presently experiencing a secure environment would be at the heart of the audit process, whilst there would not be the conflicts which may arise from auditing their own service.

We are aware that the above model may provide some challenges, however direct involvement is the ideal and worth striving for.

Key messages for improvement

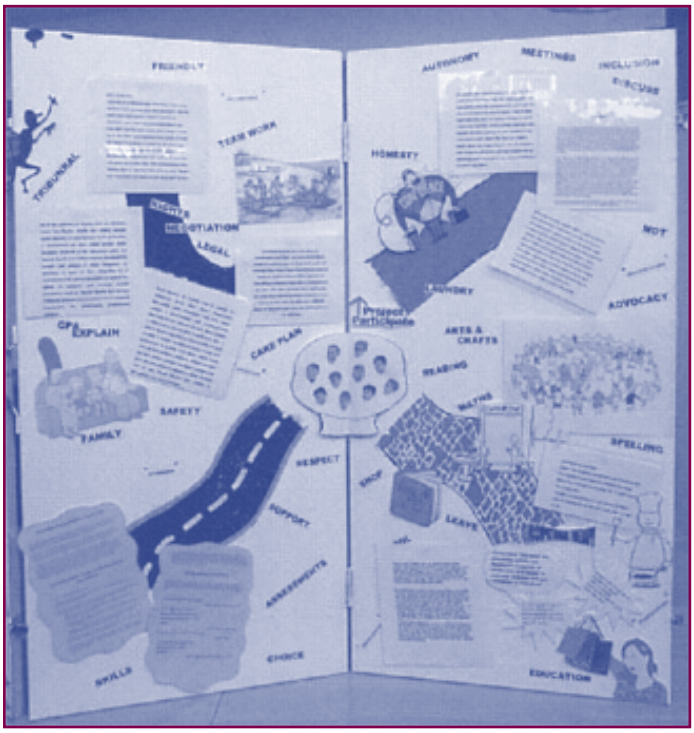
- Build capacity for cross unit collaborative audits.
- Identify challenges and joint solutions to this approach.
- Develop and define different pathways to respond to audit outcomes.

8.7 ADDRESSING THE INVOLVEMENT NEEDS DIFFERENT TARGET AUDIENCES

When involving people from minority groups, sometimes certain target audiences are desired specifically with the need to engage to meet their opinions. However the approaches which may be taken can vary, the principles underpinning involvement activity are closely related to its success.

Key messages for improvement

- Listen, understand and explore instead of making assumptions on what is needed.
- Always ask people what they want and what they feel needs to change.



8.8 COMMISSIONING

Until recently, it has been the policy makers, service planners and purchasers who have had the most direct impact upon prioritizing the scope and quality of differing types of care. The value of different treatments and experiences has been collected through services and professional discussions. However there is evidence now that this information can be misleading and that when considering the value and quality of care that is being measured, service users must be at the centre of the process.

Whilst looking to actively engage with improving service users experiences, commissioners and service providers must become more flexible, responsive and innovative to enhance the type of information they wish to collect. There needs to be a shift in the assumptions which are made, currently based widely upon cultural and organisational beliefs.

Historically it seems that services have been commissioned on providing the most appropriate placements (even if the service does not fully meet the individual's needs), but now there is a commitment to assess the purpose and value of the environment and care which is being experienced by the service user, and to monitor outcomes which have originated from them and their identified goals. This raises questions about what services are actually needed, what are they meant to do, how well they do it, and what extra do they achieve with people. Service users' views are primary in this process.

Through talking generally with a number of service users across the region, a potential platform for building milestones to assess crucial quality outcome measures are described below.

To summarise, an outcomes continuum can be developed to include areas from involvement, to choice, to recovery, to control, and back to involvement. This loop can continue to go round and round seamlessly, and elements of each of the outcome themes can be recognised and complemented across elements. Examples of milestones — and some ways to measure the user defined outcomes are explored here.

8.8.1 Involvement

There is a clear message that user defined outcomes offer a feasible, valued and effective means of developing quality standards, which reflects what service users want from the support that they receive. To achieve this it would mean that the service user is in the centre of their care packages in every way, and for this to work there must be an attempt to involve people in as many ways as possible.

This involvement must be encouraged from individual activities right through to strategic comments and feedback. Service users should be actively supported to become the 'leader' of their care, however long it is assumed they may need to get there. Collaborative involvement could be a step towards this outcome. There needs to be promotion and acknowledgement that Involvement in itself is therapeutic. All of the values and principles set out in the aims of this strategy could act as guidance to further involve people.

8.8.2 Choice

In the National Health Service the new rhetoric is framed as developing 'the choice agenda.' There is a move towards each service user receiving an improved service by being able to make choices which effect their care. In forensic services providing choice can be a contentious

issue, but all it really means is that people should be able to access the right help and support which meets their individual interests and needs. If this is available at the right times, it can act towards decreasing the need for using traditional methods of compulsory treatment and seclusion. If there was a spectrum of traditional, creative and innovative approaches to care and treatment in the ways that service are planned and designed, recovery may be quicker for individuals and it would most certainly improve each service users' experience.

8.8.3 Recovery

Service users' concerns are primarily to improve their lives and those of others who are like them — rather than the 'system.' However, it could be seen that by improving the former, the latter will be positively enhanced also.

Some service users have needs which fall beyond the current services established to work with people who use forensic services. This results in the need to care for people in services which may not have worked with the same types of issues before, and the lack of experience can be evident. However, each person is individual, with individual needs. Therefore through developing positive relationships, which are therapeutic and social as appropriate, then service users' experiences will be highly satisfactory. Relationships are a key marker in the recovery of the people using and working in services.

It is through these relationships where hope can be inspired, and an environment where people can feel empowered is established. Important relationships are not exclusive to the user/provider dynamic though. There is often an informal buddying system in place where service users who are more experienced in secure environments are influential, and can act as role models to others.

A major barrier to successful recovery for individuals and services alike, is the devaluing of service user knowledge. However, through self help initiatives and effective networking this can be overcome. Service user networking and knowledge development are closely linked. By encompassing networks and increasing knowledge, effective partnership arrangements can be developed. It is proposed that some of these discussions could be enhanced from ward to ward networking to service to service networking through confluence.

Through being exposed to others outside the secure environments, the process of maximising social inclusion can begin. By living successfully in services, individuals can work towards moving in to the community, and can help to reduce stigma and discrimination through example in their community. By reducing the need to be in the higher levels of security environments, people are taking up more control over their lives.

8.8.4 Control

People can have more control over their environment whilst still being in services too. People could make decisions over whether they want to attend ward rounds and CPAs, what they choose to eat and drink, and when to have privacy. Sometimes services try to fit service users into their institutions, when it is vital that this must be turned on its head and services should work to fit in with the people they serve. This would lead to people increasing their responsibility in recovery, and there would be more creative situations where people are involved in developing the scope of instances where choice can be initiated.

Areas where there is room for influence and negotiation about how much control people can exercise in their lives is crucial. This can be measured in various ways, and it would seem that each of the other areas described above directly reflect how much control people can benefit. In other areas of health and social care services, there is a system of direct payments. Essentially this means that people can buy in the elements of care which are uniquely selective for

themselves. People who use direct payments are more able to conceptualise outcomes and have clear ideas about positive outcomes which they feel they want to experience. Perhaps some of the principles used in direct payments can be adapted and used in commissioning forensic services for individuals.

If commissioners and providers fail to gain the benefits of service user perspectives, experiences, insights, ideas and knowledge, there would be a massive omission. Subjective views highlighted by service users as inherent outcomes increase the nature and quality of what is being measured. However, it must be noted that any system of measuring outcomes will need to take account of the fact that service users' measures of satisfaction include ones which are shared, but also others which may be different.

Taken together these ideas offer the basis for taking forward effective and inclusive partnerships, and developing measures for quality consistent with the rights of service users themselves. They are an essential complement to broader efforts and strategies to develop effective partnerships in health and social care.

8.9 RESOURCES AND SUPPORT

Dedicated time and support for involvement within each secure unit is vital to the successful implementation of this strategy. There are three different ways of developing capacity across the area. Commissioners, Service Providers and Service Users will need to work collaboratively to deliver on one of these options for each service.

Option 1

A pool of Involvement Workers, with dedicated time for each unit. This would allow for opportunities to co–work, maintain a regional focus and offer peer support.

This option would be resourced jointly by all units and co–ordinated through the Commissioning Team.

Option 2

Involvement Workers employed by each unit individually. This would ensure ownership and commitment by services to implement the Involvement Strategy.

Option 3

Dedicated time and resources through existing posts in each unit.

Which ever option is developed further, there is a recommendation that units should be proactive and open to people who have, or still do, use forensic mental health services occupying any position — paid or voluntary within the involvement process.

9 ACTION PLAN

Services and Commissioners need to identify dedicated capacity to develop involvement.

The Key messages for improvement

Individual Care
- Development of Advanced directives & user led safety plans
- Service user and staff joint communication books
- Develop greater involvement in CPA's

Ward Level
- Further develop ward based meetings
- Decision makers at key meetings
- Opportunities for non clinical and social arrangements

Unit Level and Structures
- Further development of unit based processes
- Ensuring transparent involvement processes for all service users
- Identified support for individuals and units

Regional
- Continuation of strategy steering group
- Continuation and development of project groups
- Developing network and confluence site

National
- Keeping updated on national policy and developments and influencing it
- Respond to national consultations
- Making links to the Home Office

International
- Sharing and learning form different involvement approaches used in different countries

Developing a network
- Develop confluence as a model for communication
- Overcome barriers to using the internet
- Continue to build opportunities for people to get involved and sustain this

Training
- Collaborative approach to training and receiving training
- Develop three module training programme
- Evaluate outcomes of training

Information
- Ensuring wider opportunities for accessing information
- Working towards ensuring information on confluence site is accessible for all
- Sharing common approaches and designs to information

User led audits and evaluations
- Build capacity for cross unit collaborative audits
- Identify challenges and joint solutions to this approach
- Develop and define different pathways to respond to audit outcomes

Different target audiences
- To ensure a flexible approach which responds to different target audiences
- Learning from success about how to engage with different groups

Commissioning
- To ensure that services respond to the proposed outcomes of service users
- To influence the redesign of traditional approaches to forensic secure services
- To influence commissioning to provide alternative provision, which is evidence based

Resources and Support
- To develop unit based action plans to identify local need for resources
- To invest in posts which support and enable maximum value to involvement
- To develop a common approach to valuing and supporting involvement
- Develop peer involvement network

An annual action plan will be developed to deliver the Key messages for improvement

10 APPENDIX 1

DEFINITIONS

Our definition of involvement

Throughout this document involvement is meant in its widest sense as 'any attitude, action, activity, approach, policy or structure which supports people who use forensic services to have a voice, exert influence and be part of joint solutions within their own care and the development of services.'

Direct and indirect

The ideal would be to always have 'direct involvement'. This means involvement in development of services by those people who are directly affected by the change. In Forensic services this would be those people who are currently detained or those people using community forensic services. In this strategy the term direct involvement is used to discuss training, user led audits and evaluation.

'Indirect involvement' is often used as the next best thing to 'direct involvement' and refers to 'user led' initiatives being undertaken by user led organisations or groups.

Formal and informal involvement

As the above definition of involvement indicates, it is proposed to affect involvement at every level of organisations and beyond. This is not always done through formal structures but big changes can occur through more informal approaches.

'Informal involvement' is often unplanned and refers to attitudes, approaches and activities which nurture involvement. This often occurs at the grass routes level of service delivery.

'Formal involvement' is usually planned and refers to structures and meetings, which again support involvement.

Involvement and Advocacy

There is much discussion about where advocacy fits into involvement. Advocacy is of course part of the involvement continuum as it is a mechanism for supporting people to be involved, especially in their own care. Group advocacy can also support a collective of people to come together and speak up about their common issues and can effect service provision as may the collation of individuals issues presented anonymously to providers.

To clarify the difference, this document suggests that involvement and advocacy are distinguished by their boundaries.

Advocacy, and in turn advocacy workers come completely from the service users perspective, this will be the case whether working with individuals or groups. Advocates must not have or offer their own opinions.

Involvement, and in turn involvement workers, are supporting joint working and dialogue. They will try to ensure that the different perspectives are heard. They may have, and at times offer, their own perspectives.

Therefore although advocacy is a valuable part of the involvement continuum it can and must only go so far, and ensure that it does not step beyond the clear advocacy principles and guidelines in order to reach joint solutions.

11 APPENDIX 2

Arnstein's ladder of participation

Arnstein's ladder of participation (Arnstein, 1969 — later adapted by Wilcox) is one example of a model of involvement, and is valuable in identifying, describing and debating involvement opportunities in a transparent way.

Arnstein's original model

8	Citizen control	
7	Delegated Power	6–8 Degree of citizen power
6	Partnership	
5	Placation	
4	Consultation	3–5 Degree of Tokenism
3	Informing	
2	Therapy	1–2 Non participation
1	Manipulation	

The levels explained

1.Manipulation
In the name of citizen participation, people are placed on rubberstamp advisory committees for the express purpose of "educating" them or engineering their support. Being the bottom rung of the ladder signifies the distortion of participation into a public relations vehicle by power holders.

2. Therapy
The term 'therapy' in context with this model is used to consider and shape service user involvement within groups. Professionals assuming that people with mental health problems need to 'cure their pathology' and that they are the best people to do this. What service users might prefer is to change these assumptions made by services and society, to a community where there is no discrimination or victimization which may potentially cause the 'mental illness pathology.'

3. Informing
Informing citizens of their rights, responsibilities and options can be the most important first step towards legitimate citizen participation. However too frequently the emphasis has been placed on a one way flow of information — from officials to citizens with no channel provided for feedback and no power for negotiation.

4. Consultation
Inviting citizens opinion. This can be a legitimate step towards their full participation. But if consultation is not combined with other modes of participation, this rung on the ladder is still a sham since it offers no assurance that citizen's concerns and ideas will be taken into account.

5. Placation
It is at this level that citizens begin to have some degree of influence though tokenism is still apparent. An example of placation strategy is to place a few hand–picked people on boards of organisations.

6. Partnership
At this rung of the ladder, power is in fact redistributed through negotiation between citizens and power holders. They agree to share planning and decision making through structures.

7. Delegated power
Negotiations between citizens and public officials can also result in citizens achieving dominant decision–making authority over a particular plan or programme.

8. Citizen control
Citizens participate to govern a programme, including sharing all information, creating goals, developing policy and managerial aspects. Power is redistributed so that the people which historically have not experienced such a concept, now do.

12 GLOSSARY

Advanced Directives

Advanced directives or advanced decisions are future decisions which are made by people at a time when they have capacity or are well. In the context of this strategy they will be documents which are drawn up by people when they are well, about the way they would like to be treated should they become unwell in the future. This could include what medication they feel best suits them, how and where they would choose to be cared for people they would like to be informed and involved in decisions. These decisions are purely the needs and wishes of the service user and what is written in them is not reliant on what service etc is available.

User Led Safety Plans

These are plans which are written up by service users to express the things they feel are needed to keep them safe and may include the things they feel may keep other people sate around them. They may be the service user led equivalent of Risk Assessments.

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