An evaluation of pilot services for people with personality disorder in adult forensic settings

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DISCLAIMER

The views expressed in this report are those of the research team and are not necessarily shared by those of the Department of Health, Home Office, or the funder (National Coordinating centre for Service delivery and Organisation). The timing of this study coincided with the first two years of the operation of the services. While this meant that we were able to track some of the challenges services faced and report on the steps they subsequently took to manage these challenges, it is important to note that some of the problems that we have identified may have been resolved in the period after data collection stopped. Recent correspondence with staff and service users in the pilots suggests that service development has continued since data collection ceased and it is therefore important to note that these data may not describe services as they are currently being delivered.

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ACRONYMS AND TERMS USED

CBT	**-**	Cognitive Behaviour Therapy
CMHT	**-**	Community Mental Health Team
CPA	**-**	Care Programme Approach
CPN	**-**	Community Psychiatric Nurse
DBT	**-**	Dialectical Behaviour Therapy
ELCMHT	**-**	East London and the City Mental Health NHS Trust*
FIPTS	**-**	Forensic Intensive Psychological Treatment service
MAPPA	-	Multi-agency Public Protection Arrangement
MAPPP	**-**	Multi-agency Public Protection Panel
MDT	**-**	Multi-disciplinary team
MSU	**-**	Medium Secure Unit
NIMH(E)	**-**	National Institute for Mental Health (England)
NTW	**-**	Northumberland, Tyne and Wear NHS Trust
PCT	**-**	Primary Care Trust
PD	**-**	Personality Disorder
RMO	**-**	Responsible Medical Officer
SLAM	**-**	South London & Maudsley NHS Foundation Trust
TC	**-**	Therapeutic community
THU	-	Tony Hillis Unit
VRP	-	Violence Reduction Programme

Service users Service providers used a range of different terms to refer to the people they work with including; 'patient', 'client', 'user', and 'resident' and 'customer' (the latter 2 terms have been used to refer to users of the residential services). In our original bid, we used the term 'client'. Following discussion at a Project Advisory Group meeting, in the interests of retaining clarity and simplicity, we have used the term 'service user' throughout this report.

IDENTITY OF PILOT SERVICES AND STUDY PARTICIPANTS

Although the Project Advisory Group considered the option of anonymising the services described in the three case studies, we rapidly concluded that each case study included certain details that would have rendered such an exercise superfluous. Service leads consented to their service being named in these case studies and were given an opportunity to comment on a draft version of their service's respective case study. In order to protect the identity of individual participants we have simply referred to 'staff' (denoted S when associated with a quote) and 'service users' (denoted SU when associated with a quote) in the case studies.

* Subsequent to the completion of the evaluation, the Trust changed its name to East London NHS Foundation Trust

EXECUTIVE SUMMARY

BACKGROUND

Concerns have been expressed about the quality of services for people with personality disorder (PD). In response to these concerns, the Department of Health has funded a number of pilot services for those with personality disorders, including six new forensic services for personality disordered offenders. Three of these services, provided by the South London and Maudsley (SLaM) NHS Foundation Trust, the East London and the City Mental Health NHS Trust (ELCMHT) and the Northumberland, Tyne and Wear (NTW) NHS Trust, were among the first to be funded, and agreed to take part in an external evaluation.

THE SERVICES

East London and the City Mental Health NHS Trust

This service consisted of an in-patient unit, Millfields Unit, situated in the Centre for Forensic Mental Health in Hackney and a residential service, Baxter Road, managed by a local housing organisation and situated in the London borough of Newham. The in-patient unit was comprised of two 10-bedded wards and was run as a modified therapeutic community. The residential service provided social care for eight residents, and assisted in exploring local opportunities for education, employment and other activities.

Northumberland, Tyne and Wear NHS Trust

This service consisted of an in-patient medium secure unit, Oswin Unit, and a community team, both located in St Nicholas' Hospital, Newcastle. The in-patient unit was a 16 bedded ward offering a largely CBT based programme that incorporated needs-based individual and group treatments together with formal activities. The community team offered a treatment programme aimed at reducing risk of harm to others.

South London and Maudsley NHS Foundation Trust

The SLAM Forensic Intensive Psychological Treatment Service (FIPTS) was made up of an in-patient medium secure unit (Tony Hillis Unit), a community team and a

residential service, consisting of two hostels (Akerman Road and Bonham Road). The in-patient unit consisted of a 15 bedded ward situated in Lambeth Hospital, South London, together with the community team. The hostels collectively offered both high and low support care for a total of 10 residents and were based in South London. The FIPTS service was set up to provide integrated care across all three components and ran a treatment programme based on the Violence Reduction Programme.

AIMS

Our overall aim was to produce three detailed case studies, using multiple sources of data, with a view to comparing the effectiveness, cost and acceptability of the three pilot services.

Our specific objectives were:

1. Using triangulation of multiple sources of data (staff questionnaires, in-depth interviews with staff and collation of written material), to provide a detailed description of each service.
2. To investigate the expectations and attitudes of staff working within the new services at the start of the study and one year after the evaluation had commenced.
3. To investigate the effectiveness of team functioning.
4. To describe the social, demographic and clinical characteristics of a consecutive series of service users who had been referred and taken on by the three new services over a 6-month period.
5. To follow-up the service users at 6-months, in order to determine their levels of engagement with treatment offered, changes in behaviour, pattern of service use and to investigate the views of service users about the acceptability and helpfulness of the new services.
6. To compare the costs incurred by service users over a six-month period and to compare these costs with those incurred in the six-months prior to the start of treatment.

METHODS

In order to achieve study aims we designed a multi-method research programme consisting of five overlapping modules:

(1) A cross-sectional survey of service users

A sample of service users being managed by the services over the period November 2005 to July 2006 was recruited and assessed using a range of quantitative measures. Maximum use was made of routinely collected data. In addition, these data were supplemented with measures of behaviour, therapeutic alliance and cost, gathered from interviews with the service users and staff, together with an examination of their case records.

(2) A description of service characteristics

Detailed information about the resources of each service was gathered from the following sources:

1) Collation of written information. We asked the service leads to send us all relevant current documents about the service. These were read and the information was synthesised for inclusion in the description of each service.
2) Staff questionnaires. Senior clinicians and managers from the three services were asked to complete a questionnaire inquiring about all relevant service costs and resources.
3) Qualitative interviews with staff. A sample of staff from the three services was interviewed in order to determine their expectations about, and attitudes towards working within the services.

(3) Investigation of the outcome of service users

A 6-month follow-up quantitative survey of the service users recruited to Module 1 was carried out. In addition, in-depth interviews were undertaken with a sample of service users from each of the three sites, the purpose of which was to determine the service users' experiences of treatment.

(4) An investigation of team outcomes

Staff that participated in the Module 2 qualitative interviews were invited to participate in a follow-up qualitative interview that took place approximately one year after the initial interview.

(5) A synthesis of data collected from modules 1 to 4.

RESULTS

OVER-ARCHING FINDINGS

The case studies provide a detailed picture of the initial development of the three pilot forensic services. By spring 2007, all of the pilot services were operational and were working with personality disordered offenders. The speed with which pilots developed varied considerably and reflected a number of issues, including recruiting and retaining staff, negotiating operational arrangements with local Trusts, and moving premises during the course of the evaluation. Many of the challenges faced in setting up the pilot services were generic to setting up any new service. Other challenges were more specifically related to setting up dedicated PD services.

By the end of the evaluation, all three services were accepting and treating a relatively homogenous group of extremely challenging service users. The quantitative survey showed that the majority of service users had experienced childhood maltreatment and educational disadvantage. The prevalence of substance use problems, self-harm and non-adherence with previous treatment was very high. As anticipated, violent and sexual offending was highly prevalent among the recruited sample; in many cases violence had been characterised by extreme cruelty towards the victim. Less anticipated were the findings of comparatively low intelligence (mean full scale IQ across all 3 services: 90) and low Psychopathy Checklist Scores (mean PCL-R score across all 3 services: 19). All three services were actively engaged in their own process of research and audit, however, completion of a pre-agreed common dataset of measures was variable across the three services. Staff and service users at all three sites told us that the assessment battery was unwieldy.

Each service experienced untoward incidents over the course of the evaluation and these had significant ramifications for the organisations, staff and service users concerned. Communication between the three services was limited. Although staff at all three sites thought that they might be able to usefully learn from each others' experience, contact was limited.

Across all three sites the service users seemed to appreciate the help being offered and many perceived that they were making important changes in the following domains:

- Anger management
- Improved communication with others
- Improved interpersonal skills
- Reductions in self-harming behaviour
- Increased self confidence and enhanced self esteem.
- Greater understanding about the nature of their psychopathology.

However, across all three sites, service users identified a number of areas where they felt the services needed to improve:

- The assessment process was too long.
- The fact that each treatment programme accepted people with a mixture of offending profiles and mental health needs was felt to be problematic by some.
- Service users had particular difficulties trusting non-permanent staff and frequent changes in the staffing structure were perceived to be particularly unhelpful and hampered the formation of trusting therapeutic relationships. Newly trained staff were perceived to be naïve, vulnerable and therefore, easily manipulated.
- The in-patient programmes could be busier and offer a larger range of groups.
- Clearer explanation of the nature and consequences of treatment needed to be given before service users were admitted to the services.

The six-month quantitative follow-up survey revealed that the majority (78%) of service users who had been recruited six months earlier were still under the care of the services. Nevertheless, behavioural problems in the form of violence, self-harm, absconding behaviour and non-adherence with treatment continued. Moreover, there were no significant changes in the overall level of functioning in the service users.

The working alliance between staff and service users had not significantly changed over six months.

Across all three sites, staff were energetic, hard working and generally held optimistic views about the treatment programmes they were running. The majority thought that it was too soon to draw any conclusions about whether the treatment they were providing was effective. The experience of undertaking the clinical work was extremely stressful, particularly for those engaged in regular face-to-face contact with service users in an in-patient setting - many reported feeling exhausted, drained and occasionally frightened by the work. Each site experienced difficulties in recruiting and retaining skilled staff and this was particularly the case for all three medium secure units, where the daily working environment was particularly stressful. Staff at all three sites told us that there was a lack of suitable candidates for posts and over the course of evaluation, it became clear that professional qualifications alone were insufficient predictors of who could undertake this type of clinical work. The senior clinicians and service managers working at all three services had the difficult task of containing anxiety at many levels: that of individual staff and their teams, local organisational anxiety and also anxiety from commissioners concerned about the speed of setting up the services. In addition, senior staff were heavily burdened with administrative tasks at crucial times, for example during changes in premises (a problem compounded by poor administrative support at some sites). Some senior staff told us that clear steering guidance from the Home Office with regard to the aims and day-to-day operation of the services had been lacking. Over the course of the evaluation, senior staff departed from all three services. Staff told us that in the course of setting up all three services, there had been inter-disciplinary disputes over the leadership and the clinical vision for the service.

An analysis of individual-level economic data showed that although the specialist services were predominantly run by the NHS, there were also considerable burdens to other service providers, notably social services, who were responsible for social housing for those in the community and the Criminal Justice System, for prison costs and any court costs (which could be substantial). Unsurprisingly, given the intensive and specialist nature of the PD programme, the unit costs of the MSU services (£528-547 per night) were higher than the cost of similar mainstream services and

substantially higher than the cost per night in prison. The residential service and community costs were also higher than other hostel services, though it should be noted that these are specialist services that include supervision from specialist staff. The cost per place at the specialist MSU and residential sites increased substantially when occupancy levels fell below capacity. The difference in cost between current occupancy and capacity highlighted the importance of filling places within the services.

SERVICE SPECIFIC FINDINGS

1. East London and the City Mental Health NHS Trust

Over the course of the evaluation, the main organisational challenges that this service faced were as follows:

- Initial plans for a community team had to be abandoned. In the absence of a community team, all referrals and assessments had to be performed by clinicians from the in-patient team, putting them under considerable added pressure.
- Providing a service to a large catchment area (the size of which increased over the course of the evaluation to cover the whole of North London).
- The absence of a senior manager to handle major administrative tasks e.g. a relocation of the in-patient unit which took place over the course of the evaluation.
- Several changes to key personnel. This, in turn, affected the cohesion of the staff group.
- Problems with in-patient administrative arrangements: a succession of temporary staff, coupled with an effective reduction in the overall level of administrative input provided to the ward.
- Delays in admitting service users to the residential service because of bureaucratic delays in finalising arrangements for out-of-hours cover.

The service developed a coherent treatment approach based around a therapeutic community model, and established clear care pathways into and out of the service. In addition, the relationship and quality of liaison between the ward and the residential service appeared to be good. However, service users and staff told us that the service was perceived negatively by staff and service users from the local non-PD forensic service. The service employed a full-time research fellow who was setting up a programme of research activities.

In the initial interviews with staff, the majority of those interviewed felt that they were not in an informed position to comment on the effectiveness of a treatment programme which was at that time only just being set up. However, when staff were re-interviewed in April 2007, there was a consensus of opinion that the team had been successful in engaging some very difficult service users in a busy and stimulating treatment programme. The staff identified a number of domains where they felt that

promising changes were occurring in the lives of service users, including a diminishing risk of self-harm.

The majority of service users whom we interviewed expressed positive views about the treatment programme. They also highlighted the importance of actively wanting to engage in treatment. Some service users found the mixture of service users on the ward (in terms of offence profile) problematic. Most of the service users identified the group sessions as being the most helpful aspect of treatment.

The main findings from the quantitative survey:

- Over the recruitment period to the survey (November 2005-June 2006), 13 men were being managed by this service (9 inpatients and 4 residential service users). Of these, 12 men were recruited (92% response). One residential service user refused to participate.
- The mean age of the sample was 32 years. Two-thirds of the sample was white and over 80% were unemployed.
- The mean full scale IQ of the sample was 89.0 (sd: 9.9), mean verbal IQ was 90.0 (sd: 9.6) and mean performance IQ was 87.8 (11.8). At the time of preparing this report, 6 of the 12 recruited men had PCL-R data; the mean PCL-R total score in this sample was 24.2 (sd: 3.8).
- At the time of preparing this report, 10 of the 12 men had received an IPDE assessment. Of these 10 men, 90% fulfilled criteria for a primary PD diagnosis of dissocial PD.
- Over 80% had a history of alcohol misuse and 50% had previously used opiates. Over 80% had a previous history of self-harm.
- The mean age of first conviction was 17.4 years (sd: 6.5) and mean number of previous convictions was 11.3 (sd: 8.3). The mean number of prison terms was 4.6 (sd: 5.1) and mean number of prior offences was 25 (sd: 22.6). Violent behaviour was prevalent among the recruited sample: 7 men reported injuring someone with a weapon. Three participants reported that the victim had died as a result of their injuries.
- At six month follow-up, all 12 men recruited at baseline were still being managed by the service and we were able to obtain complete follow-up ratings on 11

of the 12 men. There was no change in the prevalence of behavioural disturbance, and no significant change in therapeutic alliance scores as rated by either staff or service users. The general functioning scores showed some sign of improvement, however, this was not statistically significant at the 5% level (paired t-test $p= 0.07$).

- **Aggregate costs:** The total funding allocation to the East London service was £4,855,000 including the £715,000 payment for the residential service. The total cost of the Millfields Unit was £3,997,298. At full occupancy the cost per bed was £199,865 per year or £547 per night. The residential service consisted of the hostel accommodation at Baxter Road and the clinical management from staff based at the Millfields. The cost per bed was £162,752 per year or £446 per night.
- **Prospective individual-level economic data:** At follow-up average total costs were £99,642 in the MSU, and £73,626 for the residential service. Costs were higher for both groups at follow-up (p=0.05), reflecting the greater amount of time spent using a more intensive service.

2. Northumberland, Tyne and Wear NHS Trust

The two components of this service had evolved separately with two distinct histories and working cultures; there was no clearly established working relationship between the teams. The community team was the oldest team in the evaluation and consisted of a tightly knit multidisciplinary group of staff. This team had been very stable since its establishment in 2003, with only two departures in staff. The community team had worked hard at reinforcing a model of treatment whereby ultimate clinical responsibility rested with local community mental health teams. Whilst this had caused tension with some local teams, it had allowed the community team to focus fully on developing strong working alliances with service users. The in-patient unit first opened in an interim facility in December 2004 and in May 2006, relocated to a new purpose built ward. Over the course of the evaluation, the in-patient staff faced a significant number of challenges, some of which might have been generic to setting up any new service, whilst others seemed more specific to the problems of setting up a PD service.

- Providing a service to a large catchment area
- The building move generated a great deal of extra work for senior staff.

- Working relationships between the different disciplines remained uneasy throughout the evaluation and we were told that 'power struggles' were prevalent on the Unit. Staff told us that there was a lack of clarity over who held ultimate clinical responsibility. Attempts to power share between nursing, occupational therapy, psychology and psychiatry through the creation of a 'clinical steering group' and 'flat management structure' proved unsuccessful. Towards the end of the evaluation (and as a result of an internal review of the unit) there was a change in management structure
- Two serious untoward incidents involving staff and service users occurred during the course of the evaluation, leading to an internal inquiry.

Staff on the ward were careful to point out that the treatment programmes was still in an 'embryonic' stage of development. Nevertheless, many felt that there were some promising changes occurring in the lives of service users. In particular, staff perceived service users' to be developing a greater ability to share their feelings with others and solve problems through talking. Staff from the community team talked about needing to adjust their expectations of what they might achieve with the service users. As opposed to seeking 'radical change' in the men's personalities, over time they had found themselves focusing more on basic day-to-day needs, such as ensuring that stable accommodation was in place and that the men were actually engaging with the range of services put in place to assist them with living in the community. The fact that service users were turning up for their appointments and not 'fighting with professionals', was in itself perceived to be a marker of success.

On the whole, service users reported that treatment had been helpful. A range of positive experiences were described including learning how to better manage anger, sharing feelings with staff, gaining in confidence and learning how to act less impulsively. In this respect, group work was identified as being particularly helpful. Although service users thought that the treatment was helpful, many reported finding the experience of examining and sharing their feelings with others to be overwhelming.

The main findings from the quantitative survey:

- Over the recruitment period to the survey (November 2005-June 2006), 50 men were being managed by this service, comprising 11 inpatients and 39 service users managed over a wide catchment area in the community. Of the 50, 20 men were recruited (40% response) – 9 from Oswin unit and 11 from the community. Twenty three community-based service users did not respond to repeated attempts made to secure their participation in the study.
- The mean age of the sample was 37 years. All of the service users were white and unemployed and 65% were single.
- The mean full scale IQ of the sample was 91.1 (sd: 12.9), mean verbal IQ was 91.6 and mean performance IQ was 93.2. At the time of preparing this report, 16 men had PCL-R data; the mean PCL-R total score for this sample was 15.8 (sd: 8.7).
- At the time of preparing this report, 16 of the 20 recruited men had received an IPDE assessment. Of these 16 men, 8 fulfilled criteria for a primary PD diagnosis of dissocial PD, 5 fulfilled criteria for a primary PD diagnosis of borderline PD. 75% of the entire sample thought they had a personality disorder when questioned directly about this.
- 90% of the sample had a history of self-harming behaviour. Substance misuse was highly prevalent (50% had used opiates, 80% had previously engaged in alcohol misuse).
- The mean age of first conviction was 20.6 years (sd: 10.1) and mean number of previous convictions was 10.9 (sd: 8.6). The mean number of prison terms was 5.0 (sd: 7.7) and mean number of prior offences was 44.4 (sd: 56.1). Participants from Oswin Unit were younger at first conviction and had accrued a greater number of previous convictions and offences, however, none of the mean differences between participants recruited from the ward and the community were statistically significant at the 5% level.
- Violent behaviour was prevalent among the recruited sample: 65% reported injuring someone with a weapon. Two participants reported that the victim had died as a result of their injuries.
- At six months, 15 men recruited at baseline were still being managed by the service and we obtained complete follow-up ratings on all 15 men who were still receiving treatment at the point of follow-up. There was no change in the prevalence

of behavioural disturbance, and no significant change in general functioning or therapeutic alliance scores as rated by either staff or service users.

- **Aggregate costs:** We estimated the total cost of Oswin Unit to be £3,087,640. Oswin unit had 16 beds and the cost per bed was £192,978 per year, or £528 per night. The estimated cost of the community service was £481,074, equivalent to £16,036 per year, or £44 per day.
- **Prospective individual-level economic data:** For those in Oswin Unit, costs at follow-up were £97,124 and for those in the community team costs at follow-up were £12,215. Costs were significantly higher at follow-up (p=0.015), reflecting the greater amount of time spent in the more intensive service.

3. South London and Maudsley NHS Foundation Trust

Over the course of the evaluation, the main organisational challenges that this service faced were as follows:

- Providing a service to a large catchment area (the size of which increased over the course of the evaluation to cover the whole of South London).
- Staffing recruitment and retention problems – bank staff were relied upon in both the in-patient ward and residential service.
- Running an integrated service
- A series of untoward incidents occurred during the course of the evaluation.

Staff were initially optimistic about the likely effectiveness of the treatment programme. Over the course of the evaluation, some of this optimism had begun to fade and when re-interviewed one year later, staff talked openly about some of the inevitable problems associated with undertaking work with personality-disordered service users. Some spoke openly of the need to get respite from the clinical work. Staff were cautious in making inferences about whether or not the treatment was proving to be effective and most staff felt that insufficient time had elapsed to make an informed judgement about this. Nevertheless, it was felt that the some service users' risk of offending had reduced. Some staff reported that there had been an increase in pro social behaviour. Staff from the residential service told us that they thought that there had been a reduction in the level of self harm. Across all three service components, the quality of the relationship forged between staff and service users was thought to play a central role in determining treatment success. In this

regard, usually permanent staff faired better, as they were more familiar to the service users and therefore more readily trusted.

Service users reported that several aspects of treatment were useful. Some service users felt that the overall structure was useful. Others pinpointed the educational aspects of the programme: they had learnt a great deal about their violent offending, their diagnoses and their problems with managing anger. They valued this new knowledge because they felt that it might help to improve their management of difficult situations in the future. Service users also talked about a number of areas of dissatisfaction with the programme:

- The mixture of offender types and also ex-prisoners with mental health service users was perceived by some to be problematic.
- Some service users complained that they had not been given a clear understanding of the nature or possible consequences of treatment prior to being admitted.
- Some service users talked about being transferred into the mental health system just prior to the end of their prison sentence. This was cynically viewed as a form of 'gate arrest'.
- Some service users felt that that the ward was inadequately staffed to cover all their needs. The staffing shortfall had been covered by bank staff and relationships with bank staff were generally perceived by service users to be poor.

The main findings from the quantitative survey:

- Over the recruitment period to the survey (November 2005-July 2006) 26 men were being managed by this service (14 in-patients and 6 residential service users and 6 community service users), of whom 22 agreed to participate in the study (85% response). Of the 22 recruited to the survey, 12 were from the Tony Hillis Unit, 6 were from the community team and 4 were from the residential service.
- The mean age of the sample was 41 years. Approximately 70% of the participants were white, over 80% were unemployed and over 70% were single.
- The mean full scale IQ of the sample was 88.9 (sd: 11.0), mean verbal IQ was 83.5 and mean performance IQ was 86.5. At the time of preparing this report, 17 men had PCL-R data; the mean PCL-R total score for this sample was 20.4 (sd= 6.6).

- At the time of preparing this report, 13 of the 22 participants had received an IPDE assessment. Of these 13 participants, 6 fulfilled criteria for a primary PD diagnosis of dissocial PD, 4 fulfilled criteria for a primary PD diagnosis of borderline PD, 1 fulfilled criteria for schizoid, 1 for dependent and 1 for unspecified PD. Only 55% of the recruited sample thought they had a personality disorder (the lowest proportion across all 3 services).
- 68% of the sample had a history of self-harming behaviour. Substance misuse was highly prevalent (50% had used opiates, and over 70% had previously engaged in alcohol misuse).
- The mean age of first conviction was 17.5 years (sd: 5.8) and mean number of previous convictions was 12.5 (sd: 10.5). The mean number of prison terms was 4.5 (sd: 4.2) and mean number of prior offences was 24.5 (sd: 20.0). Thirteen participants had been previously convicted of a sexual offence (59%) - the highest proportion across all three services. Violent behaviour was also prevalent among the recruited sample: over 90% had a previous conviction for a violent offence and three participants had been previously convicted of homicide. Victims of violence included both adults and children.
- At six months, 16 of 22 participants recruited at baseline were still being managed by the service. Five participants had been transferred to prison and one participant was transferred to another medium secure unit after assaulting a member of staff. We obtained complete follow-up ratings on all 16 men who were still receiving treatment at the point of follow-up. There was no change in the prevalence of behavioural disturbance, and no significant change in general functioning or therapeutic alliance scores as rated by either staff or service users.
- **Aggregate costs:** The total revenue allocation for the SLAM service for the financial year 2006/7 was £4,146,480, which included a direct payment to Penrose Housing Association for the residential and funding for the community service. The total cost per year of the Tony Hillis Unit was £2,995,445. The Tony Hillis Unit was a 15-bedded unit, thus the cost per bed was £199,696 per year or £547 per night. The total cost for Akerman Road residential service was £451,333. In order to reflect the cost of the whole residential service however, treatment and clinical management costs of staff at the Tony Hillis Unit were included in the analyses of costs. This equated to £35,117 per service user per year, increasing the cost per year of the

residential service to £111,943 or £306 per night. The cost of the service at Bonham Road was £228,508 or £253 per night.

- **Prospective individual-level economic data:** At follow-up average total costs over six months were £100,981 in the MSU group, £68,503 in the residential services group and £8,468 in the community service group. Costs were higher for all groups at follow-up (p=0.072), reflecting the greater amount of time spent in the more intensive service.

Implications of the findings

Organisational implications

1. The need for closer working relationships between service components

Each service has identified the need to more clearly define care pathways and also to establish closer working relationships between staff working in different components.

2. The challenge of staff recruitment and retention

Some sites struggled to find the 'right staff' and this finding underscores the importance of training (which was highly valued by staff in this study) and regular high quality supervision (which was less well developed in some of the sites and is an area for important future development).

3. The use of bank staff

The use of bank staff within these services was unpopular and is not consistent with the need of personality disorder services to provide constancy of support for service users. We therefore strongly recommend that the use of bank staff within the services should be kept to an absolute minimum.

4. The need for better administrative support for senior clinicians

The administrative support provided to senior clinical staff working in some of the teams could be improved.

5. Contact between the service providers and the commissioners

Further work needs to be done in order to optimise the working relationship between service providers at all three sites and their commissioners; this would be best achieved through regular planned face-to-face meetings.

Implications for service delivery

1. Refinement of the assessment process

Both staff and service users found the lengthy assessment process and particularly the minimum dataset to be unwieldy. We recommend that this dataset should be reviewed with a view to shortening it, particularly in terms of the number of standardised risk assessments that are being undertaken. We suggest that IQ testing should be routinely carried out on all service users.

2. The need to develop drug and alcohol treatment modules within the programmes

The prevalence of drug and alcohol misuse among service users in the quantitative surveys was extremely high, as was the prevalence of drug and alcohol problems being linked to an index offence. In order to best meet the health needs of the service users, the development of drug and alcohol treatments modules is an important area for service development.

3. The need for self-harm treatment protocols

A similar issue arose in relation to self-harm, the prevalence of which was extremely high in our surveys. Although staff generally reported that self-harm was being effectively managed, some of the teams had yet to set up clear treatment protocols and were aware that this was an issue for on-going service development.

4. The need for clear information for potential service users

Potential service users need to be given clear precise information about the assessment and treatment. This should include being told that during assessment, they might not be undertaking treatment and also that if the assessment identifies particular problems (for example a lack of motivation to engage in treatment or low IQ), they might be returned to their referrer.

5. The need for a full programme of activities

Service users at all three sites expressed frustration about the limited range of group activities that had initially been available and some complained of feeling bored. Notwithstanding, senior staff were mindful of this and highlighted the expansion of the group programmes as one of their priorities for future service development.

Research implications

The evidence-base for the treatment of personality disordered offenders is weak and the services are uniquely placed to expand this. All three services were aware of the need for on-going research, however, the extent to which this was going on during the course of the evaluation varied considerably. The use of a minimum dataset represents an opportunity to further explore the predictive utility of a range of measures covering the domains of personality, risk, intelligence and psychiatric symptoms. However, in order to optimise this process, the dataset needs refinement and data needs to be pooled across the services. The ability of this evaluation to detect meaningful change in the lives of the service users was seriously constrained by a) the timing of the study and b) the short length of time we had for follow-up. Given the financial commitment that the Home Office and Department of Health has made to the services, we recommend that they consider committing funding for further waves of follow-up, in order to examine longer-term clinical and forensic outcomes.

CONCLUSION

The three forensic pilot services that we evaluated are succeeding in engaging and retaining a challenging group of service users in treatment. The service users have extensive criminal histories and high rates of psychiatric morbidity, substance misuse and self-harm. All three services anticipate the need to work with service users over long periods of time and it is too early to tell whether they are succeeding in bringing about sustained change in the behaviour of the service users. The treatments being offered are complex and multi-facted and if effectiveness of treatment is eventually demonstrated, further research will be required to establish the effective ingredients of treatment. Charting any changes in patterns of re-offending will require much longer periods of follow-up. In order to ensure an efficient use of resources, the services must ensure that beds are occupied and places in residential and community services

are fully utilised. From an organisational perspective, within each service, there is a need to foster closer working relationships between service components. Each service also needs to find a way of meeting the on-going challenges of recruiting and retaining high quality staff. All three services are engaged in continuing service development and this should include refining both the assessment procedure and the process of information-giving to potential service users.

CHAPTER 1: BACKGROUND & AIMS

1.1 BACKGROUND

Personality disorders are mental disorders characterised by *'a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption'* (1). They are common and disabling conditions, with a community prevalence of about 4% in Great Britain (2). The highest prevalence of personality disorders is found among offenders (3).

The treatment of personality-disordered offenders

Little is known about what constitutes effective treatment for personality-disordered offenders. In part, this reflects an absence of agreement on what constitutes a successful outcome of such treatment. Personality disorders affect both the individual and society and a range of outcome measures may therefore be of interest, including recidivism, symptomatic change, social functioning, quality of life and re-hospitalisation. The evidence-based literature on treatment for people with personality disorder has tended to focus on health-related outcomes. In contrast, the literature on the correctional treatment of offenders has focussed on addressing offending behaviours and risk reduction. The NIMH(E) policy implementation guidance explicitly states that services for personality-disordered offenders should focus on the treatment and/or management of social functioning, mental health issues, offending behaviour and risk.(4) The implementation of the guidance therefore requires that these two bodies of knowledge be brought together.

General personality disorder treatment literature

Previous systematic reviews of treatments for personality disorder have been carried out and the evidence has largely been inconclusive. Perry *et al* selected 15 studies for inclusion in a meta-analysis of psychotherapeutic treatments for personality disorder (5) and found inconclusive evidence for the superiority of any single treatment. Summarising literature on the psychotherapeutic treatment of personality disorders, Bateman & Fonagy (6) concluded that there were major shortcomings in the psychotherapeutic treatment literature. In their review of treatments for what they termed 'severe personality disorder' Warren *et al* (7) concluded that although a number of studies were suggestive of the potential effectiveness of a range of

treatments, reliable evidence of long-term effectiveness was extremely limited. In 2003, Bateman & Tyrer reviewed the evidence on treatment as part of the NIHM(E) policy implementation guidance (4). No treatment met the authors' criteria for full generalisability and efficacy, nevertheless, they concluded that *'a combination of psychological treatments reinforced by drug therapy at critical times was the consensus of treatment in personality disorder.'* Bateman & Tyrer also concluded that successful treatment programmes for people with personality disorder share a number of common features. Such programmes tend to be well structured, well integrated with other services, relatively long-term, encouraging of treatment compliance, clearly focused and understandable to both therapist and patient. Binks et al (8;9) published two Cochrane reviews of psychological and pharmacological treatments for borderline PD, a subtype of PD characterised by impulsive behaviour, identity disturbance and affective instability. They identified seven randomised controlled trials for inclusion in their review of psychological treatments and concluded that some of the problems encountered by people with borderline PD may be amenable to talking/behavioural treatments. However, they also concluded that all therapies remain experimental and that the studies are too few and small to inspire full confidence in their results. The review of pharmacological treatments identified ten small, short, randomised studies involving eight comparisons from which usable data could be extracted. They concluded that pharmacological treatment of people with borderline PD is not based on good evidence from trials.

Correctional treatment literature

The primary goal of correctional treatment programs is to reduce criminal behaviour. Programmes utilising cognitive-behavioural, skills-orientated and multi-modal methods have been shown to be useful in reducing recidivism (10). Interventions designed to reduce risk and re-offending are mainly cognitive behavioural, problem solving and skills acquisition based group programs and include 'Enhanced Thinking Skills' (prison and probation services), 'Think First' (probation service) and 'Reasoning and Rehabilitation'. These group programs focus on factors such as enhancing self-control and interpersonal problem-solving skills; there is some evidence to suggests that they may be helpful in reducing recidivism (11). Although not designed for personality-disordered populations, studies of sex offender treatment programs programmes are also of relevance here, as they will have included offenders

with personality disorder. These programmes run extensively in prisons and address criminogenic need in offenders. They are also based on a cognitive behavioural model and have been found to be helpful in reducing recidivism (12).

Literature on the treatment of personality-disordered offenders

Crassati, Horne & Taylor reviewed 'key treatment models' available for the treatment of personality disordered offenders, in order to inform the NIHM(E) policy implementation guidance (4). A range of treatments were identified, of which cognitive behavioural methods combined with training in social skills and problem solving ('thinking skills') and sex offender treatment programmes offered the greatest generalisability and efficacy. They concluded that an 'impressive' body of evidence supported the premise that programmes addressing criminogenic need in offenders contribute towards the management and reduction of risk.

Views about treatment

Participative user-led research has identified that personality-disordered service users have negative opinions about current mental health services (13). In a survey of fifty service users from the Colchester area, despite reporting that psychotherapy services had been helpful to them, many users expressed negative views about the value of community mental health teams. Part of the work behind the NIMH(E) policy implementation guidance involved capturing the views of a group of service users by means of a focus group (4). Key themes that emerged from this group were: that the label of personality disorder was highly stigmatising; that there were not enough services available for people with personality disorder; that there was a need to improve staff skills; and that there were key characteristics defining 'helpful' and 'unhelpful' services.

Bowers (14) conducted a rigorous qualitative study of nursing staffs' experiences of working with forensic personality-disordered patients in High Secure Care. Two interviewers conducted semi-structured interviews with a random sample of 121 nursing staff recruited from High Secure Hospitals in the UK, in order to examine their experience and attitudes towards working with personality-disordered high secure patients. The interviews revealed that in their work with these patients, nurses routinely dealt with a range of extremely difficult behaviours, the most frequently

mentioned of which was manipulation. Participants described six types of manipulative behaviour: bullying, corrupting, conditioning, capitalising, conning and dividing. Bowers also identified a number of mechanisms that allowed staff to remain positive in their work when faced with such difficult behaviour:

- Psychiatric philosophy: belief in and commitment to the importance of psychosocial factors in the cause of PD, and in the efficacy of treatment in producing improvements in patients behaviour
- Moral commitments: a set of moral choices or commitments made or acquired by the nurses, including honesty, bravery, equality and non-judgementalism.
- Cognitive-emotional self-management techniques.
- Technical mastery: interpersonal skills that enable positive attitudes to PD, including the ability to give neutral feedback about behaviour and knowing how to stay calm and reason with aroused patients.
- Organisational support, in the form of policy clarity and stability around rules for patient conduct, the provision of specialist training, an effective organisation of clinical supervision for front-line clinical staff, and a management that is deeply integrated into clinical care.

The NHS context

Currently in the United Kingdom, it is recognised that there are deficiencies in health services for people with personality disorders (4) The reasons for this are unclear, however, it is likely to reflect a combination of the inherent difficulties associated with dealing with personality disordered people, coupled with the fact that in recent years, the work of mental health services has tended to focus on the needs of people with severe mental illnesses, such as schizophrenia. This situation has become increasingly untenable. Standards 4 and 5 of the Mental Health National Services Framework are directly applicable to the development of personality disorder services (15). In addition, proposed changes to mental health legislation will mean that the treatment needs of offenders with personality disorders could form an important part of the work of future forensic mental health services (16).

The DSPD Programme

In order to ensure better public protection from, and improved management of those whose risk of serious offending is linked to a severe disorder of personality, the Home Office and Department of Health established the Dangerous and Severe Personality Disorder (DSPD) programme in 2005 (17). This programme created approximately 300 new high secure places at Whitemoor and Frankland prisons and at Rampton and Broadmoor Hospitals. The programme also funded six new medium secure and community-based services. According to DSPD Programme Planning and Delivery Guide (18), '*the medium secure and community PD pilots will deliver the Government commitment in the NHS Plan to provide 75 medium secure and specialist hostel places for people with personality disorder.*' The anticipated outcomes for this part of the DSPD programme are, according to the Guide:

- the provision of new treatment services that improve psychological health outcomes and reduce risk
- better public protection
- improving the evidence base about what works in the treatment and management of individuals with personality disorder who are at high risk to others
- developing an appropriately skilled workforce
- providing better pathways between services.

In addition, according to the Guide, the treatments offered should aim to address and reduce the risk of re-offending, address mental health needs and improve social functioning. There is also an expectation that the pilot services will work with a range of agencies to provide consultation, assessment, treatment and management of offenders with personality disorder.

Three of these services, provided by the South London and Maudsley (SLAM) NHS Foundation Trust, the East London and the City Mental Health NHS Trust (ELCMHT) and the Northumberland, Tyne and Wear (NTW) NHS Trust, were among the first to be funded, and agreed to take part in an external evaluation. This report describes the findings of this external evaluation.

1.2 STUDY AIMS

Our overall aim was to produce three detailed case studies, using multiple sources of data, with a view to comparing the effectiveness, cost and acceptability of the three pilot services.

Our specific objectives were:

1. Using triangulation of multiple sources of data (staff questionnaires, in-depth interviews with staff and collation of written material), to provide a detailed description of each service.
2. To investigate the expectations and attitudes of staff working within the new services at the start of the study and one year after the evaluation had commenced.
3. To investigate the effectiveness of team functioning.
4. To describe the social, demographic and clinical characteristics of a consecutive series of service users who had been referred and taken on by the three new services over a 6-month period.
5. To follow-up the service users at 6-months, in order to determine their levels of engagement with treatment offered, changes in behaviour, pattern of service use and to investigate the views of service users about the acceptability and helpfulness of the new services.
6. To compare the costs incurred by service users over a six-month period and to compare these costs with those incurred in the six-months prior to the start of treatment.

CHAPTER 2: METHODS

2.0 Methods

In determining the optimal design of this study, we needed to take account of several important methodological and logistical considerations. From a methodological perspective, we needed to combine qualitative and quantitative approaches in order to capture the complexity of the services. Because all the pilot services had been required to develop methods for locally evaluating their services, we needed to ensure that the methods we used minimised inconvenience to both clinicians and the service users and did not disrupt service provision.

The final study design comprised five overlapping modules:

1. A cross-sectional survey of service users
2. A description of service characteristics
3. An investigation of the outcome of service users
4. An investigation of team outcomes
5. A synthesis of data collected from modules 1-4.

At an early stage in the preparation of the original bid, the principal investigator (PM) discussed the research methods with service leads and secured their cooperation. In addition to holding regular project management meetings, we set up a Project Advisory Group to which representatives from each of the three pilot services were invited to attend.

At the start of the project**,** a series of group meetings were arranged with staff and service users, in order to explain the purpose of the project. Information leaflets were distributed and staff and service users were given an opportunity to ask questions.

2.1 A cross-sectional survey of service users

A sample of service users being managed by the services over the period November 2005 to July 2006 was recruited and assessed using a range of quantitative measures. The recruitment of potential participants was secured through each of the clinical teams. All the participants were given an information sheet (see Appendices C and F) to read, and if agreeable to taking part in the study, were then asked to sign a consent

form. Service users were paid £5 for their participation. The following assessment measures were then completed:

1. A socio-demographic schedule, including a question relating to whether they thought they were suffering from a personality disorder or not.
2. The Work and Social Adjustment Scale (WSAS) (19): a 5-item measure of work and social adjustment; each item can have a possible score of between 0 to 8. Scores range from 0 to 40 with a greater score indicating a greater overall impairment
3. Client and therapist versions of the Working Alliance Inventory (WAI) (20). The WAI is a 12-item self-report questionnaire, in which the respondent is directed to rate each item on a 7-point Likert scale. It is reliable and has good internal consistency. Scores range from 0 to 168, with higher scores indicating a better working alliance.
4. A measure of cost – the Secure Facilities Service Use Schedule (SF-SUS) (21). This collects information on the participant's accommodation including time spent in a secure facility such as prison or secure NHS unit, use of all health, social, voluntary sector services, psychotropic medication and contact with the police, lawyers and the courts. The SF-SUS does not record routine care such as nursing contacts on an inpatient ward. Although the service users in the study were aligned to one of the MSU, residential or community PD services, they continued to access health, social, voluntary and criminal justice services and the SF-SUS also collected information on all such contacts. At baseline, the SF-SUS was used to collect service use data for the 6 months preceding the interview. Case records were scrutinised for documentation of service contacts in order to supplement self-report data.

Each participant's case record was also examined to determine:

1. Mental Health Act status
2. referral details
3. history of previous contact with mental health and criminal justice services
4. recorded history of childhood maltreatment
5. number and details of any incidents of offending, self-harming and violent behaviour over the preceding 6-month period
6. use of illicit drugs or alcohol over the preceding 6-month period
7. supplementary cost information to complete the SF-SUS as described above.

Finally, participant's case records were examined for routine 'minimum dataset' assessments conducted by the teams. At the time that we commenced the evaluation, the minimum dataset consisted of:

1. International Personality Disorder Examination (22),
2. Structured Clinical Interview for Axis-I disorders (SCID-I)(23),
3. Psychopathy Checklist – Revised (PCL-R)(24),
4. HCR-20(25),
5. Violence Risk Scale(26),
6. Risk Matrix 2000(27),
7. Static 99(28)
8. Structured Assessment of Risk and Need (SARN)(29).

Completion rates for the minimum dataset were highly variable (see individual case studies for details about this). We were in fact only able to obtain consistent information across all three services on items 1, 3 and 5 from the above list and data on these three items is presented in tables in each of the case studies.

2.2 A description of service characteristics

2.2.1 Documentary and questionnaire data

Detailed information about the resources of each service was gathered from the following sources:

1. Collation of written information. We asked the service leads to send us all relevant current documents about the service. These were read and the information was synthesised for inclusion in the description of each service.
2. Staff questionnaires. Senior clinicians and managers from the three services were asked to complete a questionnaire (see Appendices A and B) inquiring about all relevant service costs and resources.

2.2.2. Qualitative interviews with staff

A sample of staff from each service was interviewed in order to determine their experience of working within the service. We sampled staff from a range of disciplines working within each service and the sample included both junior and senior members of staff. Contact details of key members of staff were obtained from service leads and senior staff were asked to nominate the names of junior members of

staff who they thought might be willing to participate in the interviews. We excluded staff who at the time of recruitment were either leaving the service, or who were undergoing a disciplinary procedure.

All the participants were given an information sheet to read (see Appendix C), and if agreeable to taking part in the study, were asked to sign a consent form (see Appendix D). At the time of recruitment, all participants agreed to the fact that their anonymised direct quotes could be used. Each participant took part in an in-depth interview with a research worker, conducted in private, in a quiet room, in the in-patient units, or team bases. One staff interview was conducted as an audio-taped telephone interview for convenience Interviews lasted between 60-90 minutes and were based on a topic guide (see Appendix E). The topic guide was drafted following a review of the literature and the contents of the guide were refined following discussion with the Project Advisory Group. The topic guide was refined progressively throughout the first few interviews although remained unchanged after the first 8 staff interviews. Questions were structured by the interviewer to cover key themes, but were also responsive to issues emerging from participants' accounts. They consisted of a series of open ended questions covering the following areas: previous experience of working with PD service users; thoughts about the term PD; attractions of the work; good things about the new service; bad things about the new service; challenges; links with other services; links with other pilot sites; team functioning; safety of staff and service users; challenges; expectations of the service; guidance; training and support and supervision. All interviews were audio-taped and transcribed verbatim.

2.2.2.1 Details of the sample

All baseline staff interviews were conducted over the period September–December 2005. In ELCMHT, we interviewed 7 members of staff: 1 consultant forensic psychiatrist, 1 consultant clinical psychologist, 1 senior nurse, 1 social worker, 1 social therapist, 1 residential service manager and 1 residential key worker. In NTW, we interviewed 9 members of staff: 1 consultant forensic psychiatrist, 1 consultant clinical psychologist, 1 senior nurse, 1 occupational therapist, 3 junior nurses, 1 manager, and 1 probation officer. In SLaM, we interviewed 10 members of staff: 1 service manager, 1 consultant forensic psychiatrist, 1 consultant clinical psychologist, 1 senior nurse, 1 junior nurse, 1 occupational therapist, 2 managers, 1 residential key

worker, and 1 social worker. Two key members of staff from the Home Office and two chairs of local MAPPA panels from SLaM and NTW were also interviewed.

2.2.2.2 Focus groups

In order to maximise the validity of the results from the analyses of data from these interviews, the provisional results were fed back to staff in the setting of three focus groups. All staff who participated in interviews were invited to take part in the focus group and a convenient time was arranged by email. The groups took place approximately 5 months after the last staff interview had been completed. Focus groups took place in a quiet room, were audio taped and transcribed verbatim. Membership of the groups varied per service. Within ELCMHT the group consisted of 1 consultant forensic psychiatrist, 1 consultant clinical psychologist, 1 social therapist and 1 manager. Within NTW the group consisted solely of staff from the community team; all participating staff were invited to take part in the group, but unfortunately the focus group took place at a time when the new Oswin Unit had just opened and in-patient staff had other pressing duties to attend to. The following disciplines were therefore present: 1 consultant forensic psychiatrist, 1 team manager, 1 probation officer, 1 nurse, and 1 psychologist (who was not part of the original group of interviewed staff but who wished to contribute to the discussion). Within SLaM the group consisted of 1 consultant psychologist, 1 junior nurse, 1 residential key worker and 1 psychologist (who was not part of the original group of interviewed staff but who wished to contribute to the discussion).

2.3 An investigation of the outcome of service users

2.3.1 Quantitative outcomes

Service users recruited to Module 1 were followed-up at 6 months and were paid a further £5 for their participation. The following measures were repeated:

1. Work and Social Adjustment Scale
2. Client and therapist versions of the Working Alliance Inventory
3. Cost: the Secure Facilities Service Use Schedule

They were also asked whether they thought they were suffering from a personality disorder or not.

Their case records were examined for the following information:

1. number and details of any incidents of offending, self-harming, violent or absconding behaviour over the preceding 6-month period
2. use of illicit drugs, alcohol or other contraband material over the preceding 6-month period.
3. supplementary cost data.

2.3.2 Qualitative investigation of service users' experiences

In-depth interviews were undertaken with a sample of service users from each of the three service, the purpose of which was to determine their experience of treatment.

2.3.2.1 Data collection procedures for individual interviews

When service users were approached to participate in the quantitative survey (November 2005-July 2006), they were also asked whether they wished to participate in a qualitative interview with another researcher at a later date. Six to 9 months later, staff on the MSUs were contacted and asked to convene groups of service users to remind them of the purpose of the project and to check to see if they were still willing to participate in a qualitative interview. This was done in pre-existing 'community groups' or in a specially convened group. Individual times for an interview were arranged either by the researcher (at SLAM and ELCMHT) or through the nursing staff (NTW). For the residential services, contacts were made through the managers of the services and for community teams, contacts were made through discussion with community staff. In all cases, before each interview, staff were asked whether they thought that the service user would be suitable to participate in an interview on a particular day; if there were concerns about the service users' mental state/level of risk the interview was postponed.

Each participating service user took part in an in-depth interview with one of the authors (ZF). The interview lasted between 50-90 minutes and was based on a topic guide (see Appendix H). The topic guide was drafted following a review of the literature. The contents of the topic guide were then refined following discussion with the Project Advisory Group. The topic guide was refined progressively during the fieldwork as important themes started to emerge, although remained unchanged after

approximately the fourth interview. Questions were structured by the interviewer to cover key themes, but were also responsive to issues emerging from participants' accounts. They consisted of a series of open ended questions covering the following areas: current health; previous experiences of being helped; coming to the service: the process and information received; help received within the service; safety; relationships with staff; the service environment; the experience of stigma as a result of using the service; outcomes/ changes they hoped to achieve; difficulties and ideas for improvements for the service. The interviews were audio-taped and transcribed verbatim. All interviews took place in a confidential quiet room. Rooms used to interview were on in-patient wards, in residential services, probation offices, GP surgeries, mental health centres and out-patient departments. On the in-patient wards, the researcher was required to carry an alarm at all times. Interviews that took place outside of in-patient wards were in designated meeting rooms with staff being in close proximity to the interview room. Service users were paid £10 for participating in an interview.

2.3.2.2 Details of the sample of service users interviewed

Within ELCMHT, 6 in-patient service users and one residential service user were interviewed over the period September-November 2006. Efforts were made to contact the other service user living in the residential service at the time but we were unable to contact him. Average age on admission was 32 years and average length of time spent with the service at the time of interview was 8 months. Within NTW, 8 in-patient service users and 7 community service users were interviewed over the period December 2006-February 2007. Average age on was admission: 37 years and average length of time with the service at the time of the interview was 18 months. Within SLaM, 7 in-patient service users, one community service user and one residential service user were interviewed over the period June – August 2006. Average age on admission was 43 years and the average length of time with the service at the time of the interview was 10 months.

2.3.2.3 Focus groups

Once individual interview data had been analysed (see section 2.5.2), the emergent themes were fed back to the service users in the setting of three focus groups (one at each site) in order to validate the themes and check for any new themes. Service users were paid £10 for participating in a focus group. Focus groups were chaired by a researcher (ZF) and co-chaired by another member of the research team (RS or DM). Groups lasted approximately 50-60 minutes and were audio-taped and transcribed verbatim. Focus groups took place approximately one month after the completion of individual service user interviews at each service. In ELCMHT, the focus group was convened in December 2006; in NTW, the group was convened in March 2007; in SLAM the group was convened in August 2006. Following discussion within the research team, it was decided that the safest and most practical way to set up focus groups would be for these to take place on the MSUs. Consequently, membership of the groups was largely restricted to in-patient service users. In ELCMHT, the group consisted of 6 service users from the in-patient unit. In NTW, the group consisted of 6 in-patient service users. In SLaM, the group consisted of 5 service users from the in-patient unit and one service user from the community.

2.4 An investigation of team outcomes

Staff that participated in the module 2 qualitative interviews were invited to participate in follow-up qualitative interviews, to take place approximately one year after the initial interview. Procedures for the individual interviews were the same as described in section 2.2.2. For practical reasons, six NTW staff were interviewed by telephone; these interviews were audiotaped and transcribed in the same fashion as the face-to-face interviews. Some staff had left the service in the preceding year and they were contacted to secure their participation in a follow-up interview. We obtained follow-up interviews on staff from all the services, with the exception of 2 SLAM staff who had been interviewed at baseline, but were on leave or uncontactable at the time of follow-up. The topic guide was revised to reflect service changes over the year and covered the following topics: perceived success of treatment, helpful/un-helpful parts of the service, changes in the service users, relationships between staff and service users, boundaries, safety, personal experience of working with the service

users, support, team functioning and relationships with other services. Staff who had left the service in that year were also asked to give their reasons for leaving.

2.5 DATA ANALYSIS

2.5.1 Quantitative survey data analysis

All data were entered onto SPSS (Version 14.0) for data analysis. Distribution and central tendency (such as Standard Deviations (SD) for normally distributed continuous data) were examined and simple descriptive statistics used to describe the samples. The significance of any changes in WSAS or WAI scores at baseline and at 6-month follow-up were tested for using paired t-tests. Given the small sample sizes involved coupled with the fact that the quantitative surveys were primarily descriptive in nature, we did not think that it was appropriate to pursue multivariate analyses in this report.

2.5.2 Qualitative data analysis

Transcripts and interview summaries were subject to thematic content analysis which was facilitated using the QSR NVivo computer software package. The researcher (ZF, who carried out all of the service user qualitative interviews and the majority of staff interviews) achieved immersion in the data by reading transcripts of all interviews as they were generated. The transcripts were then read through more thoroughly, noting any emerging connections between responses. At this point, any thoughts, reflections or interpretations were also recorded and field notes were re-read. Major themes and sub-themes were then established and each theme was titled to best reflect the original responses. All themes were then arranged as categories in a 'nodal tree' and allocated numeric codes. Another researcher (RS) also coded a proportion of the interviews using the same coding frame in order to check the reliability of the coding process. After discussion, the coding frame was revised and a proportion of the interviews coded by both researchers. These were compared once again to ensure reliability of the coding process. All transcripts were then coded according to this coding framework. During the coding process, any data not fitting existing codes led to the generation of new themes and the coding framework was revised accordingly. Continued immersion in the data allowed further refinement of the framework until it adequately captured all data as key themes. Each interviewee

was given a unique coding. Extracts of the interviews - sourced to the speaker – were cut and pasted into the coding framework for each case study. Triangulation of data sources from different staff members and different service users was important in order to justify inclusion as a theme. The final case studies were shared with the service leads in order to reduce inaccuracies and to highlight any areas of concern that they might have about the case study.

2.5.3 Economic analysis

2.5.3.1 Aggregate costs

To calculate the cost per place we used standard costing methodology. The approach has been used widely to calculate costs in health and social care settings (30) and has four related elements: describe the service, identify every service component, estimate how much has been spent on each component and calculate total and unit costs. The service description is given in detail for each service in chapters 3-5. There were some difficulties with the second and third steps of the method: identifying each service component and estimating expenditure on each. The multi-site nature of the services meant that expenditure was shared across the different settings: medium secure inpatient units, residential hostel services and the community. For example, the SLAM service includes a medium secure unit (MSU), two residential hostels with different levels of staffing and supervision, and a community team. Service users in the residential service and some from the community service are encouraged to attend treatment services at the MSU. Additionally, members of staff in the MSU are responsible for outreach and community management of those in the community. However, much of the funding for this service is allocated in one lump sum. In order to estimate the costs of the different service components, it is necessary to establish the proportion of resources that are used for each element of the service. These problems were exacerbated in some cases by a lack of available data and differences in the structural and organisational set-up of each site.

The variation in structural and financial arrangements meant that we had to employ different approaches to costing at each site.

ELCMHT

A single funding allocation was given to East London and the City Mental Health Trust to provide medium secure and residential services. Staff at the Millfields Unit

have clinical responsibility for service users in the residential service, though it is rare for service users to come onto the unit for treatment as the Millfields is run as a modified therapeutic community. Therefore we had to make assumptions on the proportion of time staff spent on inpatients at Millfields and on service users in the residential service. We assumed that staff responsible for the residential service users spent ½ day per week on the clinical management of the residential service users or on activities related to them. The residential service had two components, the hostel and the treatment and management by staff from the Millfields unit. For the hostel service at Baxter Road, we estimated the costs using budgetary data and staffing details from the Look Ahead Housing Trust, the treatment cost of the clinical management from staff were allocated as outlined above.

NTW

The NTW services at the Oswin unit and in the community are funded separately. We were therefore able to estimate the costs using data on the staff allocation and all relevant overheads and add-ons. We did not have an estimate of the capital costs for the Oswin unit, so made an estimate of this from the capital costs from the other sites. For the community service, we were not able to include the cost of utilities and capital charges as these were included in the much larger Trust overheads.

SLAM

A single funding allocation was given to SLAM to provide MSU, residential and community services. Therefore, we had to make assumptions on the proportion of staff time spent on MSU, residential and community service users in order to apportion costs appropriately. For staff principally based in the Tony Hillis unit, we apportioned 80% of their time to the delivery of inpatient services. The remainder (equivalent to one day per working week) was to cover residential and community service users attending the Unit for the VRP and for their clinical management. Some staff were employed primarily to manage the residential and community service users, so we apportioned 80% of their time to this task and assumed the remainder of their time was spent on activities with inpatients. The residential service had two components, the hostel and the treatment and management by staff from the Tony Hillis Unit. We estimated the cost per night at Akerman Road and Bonham Road hostels using budgetary data and staffing details from Penrose Housing Association.

The management and administration costs were divided equally between the two residential services, but the staffing costs, non-pay costs and indirect costs were estimated on a per site basis, so that the different intensity of staffing between sites (see above) is reflected in the final unit costs. The cost estimate provided by Penrose Housing Association did not include the rent for the properties, so this was estimated from the difference between the total cost estimate from Penrose and the funding allocation to the residential services included in the SLAM budget. The treatment component was calculated from budget data from the Tony Hillis Unit as above. For community service users, we assumed that of the 36 service users, 16 were under direct case management who consumed 80% of the apportioned costs. The other service users would receive less input from the Tony Hillis Unit team as they would be managed jointly by other service providers such as Multi Agency Public Protection Panels (MAPPPs) or general adult psychiatric teams.

2.5.3.2 Individual-level cost data

We set out to estimate the individual bottom-up costs of participants using a method successfully employed in service users with personality disorder in a high secure setting (31). In this approach, a questionnaire or schedule is used to collect data on the services used by each participant in the trial and a unit cost is applied to each service to calculate the total cost. We collected service use data using the Secure Facilities Service Use Schedule (SF-SUS) – see above. Total costs were calculated by multiplying the number of contacts with each service by an appropriate unit cost. All costs were for the financial year 2005-06. The costs of time spent in the specialist PD services were taken from the calculations outlined in the aggregate costs section of each case study. The unit costs for other services were taken from routine data sources for hospital services (reference costs), health and social care services, criminal justice and medication costs. The unit cost and source is summarised in Appendix K. The range of services used by service users in each site was examined in a descriptive analysis. Total costs were calculated by service providing sector. We compared the cost for the six months preceding baseline and the six months follow-up using paired sample t-tests.

2.6 ETHICS

Ethical committee approval was obtaining from the Central Organising Research Ethics Committee prior to the start of data collection. Each participant was provided with an information sheet, which stated the purpose of the study, the need for their involvement, what their participation would entail, issues surrounding ethics and confidentiality and a contact number for the study team. Service users were assured that the information they gave would be treated confidentially. They were also informed that they would receive payment for participation in the evaluation. Written informed consent was gained from all participants. Data was handled and analysed according to good ethical practice, using anonymised participant codes at all times. All data from the study were stored in accordance with the requirements of the Data Protection Act, with electronic files password protected and held on a secure server and hard copy files stored in a locked filing cabinet.

2.7 PROJECT ADVISORY GROUP

Members of the Project Advisory Group (PAG) are listed on page 187. The PAG met on four occasions during the course of the study and played an important role in helping to finalise details of methodology, including the final choice of research measures and the wording of topic guides. The PAG also provided a forum to consider emergent findings.

2.8 AREAS NOT COVERED BY THIS REPORT

Three areas originally highlighted in the research brief, were not covered by this report:

1. An analysis of the reasons why eligible clients cannot or do not make use of the service. The fieldworkers only interviewed service users who were safely engaged in treatment and it was impractical to interview service users who were not making good use of treatment. Under the circumstances, we were unable to undertake further analysis of this area.
2. A discussion of how the pilots responded to issues raised the NIMHE guidance (2003) and proposed legislative changes. This was not covered because the interviewed staff uniformly reported that guidance issued had

been moderately useful as a basic starting point, but their responses added little information that would have further illuminated this report.

3. Collaboration with local stakeholders. We have provided a comprehensive account of all service user-led initiatives. Unfortunately, within the specified time frame, we were unable to collect or analyse sufficient data from commissioners or other local service providers to fully cover the area of collaboration with these stakeholder groups.

CHAPTER 3:

East London and the City Mental Health Trust Forensic Personality Disorder Service

3.1 Description of service

The North East London Forensic Personality Disorder Service is situated within the East London and the City Mental Health Trust (ELCMHT). (Subsequent to the completion of the evaluation, the Trust changed its name to East London NHS Foundation Trust.) The Trust was formed in April 2000 and provides community and inpatient mental health services to the London boroughs of Tower Hamlets, Newham, Hackney and the City of London. Additionally, it provides services in forensic psychiatry to the London boroughs of Barking, Dagenham, Havering, Redbridge and Waltham Forest. The North East London Forensic Personality Disorder Service consists of an in-patient unit (Millfields Unit) and a residential service (based at Baxter Road).

Millfields Unit

The in-patient unit is situated within the larger site of the Centre for Forensic Mental Health (formerly the John Howard Centre). The interim in-patient unit was due to open in December 2004 but due to structural building problems (there was asbestos on site), was not able to open until Spring 2005. The ward completed its move from an interim 15-bedded ward to two 10-bedded wards in March 2005, situated on the same site. The unit is now called 'Millfields Unit' consisting of two wards, called West Ferry and East India Wards. The first service user was admitted on 22nd June 2005. All service users were initially housed in East India Ward. West Ferry ward was opened on 1st December 2006 and service users are now split between the two wards. In April 2007, it was agreed by all service users and staff that although the wards are split, they should remain *'integrated'*. This effectively means that although the middle door between the wards was closed, it was not locked and all activities and groups were held as joint exercises between the two wards.

Baxter Road Residential Service

The residential service is located within the London Borough of Newham and is staffed and managed by the 'Look Ahead Housing and Care' (LAHC) Association, working in collaboration with ELCMHT. LAHC is a charitable housing association which provides vulnerable people with accommodation plus the care and support services they need to live independent lives. Their mission statement is to enable *"those with particular needs to live ordinary lives in the community"* and the Association aims to assist with learning new skills, building confidence and moving towards independent living (source: http://www.lookahead.org.uk/Data/ASPPages/1/2.asp). The residential service is a large building consisting of eight bedrooms with en-suite facilities, two communal lounges with televisions, a large kitchen and a garden. The house acquired a computer which service users could use for administrative tasks, such as typing up community minutes. The service opened on the 29th March 2005 and admitted its first service user on 3rd October 2005.

3.1.1 Aims and philosophy of the service

Millfields Unit

The overall aim of the in-patient unit as specified in service documents is to *'assess and treat service users suffering from severe personality disorder who pose a serious risk to others, according to the most rigorous available evidence.'* The service aims to promote the safe reintegration of service users into the community. Service specification documents also highlight the fact that this service aims to be *'accessible to those previously excluded, including individuals from ethnic minorities.'* This is the only service to specifically state (in operational policy documents) that they will *'add to the evidence base for effective treatment'* and the team have recently appointed a dedicated research fellow to evaluate the clinical work of the service (see below). We made early contact with the ELCMHT researcher in order to

negotiate the completion of our evaluation before other planned service-led research projects went ahead.

Baxter Road Residential Service

The residential service aims to provide social care in order to assist service users to explore local opportunities for education, employment and other activities. Staff facilitate liaison between service users and local agencies with the aim of supporting them to build *'constructive networks'* with health, housing and other agencies. The in-patient clinical team maintains close contact with discharged service users in order to provide continuity of care.

Both the residential service and in-patient clinical teams work in close collaboration with the probation service, the local Multi-Agency Public Protection Panel (MAPPP) and the Mental Health Unit for the Home Office with the shared aims of:

1. maintaining improvements gained in social functioning and mental health
2. reducing risk and re-offending
3. spotting early warning signs of deterioration and particularly of increasing risk to others,
4. taking effective remedial action to maintain the safety and well being of both others and the individual concerned.

3.1.2 Inclusion and exclusion criteria

Millfields Unit

Inclusion Criteria

The inclusion criteria for the in-patient unit are that service users must:

- have a primary diagnosis of personality disorder (service users with co-morbid mental illness are not excluded)
- pose a significant risk to others because of their Personality Disorder
- be aged over 18 years
- be suitable for detention under the Mental Health Act (1983) in conditions of medium security
- come from within the North London catchment area
- display willingness to engage in treatment

Exclusion criteria

- learning disability (IQ>70)
- primary diagnosis of substance misuse, organic brain disorder and autistic spectrum disorder.
- Severe and enduring mental illness
- Child sex offenders

Baxter Road Residential Service

Inclusion Criteria

- Primary diagnosis of personality disorder of significant severity and/or complexity
- Males, aged between 18 to 65 years (decision about service users reaching upper age limit when already being cared for within the service are made on a flexible, individual basis)
- Ordinary residence within the catchment area

- For the supported housing: not in need of hospital admission, nor suitable for any other community placement; thought to pose a sufficiently low risk to be contained in this setting.
- Assessed to pose a risk that will require gradual and supported re-introduction to the community or present with risks in current community placement
- Other community accommodation not appropriate at the time of assessment due to level of need and risk
- Referrals of men made by mental health agencies must have an identified community RMO, who retains primary responsibility for care within the CMHT. With referrals from prison or probation who have not been mental health service users before, efforts are made to link the resident with their appropriate home borough CMHT. If this is not possible, the in-patient clinical team assumes responsibility and they are managed in accordance with Trust CPA policy.
- Written acceptance of ongoing responsibility by the Local Authority
- Willingness of the service user to engage with the service

Exclusion Criteria

- Presence of a severe mental illness
- Primary diagnosis of substance misuse
- Significant organic brain dysfunction or pervasive developmental disorder
- Presence of a learning disability
- Clear evidence of the need at any time for in-patient treatment in a secure setting
- Emergency referrals for assessment are not accepted.

3.1.3 The referral and assessment procedure

All referrals were discussed at a weekly referrals meeting held at Millfields Unit. Initially, the assessment process ran as follows: the lead Consultant Forensic Psychiatrist from the in-patient unit assessed the service user to ensure that the referred person was suffering from a personality disorder. A forensic psychologist then assessed the service user using a battery of tests. Nursing and social work assessments were then completed and a detailed multidisciplinary report was subsequently produced. Further assessments were then completed prior to admission (e.g. assessment of physical health). Motivation to change and the ability to use treatment in a quasi-therapeutic community setting were also assessed prior to admission. Once the service user had been admitted to the unit, further exploration of the service user's difficulties was carried out prior to the first CPA review at 12 weeks.

Each of the pilot sites was required to complete a 'minimum dataset' on each service user within 3 months of admission (see Background section). Within ELCMHT, in addition to the minimum dataset, a number of other assessment measures were being carried out:

1. Within 3 months and at discharge: Personality Assessment Inventory; Eysenck Personality Questionnaire-Revised; NEO-Personality Inventory Revised; Psychological Inventory of Criminal Thinking Styles; State-Trait Anger Inventory; Treatment Motivation Questionnaire, the Five Factor Inventory.
2. Within 3 months and annually: Joliffe's Empathy Scale; Chart of Inter-personal Reactions to Closed Living Environments; Model of Human Occupation Screening Tool.

Initial experience led senior members of staff to conclude that the assessment procedure was too slow and too resource-intensive. In addition, factors beyond the unit's control sometimes further slowed the assessment process. For example, difficulties establishing the service

user's catchment area or unexpected changes in the status of the referred person (e.g. a service user being recalled to prison at the time that they were meant to be assessed). In the light of these problems, the minimum dataset was less than complete (estimated to be 60% complete at the time of writing this report). In an attempt to improve completion rates, staff at the Millfields Unit recently agreed to have regular review meetings to ensure that the assessments are allocated to named individual clinicians. It was also decided that every 3 months, each clinician should spend a week solely concentrating on the minimum data set.

Some staff expressed concerns about the assessment measures which were described as being *"very provocative"* and *"prying"* – this was particularly so for people who might have been in a fragile state having just been transferred from prison.

So we had 100 referrals... we interviewed 40 and they will have had, most of them will have had almost every member of the MDT go and see them and we admitted 10... so there were 30 additional psychology assessments and medical assessments who didn't actually come in and that is a huge consumption of resources…what we have done now is streamline the process up front and they're just going to be seen by the psychiatrist because that's the person that needs to do the section papers ... its just as, uh... too many assessment tools to be done at the same time…this is also partly the difficulty with the assessment tools is they're very provocative…open things up in a way that can be quite difficult for people who are, perhaps a bit unsteady. S27 (follow-up)

As a result of these concerns, the assessment process was altered and at the time of preparing this report, we understand that the process now runs as follows:
1. A screening checklist is completed by a member of the clinical team to assess if the referred person meets the units' admission criteria.
2. A Consultant Forensic Psychiatrist then assesses the person.
4. Members of the nursing team then carry out a pre admission assessment.
5. A pre-admission risk assessment is carried out using the Trust standard risk assessment and management tools.
6. Prior to arrival, a member of the residential service team also meets with the referred person in order to assess suitability for admission to the residential service and an initial social care assessment is carried out.
7. A multidisciplinary case discussion is then held at Millfields Unit and relevant members of the clinical team attend a section 117 meeting at the service user's place of origin.

3.1.4 The model of treatment

Millfields Unit

The Millfields Unit is run as a modified therapeutic community (TC). Treatment consists of a 'core programme', a 'supporting programme' and a varied programme of activities and paid work termed "Therapies and Education". Only the core programme is mandatory with attendance at other aspects of the programme being dependent on the service user's individual needs. The expected duration of stay on the ward in the original specification documents was 2 years, although this was recently revised to 3 years and we were told that it was likely that some service users might require an even longer admission to the Unit.

A. The 'core programme'

This consists of community meetings, a programme of work entitled 'orientation to therapy' and small groups. Attendance was mandatory and absenteeism resulted in a 'crisis meeting' being called on that day. Absenteeism was reported to be low for this reason.

A.1. Community Meetings

The aims of the community meetings were to:

- maximise information sharing
- build a sense of cohesion and 'togetherness' in the community
- make the process of decision making more transparent
- provide a forum for personal feedback
- provide a vehicle for community members to exert pressure on individuals whose attitudes and behaviour were upsetting or threatening to others.

Community meetings were held three times a week and were chaired on a rotational basis by one of the service users, supported by staff. Crisis meetings (or emergency meetings) could be called by any service user to address a specific issue concerning an individual or the community as a whole. Service users were required to request the crisis meeting by making an application to a senior member of staff. The meetings lasted 40 minutes, were attended by the whole community and were described as being a *'focal point for the management of the crisis allowing anxiety to be contained until the next appropriate juncture in the therapeutic programme.'* The meetings could also act as a catalyst for security procedures to be implemented by staff, for example drug screening or room searching.

A.2. 'Orientation to Therapy'

This is a 12-week long group programme of weekly sessions with pre-group meetings and post-group reviews. It was designed for newly admitted service users and consisted of four modules focusing on education about diagnosis and the TC approach and also the acquisition of basic social skills that would be required for future group work. The sessions were facilitated by clinical staff and group sessions were meant to be interactive and might involve a range of different approaches including small group exercises, presentations by the service users, talks by service users from other facilities and role play exercises.

A.3. Small Groups

After each service user had completed the 'Orientation to Therapy' Group, they joined a Small Group which met for one and a half hours twice a week. The aims of the group were to: provide a regular forum for service users to work 'at a deeper level' on their problems in the areas of social functioning, personality disorder and offending. The groups also aimed:

- to provide a secure base to explore attachments in the past and present
- to promote pro-social learning through identifying antisocial attitudes, beliefs and behaviours and encouraging and reinforcing pro-social ways of resolving problems
- encourage service users to recognise links between their attachment histories, offending behaviour and interactions in the TC

B. Supporting Programme

This is an individualised programme addressing health and criminogenic needs and risk and at the time of preparing this report, it consisted of individual and group-based psychodynamic psychotherapy and individual CBT.

There was no specific substance misuse treatment programme being run on the Unit at the time of compiling this report, although we were told that the team were in the process of developing such a programme. The team intend to train all staff in the identification of drug and alcohol problems and possibly also motivational interviewing techniques. An anger management group programme was being developed by a multidisciplinary working group, with the aim of getting it up and running by 2008. Other work on helping service users to better manage their difficult emotions was also being developed, for example, encouraging service users to use 'mood diaries'. Although the team felt that they were managing self-harm well, at the time of compiling this report, there was no official protocol in place for the management of self-harm; we were told that this was also in the process of being developed.

C. Therapies and Education

i. Education

In April 2007, the team had contracted with City and Hackney MIND for the provision of numeracy, literacy and Information Technology lessons for 7 hours/week. Two teachers had been recruited to run the classes. The classes aimed to provide teaching to underpin City and Guilds qualifications in literacy and numeracy and a qualification in IT. We were told that some service users had expressed an interest in distance-based learning. In the long-term, the team hope to be able to support service users in undertaking Open University courses.

ii. Vocational projects

These are currently split into 3 components: ward jobs, Millfields vocational jobs including the Millfields Service users' Shop, and the 'Centre for Forensic Mental Health Social Firm'. The arrangements for ward jobs was under review at the time of preparing this report and the team were liaising with the local estates department in order to work out how service users might be able to take responsibility for cleaning and maintaining the ward environment and serving meals. The review was being overseen by a multidisciplinary party with service user representative from each ward. There were 3 vocational jobs on offer: a gym orderly and two shop workers. The jobs were advertised every 3 months and potential employees had to go through a formal application and interview process. Successful applicants were paid the minimum wage (£5.35 per hour).

The Millfields Unit opened its own shop in the café area on 16 March 2007 named the "East & West Pavilion" by the service users. A shop protocol had been developed which had been ratified by the Forensic Directorate's management team. Overall control of finances and management of the shop was retained by Occupational Therapy (OT) staff, although service users played an active role in setting up the shop and ordering stock. The shop sold snacks, stationery, soft drinks, tobacco and phone cards. Staff told us that they hoped that the variety of items on sale would be increased over time - one idea being to develop the shop as an outlet for other vocational projects such as selling vegetables and herbs grown in the garden.

Service users were involved in setting up a 'Social Firm' which would take on contracts from within the wider Centre for Forensic Mental Health. The work involved a range of administrative and practical tasks such as poster making, cleaning unit vans and organising some aspects of catering. At the time of preparing this report, we were told that most service users had completed a basic food hygiene course and were able to take part in cake-making. Millfields Unit provided Christmas cakes for all other wards in the Centre for Forensic Mental Health and was offering a birthday cake-making service to other wards.

iii. Activity groups

An activity programme was run by the OT department on a three-monthly semester system. The programme included gym sessions, Thai Chi, a music group, gardening sessions, sports sessions (football badminton, basketball), cookery, and art sessions. The team hoped to hire a drama therapist in order to also offer a drama workshop. The purpose of the sessions was to assist service users in developing their healthy interests, to develop planning and other cognitive skills and to improve their fitness levels. Service users were regularly consulted for feedback about the programme and any changes were made subsequent to an MDT discussion. Each service user was given a copy of the timetable and their own dairy and are encouraged to take responsibility for planning and managing their time.

Baxter Road Residential Service

The treatment within the residential service is tailored according to a service user's individual needs. The anticipated duration of stay in the service is 2 years although we were told that this

was not an imperative. Each service user was assigned a key worker and a co-key worker to shadow the key worker and work with the service user if the key worker is absent. The service user had a CPA review during which an individualised care plan would be finalised. Service users were involved in the on-going development and review of their care plans (reviews occurred at 3-6 monthly intervals, with additional reviews being organised as necessary). The CPA and reviews contained a joint assessment covering 18 domains of potential need which were rated by both the staff member and the service user. Reviews also occurred on a fortnightly basis involving service users, residential service staff and the clinical team from the Millfields Unit.

Staff from the in-patient unit met on a regular basis with the residential staff team in order to discuss the service users' progress. Staff were also able to access the out-of-hours service provided by the Centre for Forensic Mental Health for any acute problems. When the residential service first opened, this service was used fairly regularly. With time, as the residential service staff have grown in their confidence in handling difficult situations, the use of out-of-hours cover by the centre has diminished.

The residential treatment programme has over the course of the evaluation evolved from a tightly structured regime to one which is more loosely structured (see 'Developments during the course of the evaluation'). When the residential service first opened, there was a strict daily timetable. However, staff found it difficult to enforce the timetable with a group of service users who had come from previously *'un-disciplined environments'*. The programme was therefore modified and at the time of writing this report, key workers were capitalising on a variety of opportunities to work with service users in more creative ways. For example, a key worker might invite a service user to *'help out'* with gardening or cooking. Although the programme included a weekly community group most of the treatment was provided on an individual basis. A garden project formally opened in April 2007 although at the time of writing this report, the service was still waiting for an allotment to be allocated.

3.1.5 Staffing the service

Staff at Millfields Unit had responsibility for the clinical management of service users in the residential services. The type and number of staff are summarised in table 1.

Table 1. Staff at the ELCMHT MSU

Profession	WTE
Psychiatrist	4
Psychologist	3
Assistant Psychologist	1
Psychotherapist	1
Clinical scientist	1
Occupational therapists	3
Technical instructor	2
Social worker	3
Senior nurse	1
Nursing (cover both wards)	4.3
Nursing ward 1	20.67
Nursing ward 2	20.67
Administration	5
Senior manager	0

There are 8 project workers at the residential service with one manager and a deputy manager.

3.1.6 Training of staff

Millfields Unit

When the service was first set-up, staff were required to undergo a two-week specialist induction programme. The focus of training was to promote understanding about the service users' behaviour and emotional states and how these might impact on team functioning. Specific teaching was given on team working, therapeutic communities, the role of advocacy and attachment theory. The final day of induction was designed to be a team building day off-site. All staff had protected time to attend an ongoing teaching programme covering the delivery of specific psychological treatments such as Dialectical Behaviour Therapy. We were told that members of the staff team were also able to attend other external training and research meetings.

During the initial phase of interviewing staff, some told us that they thought that their training would have been improved if it had focused more on individual's needs. The team have recently completed a proposal for a training needs analysis with Surrey University. We were informed that ultimately it was hoped that this would lead to an officially accredited training programme for staff working within the service and one that might be offered externally.

Baxter Road Residential Service

Staff received a great deal of specialised training when the service first opened. However, there were no service users in the house for the first 6 months after it opened and many of the things that had been learnt were forgotten over time. At the time of preparing this report, the training for the residential staff was linked to that of staff at Millfields Unit. Residential staff received a 2-week induction from the Millfields Unit and in addition, LAHC provided training for hostel staff in a range of other areas. Residential Service staff were also encouraged to pursue training opportunities within the Trust. We were told that the residential team were keen to develop protected time slots to discuss 'case studies', for educational purposes.

3.1.7 Training provided by the staff to other teams

One of the functions of the pilot Forensic Personality Disorder services is described in the Policy Guidance Document *Personality Disorder: No Longer A Diagnosis of Exclusion* (NIMHE, 2003) as that of providing consultation, liaison and case management advice. This type of advice might therefore be requested of the service from other forensic or general adult NHS services, MAPPPs, prisons and the probation service and courts. At the time of compiling this report, although members of the team had given presentations about their work at various conferences, the Millfields team was unable (because of capacity problems) to offer training to other services. Nevertheless, we were told that they hoped to be able to offer this in the future.

3.1.8 Staff supervision

Millfields Unit

Nurses, social workers, psychologists and occupational therapists were supervised by their appropriate head of department. Administrators, team secretaries and ward clerks were supervised by the Head of Support Services who in turn, was supervised by the Forensic Services Director. Staff Grade doctors were supervised by a Consultant Psychiatrist. This Consultant, together with the lead Psychotherapist in Forensic Psychotherapy and the team's

researcher were supervised by the Lead Consultant Forensic Psychiatrist. The Lead Consultant was supervised by the Clinical Director. Staff had the option of making other arrangements for one-to-one clinical supervision other than through their line manager. The expectation was that this should be with someone who was familiar with the service user group.
Within this supervision structure, nurses were meant to have one-to-one clinical supervision at a minimum of 8 sessions per year. Supervision attendance figures were routinely recorded, collated and audited and figures were reported to the Management Team every 6 months.

There were several other supervision procedures in place:

- Staff support groups 1 hour weekly. Attended by all members of the MDT and facilitated by an external consultant group analyst. Minimum attendance of 2 times per month.
- Reflective Practice Group – 1 hour weekly, ward staff and other members of MDT. Minimum attendance of 2 times per month. This consisted of a short presentation followed by discussion, focussing on the relevant psychodynamic issues.
- Multi Disciplinary Team (MDT): 20 minutes, daily morning handover considering individual service users, ward atmosphere and staffing issues. Minimum attendance of 4 times per month.
- MDT community meeting debrief – 20 minutes, three times weekly. Minimum attendance of 4 times per month.
- The ward round was also felt to provide an opportunity for staff to share their experience of working with service users.
- Supervision of small group facilitators – 1 hour fortnightly. This was supervision by a Consultant Psychotherapist for the 3 facilitators of the small therapy groups. Minimum attendance of twice per month.
- As nurses and social therapists were exposed to the pathology of the service users most frequently, additional group supervision was provided on a monthly basis. These groups were facilitated by a Consultant Psychotherapist.
- An administrative staff support group was convened monthly by the Consultant Psychotherapist in recognition of the fact that support staff were being exposed to case material and information that seeps through from clinical staff. In the event of an urgent matter arising, administrative staff could also request a consultation with the Consultant Psychotherapist or other senior member of the multi disciplinary team.

The management team received consultation from the Director of the Portman Clinic. The purpose of the group was to think about organisational relationships and relationships between senior members of the team. It was also designed to provide a forum to discuss anxieties that were deemed inappropriate for sharing with more junior members of the team, for example in relation to funding.

Baxter Road Residential Service

Line management of each project worker was undertaken by either the manager or the deputy on a one-to-one, monthly, compulsory basis. Staff were also required to attend 4-6 weekly observed practice sessions. During these sessions, the manager or deputy would sit in on a key working session between the project worker and the service user (with the service user's permission). The idea was to monitor how the sessions were being structured and to examine how well the staff member interacted with the service user.

Staff attended a fortnightly support group facilitated by a psychologist from the Millfields Unit. Staff also had access to LAHC counselling sessions and phone line support if needed. Facilitated reflective practice groups were held fortnightly for staff, facilitated by a member of staff from Millfields Unit – these were highly valued by residential staff who told us that these groups helped to build their confidence.

3.1.9 User Involvement

Millfields Unit

User involvement is integral to the whole ethos of a therapeutic community and as described above, the Unit provided many opportunities to allow service users to influence and shape the programme.

Baxter Road Residential Service

Staff involved service users in the formulation of care plans. LAHC also provided a number of opportunities for service user involvement, such as being invited to get involved in the business planning of the service. However, service user enthusiasm for pursuing these opportunities proved to be limited.

3.1.10 Complaints/ grievance issues

As part of the TC approach to treatment, most complaints were dealt with through community meetings. Complaints that could not be dealt with in this manner were dealt with via the Trust Complaints Procedure.

3.1.11 Aggregate cost of the service

The total funding allocation to the East London service was £4,855,000 including the £715,000 payment for the hostel. Using the assumptions regarding the allocation of staff costs between the Millfields and residential services outlined in the Methods section, the total cost of the Millfield Unit was £3,997,298, of which 72% were pay costs, 4% are non-pay costs such as training, travel and IT support and 25% are capital costs and indirect costs including overheads. The cost per bed was £199,865 per year or £547 per night. When the occupancy of the unit fell below the number of beds, the cost per service user increased. Occupancy of 10 increased the cost per service user to £413,000 per year or £1094 per night.

The residential service consisted of the hostel accommodation at Baxter Road and the clinical management from staff based at the Millfields. The total cost of the residential service was £681,056, of which 58% were pay costs, 7% non-pay costs, 17% indirect costs and 18% capital costs. The treatment costs were a further £132,703. The cost per bed was therefore £162,752 per year or £446 per night. If occupancy fell below the 5 beds level, then the cost per service user increased. Assuming 3 service users instead of 5, the cost increased to £271,253 per year or £743 per night.

3.2 Baseline survey of service users managed by the service.

Over the recruitment period to the survey (November 2005-June 2006), 13 men were being managed by the service (9 inpatients and 4 residential service users). Of these, 12 men were recruited (92% response). One residential service user refused to participate.

3.2.1 Demographic characteristics (Table 2)

The mean age of the sample was 32 years (standard deviation, sd: 10.1). Eight of the men were white (67%), 10 were single and 10 were unemployed (83% respectively).

Table 2. Demographic characteristics of recruited sample from ELCMHT

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Mean age in years (SD) on entry into service	31.8 (11.3)	34 (6.0)	32 (10.1)
Age bands			
20-29 yrs	5 (56)	1 (33)	6 (50)
30-39 yrs	0 (0)	1 (33)	1 (8)
40 yrs +	4 (44)	1 (33)	5 (42)
Ethnicity			
White	6 (67)	2 (67)	8 (67)
Black	2 (22)	1 (33)	3 (25)
Other	1 (11)	0 (0)	1 (8)
Marital status			
Single	7 (78)	3 (100)	10 (83)
Divorced/separated	2 (22)	0 (0)	2 (17)
Employment status prior to been taken on by service			
Unemployed	7 (78)	3 (100)	10 (83)
Employed	2 (22)	0 (0)	2 (17)

3.2.2 **Personal histories** (Table 3)

In their personal histories, 10 men (83%) reported a history of childhood physical abuse, with 4 men reporting a history of childhood sexual abuse. Ten men (83%) reported a childhood history of being bullied and the same number reported a childhood history of bullying other children. Seven (58%) reported a history of setting fires in childhood – all of the residential service users had a previous history of fire setting. Eight men (67%) did not complete secondary education.

Table 3. Personal histories from ELCMHT

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Childhood maltreatment – physical			
Yes	8 (89)	2 (67)	10 (83)
No	1 (11)	1 (33)	2 (17)
Childhood maltreatment - sexual			
Yes	3 (33)	1 (33)	4 (33)
No	6 (67)	2 (67)	8 (67)
Ever bullied?			
Yes	8 (89)	2 (67)	10 (83)
No	1 (11)	1 (33)	2 (17)
Bullied others?			
Yes	8 (89)	2 (67)	10 (83)
No	1 (11)	1 (33)	2 (17)
Set fires?			
Yes	4 (44)	3 (100)	7 (58)
No	5 (56)	0 (0)	5 (42)
Completed secondary school?			
Yes	7 (78)	1 (33)	8 (67)
No	2 (22)	2 (67)	4 (33)

3.2.3 Clinical characteristics (Table 4)

The mean full scale IQ of the sample was 89.0 (sd: 9.9), mean verbal IQ was 90.0 (sd: 9.6) and mean performance IQ was 87.8 (11.8). There was a marked discrepancy between verbal and performance IQs for the residential service users. At the time of preparing this report, 6 participants had had PCL-R ratings; the mean PCL-R total score was 24.2 (sd: 3.8), mean PCL-R factor 1 score was 6.8 (sd: 2.6) and mean PCL-R factor 2 score was 11.8 (sd: 2.2). Nine men (75%) thought they had a personality disorder, 2 (17%) did not think that they had a personality disorder and one man (8%) did not know whether he had a personality disorder or not.

Table 4. Clinical characteristics of recruited sample from ELCMHT

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Main self-reported problem			
Personality problems/disorder	3 (33)	1 (33)	4 (33)
Substance use	1 (11)	0 (0)	1 (8)
Offending	3 (33)	0 (0)	3 (25)
Considered appropriate	0 (0)	1 (33)	1 (8)
Didn't know	0 (0)	1 (33)	1 (8)
Concern by 'authorities'	1 (11)	0 (0)	1 (8)
Miscellaneous reasons	1 (11)	0 (0)	1 (8)
Service user thought they had a PD			
Yes	6 (67)	3 (100)	9 (75)
No	2 (22)	0 (0)	2 (17)
Don't know	1 (11)	0 (0)	1 (8)
Thought they had a PD (at 6 months)			
Yes	5 (56)	2 (67)	7 (58)
No	1 (11)	0 (0)	1 (8)
Don't know	2 (22)	1 (33)	3 (25)
Missing	1 (11)	0 (0)	1 (8)
Mean IQ (n=7) (SD)			
Full scale	91.0 (7.3)	82.0 (18.4)	89.0 (9.9)
Verbal	90.7 (5.6)	86 .0(22.6)	90.0 (9.6)
Performance	92.4 (10.5)	77.0 (6.9)	87.8 (11.8)
Mean PCL-R Factor 1 score (SD)	7.1 (2.6)	4.0 (n/a)	6.8 (2.6)
Mean PCL-R Factor 2 score (SD)	11.4 (2.0)	15.0 (n/a)	11.8 (2.2)
Mean PCL-R Total score (SD) (n= 6)	25.2 (3.2)	19 (n/a)	24.2 (3.8)

At the time of preparing this report, 10 of the 12 men had received an IPDE assessment. Of these 10 men, 9 (90%) fulfilled criteria for a primary PD diagnosis of dissocial PD and one man (10%) fulfilled criteria for a primary PD diagnosis of borderline PD (Table 5).

Table 5. Main PD diagnosis in the recruited sample from ELCMHT, as determined by the IPDE (derived from ratings performed on 10 men)

Category	Millfields unit	Baxter Road	TOTAL (n=10)
Paranoid	-	-	-
Schizoid	-	-	-
Schizotypal	-	-	-
Dissocial	8	1	9
Borderline	-	1	1
Histrionic	-	-	-
Narcissistic	-	-	-
Anxious	-	-	-
Dependent	-	-	-
Anankastic	-	-	-
Unspecified	-	-	-

Six men were referred from prison, 3 from medium security, with the remainder being referred by high secure care, psychiatric intensive care unit (PICU) and court. At entry into the service, 10 men (83%) were detained under a criminal section of the Act, one man was detained under a civil section of the Act and one man was a voluntary service user. (Table 6).

Table 6. Mental Health Act status and place of referral

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
MHA status on entry into the study			
Involuntary (criminal section)	8 (89)	2 (67)	10 (83)
Involuntary (civil section)	1 (11)	0 (0)	1 (8)
Voluntary	0 (0)	1 (33)	1 (8)
Referral source			
High security	1 (11)	0 (0)	1 (8)
Medium security	1 (11)	2 (67)	3 (25)
PICU	1 (11)	0 (0)	1 (8)
Prison	6 (67)	0 (0)	6 (50)
Court	0 (0)	1 (33)	1 (8)

3.2.4 **Past psychiatric histories** (Table 7)

The mean age of first contact with mental health services was 19.7 years. Ten men (83%) had a previous history of self-harm; 4 men had committed an act of self-harm in the preceding 6 months. There was a wide range of severe self-harming behaviour reported, including cutting, overdosing, self-strangulation and swallowing razor blades.

Substance misuse was highly prevalent among the sample of recruited service users: all 12 men reported previous use of cannabis, 10 men (83%) had history of alcohol misuse, 6 men (50%) had a history of opiate misuse, 8 men (67%) reported using amphetamines, 7 men (58%) reported crack cocaine use, 5 men (42%) reported using solvents and 3 men (25%) reported cocaine use. Alcohol misuse was implicated in the index offence in the case of 7 men (58%) and substance misuse had been implicated in the index offence in the case of 5 men (42%). 8 men (67%) had a previous documented history of non-adherence with psychiatric treatment and 6 men (50%) had a history of absconding behaviour.

3.2.5 **Criminal histories** (Table 8)

The mean age of first conviction was 17.4 years (sd: 6.5) and mean number of previous convictions was 11.3 (sd: 8.3). The mean number of prison terms was 4.6 (sd: 5.1) and mean number of prior offences was 25 (sd: 22.6). Violent behaviour was prevalent among the recruited sample: 7 men reported injuring someone with a weapon and the same number reported that they had injured the victim so badly that they had required hospital treatment. In some cases, the violence was characterised by extreme cruelty; one participant had abducted a boy and subsequently tortured him by stubbing out cigarettes on his face and pulling out his finger nails. Another participant had cut his brother with a knife after he had refused to harm himself when encouraged to do so by the participant. Three participants reported that the victim had died as a result of their injuries.

Table 7. Past psychiatric and drug history for sample recruited from ELCMHT

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Mean age (SD) at 1st contact with mental health services	18.1 (9.1)	24.3 (10.1)	19.7 (9.3)
History of self-harm?			
Yes	7 (78)	3 (100)	10 (83)
No	2 (22)	0 (0)	2 (17)
Self-harm in previous 6 months?			
Yes	2 (22)	2 (67)	4 (33)
No	7 (78)	1 (33)	8 (67)
Ever injured self so badly that required hospital?			
Yes	5 (56)	3 (100)	8 (67)
No	4 (44)	0 (0)	4 (33)
History of non-adherence with treatment			
Yes	6 (67)	2 (67)	8 (67)
No	3 (33)	1 (33)	4 (33)
History of absconding behaviour			
Yes	4 (44)	2 (67)	6 (50)
No	5 (56)	1 (33)	6 (50)
History of alcohol misuse			
Yes	7 (78)	3 (100)	10 (83)
No	2 (22)	0 (0)	2 (17)
History of opiate misuse			
Yes	5 (56)	1 (33)	6 (50)
No	4 (44)	2 (67)	6 (50)
History of cannabis use			
Yes	9 (100)	3 (100)	12 (100)
No	0 (0)	0 (0)	0 (0)
History of cocaine use			
Yes	3 (33)	0 (0)	3 (25)
No	6 (67)	3(100)	9 (75)
History of crack use			
Yes	6 (67)	1 (33)	7 (58)
No	3 (33)	2 (67)	5 (42)
History of amphetamine use			
Yes	6 (67)	2 (67)	8 (67)
No	3 (33)	1 (33)	4 (33)
History of solvent misuse			
Yes	4 (44)	1 (33)	5 (42)
No	5 (56)	2 (67)	7 (58)

Table 8. Criminal history of sample recruited from ELCMHT

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Mean age (SD) of 1st conviction	15.4 (2.3)	23.3 (11.8)	17.4 (6.5)
Mean number (SD) of prior convictions	12.1 (8.0)	8.7 (10.8)	11.3 (8.3)
Mean number (SD) of prison terms	5.4 (5.7)	2.0 (2.0)	4.6 (5.1)
Mean number (SD) of prior offences	26.8 (22.9)	19.7 (25.5)	25.0 (22.6)
Convicted of homicide			
Yes	3 (33)	0 (0)	3 (25)
No	6 (67)	3 (100)	9 (75)
Convicted of other violent offence			
Yes	8 (89)	1 (33)	9 (75)
No	1 (11)	2 (67)	3 (25)
Convicted of sexual offence			
Yes	1 (11)	0 (0)	1 (8)
No	8 (89)	3 (100)	11 (92)
Convicted of property offence			
Yes	4 (44)	1 (33)	5 (42)
No	5 (56)	2 (67)	7 (58)

Table 8. Criminal history (continued)

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Convicted of acquisitive crime			
Yes	8 (89)	2 (67)	10 (83)
No	1 (11)	1 (33)	2 (17)
Convicted of drug offence			
Yes	4 (44)	0 (0)	4 (33)
No	5 (56)	3 (100)	8 (67)
Convicted of firearms offence			
Yes	2 (22)	1 (33)	3 (25)
No	7 (78)	2 (67)	9 (75)
Convicted of driving offence			
Yes	4 (44)	0 (0)	4 (33)
No	5 (56)	3 (100)	8 (67)
Substance misuse implicated in index offence			
Yes	5 (56)	0 (0)	5 (42)
No	4 (44)	3 (100)	7 (58)
Alcohol misuse implicated in index offence			
Yes	5 (56)	2 (67)	7 (58)
No	4 (44)	1 (33)	5 (42)
Ever hurt someone so badly that they died?			
Yes	3 (33)	0 (0)	3 (25)
No	6 (67)	3 (100)	9 (75)
Ever hurt someone so badly that they needed hospital treatment?			
Yes	6 (67)	1 (33)	7 (58)
No	3 (33)	2 (67)	5 (42)
Ever injured someone with a weapon?			
Yes	6 (67)	1 (33)	7 (58)
No	3 (33)	2 (67)	5 (42)
Violence Risk Scale Rating			
High	6 (67)	-	6 (50)
Medium	2 (22)	-	2 (17)
Low	0 (0)	-	0 (0)
Missing data	1 (11)	3 (100)	4 (33)

3.3 Developments over the course of the evaluation

3.3.1 Service activity

At the time of preparing this report, the service had received approximately 150 referrals for the in-patent unit and the Baxter Road Residential Service (48 new referrals were being processed at the time of writing). Administrative problems (see below) meant that the team were unable to provide exact figures for the number of referrals. As of April 2007, 15 service users were on the in-patient unit. Over the period of the evaluation, two service users were discharged back to prison. At the time of collating final figures in April 2007, the residential service had 3 service users and 3 service users had been discharged since the evaluation commenced. One service user was recalled back to a different ward in the Centre for Forensic Mental Health. One disengaged with treatment; the residential service team attempted to provide outreach support but he was eventually lost to follow-up. A further service user was admitted as an in-patient to Millfields Unit when it became clear that the residential service was not a sufficiently containing enough environment to manage the risks that he posed to others.

Over the course of the evaluation, the Home Office voiced concerns about the fact that the in-patient beds and residential service places were not being filled swiftly enough. The residential service was particularly slow to admit service users. The service opened at the end of March 2005 but did not admit its first service user until approximately 6 months later, in October 2005. A further two service users then joined the service approximately 4/5 months later in February and April 2006. Residential staff told us that greater emphasis had been placed on 'filling-up' beds on the in-patient ward simply because the in-patient unit was the most costly component part of the service. In addition, admissions to the residential service were delayed for several months because a Trust policy relating to out-of-hours cover had not been clarified. Over this period of time the residential service was running on a 'skeleton' staff with some staff also working in other Look Ahead services. At the time of writing this report, because there were only 3 service users, it had not been practical to run any groups within the residential service.

The residential staff shared some of the Home Office's frustration and were looking forward to a time when the service would be busier:

Disappointed I suppose around the number of people coming through... and I think that has been a barrier to being able to carry out some of the work ....that we would have liked to have done here so you know... more group work, more activities, more of a community spirit or whatever... if that's the right word really for here... and it's difficult to do that when you've got limited numbers. S28 (follow-up)

I'm just hoping to see the house filled, it will be really a joy, if we have more people, if we be more challenging and we will be, we get busier and we get more difficult issues being handled, now the residents we have here, they know how we work and they've settled in and it's just like routine, everyday they do the same...it be nice if we get new people in to bring in new challenges and make all of us you know be more active again you know as we should be. S29 (follow-up)

3.3.2 Changes in funding arrangements

Originally the service was due to include a community team to complement the residential and the in-patient service. However, we were told that insufficient funding was available to fund all three tiers of the originally proposed service and so plans for a community team had to be scrapped. Instead, it was decided that the in-patient team would offer consultancy and management advice and also provide clinical input to the residential service users. In the absence of a community team, all referrals and assessments had to be performed by clinicians

from the in-patient team. The extra workload has put them under considerable added pressure:

The hostel was meant to be paid for by the Trust outside the budget for this pilot and somehow its crept in, so its been paid for out of the total sum that's received from the Department of Health and that's had a big impact financially… it's meant that we've got, we can't have the community team that I think some of the pilots have got and its going to have a detrimental effect on the service users and the staff in a hostel and a huge effect on our workload. S23 (baseline)

3.3.3 Changes in catchment area

In the original service specification documents, it was stipulated that the service would cover a catchment area incorporating the London boroughs of City, Hackney, Waltham Forest, Tower Hamlets, Newham, Redbridge, Havering and Barking & Dagenham. The total catchment population for this area is approximately 1.5 million. When we interviewed staff in September 2005, many staff expressed concerns about the size of the task facing them, stating that it was overly ambitious:

We've had our hands full just trying to see, make ourselves known, and make links with the boroughs that the service covers already. Making links with the boroughs that we - our Trust - doesn't even cover, that's been um… almost beyond our reach at the moment…so that's one aspect of the links with other services. S27 (baseline)

As a result of negotiations between the Home Office and the services, the catchment area was further expanded as of 1st September 2006 and now covers the whole of North London.

3.3.4 Challenges of recruiting and retaining high calibre staff

Millfields Unit

Recruitment of staff commenced in mid 2003. A steering group agreed on a clear timetable for recruitment and work went into targeting potentially interested candidates. The lead Consultant Forensic Psychiatrist and Lead Nurse posts were identified as being the most important posts to initially fill and indeed both posts were filled fairly swiftly. However, the successful recruitment of high quality staff to the remaining posts proved to be a much slower process. In addition, retention of senior staff also proved to be problematic. The Lead Nurse was employed in February 2004 and left the service in August 2005. It was decided that the funding for this post should be diverted to pay for a Service Manager post. This was because the Forensic Services Director was having to undertake a great deal of administrative tasks to support the opening of the new unit. A Service Manager was therefore recruited and was in post between April 2006 and January 2007. Once the new unit opened in January 2007, the role of the Service Manager became less important and so funds for that post were used to re-employ a Lead Nurse. The Lead Consultant Psychiatrist has had to take on the role of Service Manager. Other changes within the staffing structure have occurred. In February 2007, the senior Psychologist left the service for a more senior position. In addition, the lead Forensic Consultant Psychiatrist had to take sick leave over Autumn 2006. During this period, RMO cover for the ward was provided by a Consultant Psychiatrist in Psychotherapy who had previously been working in the main Centre for Forensic Mental Health.

The changes in senior personnel undoubtedly affected the cohesion of the staff group and working relationships. When re-interviewed in April 2007, some staff told us that the process of re-forming the staff group had not been easy.

I think that the, that there are ways in which the team functions well and we are able to communicate and work together and there are elements of that....I think we've struggled in

that there have been a couple of fairly senior departures within the X *team and I think that has meant that there's been a constant process of then getting to know…building up a rapport again with an important member or group of the MDT…an effect I think on how well we've functioned as a team…has been how we resolve difficulties within the senior team, that whether we are able to kind of tolerate diversity…I think that with more flexibility around that and recognising the value of different styles and ways of doing things would help.* S27 (follow-up)

The problems of recruitment and retention of staff were compounded by other external factors. Staff told us that the Human Resources Department spent an inordinate amount of time working on job descriptions for posts. In addition, there was a lack of clear communication between the clinical team and the Human Resources Department. In addition, staff told us that a Trust policy restricting the use of probationary periods deterred the team from recruiting some potential applicants.

Another source of staffing problems proved to be the administrative staff. The administrative arrangements for the service were described by one member of staff as having *"collapsed"*. The referrals coordinator for the Millfields Unit was recently asked to complete all referrals for the Centre for Forensic Mental Health. This additional workload effectively meant that the amount of time available for Millfields Unit work considerably diminished. The growing unmanageable amount of work had a detrimental effect on morale and several administrative staff resigned their posts. The Management Team Secretary Post has been filled by four temporary staff since January 2007 and when staff were re-interviewed in April 2007, it was felt that staff were being recruited who could not cope with the work. At the time of writing this report, an urgent meeting was scheduled to be held between the unit management team and the Head of Admin in an attempt to resolve the issue.

Throughout the evaluation, senior staff told us that one of the biggest challenges they had faced was that of recruiting the staff with the core capabilities, training and experience necessary for working with PD service users. The available pool of people from which applicants might be recruited proved to be small. During the course of the evaluation we became aware of the fact that staff were applying to work in the ELCMHT pilot from other forensic PD pilot services.

Baxter Road Residential Service

Six of the original 10 members of residential staff were still in post when we completed data collection. The team were in the process of recruiting two new members of staff at the time of writing.

3.3.5 Working relationships between staff

Although relationships between staff appeared to be acceptable on a day-to-day basis, over the course of the evaluation we were told that there was a lack of clarity over 'leadership' and a lack of shared clinical vision:

I think it's powerful personalities, lack of clarity from the beginning of how the project is going to be run, about who's doing what, what are the roles, so you know, I think that's probably at the root of it, it's not been thought through properly…it still kind of impacts on the team though to… to have a leader and leadership perhaps, not knowing who is the leader as well, who is the… who leads all this you know. S25 (follow-up)

There hasn't always been agreement about, about our mission and, and it's particularly, I suppose that's been one particular area where it has manifested that there are tensions within our team around the vision for that community service. S27 (follow-up)

In addition, staff told us that relationships between Millfields staff and staff working in the Centre for Forensic Mental Health were not good. Negative remarks about the service had been made and some had questioned the effectiveness of the treatment being offered. Two service users told us that they had heard rumours of staff in the Centre Health expressing pejorative views about Millfields Unit.

I go out with patients on the other wards because I know quite a few of the patients on the other wards anyway but it's the staff. They call this the horror ward. SU13

By way of an attempt to remedy this situation, an "Open Afternoon" was planned to provide information about the service and to correct any misperceptions about the work of the Unit. The staff told us that they hoped that the Service Director and Medical Director would be able to spend more time familiarising themselves with the work of the service and that this might also help to improve working relationships within the wider John Howard Centre.

3.3.6 Working relationships between Millfields Unit staff and Baxter Road staff

When we first interviewed staff, the general perception was that working relationships between Millfields' and Baxter Road staff were good. One year later, the relationships and quality of liaison between Millfields and the residential service were still reported to be good – in part due to the fact that staff from the two components met regularly and reflected together on their practice. In addition, the provision of emergency on-call cover by in-patient staff to the residential service also served to consolidate good working relationships between the two components:

I've really enjoyed working with that team and um, maintain as close as contact with them as possible…so we've actually… I think built up quite a strong team spirit that's shared between Look Ahead and us [Millfields]…I guess what's also been useful is that we have reflective practice meetings... and those are fortnightly and I think that has meant that as well, across their team, that we've felt more embedded in the work because none of us are actually based there and so that obviously presents a difficulty…I think the other thing is that we've got this on-call rota where they know there's a member of the clinical team allocated each week to be contacted for emergencies... and I think they've appreciated that, so I think on the whole that's felt like a very positive working relationship and its been consolidated by when they're in crises together when patients have acted out there have been difficulties, um, I think that we've grown in confidence in working with each other. S27 (follow-up)

Staff told us that they anticipated closer collaboration between the two services when more service users eventually move from the in-patient unit to the residential service.

3.3.7 Relationships with the Home Office

When initially interviewed in September 2005, several staff indicated that they had experienced intense pressure from the Home Office to increase the level of service activity. Whilst they appreciated the need to 'fill-up' beds, staff told us that calmer and more consistent interest and guidance from the Home Office might have been more helpful. Members of the Home Office team would sometimes turn up un-announced; staff told us that they would have appreciated some warning prior to being visited. On occasions, Home Office dissatisfaction with the performance of the service had led to the threat of closure. This had created an atmosphere of great tension within the clinical team.

I would like... I think it would be quite good if their involvement was regular and predictable, rather than... oh we've got this visit on Friday, you know it would be quite good to have it mapped out, when they're visiting, what they're looking for, what we are working to, its not really some great big level of preparation, but well... be quite clear involvement about this....it would be quite good to have regular input from them, rather than a sporadic one. S25 (baseline)

I think making their [the Home Office] expectations clear... because twice now we've been in the position whereby they've said if you don't fill your ward within two, two or three months we'll take away the funding and if we'd known what their expectations were I think we could have...managed our referrals and assessments better actually to, to actually give them what they wanted. S23 (follow-up)

There's been times when the pressure to perform and produce does get transferred down the food chain and so therefore, that compromises the degree of support that there is to kind of keep productive and keep all the balls in the air... and I suppose that then, with the degree of pressure that the team has felt, that has produced tensions within the team and then that feels unsupportive, when those tensions bubble or come to the surface. S27 (follow-up)

3.3.8 Relationships with the other pilot sites

Staff felt that it would be useful to regularly communicate with the other pilot services and indeed some senior staff had been able to network with other sites at Home Office conferences. However, generally, the sheer size of the clinical workload often prevented regular communication between staff working in different services.

I feel that people just get so busy doing their own thing...I think the relationships were much stronger then than now, there's just so much to do...realistically of course it would be great to know what they are doing, we could adapt and learn and things. S25 (follow-up)

I need to go out and test the water, I want to go and visit Newcastle, we might be able to learn from each other...as an X you get so caught in your bubble of your ward but actually your skills and resources and failures could help each other. S24 (follow-up)

3.3.9 Relationships with other local services

Millfields

At the time of the first interview, (September 2005), staff had visited several prison establishments in the London area in order to forge links and generate referrals. Some members of the team had also been to visit Ashworth, Rampton, Broadmoor Hospitals and Whitemoor Prison in order to establish working relationships with these services. The team had also contacted a CPN per borough and one member of staff was attending meetings with them. The social worker for the in-patient team was an ex-probation officer and had previously established links with several London boroughs and attended MAPPP meetings in Tower Hamlets, Newham and Hackney. The team had also presented information about the pilot service to other local Medium Secure Units.

Baxter Road Residential Service

The residential service manager attended MAPPPs to identify potential clients, and other links with other services were being arranged via Millfields Unit. Staff working in the residential service told us that as the service got busier, close working relationships would inevitably have to develop with local services.

3.3.10 Untoward incidents occurring during the course of the study

We sought to obtain information about the occurrence of untoward incidents happening during the course of the evaluation. In response to our enquiries, we were sent a document listing incidents occurring over the period November 2006-March 2007. Between 17.11.06 and 20.03.07 there were 7 recorded incidents on the unit and 2 in the residential service.

Millfields Unit

Three incidents involved threats of violence. One threat of violence was made with a weapon towards another service user. The other incidents involved threats being issued to staff and were dealt with via de-escalation, local clinical review and relocation of the service user. Other incidents involved a service user collapsing after an epileptic fit (the service user was subsequently hospitalised), and 'green matter' (possibly drugs) being sent to a service user on Millfields Unit. Two Serious Untoward Incidents also occurred. These involved a service user fashioning a blade from a pencil sharpener to cut himself with and a faxed referral report on a sex offender in Rampton being sent by the secretary to the wrong mail address.

Baxter Road

The two incidents at Baxter Road involved a service user purchasing an imitation fire arm, being tasered by police and held overnight in police cells. He appeared in court the next day and was sentenced to a 2 year Community Service and Residency Order to be served at Baxter Road residential service. The final incident involved a residential service user making violent threats with a weapon.

In 2006, the Clinical Lead of HMP Whitemoor DSPD service made a complaint to the Trust regarding Millfield's decision to return a service user to Whitemoor because the man in question was judged to be unmanageable in conditions of medium security. As a result of the complaint, an independent panel of enquiry was convened. The panel made a number of recommendations for improvement to the service and these have subsequently been introduced.

3.3.11 Local research and audit

Millfields Unit

Millfields employed a full time researcher to carry out research and audit within the unit. During the evaluation, this researcher has been setting up a number of projects and at the time of writing this report, data collection is underway for the following projects:

- Research on the process of referral to, assessment for, and admission to the service. The aim of the study is to describe the key characteristics of those referred, assessed and admitted to the service and to investigate whether they form a distinct population by comparing them to two other personality disorder samples admitted to 'ordinary' MSUs.
- A project examining the impact of the clinical work on the staff. The aim is to clarify individual and organisational characteristics associated with 'success' in the job. It is envisaged that a mixed-methods approach will be taken.
- Data for the 'common/minimum' dataset was being collected (see above) as well as on some 15 other assessment tools.

During the course of the evaluation, the service became a member of the 'Community of Communities' (a quality network of therapeutic communities run by the Royal College of Psychiatrists' Research Unit). During March 2007, the service took part in a peer review

process, (an audit of standards that members deem to be essential to be defined as a TC). At the time of writing this report, the team were waiting for the report from the Community of Communities although verbal feedback was reported to be good and a number of areas of good working practice had been identified including staff relationships, consultation with service users and links with outside agencies. Suggested areas for improvement included service user feedback and attendance at the staff support group.

Baxter Road Residential Service

Managers within LAHC ran a quality assurance audit and on a monthly basis checked *"all household data"*. According to LAHC protocols, all of the hostel's systems were *"working fine."*

3.4 Is the programme working?

3.4.1 Qualitative evidence

3.4.1.1 The views of staff

In their initial interviews with us, most staff told us that they were not in an informed position to comment on the effectiveness of a treatment programme which was at that time only just being set up. When staff were re-interviewed in April 2007, there was a consensus of opinion that the team had been successful at engaging service users in a busy and stimulating treatment programme.

I think by and large its working out well, obviously its very early days and its too early to tell whether it's a success in terms of you know treating patients as much as they can be treated…we've engaged most of the patients who've come to the unit, very, very fully I would say and they're stimulated by the programme and very involved in it which I think is a good sign. S23 (follow-up)

I think as an overall structure, that the treatment milieu on the ward is working well, it feels as if there is a kind of an atmosphere that's happening, um, the patients seem to be engaging really well in the community meetings and um have been enthusiastic about the treatment they've been offered and by and large the level of engagement has been really well. S27 (follow-up)

*If you probably look at our programme they've got community meetings three times a week, they've got small group therapies, so everyone on the unit now except for one patient is engaged in quite intensive kind of group work, they've got obviously hobbies and interests so that their day is full, we have to pace them, not everyone will need the same programme.*S25 (follow-up)

One area felt to be working particularly well was the community meeting which gave the service users an opportunity to have active input into their own treatment and the ward environment. Staff were positive about the developing ward milieu.

I think it's community meetings which are very beneficial because that is where they can have the ownership of the development, where they can challenge each other when they have, um, a say about how the place is run. S25 (follow-up)

I think what feels like its working well is the level of um, the level of input the patients have and it feels like its gaining momentum, they're shaping the living environment and I suppose that's what it feel like the whole idea of having a TC ethos to what it is we're doing that increasingly that's bedding itself down and it feels as though that's been a positive. S27 (follow-up)

The team at the residential service identified a number of domains where they felt that promising changes were occurring in the lives of several service users, including a diminishing risk of self-harm.

Less self-harm, better negotiating skills, better ability to see another person's perspective, um, better able to receive feedback without, you know, taking it very personally and reacting to that you know perceived insults really, um, some, I think some of them have improved relationships with their families I think. S23 (follow-up)

There have been people who have been able to do real work around, um, their self harm because they're not able to run away from it into substance misuse and so there's been

significant gains and containment around self harm of course it can be patchy and people lapse but hey, they've made real gains. S27 (follow-up)

Staff thought that a good rapport was developing between the service users and staff and that this was central to ultimate treatment success:

The issue of trusting, working collaboratively with someone who's policing them in some way, it feels as if people have made strides in being able to, um, actually form working alliances with someone, with authority figures and I know its early, early days but that's possibly one of the most fundamental things that they need to be able to do and there does seem to be levels of rapport. S27 (follow-up)

Other staff identified the fact that some service users were becoming more tolerant of the everyday "*ups and downs"* in their relationships and were developing a greater capacity to negotiate and cope with disappointment. This theme was reiterated to us by the service users.

I would say that the patients are needy actually, it would be easy for me to sit here and say that they've been by and large good but I think what's important is that the bad aspects of it can be explored...I think the ability to put up with less than perfection and um, negotiate relationships that you know are sometimes disappointing is terribly important actually so I think in a way they have to go through a difficult relationship in order for it to be beneficial....so they're [the nurses] are using their knowledge of the individual really umm and I think they're, I think in the very early days people didn't know one another in amongst the staff and not they're working better as a team, there's more trust. S23 (follow-up)

I think the ability to put up with less than perfection [from the staff] and um, negotiate relationships that you know are sometimes disappointing is terribly important actually so I think in a way they have to go through a difficult relationship in order for it to be beneficial. S23 (follow-up)

It's a bit like the weather, its unpredictable, but I think that is healthy, I think if we were to say its settled, the relationships are settled I'd be lying, I think it's healthier to say its unpredictable and it also keeps you in mind that anything's possible. S24 (follow-up)

Some staff felt that that the service would not necessarily work for everyone - some people may be too disturbed to benefit and the treatment exacerbated psychological problems.

My worry is about people who are much more damaged and who are not going to be able to fit in or maintain quite a high level of group skill and capacity to manage group work.
S27 (follow-up)

I think for one or two of the guys the actual group work and listening to other people's pain and past experiences is just, it feel tormenting for them and I think its very hard for them to hear which then pushes them into a place psychologically that I think they want to stop it…sometimes you're making them worse by default, being in a group and really getting them to take the layers of their defences away is that people get depressed. S24 (follow-up)

The impact of the clinical work on the staff

Many of the staff that we interviewed in both the in-patient and residential service acknowledged that working with this client group was draining and relentless.

I think we've felt beaten with a big stick for a while because it felt like it was a constant investigations, complaints, letters from solicitors…it's the low level of demands all the time…I think that it's the, the front line [staff]*, they're on the coal face all day long you're*

here for 8 hours, sometimes longer if you have an incident… you don't have the capacity to just walk off the ward when you're having a bad moment because you might be doing something else you know, I come in here and open them doors and have a good cry, I can't do this work... you know just because I've felt so bombarded with it that I think hang on a minute, I need a break, have a bloody holiday. S24 (follow-up)

All the staff whom we spoke to recalled incidents when they had been afraid of the service users.

I think we've got some very intimidating men, actually what… I recall about this person that frightened me was how well he used intimidation because I don't think he had the slightest intention of hitting anybody, you know in hindsight but he was very good at invading, you know, your personal space, at shouting, at really looking as though he might do something, um, you know all those things and just towering, you know I was standing with a nurse and he was much taller than both of us, things like that towering over you, shouting, not letting you get a word in edgeways so you couldn't have a proper discussion, um, yeah, and I know other nursing staff have been afraid of actually the same bloke, yeah, and there was an incident with another patient who went into his room and picked up a chair and sort of tore it to pieces very easily, which was worrying and then um, sort of greased his arms with I think it was E45 or body lotion and that means you can't restrain somebody because you can't get a grip so that's frightening. S23 (follow-up)

There's a little walk you do by yourself along the corridor [in the ward] and that was a real fear of being maybe attacked, physically actually, because you know those people are potentially very, very violent and some of them have very paranoid thoughts of, so yes I have, I have been quite frightened on one occasion when patient put rubbish in the bin very suddenly and next to me and that was unnecessary move and I am pretty sure he's done it to scare me so it's that kind of you know, yes, so I would say I have been scared and I would imagine, and I have heard from the discussions we have in support group that other people were as well, you get shouted a lot, they invade your space… S25 (follow-up)

I think it is scary, this work is scary I'd be a fool to say its not, there's potential risk all the time. S24 (follow-up)

Some staff talked about the added pressure of having to set up the service and having to do everything *'from scratch'*. This led to key senior staff feeling over-worked, particularly during the initial phase of setting up the service.

We've got so many things to do…there's loads to do and you know, loads to develop and everything is a priority... you've got great big stress of filling the ward and processing referrals, assessment so I would say I find that stressful, the pressure, organisational pressure to, to deliver…there's loads to do and I work much more hours than I am supposed to…I think we need to work a bit better at that so we use our time better otherwise we get exhausted. S25 (follow-up)

I think the biggest problem we've had is that there's been an expectation that in terms of service development that everything is going to be able to happen from scratch, specifically for this service… and that its going to be done as comprehensively as say the high secures have done…complete mad expectation, the number of hours we've put in… its completely unreasonable…it feels like you're failing constantly and then that feel damaging because, the, this pilot's under enormous scrutiny and we want to do well, there's SLA meetings and external evaluators you know… and that…that has felt um… that's felt very difficult…it's just as, uh, too many assessment tools to be done at the same time as service development and trying to get on with treatment . S27 (follow-up)

3.4.1.2 The views of the service users

What has been helpful?

When interviewed in 2007, service users generally expressed positive views about the treatment programme. Most of the service users identified the groups (particularly the community meetings and small groups) as being the most helpful aspects of treatment. It was generally felt that groups were a place where one could unburden oneself and help and support one another.

I find them small groups help…the sort of stuff you talk about in there you know, it's where you start to change after all the stuff and get things off your chest, start to relate it back to your childhood. SU11

The small groups are good though because that's where you do all the hard work because the main hard work now… is in a group with people that are peers and like one person might lie to you and that means you can give him support and help each other and they get to know you which I think is important because it takes a brave person to come forward and start telling you his childhood abuse. SU13

The majority of service users whom we interviewed stated that for treatment to work, the service user had to come willingly to the programme and *"want to be there"*. Lack of engagement or *"faking"* meant that treatment would not work. Faking was identified as being disruptive for the other users of the service. Indeed, service users went further than this and told us that in their view, disruptive/non-engaging service users should be swiftly removed from the programme, before problems escalated:

There's no way it's going to work if you don't want to be here… you got to be willing. If you are not willing then you are not going to get nowhere. SU10

People what have pulled out of therapy, don't want to be here, disrupting the unit, about moving them because they are just here disrupting everyone else and they have got stuck. There is nowhere for them to go. So thing you know, just disrupting everyone else….you have no way of challenging that person because he is not in therapy….and it can ruin someone else's chance of therapy. SU11

Many felt that having different people at different stages of change was problematic and also potentially disruptive. Some did not like sharing a ward with sex offenders. The consensus of opinion was that potential service users should be chosen extremely carefully. Risky candidates for treatment were those identified as being:

- too young
- not having done enough psychological preparatory work/therapy prior to being admitted to the service
- 'lifers' – whom service users felt needed to *"do their time"* before entering treatment.

Service users also identified optimal periods to enter the treatment programme - it was felt that generally this was towards the end of a prison sentence, rather than at the start or middle of a sentence.

What have service users learnt?

Millfields' service users talked about learning to better control their anger and aggressive behaviour. Some service users also spoke about experiencing improvements in their communication – being able to interact more with other people and having acquired new social skills. Others spoke about reducing the amount of self-harm that they engaged in.

Learning how to control my anger, which I think I am doing very well. Um, not creating any riots - I manage that... I get angry a little bit, but not as much as I used to ... now, I will think before I act, whereas before, I didn't think, I just acted straight out, or said it, whatever, but I actually think first before I approach someone which has... this place has taught me you know....and I've learnt to interact more with people as well…this place has made me see things that I hadn't, I hadn't really seen before... So, in a way, that's me reformed, taken me out of my shell basically. SU12

What do the service users think about the staff?

In their initial interviews with us, service users told us that they felt that staff were accessible and that they could talk to them. However, when discussing this issue in the focus group, service users spoke more critically and mistrustfully about the staff, saying that they felt that caution needed to be exercised in dealing with staff as everything spoken about would subsequently be recorded in their records.

I think a bad thing in here is people writing about you all the time, 24/7 - don't matter what conversation you have with someone, they go straight in the office and write a conversation about it. SU13

Other barriers to trust were also mentioned in the interviews and these themes were also discussed in the focus group. These included staff having the *'wrong attitude'* and high staff turnover leading to difficulties in developing trusting relationships. Examples of the 'wrong attitude', included staff looking 'down on them' – the occurrence of which was attributed to a lack of training.

I think a lot of the attitude, the wrong attitude, comes with lack of training in this environment where they are dealing with the schizos from the other wards. We are the PDs, but they have been on the acute wards and they come on here and they expect us to...to, I don't know, not challenge them if something is wrong or if we want something and they say 'no you can't have it', and we know it is our right - we will challenge it won't we? That's not accepted, really from them, they are not expecting it. So that helps to enforce the wrong attitude that they do have. So I think it goes down to training really. SU10 (focus group)

Frequent changes in the staffing structure were perceived to be particularly unhelpful and inevitably hampered the formation of trusting therapeutic relationships. For example, one service user described having had 3 named nurses in a year and half. The arrival of new staff or bank staff was felt to be a particular problem - service users found it difficult to trust them.

A lot of new staff keep coming in as well, you actually get used to staff and then you've got a new one coming in so you have to get used to them all over again. SU11

Trying to get all the staff is a nightmare...but we get a lot of bank staff too...if you got a change of nurse you should be told by the senior nurse, or your own nurse or someone else, you shouldn't find out off the residents that you have got a change of nurse. SU13

Most of the staff in here are trainees... they come in for about 6 months and then they go away and another one will come in, you know, I'm not used to those sort of things, to be honest...So that's the reason why I said this place is not um, organised well....it's not really a high turnover of staff but all of a sudden out of the blue, staff are coming to the community meeting and says 'oh by the way I am leaving on such and such a date you know.' It's not happening very frequently but when it does happen it's very disruptive....working with that person and then for instance you sort of um, set your mind to be doing a long period of work with them, and then all of a sudden they up and leave you know. That throws you back you know... it makes life very unstable...if I didn't feel they were going to leave then I would yeah, I would put more trust in them. SU12

Newly trained staff were perceived to be naïve, lacking in experience and therefore, easily manipulated. Trainees were perceived to be particularly vulnerable and therefore unhelpful.

The staff we have here are very young…just starting out in the game…you know they just left college and are still training really…they're trusting, trusting in you…there are issues but hopefully staff will learn with the next lot of patients that come in because they're still learning with us if you know what I mean. A lot of mistakes are being made…all this changing of staff that's not good because staff come in here they don't know what's happening, they don't know where things are and to be quite honest, we're not to be trusted to give staff advice. Really, not with our histories, that's what I mean by some staff being naïve, you get the wrong person here and he'll take advantage of openings.SU10

More training is useful yeah but you don't need training, you need professionals in this game. Yeah, you need professionals….don't fill the place up with trainees you know, because that's what seems to be happening in here, it's trainees that are coming and going, coming and going all the time you know. And I think that needs to stop. I think they need to employ more professional people and the trainees, if they are going to bring in trainees, bring in one or two as under studies to teach them the ropes, know what I mean. That's how a place like this should run you know. Not open a brand new building and then fill it with trainees. SU12

They've got to do that to make them realise its not ordinary people they are working with. It's people with some serious problems you know, people with life sentences, I'm a lifer, you know. I'm capable of all sorts you know…they have got to be more realistic. SU12

Suggested improvements for the treatment programme

Several service users expressed frustration about the length of time being taken to set up a full group programme.

Like small group yeah, took a long time to get us into a small group. And there's people here that want to do substance misuse group….it's things like that you know. It takes… they drag their feet a little bit. They think you are all right to just be sitting on the shelf. My idea is that I thought I would be coming here to do treatment.' SU15

Finding a very easy cop out that is happening all the time is this is a pilot scheme, this is a pilot. I'm sorry, but you are dealing with men's futures here, you know, it's, it can't be used no more, really. Needs to be set up, we are not guinea pigs. SU10

Suggestions for more groups included anger management programmes, education, gardening or community work. Service users particularly suggested the need for greater help with their drug and alcohol problems. One service user described how the lack of containment surrounding his drug and alcohol problems had led him to be transferred back to prison.

When I was in the hostel I was seriously doing them [drugs] *every couple of weeks…substance misuse, as soon as I got there, see it was only uh… about 5 weeks after I got in there that's when I started, things started going wrong with my substance misuse, and then a week later I ended up in prison over it. Management, they* [residential staff] *need stuff, because if you've got people going in there with drugs and alcohol problems you want to get them into substance misuse groups pretty quickly.* SU14

Some service users told us that it would be good if people from the Home Office came to visit them to talk about the treatment programme. Coincidentally, subsequent to our interviews, two staff from the Ministry of Justice/Department of Health facilitated a meeting with service users on 26th April 2007 in which they sought to determine their views about life on Millfields Unit. (see Appendix J for details).

3.4.2 Evidence from the quantitative data: 6-month follow-up of service users managed by the service.

At six months, all 12 men recruited at baseline were still being managed by the service, although one residential service user had moved out of Baxter Road Residential Service to live with his partner and one Millfields service user was in the process of being discharged from the unit as he was not engaging in the programme. We were able to obtain complete follow-up ratings on 11 of the 12 men.

Behavioural disturbance (Table 9)
Over the 6-month follow-up period, 2 men absconded from the residential service, 5 men engaged in one or more incidents of self-harm (4 of whom had being self-harming in the 6 months preceding baseline interview), 8 men had one or more incidents of non-compliance with aspects of the treatment programme (including medication), 2 men were found in possession of contraband material (alcohol and prescribed medication). Among the cohort of men recruited, there were no documented episodes of serious violence to others, although one man threw a pack of orange juice at a member of staff. Four men were involved in incidents of property damage. (NB. We should emphasise that although there were no serious documented incidents of violence among the cohort of service users whom we followed-up over the period December 2005-June 2006, over the period November 2006-March 2007, there were 3 incidents of threatened violence – see 'Untoward incidents occurring during course of the study'.)

General function (Table 10)
The mean WSAS score at follow-up had decreased (improved) from 15.8 to 12.4. However, the difference between mean baseline and follow-up WSAS scores was not statistically significant at the 5% level (paired t-test $p= 0.07$).

Therapeutic alliance (Table 10)
The mean service user –rated alliance score had decreased (deteriorated) from 56.7 to 53.2. The difference between mean baseline and follow up service user-rated alliance scores was not statistically significant (paired t-test $p= 0.4$). The mean staff–rated alliance score had decreased from 61.7 to 60.9. The difference between mean baseline and follow up staff-rated alliance scores was not significant (paired t-test $p= 0.8$).

Belief about personality disorder diagnosis (Table 4)
Seven of the 9 men who thought that they had a PD at baseline continued to hold this belief at follow-up; 2 men changed their rating of this question to 'don't know' at follow-up.

Table 9. Behavioural disturbance* at 6-month follow-up

Variable	Millfields unit N (%)	Baxter Road N (%)	TOTAL N (%)
Use of non-prescribed substance			
Yes	0 (0)	1 (33)	1 (8)
No	9 (100)	2 (67)	11 (92)
Use of alcohol			
Yes	0 (0)	1 (33)	1 (8)
No	9 (100)	2 (67)	11 (92)
Incidence of self-harm			
Yes	3 (33)	2 (67)	5 (42)
No	6 (67)	1 (33)	7 (58)
Incidence of violence			
Yes	1 (11)	0 (0)	1 (8)
No	8 (89)	3 (100)	11 (92)
Absconded			
Yes	0 (0)	2 (67)	2 (17)
No	9 (100)	1 (33)	10 (83)
Incidence of property damage			
Yes	4 (44)	0 (0)	4 (33)
No	5 (56)	3 (100)	8 (67)
Found in possession of contraband material			
Yes	1 (11)	1 (33)	2 (17)
No	8 (89)	2 (67)	10 (83)
Incidence of non-adherence with treatment			
Yes	5 (56)	3 (100)	8 (67)
No	4 (44)	0 (0)	4 (33)

* information taken from case records

Table 10. General functioning and alliance scores at baseline and 6-month follow-up

Variable	Millfields unit	Baxter Road	TOTAL
Mean WSAS score (SD) at baseline	15.4 (6.8)	20.7 (3.2)	15.8 (6.9)
Mean WSAS score (SD) at 6-mth follow-up	11.0 (7.9)	16.3 (3.5)	12.4 (7.2)
Results of paired t-test	*P*= 0.2	*P*= 0.3	*P*= 0.07
Mean service user-rated alliance *score (SD) at baseline	58.4 (17.3)	51.3 (9.1)	56.7 (15.6)
Mean service user-rated alliance score (SD) at 6-mth follow-up	56.6 (19.4)	44.0 (14.4)	53.2 (18.4)
Results of paired t-test	*P*= 0.6	*P*= 0.2	*P*= 0.4
Mean staff-rated alliance score (SD) at baseline	64.3 (7.5)	53.7 (11.8)	61.7 (9.4)
Mean staff-rated alliance score (SD) at 6-mth follow-up	63.4 (12.7)	53.3 (17.0)	60.9 (13.8)
Results of paired t-test	*P*= 0.8	*P*=0.9	*P*= 0.8

KEY: WSAS: Work and Social Adjustment Scale (WSAS): Scores range from 0 to 40 with a greater score indicating a greater overall functional impairment

*Alliance scores: Scores range from 0 to 168, with higher scores indicating a better working alliance.

3.4.3 Individual cost

The change in accommodation from baseline to follow-up clearly showed movement into the new services from other settings. For those in Millfield's Unit, many spent time in prison and high secure hospital over the six months preceding baseline assessment, whilst they were all in the unit for almost the entire 6-month follow-up period. For those in the residential service, some had moved from prison services into the hostel service at baseline. Over follow-up, whilst many stayed in the hostel there was also for one, movement out back into the community and into their own home.

Those in the residential service had substantial contact with health and social care services over follow-up, in particular mental health professionals. Service users in both services also had regular contacts with their solicitors as well as contacts with police and court appearances.

Table 11 Service use over six months preceding baseline by service

	MSU (n=9)		Residential (n=3)	
	Mean	SD	Mean	SD
Accommodation				
Hostel (nights)	6.6	19.7	57.7	48.5
MSU (nights)	82.8	59.9	124.3	47.5
Low Secure Unit (nights)	0.0	0.0	0.0	0.0
Prison (nights)	74.1	63.6	0.0	0.0
High secure hospital (nights)	14.8	44.3	0.0	0.0
Health care/community services				
Inpatient stay (nights)	1.3	3.6	2.0	1.7
Outpatient appointment (attendances)	0.2	0.4	1.0	1.7
Accident and emergency (attendances)	0.2	0.7	1.7	1.5
General practitioner (contacts)	2.7	3.4	1.7	2.9
Practice nurse (contacts)	3.1	4.5	60.3	103.6
Key worker (contacts)	6.7	10.1	6.7	9.1
Psychiatric nurse (contacts)	2.8	6.0	65.7	99.3
Psychiatrist (contacts)	8.3	12.5	5.7	4.6
Psychologist (contacts)	7.9	11.7	3.0	4.4
Counsellor/Therapist (contacts)	2.4	5.5	0.0	0.0
Dentist (contacts)	0.2	0.4	0.7	1.2
Occupational therapist (contacts)	1.8	2.8	0.0	0.0
Sport therapist (contacts)	7.9	23.7	0.0	0.0
Social worker (contacts)	3.1	5.6	1.0	1.7
Day centre (visits)	0.1	0.3	0.0	0.0
Psychotropic medication (%)	56		33	
Criminal justice services				
Probation (contacts)	0.7	1.3	0.7	1.2
Solicitor (contacts)	3.1	6.4	3.0	3.6
Police (contacts)	0.4	1.0	1.3	2.3
Police custody (sessions)	0.2	0.7	0.0	0.0
Court appearance (per case)	0.2	0.4	0.0	0.0

Table 12. Service use over six months follow-up by service

	MSU (N=9)		Residential (N=3)	
	Mean	SD	Mean	SD
Accommodation				
Own home (nights)	0.0	0.0	20.3	35.2
Hostel (nights)	0.0	0.0	161.7	34.4
MSU (nights)	181.6	1.3	0.0	0.0
Health care/community services				
Inpatient stay (nights)	0.0	0.0	1.7	1.5
Outpatient appointment (attendances)	0.8	1.4	0.0	0.0
Accident and emergency (attendances)	0.3	0.5	1.3	1.2
General practitioner (contacts)	2.3	3.4	2.0	0.0
Practice nurse (contacts)	9.6	18.7	7.8	11.0
Key worker (contacts)	28.3	15.0	10.0	14.0
Psychiatric nurse (contacts)	0.4	1.3	15.0	24.3
Psychiatrist (contacts)	14.0	13.1	10.3	15.4
Psychologist (contacts)	14.1	13.0	5.3	2.5
Counsellor/Therapist (contacts)	8.7	13.0	0.0	0.0
Drug and alcohol worker (contacts)	0.2	0.7	0.3	0.6
Dentist (contacts)	0.9	1.3	0.3	0.6
Occupational therapist (contacts)	0.0	0.0	8.7	15.0
Sport therapist (contacts)	0.0	0.0	0.0	0.0
Social worker (contacts)	0.4	1.3	8.7	15.0
Day centre (visits)	0.0	0.0	1.0	1.7
Psychotropic medication (%)	56		67	
Criminal Justice services				
Probation (contacts)	0.1	0.3	4.3	7.5
Solicitor (contacts)	4.9	5.4	1.3	1.2
Police (contacts)	0.0	0.0	1.7	2.1
Police custody (sessions)	0.0	0.0	0.3	0.6
Court appearance (per case)	0.0	0.0	0.3	0.6
Public protection unit (per session)	0.0	0.0	0.0	0.0

Total costs for the six months preceding baseline and over the six months between baseline and follow-up are shown in tables 13 and 14. At follow-up average total costs were £99,642 in the MSU, and £73,626 for the residential service. The slight increase in costs in the residential group over follow-up compared with the six months preceding baseline reflects service users moving from secure establishments such as prisons into the residential services.

Table 13. Total cost over six months preceding baseline by service

	MSU (n =9)		Residential (n=3)	
	Mean	SD	Mean	SD
Social services	109	326	35	60
NHS	49,543	30,677	80,104	1,034
Voluntary services	0	0	0	0
Criminal justice	7,717	7,553	216	105
TOTAL COST	57,369	24,715	80,355	965

Table 14. Total cost over six months follow-up by service

	MSU (N=9)		Residential (N=3)	
	Mean	SD	Mean	SD
Social services	0	0	20	35
NHS	99,406	770	72,993	15,125
Voluntary services	0	0	0	0
Criminal justice	236	263	613	889
TOTAL COST	99,642	812	73,626	15,490

3.4.4 Summary

Strengths of the service

- Over the period of the evaluation, the service became fully operational and had established a coherent treatment programme with a range of activities that service users reported finding helpful.
- Positive treatment effects were perceived by staff and service users, including a reduction in self-harm and improved anger control.
- A full time researcher was being employed to carry out research and audit of service activity.
- The service is a member of an external evaluating network.

Suggestions for future service development

- There is a need for enhanced communication and better working relationships between the Millfields Unit and the wider Centre for Forensic Mental Health, and also the Human Resources Department.
- Consideration should be given to increasing the range of activities available within the treatment programme.
- Consideration should be given to selecting a more homogenous group of service users in order to optimise group cohesion.

CHAPTER 4:

Northumberland Tyne and Wear Forensic Personality Disorder Service

4.1 Description of service

Northumberland, Tyne and Wear NHS (NTW) Trust provides mental health, learning disability, neuro-rehabilitation and substance misuse services to the people of Northumberland, Tyne and Wear. It is the result of the merger in April 2006 of three smaller trusts: Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, Northgate and Prudhoe NHS Trust and South of Tyne and Wearside Mental Health NHS Trust. The Trust also provides a range of specialist services to people from elsewhere in the country. It has a budget of more than £250 million a year and serves a population of approximately 1.4 million people. The NTW forensic PD service consists of an in-patient medium secure unit (Oswin Unit) and a community team.

Oswin Unit

Oswin Unit opened on 17th December 2004, providing 10 in-patient beds in an interim facility, based at St Nicholas' Hospital in Gosforth, Newcastle. Money was awarded to NTW for the community component of a Forensic Personality Disorder Service although the Trust did not initially bid for money for a Medium Secure Unit, which was instead awarded to Teeside. However, Teeside subsequently pulled out of the plan to develop an MSU and the money was re-directed to NTW who used it to set up Oswin Unit. The first service user joined on 31st January 2005. On 19th May 2006, the unit relocated to a new purpose built, 16-bedded ward within Bamburgh Clinic on the St Nicholas Hospital Site. The treatment programme on the new unit commenced on 30th May 2006. The unit is split into a central area housing meeting rooms, a kitchen, pool table, visiting area, access to outside spaces and nursing station. There are three separate areas connected to the central area, known as 'living areas'. Each one houses five or six service users' bedrooms, bathrooms and a meeting area.

The Community Team

The community team is the oldest team in this evaluation – it formed in August 2003 and the first assessments took place in November 2003. The team is based at St Nicholas Hospital in Gosforth, Newcastle and runs on a 9am to 5pm working week basis, although team members often work outside of these hours.

4.1.1 Aims/ Philosophy of the service

Oswin Unit

The overall aim of the work of Oswin Unit, as specified in service documents, is *'to provide effective and meaningful assessment, treatment and management of men with personality disorders in whom there are concerns about their risk of sexual or violent behaviour towards others.'* (Service Policy Document, received 10th April 2007). The Unit aims to primarily reduce the risk of harm to others, by addressing the behaviours that lead to offending. Service documents specify that the treatment programme has 3 specific aims:

1. A reduction in re-offending and enhanced protection of the public
2. Modification of the individual's personality disorder
3. Enhancement of life skills and general functioning.

Community Team

The overall aim of the work of the community team, as specified in service documents, is to is to provide *'effective and meaningful assessment, treatment and management of men with personality disorders in whom there are concerns about the risk of sexual or violent behaviour towards others'* . The primary aim is to reduce the risk of harm to others.

4.1.2 Inclusion/exclusion criteria

Inclusion criteria

- male aged over 18 years
- primary diagnosis of personality disorder (determined by psychiatric/psychological assessment for the Oswin Unit)
- from the North Forensic catchment area (a subgroup of the Northern Specialist Commissioning Group)
- history of violent or sexual offending, or there is significant concern about the risk of violent or sexual offending
- require and are capable of being managed in a secure setting less than high security (Oswin Unit only)

Exclusion criteria

- there is clear evidence of the need for high security
- a primary diagnosis of mental illness, substance misuse or significant organic dysfunction
- IQ<80 (those with an IQ between 70-79 are considered on an individual basis).

4.1.3 The Referral and Assessment Procedure

Oswin Unit

All referrals were processed through a central administration point for all forensic referrals within the 'North Forensic Catchment Group'. They were then directed to Oswin Unit or the community team as appropriate. The referral was then discussed by the multi-disciplinary team and a decision was then made about the need for further assessment. If the service user was well known to services, then a review of notes and a discussion with clinicians was carried out. If the service user was unknown/had little historical contact with services, then a full clinical interview was carried out to assess the suitability of the service user for admission to Oswin Unit. The final decision about whether someone was to be offered an admission was made by a multi-disciplinary referral panel. Prospective in-patient service users were then allocated to a care coordinator and Responsible Medical Officer. Plans were then drawn up for the service user to make further visits to the Unit.

Once admitted, the service user entered an initial phase of assessment, lasting approximately 3-4 months. During this phase, the focus was on acute observation, the completion of the minimum data set measures, together with psychological engagement and the development of a therapeutic relationship with the service user. The assessment phase could be extended if further information was required, although generally most service users actively moved into treatment after 3-4 months.

Community Team

Referrals were accepted from care co-coordinators working within CMHTs, in-patient and out-patient services. All referrals were processed through the same central administration point as referrals to Oswin Unit. The team stipulated that all referrals needed to be made with the service user's full knowledge and that they needed to be accompanied by the care co-coordinator's assessment, care plan, risk assessment and any other relevant information. Clinical responsibility and RMO status remained with the local CMHT. Referrals from MAPPPs needed to be linked to a CMHT; if a CMHT had not been involved with the case, then CMHT involvement needed to be arranged before the community team would get involved (this became a source of tension with some of the local CMHTs – see section 4.3.7). All referral were discussed at a weekly team meeting - if the referral was considered to be appropriate then the team allocated two workers to commence assessment and liaise with the local CMHT. The allocated staff members would be responsible for gathering as much information as possible to allow the team to produce a *'formulation'* within 3 months of receiving the referral.

During the course of the evaluation, the length and intensity of the assessment process and the need to complete a minimum dataset of measures were contentious subjects for the community team. Staff told us that whilst the service users were being assessed, they would receive little direct therapeutic input and that this potentially acted as a barrier to engaging service users. Some staff lacked confidence in the choice of measures and questioned their inclusion by the Home Office. The team estimated that the minimum data set was only being completed with 50% of all service users and that half of all formulations did not have complete minimum data set ratings within three months.

I think the minimum dataset is important…I think we need to be careful of a very large one. The other thing we've noticed is that the emphasis on assessment and getting through the assessment has meant… engagement with patients has suffered to some extent, because what we found is that the patients like the assessment, it focuses on them, they can talk about themselves… Then they are not prepared for the transition of having to do something, to make changes, because that's more hard work. S20 (baseline)

I don't have a problem with the idea of a minimum data set…I can't believe that…all pilot sites were being asked to routinely complete a measure [the VRS] *that has no research back to it and no evidence base, so I really feel very strongly about that one, so I'm not sure why some of them are in there.* S17 (baseline)

4.1.4 The model of treatment

Oswin Unit

The Unit offers a treatment programme incorporating a selection of needs-based individual and group formal treatments, together with informal activities designed to transfer learned skills from formal treatment into a community setting. The focus of treatment is to strengthen existing adaptive coping mechanisms and to help service users develop alternatives to maladaptive coping mechanisms. The underpinning ethos of the Unit is one of encouraging service users to take increasing responsibility for their own actions. The length of stay on the unit can be up to 2 years (or more if necessary) but largely depends on individual needs of the service user.

Treatment fell into two categories: formal therapy and informal activities.

i. Formal Therapy
This consisted of a range of individual and group-based therapies, which were tailored to the service user's care plan. Group-based treatments targeted core personality pathology, offending behaviour (an accredited Sex Offender Treatment Programme and a CBT-based violence treatment programme) and shorter groups aimed at targeting affect regulation, behavioural control, cognitive processing and problem-solving. The therapy programme was led by the lead Consultant Psychologist for the unit.

Following completion of the assessment, each service user had a care programme drawn up which focused on areas of individual need. Initially, each service user was expected to attend an 8-week group aimed at enhancing motivation to engage in the programme. Depending on the outcome achieved from this group, the service user then progressed on to one of a number of groups each underpinned by CBT principals. Groups included:

- 'Cognitive processing' (12 weeks) – a basic introduction to the Cognitive Behavioural Model and related concepts
- 'Save Our Senses' (16 weeks) – an emotional regulation group
- 'Social Problem Solving' (12 weeks) – addressing problem solving within social situations.

Following this and again, dependent on outcomes achieved, service users progressed on to a group called 'Me Myself and I', which addressed core issues relating to personality pathology (6-9 months). Following this group programme, service users then completed a programme of therapy specifically aimed at tackling violent offending through either a 'Cognitive Self Change Programme' (12 months) or a Sex Offender Treatment Programme (18 months). Finally, service users had the opportunity to undertake group work aimed at tackling substance misuse or relationship problems. Additionally, service users received individual treatment as required e.g. clinical input for physical health problems.

Running alongside the formal therapy, was a programme of meetings:

1. weekly compulsory 'process groups' designed to address dynamic issues within the community. This group was facilitated by staff who are observed and gave feedback after the group.
2. weekly compulsory community meetings, activity planning meetings and social groups run by occupational therapy staff.
3. a daily clinical meeting between service users and staff in individual living areas.

Non-attendance at compulsory groups was documented in case records and used as a 'measure' of non-engagement.

ii. Informal activities

We were told that the majority of service users' time on the Unit was spent undertaking informal activities. Between October and December 2006, the Unit recruited three full-time activity workers. Their role was to assist service users to identify their interests and areas of future personal development. They also acted as a *'natural link'* between the ward-based staff and non ward-based occupational therapy staff. The unit had recently employed a teacher who undertook one-to-one educational work on numeracy, literacy and IT skills. Sports and gym sessions took place on a daily basis. Weekly groups included gardening, music, arts, cookery and a 'newspaper group'. Non-PD service users from other wards within the Bamburgh Clinic would engage in joint sporting activities with Oswin service users on a weekly basis.

Community Team

Service users continued to be managed by their local CMHT, but were offered specific, individually tailored input from the team. Staff were initially assigned to work in pairs with each new service user. Meetings took place either at the out-patient unit at St Nicholas' Hospital or at designated probation, Mental Health or GP centres within the catchment area. Staff met with the service user approximately once a week but frequency of contact was varied occasionally depending on individual need. For example, staff provided additional telephone support within office hours if required. After working with a service user for 3 months, a CPA care plan was drawn up based on information gathered by the 2 members of staff. After completion of the assessment, each service user received psycho-education (usually 4-8 weeks) and individual feedback about the findings from the assessment phase as well as education about their diagnosis and risk. A programme of individualised treatment then commenced, delivered by the staff originally allocated to the case. Occasionally service users were re-allocated to another member of staff if the original staff lacked the necessary skills to undertake a specific piece of work e.g. CBT. We were informed that the overall treatment model was based on cognitive behavioural principles, although basic dialectical behavioural treatment was also incorporated into individual's care plan.
Individual treatment included:

1. work on the development of emotional regulation
2. distress tolerance skills
3. CBT for mood disorders
4. 'Stop and Think' problem solving
5. anger management

6. offence-related work.

Individual work also included ‘manualised’ programmes running on Oswin Unit, such as ‘Better Thinking Skills’. Service users in the community were also encouraged to attend the groups that ran on Oswin Unit if the staff felt that the service user was both capable of attending the group and would benefit from it. The team also facilitated linking appropriate service users to a Sex Offender Treatment Programme (based at the Sexual Behaviour Unit at St Nicolas Hospital), or with probation for offence related work.

4.1.5 Staffing

The staff for Oswin Unit are summarised in Table 1.

Table 1. Staff at the Newcastle MSU

Profession	WTE
Nurse	42.0
Consultant	1.0
Psychotherapist	0.5
Staff grade doctor	1.5
Occupational therapy	4.0
Physiotherapy	1.0
Technical Instructor	1.0
Psychologist	3.0
Assistant Psychologist	2.0
Teacher	1.0
Social Worker	1.0
Administration	3.0

The community team staff are summarised in Table 2.

Table 2: Staff at the Newcastle community team

Profession	WTE
Community Psychiatric Nurse	1
Occupational Therapist	1
Probation Officer	1
Psychiatrist	0.4
Psychologist	1
Social Worker	1
Team Leader	0.5

4.1.6 The management structure

Oswin Unit

The management structure on the unit has evolved considerably during the course of our evaluation (see section 4.3.5 for detailed discussion).

Community Team

The team manager oversees all administrative tasks for the team, facilitates the team meetings and appraises all the staff.

4.1.7 Training of staff

Oswin Unit

When the service first opened, staff received 6 weeks of training, consisting of introductory work on CBT, specific training on personality disorder and a series of role playing exercises to help them develop skills to manage difficult clinical situations. Staff also worked together on the development of the unit's policies and procedures during this time. The staff we spoke to told us that this period of training provided an invaluable educational opportunity and also enhanced morale. However, over time, it was not possible to sustain this experience for new staff and at the time of preparing this report, the system for training ran as follows:

1. On joining the service, staff received a 3-day induction covering a wide range of service-related and clinical topics. Service-related topics include: an introduction to the use of assessment tools, service structure, the referrals and assessment procedure, clinical supervision and staff support, the treatment model and the weekly timetable. Clinical topics included: working with PD service users, cognitive group-based interventions, therapy tools, the management of self-harm and substance misuse.
2. Staff then received a further 5 days of training focusing on the management of violence and aggression.
3. Finally new staff received the Trust's 5-day induction programme.

Staff were required to continue with their training after completing the above. A weekly training group took place on the Unit, covering a wide range of issues including treatment approaches to PD, the identification and management of risk, organisational dynamics, theoretical aspects relating to personality disorder and the avoidance of conflict with colleagues. As part of this ongoing training, staff were issued with a 'PD Passport' which documented the training that they had received and highlighted areas for future educational development.

Community Team

When the team was first set up, staff received a 4-week training period. This focused on evidence-based treatment, theoretical aspects about personality disorder and training in the use of minimum data set measures. There has been very little turnover of staff since the team was set up (2 members of staff have left since 2003) and so there has not been a need to have a rolling induction programme and at the time of compiling this report, training was largely based on individual staff member's needs. For example, a psychologist recently joined the service and required training in assessment tools and forensic services. One member of staff was undertaking a part-time PhD; another member of staff was a trained CBT therapist; one member of staff was completing psychotherapy practitioner training. All staff received training in working with perpetrators of domestic violence. Alongside this, the team completed group training exercises. For example, the team recently completed mindfulness training. The team are furthering their work from a CBT perspective and are awaiting feedback from two training organisations on an intermediate level of training for all staff.

4.1.8 Training provided to other teams

The community team provided extensive training to CMHTs, police, magistrates, and probation. Training was provided on a request basis and covered basic information about the service, risk assessment and working with people with PD. The team also advised MAPPPs on the management of PD service users and offered other services advice on service users not falling within their remit (e.g. female service users). These training/advisory activities were highly valued by the community team staff, who told us that they helped to facilitate good working relationships with other services.

4.1.9 Staff supervision

Oswin Unit

The original system of supervision on the unit was based on standard Trust policy i.e. that each member of staff was supervised by higher grade staff from within their professional group. Under this system, the ward manager supervised band 6 nurses, who themselves supervised band 5 nurses, who in turn supervised the band 3 support workers. The system however proved to be problematic and staff anxiety was not adequately contained. Although it should have been theoretically possible for a higher banded nurse to supervise a lower band colleague, sometimes the higher banded nurse lacked relevant clinical experience and this adversely effected the quality of supervision – a situation described by one staff member as *"the blind leading the blind"*. This system was revised in the aftermath of a serious untoward incident (see section 4.3.9).

We have introduced new supervision structures that are far more intensive… the nursing supervision structure would go up so you have Ds who are supervised by Es who are supervised by Fs which is a bit like the blind leading the blind because the E who may be supervising you with a D doesn't have any experience either and I just worry about that, about the quality of supervision and then after the second major fiasco that we had over the summer with the second nurse member, um, we actually did implement a different nurse structure which is a handful of experienced senior staff who supervise everybody so it has now become cross-professional, in addition to professional supervision which obviously remains. S17 (follow-up)

In an attempt to remedy this problem, a system of clinical mentorship was being introduced on the Unit whereby a core group of senior staff would provide individual monthly supervision to all members of staff. At the time of preparing this report, the full details of the clinical mentorship scheme had yet to be worked out. All staff also had access to a reflective practice group, which was facilitated by a Consultant Psychotherapist. We were told that although the group was open to all staff, generally only nurses attended.

Community Team

The team employed a psychotherapist on a sessional basis to facilitate an open discussion initially focused on team dynamics but enlarged to include the impact of service users on team dynamics. This session is now fortnightly having previously been monthly. Team dynamics were also discussed at a fortnightly psychotherapy group. All staff received managerial supervision from the manager of the team. For clinical supervision, the supervisee had to arrange their own supervision with an 'appropriate' clinician from within the team, the Oswin Unit or outside the adult forensic service. This needed to take place on a monthly mandatory basis for all staff, with the exception of psychologists who were required to attend for fortnightly clinical supervision.

4.1.10 User involvement

Oswin Unit

The Unit had service user representatives who ran a drop-in service on Friday afternoons. The Patient Advisory and Liaison Service (PALS) worked alongside the service user representatives and offered input as required. A service user representative sat on the monthly Clinical Management Group. (The elected service user was not an active PD service user, but was part of the St Nicholas Hospital service user representative scheme.) Service user representatives and PALS dealt with day-to-day problems arising on the unit with the aim of attempting to resolve complaints amicably. Many of the staff we spoke to told us that they thought that it was very difficult to engage carers with forensic services because carers might harbour a range of complex and sometimes hostile feelings towards service users. Nevertheless, despite their reservations, staff had formed links with the carers support group located within the wider forensic service. Other service user-led initiatives include contributing to an induction pack.

Community Team

The team went to great lengths to organise a series of consultations with a variety of internal and external service user groups in order to help them more clearly define the nature of service user involvement. Our impression was that unfortunately little progress was made as a result of these meetings. Staff told us that further work was required to more clearly define the aims and expectations of service user involvement with the team. One member of staff recently attempted to undertake a telephone-based survey of service users' views about the treatment being offered, but unfortunately the study was badly affected by recruitment problems. In the future, the team plan to convene a focus group in order to examine service users' experiences of receiving help from the service.

4.1.11 Complaints/ grievances

Oswin Unit

All complaints are dealt with according to Trust policy. In addition, service users are able to use the Patient Advice and Liaison Service, discuss any complaints with the ward manager and also refer complaints to the service user representative of the Clinical Management Group. At the time of preparing this report, the team were working on refining the arrangements.

Community team

We were told that all complaints were dealt with according to Trust policy.

4.1.12 Relationships with other services

Oswin Unit

The main established links for Oswin Unit were the local Medium Secure Unit, based at St Nicholas' Hospital and the local High Secure Hospital (Ashworth). Links between Oswin Unit and MAPPPs were established as required and were firmed up as the relevant service user approached discharge.

Community Team

Links had been made with the local Custody Diversion Service in Newcastle and North Tyneside and also with the mental health in-reach teams working in local prisons (HMP Frankland, HMP Durham, HMP/YOI Low Newton, HMP Holme House, HMP Acklington, HMP/YOI Castington). A probation officer had been seconded to work full time with the community team. The Team Leader was also the forensic case manager for the Northern Forensic Catchment Group and in this role had access to detailed information on all Northern Forensic Catchment patients in all three High Secure Hospitals, Medium Secure or Low Secure services and the independent sector. The Team Leader was also the referrals co-ordinator for the Trust's adult forensic service and had knowledge of all patients referred to the service from the Trust's open wards and community services. The Consultant Forensic Psychiatrist who worked with the community team was also the Trust's representative on the MAPPA Strategic Management Board and was therefore in a position to provide up to date information to the rest of the team about potential referrals.

4.1.13 Aggregate cost of the service

We estimated the total cost of the Oswin Unit to be £3,087,640, of which 62% were pay costs, 4% were non-pay costs, 24% were indirect and overhead costs. We calculated an estimate for capital costs based on the other services, which accounted for 10% of total costs. The Oswin unit had 16 beds, so the cost per bed was £192,978 per year, or £528 per night. If occupancy fell below capacity, the cost per service user increased - at occupancy of 11, the cost per service user increased to £280,695 per year or £768 per night.

The estimated cost of the community service was £481,074. The community service had provision for 30 service users, so the cost per year was £16,036 or £44 per day. When case load diminished, the cost per service user increased: when the community service was managing 24 service users, the cost per service user increased to £20,045 per year or £55 per day.

4.2. Baseline survey of service users managed by the service.

Over the recruitment period to the survey (November 2005-June 2006), 50 men were being managed by this service. This comprised of 11 inpatients and 39 service users managed over a wide catchment area in the community. Of the 50, 20 men were recruited (40% response) – 9 from Oswin unit and 11 from the community. Reasons for non-recruitment (n=30) were: two in-patients refused; 3 community service users were being discharged/transferred to another service during the recruitment phase; two community service users were considered too dangerous to interview and 23 did not respond to repeated attempts made to secure their participation in the study.

4.2.1 Demographic characteristics (Table 3)

The mean age of the sample was 37 years (standard deviation, sd: 6.9). All of the service users were white and unemployed and 65% were single.

Table 3. Demographic characteristics of recruited sample from NTW

Variable	Oswin unit N (%)	Community team N (%)	TOTAL N(%)
Mean age in years (SD) on entry into service	33.2 (4.6)	40.2 (7.1)	37.1 (6.9)
Age bands			
20-29 yrs	2 (22)	1 (9)	3 (15)
30-39 yrs	7 (78)	4 (36)	11 (55)
40 yrs +	0 (0)	6 (55)	6 (30)
Ethnicity			
White	9 (100)	11 (100)	20 (100)
Black	0 (0)	0 (0)	0 (0)
Other	0 (0)	0 (0)	0 (0)
Marital status			
Single	6 (67)	7 (64)	13 (65)
Divorced/separated/widowed	3 (33)	4 (36)	7 (35)
Employment status prior to been taken on by service			
Unemployed	9 (100)	11 (100)	20 (100)
Employed	0 (0)	0 (0)	0 (0)

4.2.2 **Personal histories** (Table 4)

In their personal histories, 12 men (60%) reported a history of childhood physical abuse, with 9 (45%) reporting a history of childhood sexual abuse. Sixteen men (80%) reported a childhood history of being bullied and 8 (40%) reported a childhood history of bullying other children. Ten (50%) reported a history of setting fires in childhood. Thirteen men (65%) had not completed secondary education. Four of the community participants had previously served in the armed forces.

Table 4. Personal histories from NTW

Variable	Oswin Unit N (%)	Community team N (%)	TOTAL N (%)
Childhood maltreatment – physical			
Yes	4 (44)	8 (73)	12 (60)
No	5 (56)	3 (27)	8 (40)
Childhood maltreatment - sexual			
Yes	5 (56)	4 (36)	9 (45)
No	4 (44)	7 (64)	11 (55)
Ever bullied?			
Yes	8 (89)	8 (73)	16 (80)
No	1 (11)	3 (27)	4 (20)
Bullied others?			
Yes	3 (33)	5 (46)	8 (40)
No	6 (67)	6 (54)	12 (60)
Set fires?			
Yes	5 (56)	5 (46)	10 (50)
No	4 (44)	6 (54)	10 (50)
Completed secondary school?			
Yes	3 (33)	3 (27)	6 (30)
No	6 (67)	7 (64)	13 (65)
missing	0 (0)	1 (9)	1 (5)
Served in armed forces			
Yes	0 (0)	4 (36)	4 (20)
No	9 (100)	7 (64)	16 (80)

4.2.3 Clinical characteristics (Table 5)

The mean full scale IQ of the sample was 91.1 (sd: 12.9), mean verbal IQ was 91.6 and mean performance IQ was 93.2. The mean PCL-R total score was 15.8 (sd: 8.7), mean PCL-R factor 1 score was 6.6 (sd: 4.5) and mean PCL-R factor 2 score was 8.9 (sd: 4.2). Fifteen men (75%) thought they had a personality disorder, 2 did not think that they had a personality disorder and 3 men did not know whether he had a personality disorder or not.

Table 5. Clinical characteristics of recruited sample from NTW

Variable	Oswin unit N (%)	Community team N (%)	TOTAL N (%)
Main self-reported problem			
Personality problems/disorder	6 (67)	4 (36)	10 (50)
Depressive symptoms	2 (22)	2 (18)	4 (20)
Substance use	0 (0)	1 (9)	1 (5)
Considered appropriate	1 (11)	3 (27)	4 (20)
Miscellaneous reasons	0 (0)	1 (9)	1 (5)
Service user thought they had a PD			
Yes	6 (67)	9 (82)	15 (75)
No	1 (11)	1 (9)	2 (10)
Don't know	2 (22)	1 (9)	3 (15)
Thought they had a PD (at 6 months)			
Yes	7 (78)	7 (64)	14 (70)
No	0 (0)	0 (0)	0 (0)
Don't know	0 (0)	1 (9)	1 (5)
Missing	2 (22)	3 (27)	5 (25)
Mean IQ (SD)			
Full scale	95.3 (10.6)	86.8 (14.2)	91.1 (12.9)
Verbal	91.7 (10.4)	91.4 (12.5)	91.6 (11.0)
Performance	96.6 (12.0)	89.3 (15.9)	93.2 (14.0)
Mean PCL-R Factor 1 score (SD)	5.4 (4.1)	7.7 (4.8)	6.6 (4.5)
Mean PCL-R Factor 2 score (SD)	8.4 (5.9)	9.3 (2.3)	8.9 (4.2)
Mean PCL-R Total score (SD) (n= 16)	14.6 (11.0)	16.9 (6.2)	15.8 (8.7)

At the time of writing this report, 16 of the 20 recruited men had received an IPDE assessment. Of these 16 men, 8 fulfilled criteria for a primary PD diagnosis of dissocial PD, 5 fulfilled criteria for a primary PD diagnosis of borderline PD (Table 6).

Table 6. Main PD diagnosis in the recruited sample from NTW, as determined by the IPDE (derived from ratings performed on 16 men)

Category	Oswin unit	Community team	TOTAL
Paranoid	-	1	1
Schizoid	-	-	-
Schizotypal	-	-	-
Dissocial	5	3	8
Borderline	2	3	5
Histrionic	-	-	-
Narcissistic	-	-	-
Anxious	1	-	1
Dependent	-	-	-
Anankastic	-	-	-
Unspecified	1	-	1

All of the community participants had been referred by community agencies and all Oswin Unit participants had been referred from secure care or prison. At entry into the service, all in-patient participants were detained under a criminal section of the Act and all the community participants were informal (Table 7).

Table 7. Service characteristics on entry into the NTW service

Variable	Oswin unit N (%)	Community team N (%)	TOTAL N (%)
MHA status on entry into the study			
Involuntary (criminal section)	9 (100)	0 (0)	9 (45)
Involuntary (civil section)	0 (0)	0 (0)	0 (0)
Voluntary	0 (0)	11 (100)	11 (55)
Referral source			
High security	3 (33)	0 (0)	3 (15)
Medium security	1 (11)	0 (0)	1 (5)
Low security	1 (11)	0 (0)	1 (5)
Prison	4 (44)	0 (0)	4 (20)
Court	0 (0)	0 (0)	0 (0)
Community/other	0 (0)	11 (100)	11 (55)

4.2.4 **Past psychiatric Histories** (Table 8)

The mean age of first contact with mental health services was 24 years. Eighteen men (90%) had a previous history of self-harm, a third of whom had committed an act of self-harm in the preceding 6 months. There was a wide range of severe self-harming behaviour reported, including cutting, attempted hanging and overdosing. Fifteen men (75%) had injured themselves badly enough to require hospital treatment.

Substance misuse was highly prevalent among the sample of recruited service users: 85% reported previous use of cannabis, 80% had history of alcohol misuse, and 50% had a history of opiate misuse. Fifteen participants (85%) had a previous documented history of non-adherence with psychiatric treatment and 6 men (50%) had a history of absconding behaviour.

4.2.5 **Criminal histories** (Table 9)

The mean age of first conviction was 20.6 years (sd: 10.1) and mean number of previous convictions was 10.9 (sd: 8.6). The mean number of prison terms was 5.0 (sd: 7.7) and mean number of prior offences was 44.4 (sd: 56.1). Participants from Oswin Unit were younger at first conviction and had accrued a greater number of previous convictions and offences, however, none of the mean differences between participants recruited from the ward and the community were statistically significant at the 5% level.

Violent behaviour was prevalent among the recruited sample: 65% reported injuring someone with a weapon and the same proportion reported injuring the victim so badly that they had required hospital treatment. In several cases, the victims had been children; examples included a participant who held a baby's head under water, another who fractured his daughter's skull in an assault and another who threw an ammonia-based cleaning product into a boy's face. A variety of weapons had been used in assaults: swords, cross bows, air rifles, bricks, bats, dumb bell bars and furniture. Two participants reported that the victim had died as a result of their injuries.

Table 8. Past psychiatric and drug history for sample recruited from NTW

Variable	Oswin Unit N (%)	Community team N (%)	TOTAL N (%)
Mean age (SD) at 1st contact with mental health services	19.8 (7.5)	27.2 (12.9)	23.9 (11.2)
History of self-harm?			
Yes	8 (89)	10 (91)	18 (90)
No	1 (11)	1 (9)	2 (10)
Self-harm in previous 6 months?			
Yes	4 (44)	2 (18)	6 (30)
No	5 (56)	9 (82)	14 (70)
Ever injured self so badly that required hospital?			
Yes	6 (67)	9 (82)	15 (75)
No	3 (33)	2 (18)	5 (25)
History of non-adherence with treatment			
Yes	7 (78)	8 (73)	15 (75)
No	2 (22)	3 (27)	5 (25)
History of absconding behaviour			
Yes	5 (56)	0 (0)	5 (25)
No	4 (44)	11 (100)	15 (75)
History of alcohol misuse			
Yes	7 (78)	9 (82)	16 (80)
No	2 (22)	2 (18)	4 (20)
History of opiate use			
Yes	6 (67)	4 (36)	10 (50)
No	3 (33)	7 (64)	10 (50)
History of cannabis use			
Yes	8 (89)	9 (82)	17 (85)
No	1 (11)	2 (18)	3 (15)
History of cocaine use			
Yes	1 (11)	3 (27)	4 (20)
No	8 (89)	8 (73)	16 (80)
History of crack use			
Yes	3 (33)	1 (9)	4 (20)
No	6 (67)	10 (91)	16 (80)
History of amphetamine use			
Yes	5 (56)	4 (36)	9 (45)
No	4 (44)	7 (64)	11 (55)
History of solvent misuse			
Yes	5 (56)	4 (36)	9 (45)
No	4 (44)	7 (64)	11 (55)

Table 9. Criminal history of sample recruited from NTW

Variable	Oswin unit N (%)	Community team N (%)	TOTAL N (%)
Mean age (SD) of 1st conviction	17.6 (5.8)	23.4 (12.6)	20.6 (10.1)
Mean number (SD) of prior convictions	13.2 (10.9)	8.9 (6.0)	10.9 (8.6)
Mean number (SD) of prison terms	8.1 (10.1)	2.4 (3.7)	5.0 (7.7)
Mean number (SD) of prior offences	55.9 (54)	34.9 (58.5)	44.4 (56.1)
Convicted of homicide			
Yes	1 (11)	0 (0)	1 (5)
No	8 (89)	11 (100)	19 (95)
Convicted of other violent offence			
Yes	5 (56)	9 (82)	14 (70)
No	4 (44)	2 (18)	6 (30)
Convicted of sexual offence			
Yes	2 (22)	1 (9)	3 (15)
No	7 (78)	10 (91)	17 (85)
Convicted of property offence			
Yes	4 (44)	5 (45)	9 (45)
No	5 (56)	6 (55)	11 (55)

Table 9. Criminal history (continued)

	Oswin unit N (%)	Community team N (%)	TOTAL N (%)
Convicted of acquisitive crime			
Yes	5 (56)	7 (64)	12 (60)
No	4 (44)	4 (36)	8 (40)
Convicted of drug offence			
Yes	4 (44)	1 (9)	5 (25)
No	5 (56)	10 (91)	15 (75)
Convicted of firearms offence			
Yes	2 (22)	2 (18)	4 (20)
No	7 (78)	9 (82)	16 (80)
Convicted of driving offence			
Yes	4 (44)	4 (36)	8 (40)
No	5 (56)	7 (64)	12 (60)
Substance misuse implicated in index offence			
Yes	5 (56)	1 (9)	6 (30)
No	4 (44)	10 (91)	14 (70)
Alcohol misuse implicated in index offence			
Yes	1 (11)	5 (45)	6 (30)
No	8 (89)	6 (55)	14 (70)
Ever hurt someone so badly that they died?			
Yes	1 (11)	1 (9)	2 (10)
No	8 (89)	10 (91)	18 (90)
Ever hurt someone so badly that they needed hospital treatment?			
Yes	5 (56)	8 (73)	13 (65)
No	4 (44)	2 (18)	6 (30)
Didn't know	0 (0)	1 (9)	1 (5)
Ever injured someone with a weapon?			
Yes	7 (78)	8 (73)	15 (75)
No	2 (22)	3 (27)	5 (25)
Violence Risk Scale Rating			
High	3 (33)	6 (55)	9 (45)
Medium	2 (22)	3 (27)	5 (25)
Low	2 (22)	0 (0)	2 (10)
Missing data	2 (22)	2 (18)	4 (20)

4.3 Developments over the course of the evaluation

4.3.1 Service activity

Oswin Unit

At the time of preparing this report, 59 referrals had been received by Oswin Unit and there were 9 service users on the ward. A total of 9 service users had been discharged since the Unit opened. Five of these were transferred to prison; two were transferred to High Secure services. One service user was discharged to a local hostel and one service user was transferred to a long-term secure provider in the private sector.

Community Team

At the time of preparing this report, the team had received 77 'appropriate' referrals and were actively working with 36 service users (further information was awaited on a further 5 service users before a decision could be made about whether or not to take them on). Since opening in 2003, the team had received 84 'inappropriate' referrals; these included a number of cases of learning disabled or adolescent service users who were clearly inappropriate for the service. Fifteen of the 77 active cases were being managed as liaison cases, the input being limited to advice only. We were told that between 31st March 2006 and 16th July 2007, 52 service users had been discharged from the service for a variety of reasons.

4.3.2 Changes to the operation of the service

Oswin Unit

Ward timetable

When the Oswin Unit was first set up, activities at weekends were considered optional. In response to feedback given by service users, the team were developing a programme of weekend activities.

Nursing care

When we first interviewed staff (September to December 2005) a triumvirate system of nursing was in operation and several staff told us that this style of working had caused problems (see section 4.3.5). We understand that this system was replaced with a new system, whereby 'core teams' of senior clinicians linked withed a team of ward-based nurses.

Community Team

When the team was initially set up, staff always worked with service users in pairs. However, as time progressed, staff told us that they had become increasingly aware that this practice might impede the process of establishing a close working alliance with a service user. In addition, staff reported that they generally felt comfortable with the service users and questioned the necessity of always having a second person present for a second opinion on the assessment. As a result, practice was changing. At the time of compiling this report, after the assessment phase had been completed, individual treatment was undertaken on a one-to-one basis (the presence of another member of staff could be requested if required).

4.3.3 Staffing the service

Oswin Unit

Changes to the staffing structure
The original Oswin Unit had a capacity of 30 nursing staff. When the Unit moved to its new site in May 2006, this figure increased to 41.5wte. At the time of preparing this report, not all the posts had been filled or were indeed required, as only 9 of the 16 beds were filled. Nevertheless, posts still needed to be recruited to, in order to address the potential shortfall which would occur once the remaining 7 beds were filled. Some key clinical posts remained unfilled; for example, at the time of compiling this report, the team had just recruited a new 0.5 wte locum Consultant Psychiatrist for a period of four months, replacing a previous locum who had just left the service. The future of some proposed nurse consultant posts was under Trust review, subject to budgetary considerations. Some posts had been modified in order to provide other hybrid posts to suit the ongoing development of the service. For example, some 'support worker' posts (band 3) had been transformed into 'activity worker' posts (band 4) associated with a greater degree of clinical responsibility (and pay). In order to reflect the greater emphasis on informal therapeutic activities, the unit recently invested money into three 'activity worker' posts for each living area. These staff came from a range of backgrounds: one worker had a broad range of experience of working in acute mental health services, whilst another was a musician with previous experience of working in Frankland DSPD and the third had a background in fine arts and horticulture.

Problems recruiting the 'right staff'
Some staff told us that the need to fill nursing posts quickly had meant that some individuals who were inexperienced at handling people with challenging personalities or who were temperamentally ill-suited to the work had been employed. Professional qualifications alone were insufficient predictors of who could undertake this type of clinical work – practitioners needed to be solid, dependable and robust.

Most of our tensions are from the fact that we have hired staff because we needed F grades and E grades rather than thinking well actually we want someone who can work within a social milieu. And their profession is irrelevant…it's how you relate to patients and the ability to have that wider understanding. And I think that will be the biggest….that will be the biggest threat I think to the success of our unit. S17 (follow-up)

Related to this, we were told that better 'exit strategies' were required for staff who wanted to leave the Unit once they realised that they could not cope or did not want to undertake clinical work with men with personality disorders.

I think we need a better HR structure so that we have better exit routes for staff that are seen as proactive if staff realise that they don't want to work with PD. That should be seen as that's fine, and we actually want to move them off the ward. Because we do have some staff downstairs who actually don't want to work with PDs... but we don't have many exit strategies or we don't have a proactive way of dealing with them and then they become more disgruntled. S17 (follow-up)

Community Team

The team had been very stable since established in 2003, with only two departures. Staff told us that they thought they were functioning well as a team and morale appeared to be good. Contributory factors to the good morale included the fact that the team was relatively small and so everyone established close working relationships.

4.3.4 Supervision

Oswin Unit

A powerful theme emerging from the initial staff interviews was that there were concerns about the adequacy of supervision arrangements; these concerns actually led to the change in the supervision arrangements described above. One area of disagreement was whether group supervision should be compulsory or not; whilst some staff were committed to the exercise, others simply voted with their feet by not attending supervision groups.

The only mandatory supervision that we have is individual supervision through our own respective disciplines, and that goes ahead - that's... that's a given, but in terms of group supervision and process group… some that would feel that that's a mandatory process that all staff should go to, and there's others... who feel that the whole concept of compulsory and enforced supervision is a flawed concept. S13 (baseline)

The problem with the group supervision is that…[some] staff don't think it should be mandatory whereas everybody else thinks it should be so there's a lot of hostility to that and people are sabotaging it really by not turning up, so we're having to try and deal with that. S17 (baseline)

Community Team

The staff that we interviewed spoke positively about their experiences of supervision and support derived from colleagues. Group dynamic supervision was particularly valued for providing a forum in which difficult areas such as the maintenance of firm therapeutic boundaries could be tackled. As a result of its perceived value, over the course of our evaluation, the frequency of group supervision was increased from monthly to fortnightly.

I mean we've got three levels of supervision…you've got like individual, you've got group supervision, and then you've got group dynamic supervision and on top of that you've got your colleagues around you all day. You're visiting people with your colleagues, you're constantly around folk who actually do care for you so at no point do you feel isolated or alone or under too much pressure - there's always somebody to help you out.
S21 (follow-up)

4.3.5 Working relationships between staff

Oswin Unit

When Oswin Unit first opened, a 'Clinical Management Group' (CMG), consisting of four senior clinicians was established. The CMG was gradually enlarged and consisted of representatives from all grades and disciplines and the group met on a monthly basis to discuss clinical work. A decision was then made to create an additional 'Steering Group' consisting of four professional leads: the ward manager, the lead occupational therapist, the consultant psychologist and the consultant forensic psychiatrist. Each member held key responsibilities such as clinical lead, operational manager, staff development, research and audit coordinator, and the group was responsible for managing all clinical decisions. The CMG was required to defer to the Steering Group for any final clinical decision. Such an arrangement might have worked had the Steering Group functioned successfully, but this was not the case. The group was described by staff as being *'massively split'* and characterised by *'power struggles*' between members of the group who were *'fighting'* each other for overall leadership of the group.

The in-patient service is struggling at the minute with trying to determine who... who leads that service um... and they have 4 individuals, three of which are sort of vying to be the leader of the service. S18 (follow-up)

Psychology and psychiatry can't decide who's the lead clinician…so there's a massive split at the very top of our service in terms of um, power struggles… S13 (follow-up)

When initially interviewed, staff reported that they thought that the lack of cohesion within the Steering Group might have wider repercussions for the staff team and the service users. Nurses particularly struggled to define their role in relation to that of other disciplines – particularly with the introduction of a triumvirate system of working with service users. Nursing morale on the Unit had been affected by the disagreements about allocation of roles and clinical responsibility.

The other issue with triumvirate working is that nurses have felt excluded…historically nurses have worked where they have been the primary, the primary care givers…I think nurses had a real problem with trying to adjust to that… they feel almost disempowered now because qualified nurses aren't …in a triumvirate or aren't acting as care coordinator and that's been frustrating for them…I think in terms of clinical direction and leadership they've [the nurses] have suffered and I… really think that there needs to be some renewed vigour, if you're going to have such a large group of staff how we support them um, both professionally and um clinically I suppose. S13 (baseline)

When staff members were followed up a year after their initial interview, relationships between the different disciplines remained tense and 'power struggles' still existed on the Unit. Some staff felt that the Unit's staffing problems were attributed to the fact that no single senior clinician was in charge of the unit. Instead a *'flat management structure'* governed the Unit and by virtue of this, the process of clinical decision-making was characterised by unnecessary bureaucracy and convoluted discussions between multiple members of staff. In November 2006, an attempt was made to find a solution to these problems. Following an internal review of the entire PD service (see section 4.3.9), the Steering Group was disbanded and the Clinical Management Group was given ultimate responsibility for clinical decisions. Its membership was widened to include representatives from nurses at all levels, OTs, a service user representative, service manager and a consultant psychotherapist. In addition, clinical responsibility for admission to and discharge from the Unit was clarified; at the time of preparing this report, the Consultant Forensic Psychiatrist made the final decision on whether a referred service user was admitted to the Unit and the Consultant Psychologist made the final decision on who should be discharged. At the time of compiling this report, it is unclear how well such a system was working; in their interviews with us, staff acknowledged that there might be a need for further revisions of this system.

I think we need fundamental change within the structures. We need clear authority at the top… we had a flat hierarchy…and we said that we have hit an impasse because there were 4 on this flat management structure…and that flat structure just doesn't work. And the way we have tried to do it in the interim - which I don't think is that good but is better - is to identify specific roles. And the top 4, the 4 managers which is the lead from each major profession, have adopted certain roles but there is no clear authority… it's still a bit nebulous.
S17 (follow-up)

Community Team

Throughout the evaluation, we perceived relationships between staff and general morale to be good within this team. The team had evolved as a tightly knit group of staff who communicated openly and honestly with each other. Differing views were aired and discussed and decision-making appeared to be a collaborative, albeit sometimes tiring, exercise.

I think the team works really well…we really do trust each other…we actually care abut each other, each individual member of the team, you know if somebody's feeling down everybody else knows about it and go out of their way to help them. S21 (follow-up)

Draining I suppose has been a couple of issues, one is the interdisciplinary discussions or differences of opinion about directions we go forward, and trying to contain those differences of opinion so that the team still functions, there has been times here that, that personally for me has, has felt draining….I suppose it's differences in professions. S18 (follow-up)

4.3.6 Relationships between Oswin Unit and the Community Team

Staff from both teams told us that there was no clearly established working relationship between the teams. This was evident in the accounts that we were given at both baseline and follow-up. The two components of the NTW service had evolved very separately and had two distinct histories and cultures. Although the Consultant Psychologist worked across both teams, there had never been a concerted effort to 'join up' the clinical work of the two teams into a *'seamless service'*. Some staff felt that the lack of clear pathways of care between the teams presented a major problem.

There are no pathways of care. We [Oswin Unit] *get stuck with patients. We've already got stuck with one patient, this causes huge dynamics on the ward that patients pick up on and it all feeds into a negative cycle with the patients because we know nobody else wants him either.* S17 (baseline)

They developed as two separate systems and they remain two separate systems…we should be sharing skills, we should be working much closer together, we share the same population albeit they work in the community and we have an inpatient unit... you know we could do joint training, joint assessment, supervision, all of those factors could come into play but it is unlikely in the foreseeable future….the personnel are completely separate and the job is somewhat different, trying to work with a patient in the community there are differences, different demands and different risks really and I think that is all played out and evident in the fact that we don't have a close relationship. S17 (follow-up)

I don't think we've got any relationship with Oswin at all which is, which is odd but we don't, I mean we've referred there and been knocked back...I mean we've got all like individual relationships with different members of staff so that works quite well on the ground but I think as a structure we don't really have much of an over-arching structure between the two teams. S21 (follow-up)

As far as linking over individual cases, Oswin staff told us that they would not necessarily engage with the community team until the point at which the service users were looking to move back into the community. Nevertheless, successful joint working had occasionally been possible - recently one service user was able to move relatively seamlessly from Oswin Unit to the community. One suggestion for improving working relationships between the two components was an idea that staff might be rotated between the two teams. However, doubts were expressed about how popular such a proposal would be to the Community team.

4.3.7 Relationships with other services

Oswin Unit

Staff from Oswin Unit told us that because the ward covered such a wide catchment area, they did not have the capacity to proactively seek out relationships with community-based services. Instead, they adopted a pragmatic approach, whereby relationships with other services were developed as required. For example, on the point of admission of a service user, contact would be initiated with key professionals (e.g. the local CMHT or probation officer). These key staff were then invited to case conferences and through these meetings working relationships would be firmed up. Staff told us that in their experience this arrangement had been working well.

Regarding relationships with the other pilot PD sites, at the initial interviews, staff told us that such relationships were effectively non-existent; they were simply not a priority when there was so much work to be done in their own service and establishing 'links' meant having to travel long distances.

They're minimal…it would be good to have more links…again it should be a simple thing that you know that we could make arranged meetings. But you're busy. Something has to get dropped off your list of priorities and it is nearly always meeting with the other sites because an emergency arrives within your own service and obviously you have to prioritise that.
S17 (baseline)

Community Team

Staff told us that the team's relationships with MAPPPs and probation were good. However, at both baseline interview and at follow-up, tensions were described in the relationships with some local CMHTs. In particular, the need for local CMHT involvement before the Community team would get involved in a case had caused difficulties. For example, a service user might be identified by probation services, however, if that individual was not known to mental health services, the local CMHT needed to first assess and then agree to manage this individual, before the community forensic team would get involved. CMHTs however were already under great pressure to manage their existing work with the seriously mentally ill and sometimes resisted taking on personality disordered service users. This had been a particular problem in the Newcastle area.

Community mental health team links are really poor, the MAPPA links are good, probation links are good, some community mental health teams outside of the Newcastle area, very good strong links, we go and see folk... no problems care co-ordination, but within Newcastle they're just a brick wall, people aren't willing to take PD clients on, so therefore we don't actually get them through to assessments and there are lots of people out there who deserve a service, require a service, and they're just not getting it…it causes problems with the community mental health teams so, they clearly don't want these folk, and so they feel like they are burdened and pushed or…and that creates problems with us because we get lots of negative feedback... it gets you down. S21 (baseline)

[Relationships with CMHTs] *are more problematic and it varies because one of the issues is they have to continue to care co-ordinate so some teams are happy to do that and others aren't so it's been very variable…because they don't feel these patients are patients they should be dealing with, they either just see them as being forensic so they shouldn't have to deal with them or as being personality disorder, they don't treat personality disorder.*
S20 (follow-up)

As was the case with the Oswin team, staff in the Community team told us that there was an absence of any meaningful relationship between the London forensic PD services and the

Newcastle service. There were limited opportunities for networking with staff from other sites (occasional meetings of senior clinical staff at meetings organised by the Home Office) and moreover, each service was perceived to be working on different principles and there was therefore little scope for joint work. In addition, on a practical note, staff felt that it was geographically easier to develop relationships with more proximal services (e.g. the medium secure unit at Arnold Lodge in Leicester).

We don't have as good a relationship with the London sites as well as other people seem to think we should have. I'm not sure if it's going to be beneficial - we may well end up with a northern forum where we look at issues because it's geographically it's…easier…plus the fact that the pilot sites are different because the commissioning arrangements are different. S18 (baseline)

I set up an appointment last week [between some Northern sites]…*we just go there, because we, we can actually get clinical issues sorted, we did so much more, we spent a day but we did more in that day than we have done in about 10 clinical forums, its just easier.*
S21 (baseline)

4.3.8 Relationships with the Home Office

Staff from both teams told us that they would have appreciated clearer direction around the aims and operation of the service and greater assistance in raising the profile of the service.

Assist us in the bridge building…what we need the commissioners to do is sort of assist new teams like this, particularly where its about developing services for people with personality disorder, assist us in working with your services… so us and commissioners really need to be working together to build a decent working relationship between us and the secondary services. S18 (baseline)

I think the lack of direction um is a nightmare, all we are told is um, males only, over 18 with certain criteria, other than that its up to you what you do. I can see the sense in that at one level but actually lack of support I guess, they are putting in loads of money to this pilot site and it's my local trust that supports me and yet it's their [Home office] *money. So it would be nice I guess to have more support from them to actually say no they are not just another medium secure ward within your trust, they are a pilot site with separate funding and they are allowed to do things differently.* S17 (follow-up)

The need for the service to maintain a high profile was also raised by the chair of the local MAPPP who thought that it was crucial for all the PD pilot services to remind local services of their existence.

I think keep their profile high. You know, the training that X has provided is valuable but they need to keep reminding us of their profile because it's an extremely busy world and we're dealing with risk and it might seem unbelievable that the service could be over looked but its about keeping high profile and we're aware of the service and what it can deliver. It's about reminding the outside world that they are there and the service that's on offer. S22 (baseline)

4.3.9 Untoward incidents occurring during the course of the study

Oswin Unit

Two serious untoward incidents involving staff and service users occurred during the course of the evaluation. In December 2005, staff raised suspicions that a nurse was *'getting close'* to a service user. An informal investigation concluded that there was no evidence to suggest that anything untoward was happening and the staff member denied any wrong doing. As a result, the staff member was advised of colleagues concerns and supervision arrangements were *'tightened'*. However, in February 2006 a routine inspection of phone numbers dialling into the unit found that the staff member's home phone had been used to dial the service user's phone. The staff member was suspended and a full investigation carried out. The staff member admitted close phone contact over many weeks but claimed she was blackmailed into this. There was no evidence of this. The client admitted the calls and explained that they occurred in the context of a *'verbal relationship'*. The staff member was dismissed in July 2006 for professional misconduct.

The second incident involved a service user absconding whilst on escorted leave and returning to the Unit of his own volition after being missing for 5 days. Two days later, the escorting nurse came forward and admitted that she had known the whereabouts of the service user, that he was with another staff member and that he and that staff member had been having sexual intercourse for weeks and they were together in the community. Both nurses were suspended pending an investigation. The Protection of Vulnerable Adults (POVA) policy was invoked and police involved. The Trust was advised not to investigate until police had finished their investigations. As a result of the police investigation, the staff member was given an official police caution for aiding and abetting a detained service user to abscond and remain at large in the community. There was not enough evidence to proceed with allegations of a sexual relationship. The escorting nurse was not charged.

As a result of these incidents, management responded by:

1) conducting an immediate review of supervision arrangements and systems to raise concern
2) implementing additional staff training around boundary and confidentiality issues
3) commissioning a semi-independent review of Oswin Unit in December 2006.

Two major recommendations emerged from the review:

1. *'that concerns about the behaviour of staff should be taken seriously - they are likely to have some foundation. The unit should consider moving staff completely on a case-by-case basis from a situation where they might be compromised although it is recognised that this is potentially every staff member on a daily basis and therefore needs careful monitoring.'*
2. *'boundary issues'* were a problem on the Unit and that an intensive plan to reinforce boundaries and information sharing was needed immediately.

At the time of compiling this report, the two members of staff involved in the incidents remained suspended and subject to Trust disciplinary procedures. One of the disciplinary procedures was unable to progress as the member of staff involved was unwell. We understand that the disciplinary hearing for the other member of staff is imminent.

At the time of writing this report, we became aware of a further incident that took place on the Oswin Unit in May 2007. During the course of a transfer of a service user to High Secure Services, there was a violent struggle necessitating the use of CS spray and batons; two policemen were injured in the process. At the time of writing this report, formal Trust processes in response to this incident had not yet commenced.

Community Team

The team reported that no major incidents occurred during the course of the evaluation. There were some minor incidents such as service users being verbally abusive during treatment sessions although there was no reported physical violence. One service user made threats to team members and this was reported to the police who dealt with this as part of an ongoing investigation with this service user. There were some incidents of self harm although these were not reported to be life threatening.

4.3.10 Findings from local research and audit

Oswin Unit

When we spoke to staff in April 2007, our understanding was that little research or audit was being carried out on the unit. Staff told us that in the future, they hoped to carry out an audit examining the efficacy of groups being run on the unit. A research group had been set up consisting of the 4 lead clinicians and this was due to have its first meeting in April 2007 to discuss how to take the research and audit agenda forward.

Community Team

The team's Consultant Forensic Psychiatrist has a longstanding interest in research and was leading research activity within the team. At the time of preparing this report, the team were carrying out an audit of health records. They were also bringing together all outcome data from the standardised assessments.

4.4. Is the programme working?

4.4.1 Qualitative evidence

4.4.1.1 The views of staff

In both their initial and one-year follow-up interviews, the majority of staff felt that although there were some promising day-to-day changes in service users, overall, they were not in an informed position to comment on the effectiveness of a treatment programme which was still in an ‘embryonic’ stage of development.

It’s so early days that it is difficult to tell. I think in terms of people’s day-to-day behaviour there are clearly obviously some improvements, whether that is going to have any impact on long term offending I don’t know…On a day-to-day level I think they [treatments] are good I’ve not got any concerns about our treatment programme, I think it needs bedding in, I think the groups need to be run a number more times to get the facilitators confident in them...I would give it about 5 years to be honest…its really difficult to be clear about the actual impact, especially when you have only got small numbers as well going through it you can’t generalise…we are well in the teething stages, starting a new unit from scratch I mean I, common sense tells you there is a lot to be done, but until you do it, you have got no idea, our service is so embryonic, its not a mature service yet, the staff are not mature. S17 (Follow-up)

Oswin Unit

Despite the above reservations, staff highlighted some areas where they felt promising changes appeared to be occurring in the lives of the service users. One area that particularly stood out in the minds of staff was their perception that some service users’ were developing a greater ability to share their feelings with others and solve problems through talking.

Probably the biggest change is probably the ability of those patients we have, a lot of the patients to be reflective... …the ability of those patients to, to discuss some really thorny issues that may affect one or two of them or may affect the whole group but actually discuss it in a... considered and... relatively reduced emotional state because we both know that these men have difficulty in regulating their emotion and secondly have real difficulty in problem solving... Historically the way they would problem solve is to puff out their chest and have a fight or um, or commit a crime and although this is an artificial environment it’s really positive to say that these people can actually talk about things and actually express um, express their opinion in an um, fairly dispassionate and considered way, I think that’s a massive progression. S13 (follow-up)

There was a lack of consensus about which aspects of the treatment programme were most helpful. Some staff identified individual components of the content of the programme (CBT groups, informal therapy, 1:1 sessions) whilst others spoke about the overall structure of the programme.

We have noticed some change in some people who have been through certain groups...we have had a year long ‘personality disorder group’ that's run along CBT principles and certainly the 3, there was only 3 who finished it, but the 3 who did…finish it seem[ed] to gain a lot of benefit from that in terms of personal awareness and as I say beginning to make some changes in actual behaviour…Individual psychology sessions have clearly been important for one or two individuals, um, and I guess the structured day that we have here, um, has probably been quite helpful for some people, in terms of helping to contain and manage their behaviour...it's just really difficult to say how it's going to in reality it is going to impact on offending. S17 (follow-up)

Several staff stated that in their view, for treatment to be successful, it was essential that the Unit selected service users who were motivated to undertake the work.

They've got to want to do it, they've got to want to come along and they've got to want to engage, they've got to want to put the effort in. S21 (follow-up)

Other staff highlighted the importance of identifying unsuitable service users and the ability to swiftly transfer these individuals off the unit as quickly as possible.

We've also been able to identify... fairly quickly, patients that aren't suitable to be in our service and we've been able to move those back successfully into the prison service so I would say that has been a success and we have 10 men at the moment and.... I would suggest that they're all appropriately placed, the assessment selection criteria has been successful....they're all engaged at a certain level and again I would say that would be a success as well I suppose. S13 (follow-up)

Community Team

Staff from the community team talked about needing to adjust their expectations of what they might achieve with the service users. As opposed to seeking 'radical change' in the men's personalities, over time they had found themselves focusing more on basic day-to-day needs, such as ensuring that stable accommodation was in place and that the men were actually engaging with the range of services put in place to assist them with community living. The fact that service users were turning up for their appointments and not fighting with professionals was in itself perceived to be a marker of success.

Our vision of the treatment programme then was that we'd be looking at doing…offence related work, individualised programmes with people, concentrating on their risks and concentrating upon issues about their personality. I think its fair to say that for some of the lads we do that, but for a larger number there's a sense that the treatment programme is more geared towards getting them into a normal, normal lifestyle, normalising their life and by that I mean the sort of basics of a roof over their head, stable accommodation of a reasonable quality, ensuring that they're eating appropriate foods, ensuring that they're engaging with the various services that are there to assist them, um, and looking at issues of relationships in terms of how they socialise with people…its more of a social feel to the treatment model than I suppose we initially envisaged. S18 (follow-up)

What you've got to do is change the way you measure success, I mean these lads are still coming in every session, they're still sitting with you, they're still trying and that's probably a better measure of success than expecting radical change. S21 (follow-up)

They seem to engage more with services rather than fighting them all the time.
S20 (follow-up)

Notwithstanding, some staff told us that they thought that as a result of treatment there had been a reduction in the risk that some service users posed to themselves and others.

…not getting into trouble, bear in mind that we're a forensic programme them not getting into trouble for a sustained period... they haven't harmed themselves particularly or harmed other people, um, their substance misuse is reduced, um, in certain cases their general quality of life they've been reported that to be improved. S19 (follow-up)

They've been assisted in thinking their way through crises so they haven't gotten themselves into trouble when they might have done…some have responded positively to um ways to manage their symptoms either through medication or through psychological methods…a number of them are now staying out of trouble. S20 (follow-up)

The impact of the work on the staff

In the first round of interviews, staff in the Oswin Unit talked about the stark realisation that the clinical work was going to be challenging - indeed for some staff the work proved to be much tougher than they had originally anticipated.

Staff have er, woken up and smelt the coffee in terms of what, what patients we really work with. I think there was an awakening really in the staff as to this really is probably what we're going to have to work with, this is what's going to be around. S13 (baseline)

When the staff were re-interviewed a year later, more specific difficulties had emerged in the relationships between staff and service users. Some staff talked about the tension between providing care whilst at the same time maintaining 'professional distance'.

In terms of relationships we've had some real difficulties, but in terms of percentages of staff it's quite a low percentage of staff but we have some staff who have found it difficult to maintain that professional distance...I think what we're realising is that our patients are incredibly skilled at exploiting whatever holes that you have and I think that staff um really have to be careful about that. S13 (follow-up)

There is some splitting of the staff, some of the staff aren't that happy here and I think that's for a variety of reasons - one, its maybe not what they thought it was going to be. Two, just the emotional impact of working with these guys is quite hard on you at times.
S15 (follow-up)

All the staff that we interviewed from Oswin Unit reported that there had been moments when they had felt fear or anxiety when spending time with the service users. For some staff, the sheer physical size and presence of the men was a source of intimidation. Others reported being afraid of service users due to the nature of their index offence.

There have been one or two clear examples where patients have been violent and quite clearly the staff have reacted with reasonable fear because we had one guy who would kick off very unpredictably and we had to ship him back to prison, he was unmanageable and I think he is being assessed for high secure. And that raised a lot of tension about the fact that they thought we probably delayed in sending him back, we could have sent him back sooner than we did. And I think that is probably right to be honest. So there are clear examples like that, there's only 1 or 2 of those kind, we've got one chap in at the moment who is quite physically intimidating and we know would take a lot to pin him down and he would actually probably seriously hurt in that because he has done that a lot in the past, hurt other people on purpose, and so people are wary of him. There's also other kinds of fears... um, people are more fearful of the rapists that we have got because of the lack of understanding around sexual offenders and how they operate. And just because they have raped does not mean that every woman that works on the ward is necessarily going to be at immediate risk.… and um, fears about being groomed or seduced by patients. S17 (follow-up)

One of the things that is… is that was noted early days, was that people were going home and making sure they locked the doors or closing the bedroom window on a night - a practice that they hadn't previously done and it was almost like that's an impact of working with this client group. You become, um, more cautious, it effects you in your day-to- day.… you're just more cautious, not less trusting but just more cautious, a little more safety conscience. However, the first secretary we had um, did admit that she had periods of time, early days, when she had nightmares, and she found difficulty sleeping because she was thinking about what if this person comes round to my estate. S18 (follow-up)

Senior clinical staff in both the Oswin Unit and the Community team described feeling over-burdened with administrative tasks. In particular, for senior Oswin Unit staff, the building moves had generated an enormous amount of administrative work. Sometimes the need to complete routine administration had taken them away from core clinical work.

One the sheer amount of work... and it's never ending! …You know you don't mind doing 40 to 50 hours a week if it is now and again but it seems constant, um, and it's fundamental things like trying to get things up and running when there is resistance to it, it just doesn't go away. S17 (follow-up)

4.4.1.2 The views of the service users

Service users generally reported that treatment had been helpful. A range of positive experiences were described including learning how to better manage anger, sharing feelings with staff, gaining in confidence and learning how to act less impulsively. In this respect, group work was identified as being particularly helpful.

I have learnt how to change, how to go about things, how to not get worked up on the spur of the moment and that basically if there's no help and support available at the time I feel that I am getting worked up, it's best to go away and think about the situation while listening to some relaxation therapy tapes that I have been given. SU25

It's like staying calm and relaxed because it stops the emotion from building in anger, it's like relaxed, supported. Hopefully you will feel responsible for your behaviour. SU19

It did seem to help a lot…made us think about things instead of just reacting straight away. SU29

I guess I am more open now, I am more um, I guess I consider myself more…um, I guess it's like being aware of things. I am aware of things more…I used to be really quiet, I was a private person but I guess I am more open about things more now, little bit more confident, looking at my problems. SU21

Useful is doing me courses, getting the confidence to come and sit in group. Which I have never done before…that is helping a lot. I am still getting used to just talking in a group and that but, I am just gradually getting there. SU17

Although service users thought that the treatment was helpful, it could also be extremely challenging and stressful. Many service users found the experience of examining and sharing their feelings with others to be overwhelming.

So the treatment since I came here has always been very much emotional focused. People are at us all the time about how I feel, 'how do you feel about this', 'how do you feel about that'. You know, have a conversation, 'what do you feel' - bombarded by 'how you feel' questions, you know it's just... I know why they are doing it, because the logic is not enough to stop us from getting in trouble again to have an emotional connection to what I have done in the past with my crimes and to have an emotional connection between what's wrong and right makes a difference in whether or not I will re offend again. But I know why they are doing it, but it doesn't make it easy. Does my head in some days you know, really does my head in. But it has got to be done hasn't it, some days I don't feel like doing it. SU23

I found it [the group session] *very stressful because I have been in a low mood for the last few days, well, the last week or so and going to the new group, meeting new people and just talking about my emotions and that, I just felt over-whelmed at the time…what has been unhelpful? Having to do it basically.… not wanting to be in this situation talking through my*

life and that to everybody, it's been unwanted like, its not been something I really want, you know I have had no pleasure in doing, but knowing that I am having to do it, to better myself, helps. SU29

What do the service users think about the staff?

The majority of community-based service users reported that they had found the staff to be helpful and felt that they could talk to them – a novel and relieving experience for those who had previously *"bottled feelings up"*.

I have got people I can talk to, whereas in the past it would be like, self harm straight away and I talk to them now, and that's good that. SU31

I just bottled all my feelings up, I had never... I was just bottling all my feelings up and stopped talking to people and I was just bottling everything up and was not handling it and was just getting into my own little world. Whereas when I started talking about thing it helped us realise the way I was going on sort of thing…it felt like a relief to actually get help. It felt like I was drowning in it…and actually to get somebody to listen to us and understand sort of what I was going through was a big relief…a weight off my shoulders sort of thing. SU29

Users of both services said that they could trust most of the staff that they encountered, although on Oswin Unit, some staff were perceived to be more trustworthy than others.

I find them friendly... I can have a laugh and a joke with them and I can ask them for advice when I need to. You know I find them approachable... there is nobody on here that I would say I dislike which is quite a rare thing you know…on the whole I think they are good yeah…I trust the people I deal with. I mean obviously there are people I trust more than others but my core team I trust them yeah. SU20

The theme of trusting staff was discussed at length in the focus group (which consisted entirely of service users from the Oswin Unit). There was a clear consensus of opinion among participants that about half the staff of staff could be trusted whilst 50% were not to be trusted (*"fifty-fifty"*). Staff not to be trusted also attracted a range of other negative descriptions: they were *'just not right'* or *'wrong'* due to their tendency to *'talk down'* to service users and treat them as criminals rather than as people needing help. They also *'jumped to conclusions'* about the motives behind actions of a service user and were inconsistent about boundaries and rules.

There's a lot of talk down here, talk down to people, certain members of staff talk down to the patients like they are shit under their feet. SU19 (focus group)

[Service users have] *paid debt to society, finished their sentences nearly. I don't expect to be still treated like a prisoner when I have committed a crime, I have done my sentence for that crime and I have been punished more ways than enough inside prison, know what I mean. And I have come here for a brand new start and I am still getting treated like a criminal. I mean when this place is supposed to be about rehabilitating you back into society you know, and that's just not what's happening.* SU22 (focus group)

What has been unhelpful?

Service users from both teams complained of *'lack of communication'* between staff and service users. This lack of communication tapped into a number of areas: lack of information being given to them regarding their diagnosis, lack of information about their progress through the assessment phase, and lack of feedback about their treatment progress.

There's not enough feedback and all that...I don't feel any further forward of the service, but like, there has got to be the end of the road somewhere, I don't feel as if I am getting to the

end of the road, how long do I have to come here like, I can't repeat myself enough like, there is not a time when they have come back to us and said right, 'we will look into this, look into that, we will progress on this, we think that thus is wrong' - it's always, 'we will go back to this and we will go back to that, we will do this and we will do that'. There is nothing going forward, so I don't feel as if I am getting somewhere. SU30

The feedback off staff like how well you are doing or how bad you are doing. Like you hardly get any feedback. SU24

It just seems like at the minute one-way traffic you know... if the people gave a little bit more information, about you, where you stand at the current time, then I think it would be a lot better. SU22

That's what does not happen enough on here. People just come flat out and say 'no - you can't do it' - end of story. Not enough explaining. Not enough. It's that communication thing again that I was on about before, there is not enough explanations... know what I mean? SU23

Many of the service users whom we spoke to from both the community and the ward talked about their dissatisfaction with the assessment. Most of the service users complained about the length of the assessment. In addition, others flagged up the fact that whilst they were being assessed they were not receiving active help and were, in their own words, *"left to your own devices"* to manage the difficult emotions stirred up by talking about their histories.

The assessment that you have - the 3 months assessment when you come. Be talking about personal things and that, that was hard…it could be like three days a week or one day a week I would discuss - like have meetings with a psychologist and psychiatrist I think it was, and then they would ask questions and I would answer them and I had to fill in and things like that what them needed to know really…to give us a treatment plan. That was hard because I had to talk about all my like, the crimes that I had done and my life really, sometimes it was hard, sometimes it was easy…if they could shorten the length of time because with that three month you are doing like that group and then you have still got things on your mind so you need to do other things to take your mind off that you know, but that's not what happens. You are doing the 3 month assessment and then you get left to your own devices on the ward and that, you start to think things and that. So I think while you are doing that, I think you need to be in group sessions as well. Might not work but I think it might. SU24

Just when I had to explain the things that had happened because there was a few like I was abused and that and just thinking about that you know talking about it, and then when you leave you feel a little bit down you know so that can be stressful…I was getting sick of it. It had got to the stage where I thought I can't be bothered to do this anymore, I have had enough of it. And although the assessment was easy, the questions were easy and everything, it was just taxing on the brain all the time and by the time I left I was shattered you know. And I thought to myself its taking ages... and I am not actually doing any work, I am not progressing. SU28

Other users of both services expressed concern about the fact that there was a possibility that once the assessment had been completed they might be sent away from the service; this was something that they said that they had not been made aware of from the outset of contact with the ward or community team.

When I first came here, I thought I was here, I didn't really know until I got here that I was on three months assessment and after that three months I could be sent back. I didn't know that… so I didn't know if I was coming or going and a lot of people that have come here felt like that too, they didn't know if they were coming or going, and it's like I've got to do the

assessment and I've got to tell you my entire life story and then in three months time I might be gone. And I think well why have I just told you all this stuff you know and, so it does mix up your mind a bit yeah. SU20

Many of the service users from Oswin Unit complained that they were often bored; there were simply not enough activities going on to keep them fully occupied throughout the day.

I think they should have quite a few groups, not just the ones they do now. They should have like stress busters, we used to do that…[where] I have just come from. Like on a Friday we used to do 2 hours, we used to have games, games like football, table tennis, jenga, connect 4, everyone is getting together. Just getting you de-stressed. If you are feeling stressed there should be something there for you. Because we have nothing to do, usually during the day we are just sitting about doing nothing. And I find that really stressful, boring. If you are sitting there doing nothing. There should be more activities. SU17

Another complaint was that there were not enough practical groups available on the Unit in which they might learn some transferable skills which they could take away when they eventually left the service. Examples cited by service users included woodwork, or bricklaying courses. Service users felt that learning a skill which they could use 'on the outside' might go some way towards preventing them from re-offending.

I have done no courses, I have done nothing, I am just sitting here doing, know what I mean. That's the only thing about this place, its quite boring…well if people are saying this place is about rehabilitation and all that carry on into society they should have things like bricklaying, painting and decorating…there should be a… you know like a woodwork shop or something like that because we are all adults on here as you see. And most of us are looking to get out after the 2 or 3 year in here and most of us haven't even got any qualification or anything... so I think they could have done like a mechanic shop or woodwork shop or something like painting or decorating shop like they have in prisons you know. Because then at least you are going to get training for some kind of job as well as dealing with your stuff. SU22

I am getting treatment for like better thinking and things like that, and that's, that's what I am here for. But I also think they should have like a woodwork shop because when I get out its not just… its like the lack of qualification I've got taking me down the same road again know what I mean and I think most people have got that problem. SU24

The impact of untoward incidents

The incidents that took place on Oswin Unit in recent months (see above) have had a major impact on both the ward staff and the service users. In the focus group that was convened with Oswin Unit service users in February 2007, they talked about the detrimental effect that the incidents and subsequent investigation had had on the ward atmosphere. Trust had been damaged and 'community spirit' had been lost. There was a perception that the number of unit protocols and rules had increased as staff were '*trying to regain control'* of the Unit. The overall effect of these changes was that the Unit had become more prison-like.

Well there have been a couple of staff suspended and allegations so obviously that is not helpful and you know, you are thinking, it does throw in the question of trust…. Obviously you are supposed to trust some of these, you are supposed to trust all the staff but if someone is doing stuff that is not trustworthy then obviously that calls into that trust so that is not helpful yeah. SU20

I feel majority of patients on this ward feel…that they can't talk to the staff… we are getting better at listening to them… it seems like the staff are just wanting to put protocols in place, restrictions… make life harder, because of what has happened with these two people, know

what I mean… And the staff don't seem to be bothered with using excuses for like health and safety, health and safety, protocol and excuses to justify bringing in sanctions on what they are doing. And the quality of life on this unit is slowly and truly getting diminished. SU19

Staff don't want to go too far out of their way to help somebody because of liable of bias, favouritism…they don't want to leave themselves wide open for anything…it seems that the people that actually run the PD unit, they all, somewhere along the… line, they have lost control of something. I suppose their way of gaining it back is to just keep on bringing rules in, one after the other, its their way of saying look we are controlling what happens here, not you…and I think why should I trust somebody if all they are going to do is tell us what to do all the time…What you call it? Community spirit - that's gone, not here any more and it's a shame really because I used to like that. SU23

In response to feedback from service users, we understand that a number of new initiatives were underway at the time of writing this report, including the development of further weekend-based activities, and a new vocational/educational strategy for service users.

4.4.2 Evidence from the quantitative data: 6-month follow-up of service users managed by the service.

At six months, 15 of the 20 men recruited at baseline were still being managed by the service. One in-patient was returned to prison because he did not engage in the treatment programme and a second in-patient proved to be unmanageable on the Unit. One community participant was discharged from the team because they were unable to engage him in work due to his alcohol dependency. Two other community participants did not want to continue their work with the community team. We obtained complete follow-up ratings on all 15 men who were still receiving treatment at the point of follow-up.

Behavioural disturbance (Table 7)

Over the 6-month follow-up period (May 2006-December 2006) none of the participants had engaged in absconding behaviour; however, one participant who had a follow-up interview in June 2006, subsequently absconded from hospital in August 2006. Five men engaged in one or more incidents of self-harm (only one of whom had being self-harming in the 6 months preceding baseline interview), 7 men had one or more incidents of non-compliance with aspects of the treatment programme (including medication), 3 men were found in possession of contraband material. Five community participants engaged in one or more incidents of violence over the follow-up period. We were only able to obtain limited information on the details of violence in two cases: one participant committed an assault using a sword; the other participant had subjected his girlfriend to a brutal assault in which he attempted to set her alight with petrol after beating her. Eight men were involved in incidents of property damage.

General function (Table 8)

The mean WSAS score at follow-up for the overall NTW group had slightly decreased (improved) from 19.0 to 18.5. However, the difference between baseline and follow-up score was not statistically significant (paired t-test $p= 0.9$).

Therapeutic alliance (Table 8)

The mean service user –rated alliance score for the overall NTW group remained unchanged at 6-month follow-up. The mean staff –rated alliance score had slightly increased from 57.6 to 58, however, the difference in scores was non-significant (paired t-test $p= 0.5$).

Belief about personality disorder diagnosis (Table 3)

Fourteen of the 15 men who thought that they had a PD at baseline continued to hold this belief at follow-up.

Table 10. Behavioural disturbance* at 6-month follow-up

Variable	Oswin unit N (%)	Community team N (%)	TOTAL N (%)
Use of non-prescribed substance			
Yes	0 (0)	4 (36)	4 (20)
No	7 (78)	4 (36)	11 (55)
missing	2 (22)	3 (27)	5 (25)
Use of alcohol			
Yes	0 (0)	6 (55)	6 (30)
No	7 (78)	2 (18)	9 (45)
missing	2 (22)	3 (27)	5 (25)
Incidence of self-harm			
Yes	3 (33)	2 (18)	5 (25)
No	4 (44)	6 (55)	10 (50)
missing	2 (22)	3 (27)	5 (25)
Incidence of violence			
Yes	0 (0)	5 (46)	5 (25)
No	7 (78)	3 (27)	10 (50)
missing	2 (22)	3 (27)	5 (25)
Absconded [a]			
Yes	0 (0)	0 (0)	0 (0)
No	7 (78)	8 (72)	15 (75)
missing	2 (22)	3 (27)	5 (25)
Incidence of property damage			
Yes	1 (11)	7 (64)	8 (40)
No	6 (67)	1 (9)	7 (35)
missing	2 (22)	3 (27)	5 (25)
Found in possession of contraband material			
Yes	1 (11)	2 (18)	3 (15)
No	6 (67)	6 (55)	12 (60)
missing	2 (22)	3 (27)	5 (25)
Incidence of non-adherence with treatment			
Yes	1 (11)	6 (55)	7 (35)
No	6 (67)	2 (18)	8 (40)
missing	2 (22)	3 (27)	5 (25)

* information taken from case records

[a] Over the 6-month follow-up period (May 2006-December 2006) none of the participants had engaged in absconding behaviour; however, one participant who had a follow-up interview in June 2006, subsequently absconded from Oswin Unit in August 2006.

Table 11. General functioning and alliance scores at baseline and 6-month follow-up.

Variable	Oswin unit	Community team	TOTAL
Mean WSAS score (SD) at baseline	13.2 (9.5)	23.6 (13.3)	19.0 (12.6)
Mean WSAS score (SD) at 6-mth follow-up	13.4 (9.2)	23 (11.5)	18.5 (11.3)
Results of paired t-test	*P*= 0.4	*P*= 0.6	*P*= 0.9
Mean service user rated alliance *score (SD) at baseline	64.3 (10.7)	62.7 (14.6)	63.5 (12.7)
Mean service user rated alliance score (SD) at 6-mth follow-up	65.4 (13.2)	61.8 (14.0)	63.5 (13.3)
Results of paired t-test	*P*= 0.6	*P*= 0.8	*P*= 0.8
Mean staff-rated alliance score (SD) at baseline	58.6 (9.1)	56.8 (7.7)	57.6 (8.2)
Mean staff-rated alliance score (SD) at 6-mth follow-up	58.4 (10.1)	57.6 (10.2)	58.0 (9.8)
Results of paired t-test	*P*= 0.2	*P*= 0.8	*P*= 0.5

KEY: WSAS: Work and Social Adjustment Scale (WSAS): Scores range from 0 to 40 with a greater score indicating a greater overall functional impairment

*Alliance scores: Scores range from 0 to 168, with higher scores indicating a better working alliance.

4.4.3 Individual costs

For those in Oswin Unit, the pattern of accommodation from baseline to follow-up clearly showed movement into the new services from other settings. Many spent time in prison and low and high secure hospitals over the six months preceding baseline, whilst they were all in the Unit for the follow-up period.

The pattern of service use for the community team in Newcastle reflected the fact that the service was well established at the beginning of the study. Thus, there was little use of prison or other secure services by those in the community group, who generally resided in their own homes or in hostel accommodation. It is worth noting that some community service users spent time in less permanent accommodation such as bed and breakfast, living with friends or for short periods of time, homeless. Community participants also had regular contacts with community mental health services and day care services. Almost all the community service users were on some type of psychotropic medication.

Table 12 Service use over six months preceding baseline by service

	MSU (n=9)		Community (n=11)	
	Mean	SD	Mean	SD
Accommodation				
Own home (nights)	0.0	0.0	132.0	84.8
Hostel (nights)	0.0	0.0	33.4	73.5
MSU (nights)	113.7	72.5	0.0	0.0
Low Secure Unit (nights)	11.9	35.7	0.0	0.0
Prison (nights)	50.8	76.3	0.0	0.0
High secure hospital (nights)	6.2	18.7	0.0	0.0
Bed and breakfast (nights)	0.0	0.0	1.5	4.8
Homeless (nights)	0.0	0.0	0.5	1.5
Staying with friends (nights)	0.0	0.0	14.3	47.3
Health care/community services				
Inpatient stay (nights)	0.2	0.4	6.9	10.6
Outpatient appointment (attendances)	0.8	1.6	0.6	1.2
Accident and emergency (attendances)	0.2	0.4	0.3	0.9
General practitioner (contacts)	9.1	9.4	3.6	4.7
Practice nurse (contacts)	0.2	0.7	0.5	0.7
Key worker (contacts)	6.1	11.3	16.6	10.4
Psychiatric nurse (contacts)	0.7	2.0	8.0	16.4
Psychiatrist (contacts)	5.1	8.3	4.0	8.0
Psychologist (contacts)	8.2	5.7	2.6	4.9
Counsellor/Therapist (contacts)	0.8	2.3	0.0	0.0
Drug and alcohol worker (contacts)	0.0	0.0	2.4	7.8
Dentist (contacts)	0.7	1.3	0.9	1.3
Occupational therapist (contacts)	8.7	11.4	4.4	9.5
Sport therapist (contacts)	0.0	0.0	0.0	0.0
Social worker (contacts)	0.1	0.3	6.3	10.5
Day centre (visits)	0.0	0.0	16.4	33.0
Psychotropic medication (%)	67		82	
Criminal justice services				
Probation (contacts)	0.1	0.3	8.4	10.1
Solicitor (contacts)	0.8	1.6	1.7	3.6
Police (contacts)	1.0	3.0	1.3	1.1
Police custody (sessions)	0.0	0.0	0.4	0.7
Court appearance (per case)	0.1	0.3	0.5	0.8
Public protection unit (per session)	0.0	0.0	0.1	0.3

Table 13 Service use over six month follow-up by service

	MSU (N=8)		Community (N=11)	
	Mean	SD	Mean	SD
Accommodation				
Own home (nights)	0.0	0.0	101.7	97.6
Hostel (nights)	0.0	0.0	37.8	67.1
MSU (nights)	181.0	21.7	0.0	0.0
Homeless (nights)	0.0	0.0	5.5	18.4
Staying with friends (nights)	0.0	0.0	27.9	63.6
Healthcare/community services				
Inpatient stay (nights)	0.0	0.0	5.0	13.6
Outpatient appointment (attendances)	1.3	1.8	0.4	1.2
Accident and emergency (attendances)	0.3	0.7	0.4	0.7
General practitioner (contacts)	7.5	9.8	2.9	5.0
Practice nurse (contacts)	3.8	7.4	0.1	0.3
Key worker (contacts)	43.4	67.4	20.0	10.7
Psychiatric nurse (contacts)	16.8	36.0	7.8	11.0
Psychiatrist (contacts)	19.8	16.8	0.9	0.9
Psychologist (contacts)	29.9	42.6	0.0	0.0
Counsellor/Therapist (contacts)	0.4	1.1	0.0	0.0
Drug and alcohol worker (contacts)	0.0	0.0	0.0	0.0
Dentist (contacts)	2.6	4.3	0.3	0.6
Occupational therapist (contacts)	3.8	8.4	0.1	0.3
Social worker (contacts)	0.3	0.7	7.4	11.2
Day centre (visits)	0.0	0.0	4.5	10.1
Psychotropic medication (%)	63		91	
Criminal Justice services				
Probation (contacts)	0.3	0.5	4.7	7.1
Solicitor (contacts)	1.0	1.3	2.1	4.4
Police (contacts)	0.5	0.8	2.2	4.4
Police custody (sessions)	0.0	0.0	0.7	1.0
Court appearance (per case)	0.1	0.4	0.4	0.7

Total costs for the six months preceding baseline and over the six months between baseline and follow-up are shown in tables 14 and 15. For those in Oswin Unit, costs at follow-up were £97,124 and for those in the community team costs at follow-up were £12,215. Costs were significantly higher at follow-up (p=0.015), which reflects the greater amount of time spent in the more intensive service.

Table 14 Total cost over six months preceding baseline by service

	MSU (n=9)		Community (n=11)	
	Mean	SD	Mean	SD
Social services	0	0	1,869	3,383
NHS	68,554	40,051	2,143	2,434
Voluntary services	0	0	0	0
Criminal justice	8,797	14,967	829	728
TOTAL COST	77,351	31,696	4,841	4,478

Table 15 Total cost over six months follow-up by service

	MSU (N=8)		Community (N=11)	
	Mean	SD	Mean	SD
Social services	0	0	2,202	4,203
NHS	95,722	11,355	9,345	3,799
Voluntary services	0	0	0	0
Criminal justice	1,402	3,779	668	511
TOTAL COST	97,124	12,904	12,215	5,094

4.4.4 Summary

Strengths

- Staff and service users perceived positive effects of treatment, including improved anger management and increased self confidence.
- Over the period of the evaluation, the in-patient team successfully negotiated relocating to a new site and despite the disruption continued to deliver an active treatment programme to the service users.
- The morale of the community team (the oldest in the evaluation) was noted to be particularly good.

Suggestions for future service development

- An overall clinical leader, with ultimate clinical responsibility, needs to be clearly (and swiftly) identified on Oswin unit.
- In-patient staff supervision arrangements need to be more clearly defined
- The work of the community and in-patient teams could be better integrated with the aim of improving the movement of service users between the two teams.
- Consideration should be given to increasing the range of activities available within the in-patient treatment programme, including the provision of more practical activities.

CHAPTER 5:

South London and Maudsley NHS Foundation Trust Forensic Intensive Psychological Treatment Service

5.1 Description of the service

The Forensic Intensive Psychological Treatment Service (FIPTS) sits within the South London and Maudsley NHS Trust (SLAM). SLAM provides mental health and substance misuse services for people of all ages living in the London Boroughs of Croydon, Lambeth, Southwark and Lewisham. It also provides substance misuse services to the populations of Bexley, Bromley and Greenwich, and specialist mental health services to adults and children from across the UK. The Trust has a budget of £313 million, and a serves a population of approximately 1,105,200 across four London Boroughs.

FIPTS is an 'integrated' service consisting of three components: an interim 15-bedded Medium Secure Unit, based (at the time of preparing this report) at the Tony Hillis Unit (THU); two residential services and a community team.

Tony Hillis Unit (THU)

The THU is a 15-bedded Medium Secure Unit situated at Lambeth Hospital in South East London. The unit opened and received its first service user on 19th December 2004 and at the time of preparing this report had 10 service users. The anticipated length of stay is 2 years. The unit is due to move to a newly-built unit at the Bethlem Royal Hospital in Beckenham, Kent, on 14th February 2008.

Residential Service

The residential services are owned and run by Penrose Housing Association in collaboration with SLAM. Penrose is *"an independent charity committed to making a difference and giving new hope to people whose lives have been affected by crime and mental disorder. Penrose provides housing, care, resettlement and community services for people with mental health problems, challenging behaviour and criminal histories in London and the South East."* (source: http://www.penroseha.org.uk/). They work in partnership with statutory, voluntary and community agencies to reduce crime, re-build lives and contribute to safer and more inclusive communities.

The residential service consists of two houses. One located in Akerman Road, South London; providing a service for six service users (at the time of preparing this report, there were five service users in residence); it is classified as 'high support' and is therefore staffed on a 24-hour basis. It opened in June 2004 and received its first service user on 15th November 2004. The other house is situated in Bonham Road, South London and is a 'low-support' service, staffed on a 9am-5pm basis and has a capacity to house 4 service users. It opened on 28th June 2004 and received its first service user on 13th March 2006 and currently has 3 service users. The anticipated duration of stay for the whole residential service is 2 years although staff anticipated that some service users will be there for 3 or 4 years.

Community Team

The community team is based at Lambeth Hospital. It was formed in January 2004 although members of the team started working with their first service user prior to this, on 18th October 2003. At the time of preparing this report, the team had a case load of 43 service users. The anticipated duration of stay is 2 years although staff anticipated that this might extend. The team carry out in-reach work with in-patients in the THU, in-reach work with residents in the residential service and also work with some service users living independently in the community. Work is also carried out with some service users who are not part of the FIPTS programme.

5.1.1 Aims and philosophy of the service

The service is designed to be as integrated as possible and as such, has one overall aim and philosophy covering all three service components. The operational policy (January 2007) for the whole of the FIPTS states: *'The purpose of the FIPTS is to provide effective and meaningful assessment, treatment and management of people, having their home within Lambeth & Southwark, with personality disorders which cause them to present a high risk of sexual or violent offending behaviour directed towards others. The service will aim to reduce and manage the risk presented by clients in the least restrictive environment possible, reduce personality pathology and associated suffering and distress. It also aims to increase pro-social and adaptive behaviours in the areas of relationships, employment, education and community integration and promote independence and improved quality of life.'* Operational policy documents also emphasise the need to create care pathways into and out of the service that are as seamless as possible.

5.1.2 Inclusion/exclusion criteria

Inclusion criteria

- Living within the catchment area
- Male
- DSM-IV/ICD-10 criteria for diagnosis for personality disorder
- Forensic and/or offending history
- Offending behaviour is functionally linked to personality disorder
- Service user presents a high level of risk
- Concurrent Axis I diagnosis of major mental illness are accepted provided:
    - Offending history is functionally linked to their personality pathology rather than mental illness
    - Current active symptoms of major mental illness do not preclude the client from engaging in therapeutic interventions designed to reduce their personality pathology and risk
- Motivation to engage in the treatment programme

Exclusion criteria

- Female*
- Below age 18 years
- Service users are not excluded for primary problems of illicit drug use but it is acknowledged that current addictions or drug/alcohol use may preclude effective engagement with team and elevate risk **
- Learning disabled IQ<70
- Institutionally challenging behaviour (i.e. currently needing seclusion regularly)

* At the time of preparing this report, the community team were working with two female service users.

** Within the residential service, whilst the team does not discriminate against service users with substance misuse problems, to be accepted into the service, the service user must be motivated and have already started working on their addiction problems.

5.1.3 Referral and Assessment Procedure

THU

1. Referrals were received from Criminal Justice Services, Forensic Mental Health services, Mental Health services and other services such as GP or Social Services.
2. All referrals were processed through the Forensic Assessment and Treatment Team situated in the community team base at Lambeth Hospital.
3. A weekly meeting was held by the FIPTS team during which referral information was considered and a team member allocated to the case who then liaised with the referrer and other relevant agencies.
4. A pre-assessment screening was then completed. This involved a review of the case records and other documentary material, talking to people involved with the service user and sometimes interviewing the service user. It was anticipated that the pre-assessment screen should be carried out within three weeks of receiving the referral. The pre-assessment information was then discussed at a team meeting and a decision about made whether to go ahead with a full assessment. If it was felt that the FIPTS programme was inappropriate for the service user, then written advice was given to the referrer together with advice and recommendations on risk and management.
5. If the service user was thought to be potentially appropriate for FIPTS, then a fuller clinical assessment was carried out.

An experienced senior clinician (medical, nursing, psychology, OT or social work) conducted the initial clinical assessment. Follow up assessments were then carried out and on average each service user was assessed two or three times prior to admission. The service user was then admitted on a three-month trial basis during which time the minimum data set was completed and suitability for intensive treatment assessed.

Residential Service

One of the deputy managers took the lead on assessment and conducted a pre-assessment with another project worker and a member of staff from the community team. A decision was then made about whether to proceed with a full assessment. As part of the assessment, service users were invited to visit the service (the choice of house - low support or high support - depended on their level of need and/or risk). The service user underwent a 2-hour assessment with staff during which information was obtained about level of need, psychiatric history, life before entering the service and future plans. If the assessment proceeded favourably, the service user was then invited to commence a series of overnight stays.

Community Team

If the referral was felt to be appropriate for the community team, then the referred person was assigned to one of three levels:

1. 'Case Management'. This could be either in the community or at the Residential Service. RMO responsibility was taken on by FIPTS Consultant Psychiatrist with the service user being placed on enhanced CPA. A FIPTS care co-ordinator assumed responsibility for overseeing the case and the multidisciplinary team provided specific therapeutic interventions as appropriate.

2. 'Co-Working'. The FIPTS Community team provided a specific therapeutic intervention (e.g. anger management), and clinical responsibility remained with the referring agency.

3. 'Consultancy'. A FIPTS staff member was allocated to provide one-off/ ongoing advice to the referring agent regarding risk assessment, therapeutic intervention and

the management of difficult interpersonal dynamics related to personality pathology. The FIPTS staff member also attended relevant clinical meetings.

For all components of the service, when a service user left the service, an up-to-date risk assessment was carried out, at least three months before discharge. This process involved liaising with criminal justice agencies and MAPPP, where there were on-going concerns about the level of risk. Care co-ordinators often continued to provide on-going input until an appropriate level of care and risk management had been achieved within a new setting.

5.1.4 The model of treatment

The treatment offered by the FIPTS service is based on the Violence Reduction Programme (VRP) (32). The description of treatment provided below has been taken from the following document: 'Violence Reduction Program: Program Overview' (33).

Aims

The principal aim of the Violence Reduction Program (VRP) is to decrease the frequency and intensity of violent behaviours, decrease or eliminate the antisocial beliefs and attitudes that support the use of aggression and violence, and to assist the program participants to acquire appropriate interpersonal skills that are effective in reducing the risk of recidivisim, in particular, violent offending. The VRP is designed to address the treatment needs of high-risk violent offenders, in particular those who are non-compliant, lacking in motivation, resistant to treatment and have a history of institutional misconduct. However, it is recognised that a sub-group of violent offenders are heterogeneous with respect to their criminogenic needs and responsivity and may have a combination of needs such as substance use, cognitive distortions, impulsivity, lack of motivation and mental health issues such as anxiety and depression. The authors state that the program is flexible enough to accommodate heterogeneity of criminogenic needs.

The programme uses cognitive behavioural approaches and social learning principles within a relapse prevention model. The various VRP program modules are designed to address treatment targets that are characteristic of violent offender populations. In addition, it uses the 'Stages of Change Model' (34) to guide the selection of intervention strategies that are appropriate for offenders with different levels of motivation and compliance.

The VRP is delivered in three phases, each with its own set of tasks and objectives for both the service user and program deliverer. Progression through the VRP depends on achievement of phase objectives.

- *Phase 1*: focuses on enhancing the service user's understanding of the origins and maintenance of aggressive behaviours, identification of treatment targets and the development of the therapeutic/working alliance. Motivational interviewing techniques are used throughout the program but are particularly important in Phase 1 and are used to increase the service user's motivation and commitment.

- *Phase 2: 'Moving On'*. This is also referred to as the 'Breaking the Cycle Phase' and focuses on the acquisition of relevant skills to restructure negative thoughts, feelings and behaviours that are associated with destructive patterns and offence cycles that culminate in aggression and/or violence. Within this phase, service users may also be offered vocational rehabilitation, work around community living, specific individualised therapies including DBT, CBT/schema therapy, substance misuse therapy, cognitive skills groups and community groups.

- *Phase 3: Relapse Prevention.* This is a community group that focuses on relapse prevention and generalisation of skills across situations to mitigate the risk of future violence. The group are expected to demonstrate problem solving, joint working, anger control and reality testing. The focus is on breaking destructive behavioural patterns associated with aggression and violence.

Throughout the programme, small improvements are reinforced both inside and outside the formal treatment group through contact with other support and custodial staff who come into contact with the service users. The preferred method of delivery is in a group format although the authors state that it can also be delivered effectively in a one-to-one format with those who are highly disruptive or those who have significant mental health issues. Other interventions such as substance abuse treatment can be incorporated within phase 3.

Wong & Gordon state that the VRP program should be delivered in approximately 12 to 18 months although this can depend on the individual service user and the supplementary interventions that the service user might require.

THU

The VRP was offered on the THU to in-patients (who were all requested to attend the programme) as well as service users from the residential services and those working with the community team. It was designed to be a '24/7' programme with staff continuously reinforcing the principles of the VRP.

In addition to the group-based programme, each service user was allocated their own 'VRP mentor'. Staff informed us that this arrangement had not always run smoothly given time constraints and difficulties in ensuring that all staff were familiar with the programme and which specific problem area was currently being focused on in the VRP.

A range of other therapies, depending on need, were also offered to run alongside the VRP and these include: dialectical behavioural therapy (DBT), psychoeducation, Anger Reduction Therapy, Rehabilitation and Reasoning, a Sex Offender Treatment Programme and Schema Focussed Therapy. The unit also held fortnightly community meetings.

At the time of preparing this report, there was no substance misuse treatment programme being offered, although the role of drugs and alcohol in the offending cycle were being examined as part of the VRP.

Residential Services

On arrival at the service, each service user was assigned a project worker and a 'link' worker who worked with the service user when the main project worker was unavailable. The role of the project worker was described as being an *'amalgamation of an Occupational Therapist and a Counsellor'*. They assessed a service user's needs and supported the work of the THU and community team. They also focused on the development of individual life skills.

When they first moved in, service users received a support plan which was reviewed every 3-6 months. In addition, each service user had a CPA review every 6 months. The CPA documents focused on examining risks and risk management plan, relationships triggers/relapse indicators. At the time of preparing this report, the team were developing additional care planning tools based on Penrose Housing standards.

The majority of work at the residential services was carried out by project workers. In addition, each service user was encouraged to attend the VRP at the THU (if this was felt to be appropriate) and therapeutic work on targeted areas was carried out on a regular basis by visiting staff from the community team. Service users were also able to access a Sex

Offender Treatment Programme if this was required. On a typical day, a service user at Akerman Road might participate in some or all of the following activities: key working session with a project worker focusing on a particular area of need; attending the THU programme; receiving individual therapy from staff from the community team; planned activities with their project worker, such as opening a bank account or preparing a meal; a residents house meeting; shopping; visiting friends or relatives. Service users could also receive additional support such as supervision of medication, or additional telephone support in the evening from their project worker if required.

Penrose runs an employment, training and education programme with a dedicated manager. All Penrose tenants were eligible to access this facility and were encouraged to do so. Penrose provided paid part-time work on its maintenance team for service users who undertook painting and minor repairs for the Project. Some service users were also offered cleaning and gardening duties as therapeutic employment. The team at Akerman Road were hoping to start a re-settlement programme giving housing advice and support for residents. This initiative came about as it was felt that service users leaving the residential service would struggle to secure stable housing given the nature of their previous offending histories.

We were told that approximately 60% of residential service users had experienced a drug and alcohol problem (our own survey indicated that the prevalence was actually far higher than this – see section 5.2). These problems had precipitated behavioural problems and had been a large factor in determining the transfer of service users back to prison or to the THU. No specific drug and alcohol programme was being offered to service users from within the residential service. Nevertheless, staff told us that they expected service users to be motivated to work on these problems and staff would facilitate work with external drug and alcohol agencies. There were also regular random urine and breathalyser tests.

The community team

Staff from the community team worked with service users in all three FIPTS components carrying out individual therapy, using the Lambeth Hospital site or residential services as a base. They provided assessment, care co-ordination and therapy. Service users could be resident in Akerman or Bonham Road, be living independently in the community, in custody pending release (or temporarily in custody e.g. on remand), in in-patient services other than FIPTS or in probation or other hostels. Each service user had a care co-ordinator, a shadow care co-ordinator and a therapist from the community team. In addition, the team provided a 'link worker' to all service users on the THU, in order to ensure the development of a relationship with the community team from the outset of admission. The level of contact between the service user and their link worker increased as they approached discharge.

The treatment programme was tailored according to each service user's needs and all service users were seen by a member of the community team at least once a week. The overall framework for treatment was the VRP, with risk assessment tools (specifically the VRS and HCR-20) being used to assess treatment progress. In addition, staff were trained in a range of individual therapies including schema-focused, dialectical behavioural and cognitive behavioural therapy and Eye Movement Desensitization and Reprocessing.

The length of time that the VRP took for community-based service users varied depending on level of need. Phase one took approximately 6 months depending on response levels and motivation levels; phase 2 took approximately 1- 1½ years; phase 3 could take anything up to 3 years although the level of input provided decreased once appropriate community links were in place and successfully accessed.

Staff told us that in the future, they hoped to develop further group work (e.g. relapse prevention) to run at Bonham Road house. The team were thinking of developing a drug and alcohol group which would be a facility for the whole service. Other proposed groups

included an unstructured group to promote pro-social behaviour and groups to discuss physical health problems.

5.1.5 Staffing

The type and number of staff employed by the THU are summarised in Table 1:

Table 1: Staff at the SLAM MSU

Profession	WTE
Consultant Psychiatrist in Psychotherapy	1.00
Consultant Psychiatrist	1.00
SHO	1.00
Team Leader	1.00
Clinical Nurse Specialist	1.00
Senior Clinical Nurse	3.00
Staff Nurse	9.00
Clinical Psychologist	1.80
Psychology Assistant	1.00
Senior OT	1.00
Basic Grade OT	1.00
Senior Sports Instructor	1.00
Senior Therapist	2.00
Intermediate Therapist	2.00
Foundation Therapist	4.00
IT Therapist	0.4*
Unit Secretary	1.00
Receptionist/Administrator	1.00*
Advocacy	0.2

* Covered by locum

At the time of compiling the report, the following posts were vacant: Clinical Nurse Specialist; Staff Nurses (2 WTE); Psychology Assistant; Senior Therapists (2 WTE); Intermediate Therapists (2 WTE).

The residential service had one project manager and two deputy managers. A service administrator supported the residential and other mentally-disordered offender services run by Penrose. Across the residential service there were a total of eight whole time equivalent project workers and three night workers. The expected staffing level at Bonham Road was two project workers.

The type and number of staff employed by the community team are summarised in Table 2.

Table 2: Staff at the SLAM Community Team

Profession	WTE
Team Leader	1.00
Psychologist	1.00
Trainee Psychologist	1.00
Community Forensic Mental Health Practitioner – Social Work	1.00
Community Forensic Mental Health Practitioner – Nursing	1.00*
Administrator	1.00

* Covered by locum

5.1.6 The management structure

THU

The THU had one nursing team leader and two deputy nurse managers. The nursing team leader ultimately reported to the general service manager and supervised the work of the band 6 nurses and the band 6 senior sports instructor. Other bands on the unit included band 5 staff nurse therapists and senior social therapists.

Residential Service

All staff were employed by Penrose Housing. All residential staff worked at both Akerman and Bonham Road sites. Staff were required to spend one or two days a week at Bonham Road and the rest of the time at Akerman Road. (Akerman Road was a registered care home and therefore needed to be staffed at all times. Bonham Road was not a registered care home, but as the occupancy of Bonham Road increased, two members of staff were required to work there at all times in order to comply with health and safety rules.) The team had two deputy managers who managed day-to-day staff and reported to the manager of the residential service.

Community Team

All staff members were responsible to the manager of the community team.

5.1.7 Training of staff

In early 2004, when the first staff joined the service, they received 6 weeks of protected training time. The service manager, community team manager and two psychology leads visited Canada for four days to identify the framework for treatment. The founders of the VRP (Wong and Gordon) visited the team at the THU several times during the 6 week period to train all staff in the delivery of the VRP. All staff received approximately 2 weeks of training in the VRP and a further 4 weeks in enhancing skills to work with PD offenders.

Once the service became fully operational, it was not possible to deliver a 6-week training programme to all new staff and the system was changed; at the time of preparing this report all new staff were required to undergo a minimum 2-week induction and training period. (The induction covered a wide range of topics including risk assessment, the minimum data set, psychopathy, Dialectical Behavioural Therapy and MAPPA). Once this standard training had been completed, staff were then required to progress on to 'Reinforce Appropriate, Inappropriate Downplayed' (RAID) training in the third week. Some staff were required to complete a further fourth week of training in incident management, although this was only required for ward staff or FIPTS staff who spent a significant period of time on the THU. After completion of this training/induction period, staff received on-going training delivered by the particular component of the service in which they were working.

THU

At the time of preparing this report, each staff member was being asked to complete an assessment to ascertain ongoing training needs. All staff had completed RAID training and training in the assessment tools; HCR-20 training for trainers had been undertaken. Some staff had additionally undergone a 3-day period of training in schema focus therapy.

Residential Service

All staff received a 3-month induction period. Residential staff could access training provided by SLaM and FIPTS. In addition, Penrose provided a range of training in topics such as health and safety, the protection of vulnerable adults, breakaway training and approved first aid training. The management team were trying to secure additional on-going training for staff although budgetary constraints had restricted the amount of additional training that could

be purchased (the residential service spent £13,000 in 2006 on behavioural management training and the budget will not stretch to this again).

Community Team

Staff were required to have an understanding of personality disorder prior to joining the service and individual training needs were identified through an assessment process. Each team member then underwent training depending on need and interest. Both the Assistant Psychologist and the Psychologist received training through local psychology services. The nurse in the team had recently attended a forensic course and some members of staff have been on external schema training. In October 2006, a freeze on all but the essential in-house training was put in place across the service by the Trust except monthly schema therapy supervision for 13 members of staff and any training that had been pre-booked prior to the freeze. When we spoke to staff in July 2007, they reported that the training programme was changing again. The teams hoped to deliver one week of training each quarter 'topped up' with short training modules being provided as required.

5.1.8 Staff supervision

Staff received both clinical and managerial supervision. Across all three components of the service, staff had mandatory meetings with their line manager on a monthly basis. Within both the THU and the community team, staff were required to organise their own clinical supervision. Within the residential service, staff supervision was provided by the two deputy managers who in turn were supervised by the project manager. Some residential staff had individual clinical supervision from the clinical team as required. Residential staff also met on a fortnightly basis to discuss clinical issues, but these meetings also served to provide some informal support. In addition, one project worker from the residential service attended the community team's weekly meetings in order to relay any concerns arising from work undertaken with residential service users. When we first spoke to staff in 2005, some reported that supervision arrangements across the service needed tightening up and indeed at the time of finalising information for this section of the report (April 2007), these arrangements were under review.

Recently, the FIPTS service employed an independent facilitator to run a 'Staff Support Service' (referred to in operational documents as S^3). The facilitator was on site at the THU for three half days per week. One of the primary aims of S^3 was (according to the operational document) *'to help people develop their links with their clinical or working teams as well as being fully aware of the FIPTS service as a whole.'* S^3 was a relatively new development at the time of preparing this report. However, we understand that it provides a combined programme of group and individual sessions which is open to all permanent and bank staff working within all three components of the service. (Historically, the two non-permanent staff working in the community were not provided with formal support).

5.1.9 Training provided to other teams

THU

Training programmes run on the THU were open to staff working within other parts of SLAM Forensic Services. For example, staff from other SLAM teams recently attended HCR-20 training.

Residential Service

We are not aware of any external training provided by the residential team.

Community Team

The community team offered training to probation hostel staff on the subject of personality disorder. In addition, they recently completed training on the management of challenging behaviour to local London hostel staff. Based on the response received, there appears to be a high demand for such training and the team have increased the number of sessions to meet this demand.

5.1.10 User Involvement

THU

We were told that this was an area of on-going development. Some initiatives that had involved service users included:

- An ex-service user designed the patient information booklet
- Service users had been involved in some of the training sessions for new staff, providing an overview of their perspective of treatment.
- In May 2007, the team introduced a 'buddy' system, whereby a service user representative from the ward was responsible for inducting new service users to the ward.
- A senior manager attending the service users' community meetings every fortnight in order to register any concerns or suggestions that they might have.

Residential Service

Within Penrose Housing organisation, there were several opportunities for service user involvement. Each Penrose project had an elected service user representative. On a monthly basis, all service user representatives from across all the Penrose projects were invited to attend a meeting to air their views about service delivery. The service user representative also attended staff meetings. In addition, residents had a 'house meeting' every fortnight and were also able to meet the residential manager every four weeks. Service users were expected to take an active role in the development of their support plan and this counted towards part of their 'meaningful occupation' whilst in treatment.

Community Team

At the time of compiling this report, there were no specific user involvement initiatives.

5.1.11 Complaints/ grievances

THU

In addition to the normal Trust complaints procedure, the team leader held weekly service user surgeries on the unit; this was due to be joined by a bi-monthly surgery conducted by the Project Lead.

Residential Service

In response to a complaint, service users received a formal letter and verbal feedback outlining the issue and what steps had been taken to address it. The complaint was also discussed within the wider MDT.

Community Team

All complaints were dealt with according to Trust procedure.

5.1.12 Relationships with other services

THU

Staff told us that they had a good working relationship with the local prison, HMP Brixton and were developing links with other prisons. Links with probation were good with fortnightly surgeries being held at both Southwark and Lambeth probation offices. Most of the links with MAPPA were made through the community team

Residential Service

Staff had been in contact with HMP Brixton, HMP Durham, Broadmoor Hospital and Chadwick Lodge to visit or assess newly-referred service users. The team also liaised with the Shaw Trust and 'Mosaic', who provided some employment contact for service users. In supporting service users to receive financial support, the team were also in contact with the local benefits office. Individual service user needs had resulted in occasional contacts with Weight Watchers and Narcotics Anonymous. The team were in regular contact with the Public Protection Unit and probation staff regularly attended Akerman Road in order to visit their clients. MAPPA meetings were attended by the staff (in conjunction with the community team) when a service user moved from the in-patient unit to the residential service.

Community Team

The manager was the Trust's forensic mental health representative on the local MAPPP. One member of the community team was an ex-probation officer and was well placed to facilitate good working relationships with the local probation service. Staff reported that they wanted to develop better working relationships with other hostels that some service users resided in (for example, for historical reasons, one community service user resided in North London). Members of the community team recently presented information about the service to all the local MAPPA team chairs at a conference.

Formal links between all three components of FITPS and drug and alcohol services were still being negotiated at the time of compiling this report. We were told that the residential team were hoping to train a member of staff in substance misuse work up to the Drug and Alcohol National Occupational Standards.

5.1.13 Aggregate cost of the service

The total revenue allocation for the SLAM service for the financial year 2006/7 was £4,146,480, which included a direct payment to Penrose Housing Association for the residential and funding for the community service.

Using the assumptions regarding the allocation of staff costs between the services outlined in methods section, the total cost per year of the Tony Hillis medium secure service was £2,995,445, of which 60% were pay costs, 34% were non-pay costs and indirect costs such as training, travel, IT support and overheads and 6% were capital costs. The Tony Hillis Unit was a 15-bedded unit, thus the cost per bed was £199,696 per year or £547 per night. When the occupancy of the unit fell below capacity, the cost per service user increased substantially. For example, over the period March 2006 to March 2007, the THU maintained an average monthly bed occupancy of 70%. – equivalent to about 10 service users (FIPTS SLA Meeting March 14th 2007 document). When there were only 10 occupied beds, the cost per service user increased to £299,544 per year or £820 per night.

The total cost for the hostel at Akerman Road was £451,333, of which 83% were pay costs, 8% were indirect costs and 9% were capital costs. In order to reflect the cost of the whole residential service however, we need to include the treatment and clinical management costs

of staff at the Tony Hillis Unit. This equated to £35,117 per service user per year, increasing the cost per year of the residential service to £111,943 or £306 per night. Similarly, the cost per service user of the residential service was influenced by the occupancy of the service. If, for example, only 4 of the Akerman Road house places were taken up, then the total cost of the residential service including treatment costs was £150,356 per year or £412 per night.

The cost of the service at Bonham Road was £228,508, of which 77% were pay costs, 6% non-pay and indirect costs and 17% other indirect costs and capital charges. The treatment costs there were also £35,117 per service user per year, so the total cost per service user was £92,244 per year or £253 per night. The cost per service user of Bonham Road was also influenced by occupancy; at two service users instead of four, the yearly cost increased to £149,371 or £409 per service user per night.

5.2 Baseline survey of service users managed by the service.

Over the recruitment period to the survey (November 2005-July 2006), 26 men were being managed by this service (14 in-patients and 6 residents and 6 community service users), of whom 22 agreed to participate in the study (85% response). Of the 22 recruited to the survey, 12 were from the THU, 6 were from the community team and 4 were from the residential service. One man was too disturbed to participate and three men did not wish to participate or were uncontactable.

5.2.1 Demographic characteristics (Table 1)

The mean age of the sample was 40.6 years (standard deviation, sd: 7.4). Fifteen (68%) of the participants were white, 18 (82%) were unemployed and 16 (73%) were single.

Table 2. Demographic characteristics of recruited sample from SLAM

Variable	THU* N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Mean age in years (SD) on entry into service	39.9 (7.9)	46.5 (6.0)	37.8 (5.7)	40.6 (7.4)
Age bands				
20-29 yrs	1 (8)	0 (0)	1 (17)	2 (9)
30-39 yrs	5 (42)	0 (0)	1 (17)	6 (27)
40 yrs +	6 (50)	4 (100)	4 (67)	14 (64)
Ethnicity				
White	6 (50)	3 (75)	6 (100)	15 (68)
Black	4 (33)	1 (25)	0 (0)	5 (23)
Other	2 (17)	0 (0)	0 (0)	2 (9)
Marital status				
Single	9 (75)	3 (75)	4 (67)	16 (73)
Divorced/separated	3 (25)	1 (25)	2 (33)	6 (27)
Employment status prior to been taken on by service				
Unemployed	8 (67)	4 (100)	6 (100)	18 (82)
Employed – temporary	2 (17)	0 (0)	0 (0)	2 (9)
Employed – full time	2 (17)	0 (0)	0 (0)	2 (9)

* THU= Tony Hillis Unit

5.2.2 **Personal histories** (Table 3)

In their personal histories, 15 participants (68%) reported a history of childhood physical abuse, with 8 (36%) reporting a history of childhood sexual abuse. Seventeen participants (77%) reported a childhood history of being bullied and 15 (68%) reported a childhood history of bullying other children. Seven (32%) reported a history of setting fires in childhood. Eighteen participants (82%) had not completed secondary education. Two of the participants had previously served in the armed forces

Table 3. Personal histories from SLAM

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Childhood maltreatment – physical				
Yes	6 (50)	4 (100)	5 (83)	15 (68)
No	6 (50)	0 (0)	1 (17)	7 (32)
Childhood maltreatment - sexual				
Yes	4 (33)	2 (50)	2 (33)	8 (36)
No	8 (67)	2 (50)	4 (67)	14 (64)
Ever bullied?				
Yes	8 (67)	3 (75)	6 (100)	17 (77)
No	4 (33)	1 (25)	0 (0)	5 (23)
Bullied others?				
Yes	10 (83)	2 (50)	3 (50)	15 (68)
No	2 (17)	2 (50)	3 (50)	7 (32)
Set fires?				
Yes	4 (33)	0 (0)	3 (50)	7 (32)
No	8 (67)	4 (100)	3 (50)	15 (68)
Completed secondary school?				
Yes	2 (17)	0 (0)	2 (33)	4 (18)
No	10 (83)	4 (100)	4 (67)	18 (82)
Served in armed forces				
Yes	0 (0)	1 (25)	1 (17)	2 (9)
No	12 (100)	3 (75)	5 (83)	20 (91)

5.2.3 **Clinical characteristics** (Table 4)

The mean full scale IQ of the sample was 88.9 (sd: 11.0), mean verbal IQ was 83.5 and mean performance IQ was 86.5. The mean PCL-R total score was 20.4 (sd: 6.6), mean PCL-R factor 1 score was 7.7 (sd: 3.4) and mean PCL-R factor 2 score was 11.6 (sd: 4.7). Thirteen participants (55%) thought they had a personality disorder (the lowest proportion across all 3 services), 7 did not think that they had a personality disorder and 3 men did not know whether he had a personality disorder or not.

Table 4. Clinical characteristics of recruited sample from SLAM

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Main self-reported problem				
Personality problems/disorder	1 (8)	2 (50)	1 (17)	4 (18)
Depressive symptoms	0 (0)	0 (0)	2 (33)	2 (9)
Substance use	1 (8)	0 (0)	0 (0)	1 (5)
Offending	3 (25)	0 (0)	3 (50)	6 (27)
Considered appropriate	2 (7)	1 (25)	0 (0)	3 (14)
Concern by authorities	3 (25)	0 (0)	0 (0)	3 (14)
Miscellaneous reasons	2 (17)	0 (0)	0 (0)	2 (9)
Don't know	0 (0)	1 (25)	0 (0)	1 (5)
Service user thought they had a PD				
Yes	3 (25)	4 (100)	5 (83)	12 (55)
No	6 (50)	0 (0)	1 (17)	7 (32)
Don't know	3 (25)	0 (0)	0 (0)	3 (14)
Thought they had a PD (at 6 months)				
Yes	6 (50)	3 (75)	2 (33)	11 (50)
No	3 (25)	0 (0)	1 (17)	4 (18)
Don't know	1 8)	0 (0)	0 (0)	1 (5)
missing	2 (17)	1 (25)	3 (50)	6 (27)
Mean IQ (SD)				
Full scale	91.5 (16.3)	89.3 (4.7)	83 (5.7)	88.9 (11.0)
Verbal	92.0 (n/a)	79.0 (n/a)	81.5 (2.1)	83.5 (5.9)
Performance	78.0 (n/a)	93.0 (n/a)	87.5 (9.2)	86.5 (8.2)
Mean PCL-R Factor 1 score (SD)	8.8 (2.6)	5.7 (4.9)	7.8 (3.3)	7.7 (3.4)
Mean PCL-R Factor 2 score (SD)	10.8 (3.3)	10.0 (4.4)	13.4 (6.3)	11.6 (4.7)
Mean PCL-R Total score (SD)	21.1 (4.6)	16.0 (7.0)	22.8 (8.6)	20.4 (6.6)

At the time of writing this report, 13 of the 22 participants had received an IPDE assessment. Of these 13 participants, 6 fulfilled criteria for a primary PD diagnosis of dissocial PD, 4 fulfilled criteria for a primary PD diagnosis of borderline PD, 1 fulfilled criteria for schizoid, 1 for dependent and 1 for unspecified PD (Table 4).

Table 5. Main PD diagnosis in the recruited sample from SLAM, as determined by the IPDE (derived from ratings performed on 13 men)

Category	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Paranoid	-	-	-	-
Schizoid	1	-	-	1
Schizotypal	-	-	-	-
Dissocial	2	2	2	6
Borderline	2	1	1	4
Histrionic	-	-	-	-
Narcissistic	-	-	-	-
Anxious	-	-	-	-
Dependent	1	-	-	1
Anankastic	-	-	-	-
Unspecified	-	-	1	1

One third of the sample (and nearly 60% of the THU sample) had been referred from prison. At entry into the service, all 12 in-patient participants were detained under a criminal section of the Act. Only 4 of the participants were informal.

Table 6. Service characteristics on entry into the SLAM service

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
MHA status on entry into the study				
Involuntary (criminal section)	12 (100)	3 (75)	3 (50)	18 (82)
Involuntary (civil section)	0 (0)	0 (0)	0 (0)	0 (0)
Voluntary	0 (0)	1 (25)	3 (50)	4 (18)
Referral source				
High security	3 (25)	2 (50)	0 (0)	5 (23)
Medium security	2 (17)	0 (0)	2 (33)	4 (18)
Prison	7 (58)	0 (0)	0 (0)	7 (32)
Community/other	0 (0)	2 (50)	4 (67)	6 (27)

5.2.4 **Past psychiatric histories** (Table 6)

The mean age of first contact with mental health services was 24.6 years. Fifteen participants (68%) had a previous history of self-harm, a third of whom had committed an act of self-harm in the preceding 6 months. There was a wide range of severe self-harming behaviour reported, including cutting, attempted hanging, overdosing and swallowing razor blades. Ten participants (45%) had injured themselves badly enough to require hospital treatment.

Substance misuse was highly prevalent among the sample of recruited service users: over 90% reported previous use of cannabis, 73% had history of alcohol misuse, 50% had a history of opiate use and 50% reported use of crack cocaine. Substance misuse had been implicated in the index offence in 50% of participants. Seventeen participants (77%) had a previous documented history of non-adherence with psychiatric treatment and 9 (40%) had a history of absconding behaviour.

5.2.5 **Criminal histories** (Table 7)

The mean age of first conviction was 17.5 years (sd: 5.8) and mean number of previous convictions was 12.5. The mean number of prison terms was 4.5 and mean number of prior offences was 24.5. Thirteen participants had been previously convicted of a sexual offence (59%) - the highest proportion across all three services. Violent behaviour was also prevalent among the recruited sample: over 90% had a previous conviction for a violent offence and three participants had been previously convicted of homicide. Victims of violence included both adults and children.

Table 7. Past psychiatric and drug history for sample recruited from SLAM

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Mean age (SD) 1st contact with services	25.1 (12.9)	22.3 (7.3)	25.2 (7.8)	24.6 (10.5)
History of self-harm?				
Yes	9 (75)	1 (25)	5 (83)	15 (68)
No	3 (25)	3 (75)	1 (17)	7 (32)
Self-harm in previous 6 months?				
Yes	3 (25)	0 (0)	2 (33)	5 (23)
No	9 (75)	4 (100)	4 (67)	17 977)
Hospital treatment post self harm?				
Yes	5 (42)	1 (25)	4 (67)	10 (45)
No	7 (58)	3 (25)	2 (33)	12 (55)
History of non-adherence				
Yes	11 (92)	1 (25)	5 (83)	17 (77)
No	1 (8)	3 (75)	1 (17)	5 (23)
History of absconding behaviour				
Yes	6 (50)	1 (25)	2 (33)	9 (41)
No	6 (50)	3 (75)	4 (67)	13 (59)
History of alcohol misuse				
Yes	10 (83)	3 (75)	3 (50)	16 (73)
No	2 (17)	1 (25)	3 (50)	6 (27)
History of opiate use				
Yes	9 (75)	1 (25)	1 (17)	11 (50)
No	3 (25)	3 (75)	5 (83)	11 (50)
History of cannabis use				
Yes	11 (92)	3 (75)	6 (100)	20 (91)
No	1 (8)	1 (25)	0 (0)	2 (9)
History of cocaine use				
Yes	4 (33)	2 (50)	2 (33)	8 (36)
No	8 (67)	2 (50)	4 (67)	14 (64)
History of crack use				
Yes	7 (58)	2 (50)	2 (33)	11 (50)
No	5 (42)	2 (50)	4 (67)	11 (50)
History of amphetamine use				
Yes	6 (50)	3 (75)	1 (17)	10 (45)
No	6 (50)	1 (25)	5 (83)	12 (55)
History of solvent misuse				
Yes	3 (25)	0 (0)	0 (0)	3 (14)
No	9 (75)	4 (100)	6 (100)	19 (86)

Table 8. Criminal history of sample recruited from SLAM

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Mean age (SD) of 1st conviction	17.3 (5.9)	15.0 (1.6)	19.3 (7.2)	17.5 (5.8)
Mean number (SD) of prior convictions	12.9 (12.6)	12.3 (6.0)	12.0 (10.1)	12.5 (10.5)
Mean number (SD) of prison terms	4.6 (4.4)	5 (4.7)	4.0 (4.1)	4.5 (4.2)
Mean number (SD) of prior offences	24.9 (23.7)	21.8 (11.9)	25.5 (19.8)	24.5 (20.0)
Convicted of homicide				
Yes	2 (17)	1 (25)	0 (0)	3 (14)
No	10 (83)	3 (75)	6 (100)	19 (86)
Convicted of other violent offence				
Yes	11 (92)	4 (100)	5 (83)	20 (91)
No	1 (8)	0 (0)	1 (17)	2 (9)
Convicted of sexual offence				
Yes	6 (50)	4 (100)	3 (50)	13 (59)
No	6 (50)	0 (0)	3 (50)	9 (41)
Convicted of property offence				
Yes	6 (50)	1 (25)	3 (50)	10 (45)
No	6 (50)	3 (75)	3 (50)	12 (55)
Convicted of acquisitive crime				
Yes	9 (75)	4 (100)	4 (67)	17 (77)
No	3 (25)	0 (0)	2 (33)	5 (23)
Convicted of drug offence				
Yes	3 (25)	1 (25)	1 (17)	5 (23)
No	9 (75)	3 (75)	5 (83)	17 (77)

Table 8. Criminal history (continued)

	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Convicted of firearms offence				
Yes	1 (8)	1 (25)	1 (17)	3 (14)
No	11 (92)	3 (75)	5 (83)	19 (86)
Convicted of driving offence				
Yes	3 (25)	2 (50)	1 (17)	6 (27)
No	9 (75)	2 (50)	5 (83)	16 (73)
Substance misuse implicated in index offence				
Yes	8 (67)	1 (25)	2 (33)	11 (50)
No	4 (33)	3 (75)	4 (67)	11 (50)
Alcohol misuse implicated in index offence				
Yes	7 (58)	3 (75)	2 (33)	12 (55)
No	5 (42)	1 (25)	4 (67)	10 (45)
Ever hurt someone so badly that they died?				
Yes	2 (17)	1 (25)	0 (0)	3 (14)
No	10 (83)	2 (50)	6 (100)	18 (82)
Don't know	0 (0)	1 (25)	0 (0)	1 (5)
Ever hurt someone so badly that they needed hospital treatment?				
Yes	6 (50)	3 (75)	4 (67)	13 (59)
No	6 (50)	1 (25)	2 (33)	9 (41)
Ever injured someone with a weapon?				
Yes	6 (50)	3 (75)	3 (50)	12 (55)
No	6 (50)	1 (25)	3 (50)	10 (45)
Violence Risk Scale Rating				
High	3 (25)	2 (50)	3 (50)	8 (36)
Medium	3 (25)	2 (50)	2 (33)	7 (32)
Low	0 (0)	0 (0)	0 (0)	0 (0)
Missing data	6 (5)	0 (0)	1 (17)	7 (32)

5.3 Developments over the course of the evaluation

5.3.1 Service activity

From its inception in 2004, until the time that we completed gathering information about service activity in April 2007, the FIPTS service had received a total of 195 referrals.

THU

Up until April 2007, the THU in-patient unit had received a total of 64 referrals. At the time of preparing this report, the service had 10 service users. Fourteen service users had been discharged since the THU had been set up. Three service users were transferred to another medium secure unit because they were deemed to be unsuitable for treatment by FIPTS; three were transferred to prison (one of whom absconded from the THU and assaulted a member of the public, was sent to Wandsworth Prison); two service users were successfully discharged to the residential service; two were transferred to a private medium secure unit due to an increase in their level of risk to others; one was transferred to high secure care; one was transferred to HMP Grendon as a planned discharge; one was discharged to his accommodation in the community after completing the VRP; and one absconded from the THU.

Residential Service

At the time of preparing this report, Akerman Road had 5 residential service users and Bonham Road had 2. Since first opening in 2004, the residential service had had 2 discharges and recently received 2 new service users. There have been 3 transfers from Akerman Road High Support to Bonham Road Low support and at the time of preparing this report, another one transfer was imminent. For many months, the residential service maintained an occupancy rate of 50%; we were informed this occupancy rate reflected the lack of appropriate referrals from the community team as they were the sole agreed source of referrals. The residential service improved its occupancy rate during the latter half of 2006 and at the time of compiling information for this report, occupancy was 100% in Akerman Road. Bonham Road however, proved to be more difficult to fill, due to the fact that many of the potential residents were sex offenders and the facility was proximal to a school.

Community Team

Throughout the latter half of 2006, there were over 60 referrals to the Community Team. At the time of collating final figures for this report (April 2007), the community team had a case load of 43 service users: 8 in pre assessment; 7 in the residential service; 9 living in the community (independent home or other hostel); 3 in custody receiving in-reach and awaiting planned release; 4 in-patients outside the FIPTS service and awaiting planned discharge; 12 FIPTS inpatients in the THU receiving in-reach. No service users had been discharged, although this was consistent with an anticipated length of contact of 2 years. When we spoke to senior staff in April 2007, they expressed concerns about the fact that it was difficult to discharge people from under their care, as there was often uncertainty about where to discharge service users to, and a lack of clearly established pathways out of care. One of the barriers to discharge was the fact that although many service users were not considered to be 'dangerous enough' to warrant a forensic team, they still carried the label of being a 'forensic PD patient' and for this reason, generic services resisted taking them on.

5.3.2 Changes in catchment area

The service was originally set up to take referrals from within the London boroughs of Lambeth and Southwark, a population of approximately 500,000 people. In September 2006, as a result of negotiations between the Home Office and the services, the whole of London was split between the SLaM and ELCMHT teams, with SLAM serving the whole of South

London. Senior staff from the THU told us that the change in catchment area had not had a great impact on the work of the service. This was because the service continued to prioritise Southwark and Lambeth referrals. Occasionally referrals had been received from outside the London area (e.g. Sussex); however demand from outside London had not been great.

5.3.3 Changes in the operation of the service

THU

At the time of preparing this report, the in-patient team was in the process of adopting a new system whereby a service user was admitted to the THU for a 3-month assessment period and then returned to the service from which they were referred. When a new phase of the VRP was due to start, the service user was then readmitted to the unit. The rationale for this new system was that it ensured that a consistent number of service users were on the ward at any one point in time.

Residential Service

For a considerable period of time, the service maintained only 50% occupancy and by way of an attempt to make better use of all 6 beds in Akerman Road, the remit of the service was broadened to cover a wider range of potential service users. In future, we understand that the residential services may take referrals from other Trusts within the London area to ensure that beds remain filled.

Community

When the service first opened, the team accepted referrals of female service users. However, staff told us that this practice was discouraged by the Home Office, as it was not in their original remit to care for women. Nevertheless, the team continued to carry out some therapeutic work with female service users, although this was not under the auspices of the FIPTS service. Staff told us that the team was under some pressure from the Trust to increase the size of its caseload. Originally, each care coordinator had a case load of 6 service users. This seemed likely to increase to 8.

5.3.4 The minimum dataset

As with the other two pilot services, the assessment phase was perceived to be problematic by staff. This was particularly so for staff working within the THU, where it was estimated that the assessment battery took between 2-3 whole days per service user. When interview time, file time, scoring, write up and third party checks were included, the team estimated that a full minimum data set battery took up to 41 hours to complete. In addition, in spite of reassurances offered by staff, some service users were unwilling to co-operate with some parts of the assessment, for fear of being labelled a ‘psychopath’. Residential staff told us that the minimum dataset was taking them up to six months to complete and in the light of their experience, they were considering developing their own one page risk assessment focusing on the more salient clinical issues, with a view to facilitating easier and quicker judgements that did not necessitate having to plough through unwieldy case files. Within the community team, certain battery items had been abandoned (e.g. SCID) and the team had focused on completing their assessment and constructing treatment targets around the Violence Risk Scale.

5.3.5 Staffing recruitment and retention challenges

THU

Throughout the evaluation the THU experienced a shortfall in staffing levels and never achieved 100% complement of staff. In May 2006, the in-patient unit was experiencing a shortfall of approximately 20% of staff. A great deal of time and effort had been placed on

recruiting the 'right staff' and the initial recruitment process had been extremely labour intensive, including psychometric testing, group work, written work and individual interviews. When staff were re-interviewed in September 2006, they reported that the unit had a 55% vacancy rate. At the time of collating information for this report, the unit had several vacant posts that were being covered by bank staff. The vacancies were as follows: 1 Clinical Nurse Specialist (band 6); 1 psychologist assistant; 2 staff nurses (band 5); 2 senior therapists (band 5); 2 intermediate therapists (band 5). A further 2 posts were being covered by locums: IT therapist (0.4 WTE - band 3); and receptionist/administrator (1.0 WTE - band 3). In attempt to remedy the problem, the team carried out a recruitment day in February 2007 and plans to fill several of the vacant posts were actively underway.

Staff suggested that the main reason for the staffing shortfall was that the recruitment process was both very intensive and very selective and consequently could only be carried out at most three or four times a year. Nevertheless, senior staff retained the view that the selection and interview process was the best way to proceed. The unit relied heavily on a 'core group' of bank staff who regularly worked on the unit. Some permanent members of staff told us that the use of bank staff was indeed problematic – bank staff could not undertake care coordination and often the rapport between service users and bank staff was not as good as with regular staff. This in turn created additional pressure on permanent staff who had to absorb the extra work.

[when there are] *regular staff on shift, the guys would naturally come to you a lot, because they didn't really want to talk to people who as they would say themselves, 'they don't know me, they don't know my history, they don't know anything about me'*. S3 (follow-up)

Residential Service

The residential service also experienced staffing recruitment problems. At the time of preparing this report, the service lacked 2 project workers and a part-time night worker and was reliant on both bank (recruited from within Penrose organisation) and agency staff, although the service was advertising for new staff. We were unable to clearly establish whether the residential service had experienced any retention problems. This was because we were given conflicting accounts by different members of staff when we enquired about this issue in 2007.

Permanent staff from the residential service expressed identical concerns to those of their colleagues on the in-patient unit - that service users were less trusting of bank staff and bank staff were unable to perform certain duties, thus creating additional work for the permanent staff. Some staff even speculated that the service users 'acted out' less frequently with bank staff, saving up their distress and difficulty for permanent staff.

I think [it] *impacts on the way the relationships* [are] *between the staff and residents, because the more bank staff we use, I can see the clients - they don't want to talk much about issues to bank staff…it makes them have more work to do, you know every night you're doing… clients key work sessions and you're doing, you're now link worker for 3 people - extra work it's very hard because the bank staff don't do any of that work, they just do paperwork and telephone answering, they will not do any key work sessions because it's best to deliver it with the permanent member of staff so it's more work for them.* S8 (follow-up)

I think it puts more pressure on permanent staff to make sure things are done and are handed over or that... and I think that, I think we actually find that the clients act out less actually when there's bank staff... so it could be what they need, but there's that bit when, you know they seem to save their distress until somebody permanent's on. S9 (follow-up)

The Community Team
At the time of preparing this report, the team were experiencing a shortfall of 2 members of staff, the posts being covered by long-term agency staff. Reasons given by staff for the recruitment problems included a staff perception that management had not *'got their act together'*, coupled with Trust financial restrictions. Staff from the community team had loaned staff to help out the in-patient unit. For example, when the THU social worker left the Unit for 4 months to attend a training course, the community team lent the two members of staff on a half-time basis to cover the gap created by the absent social worker.

5.3.6 Working relationships between staff

We perceived working relationships between the clinical teams and managers of the service to be poor. When we first interviewed staff in late 2005/early 2006 individually and also in a focus group conducted in Spring 2006, clinical staff felt very strongly about this problem. Indeed the topic dominated the focus group discussion. Staff described experiencing a lack of support from management. Managerial staff were considered to lack clinical experience and clinical staff reported that the managers seemed unwilling to learn about the pertinent clinical issues.

And I think the poor relationship with management…there is a philosophy in the service that you have managers who only manage, and they know nothing about personality disorder and don't want to know and then you've got clinicians… I feel like there's just this complete lack of understanding. S4 (focus group)

I think there is, there have been various soundings from staff about the fact that perhaps the service needs to be more tightly, assertively, creatively managed and that we need to run a sort of tighter ship…and that may well be true. S7 (baseline)

When we spoke to staff in 2007, relationships with management were still perceived by staff working in all three components of the service to be the service's biggest problem. Staff again described experiencing a lack of support from management. In addition, the overall level of communication between senior management and clinicians was perceived to be poor.

The senior management's not very open, they're not very open about where the money goes…there is definitely quite a lack of communication, I mean my direct manager never turns up for appointments X *makes with me, almost never. I think…*[they've] *done it about once…I find it quite a strain* S10 (follow-up)

Other tensions existed between disciplines and some staff told us that there was insufficient understanding of what people from different disciplines did. Moreover, there was a lack of appreciation of the impact of the clinical work on people engaged in 'front-line work' and this compounded any day-to-day splits which inevitably occurred in working with personality-disordered service users.

Better understanding about what other people are having to do, the psychologists are doing, what we're doing, what stresses we have, what stresses they're under, what needs they have to be met, I think just better understanding of ourselves, and also I think for the one, people who aren't working on the ward what its actually like for the staff on the floor with the intensity of the day to day work because a lot of the problem was people were coming and saying 'oh he's fine, there's no problem', thinking 'well he's not fine, we've been here all day, you've not seen this and this and this, we're here at the moment they wake up and the moment they go to bed, you come in for an hour and you see them and they're perfect at that hour'…. so a lot of… I think there's got to be more understanding with the, the work that

we're doing as well and what everyone's doing and how it impacts on that person, how it impacts on everyone else as well. S3 (follow-up)

5.3.7 Relationships between the service components: the challenges of running an 'integrated service'

At the beginning of the study, staff from all three components told us that running an 'integrated service' was proving to be more difficult than was originally anticipated. One of the main barriers to the smooth running of the integrated service model was the fact that communication between the three components was not as good as staff had initially hoped.

The service isn't integrated enough in terms of communication... I'm not quite sure why that is or what? I think the structures are there - you have the meetings, you have the forms, we have kind of, the reports get done and stuff like that, but things seem to get missed.
S3 (focus group)

The only negative thing when you have an integrated service, is the communication sometimes isn't as good as it should be... it can be very stressful and information doesn't always flow as it should flow, I think we can perhaps be a bit better information sharing, we [can be] *much better in how we collaborate with each other.* S8 (baseline)

When staff were re-interviewed one year later at the end of 2006, we were told that teams were still trying to establish the best way of working together.

I don't think we worked together as well as we could, there could have been better communication between all three services…I mean at the start when they were setting up the services they said that maybe we could go and spend some time at the X team *or spend some time with the* X team*, that never actually happened, you know just things like that to see how we work… those things were all idealistic… realistically… for things like that to happen, you've got to have time to send staff and the resources to do it.* S3 (follow-up)

It's not integrated, it's not pulled together and that's where in my opinion we could do better, is if the team, if we really did work as a team to make decisions, agree upon the way forward and to implement them in a consistent way. S4 (follow-up)

We don't overlap so much, it just seems very separate, there's no communal training there's no, I can't remember the last time everybody was together where you knew people, we used to attend the ward rounds even though it became a bit pointless. S9 (follow-up)

Working relations between the residential service and the community team had to be delicately negotiated, although we were unable to obtain a clear consensus view about how problematic this issue was. Residential project workers told us that they felt the need to take the lead to ensure that meetings with the community team took place. Against this, staff from the community team told us that although they made the effort to attend residential service meetings, this was not always reciprocated by residential staff. The community staff felt that they had to tread a fine line between making the residential staff feel clinically redundant by getting very involved with service users, or alternatively leaving them feeling unsupported.

I think that some of the [staff] *here feel overwhelmed by some of the clinical expertise that SLaM has, they, there's a tendency I think of them wanting to move back from being a pilot project to being an old fashioned care home…I think Penrose is scared of doing things which are clinical, I think they feel over-whelmed by it, they feel incompetent, out of their depth and they back away from it all the time*. S32 (follow-up)

I think when it feels like its these separate areas, when there doesn't seem so much you know integration, um, and then I think the residential setting becomes more like, more like a bed and breakfast, more like a B&B than actually a therapeutic environment as part of treatment. S9 (follow-up)

We could improve better how Akerman Road work with us, we constantly run into troubles with that, because if we act the clinician too much, they feel… they feel de-skilled and if we don't go in enough, they say that they're not being supported - so getting the balance right is quite difficult. S10 (follow-up)

5.3.8 Relationships with the other pilot sites

Only one senior member of staff whom we interviewed maintained formal links with the other pilot sites. Other staff were informed about these relationships through audits, although staff reported that learning about the other pilot sites experiences was generally helpful.

I don't really know anything about them apart from when we get feedback from audits…I think it was useful when we got some feedback once after an audit…that they were having the same issues as us and the same problems you know same frustrations, or same successes or whatever, it was good…because then you don't feel like oh my god, this is like, we're just going through this and you know that everyone's going through the same thing and I think that's useful. S3 (follow-up)

5.3.9 Relationships with the Home Office

When staff were first interviewed, some told us that they would have appreciated clearer Home Office guidance in terms of how to best work alongside other services and particularly MAPPA. For example, one member of staff told us that a *'statute policy about how these services work with the police, and how confidentiality is worked within PD services and MAPPA'* would have been helpful. Staff also told us that they would have appreciated more frequent visits from Home Office staff so that the Home Office would obtain a clearer understanding of how the services functioned and the day-to-day pressures that staff were under:

I just think it would be really useful for people to actually, maybe spend some time on a unit like this, maybe work a few shifts…people as in people in management who are higher up…I think that of our management as well actually… um they only get to see or hear, or sort of our sort of input or side of things and they put down sort of directives or we'll do this or we won't do this…I just really think to have a good hands on approach and actually spend some time on some of these units, to see what its like um, might help in the overall management of things, I don't know. S3 (baseline)

I suppose, without sounding trite, that the people that commission the services need to keep one foot on the ground and make sure they have an awareness of what is going on in practice and because it will, it will um, have an impact on the sort of research they do, if they know what are the pressures on the ground face…but I suppose that's just the thing, just to continue to keep the lines of communication open and which I suppose this is about. S2 (baseline)

5.3.10 Untoward incidents occurring during the course of the study

THU

As part of the evaluation, we requested incident information from all of the services and the information we received from the THU is based on recorded incidents over a nine month period, from October 2006 until June 2007. The following incidents occurred over the nine month period:

- Three incidents of absconding behaviour. In one case, a service user was recalled from the community due to increased risk. He later absconded from the THU and assaulted a man with a glass and is currently awaiting trail.
- Thirty eight incidents of violence/aggression/assault were recorded. This was mainly directed towards staff and ranged from verbal aggression and threatening behaviour to throwing furniture (although staff reported that physical assaults on staff have been low and since the service opened, there has only been one recorded incident of a member of staff being physically assaulted).
- Five incidents of self harm were recorded: ranging from refusal of medication to cutting behaviour using fashioned blades.
- Four incidents with 'clinical care'. These were incidents of service users engaging in behaviours that were felt to jeopardise their own or the group's treatment such as being late to groups or deliberately sabotaging groups.
- One incident of lost keys
- One incident of a member of staff leaving their belongings unattended and items subsequently disappearing.
- Eight recorded incidents involving security. These ranged from doors being left opened to service users objecting to the use of a sniffer dog for a routine search.
- Ten incidents involving 'accidents/health & safety/fire'. These were usually incidents of service users refusing to abide by Health and Safety recommendations.
- One recorded incident with a 'record' – when asked for clarification, staff said that this was a record of practice from a member of staff that was not up to standard.
- Five incidents were listed as 'other' and 26 recorded incidents were unspecified; these were incidents that did not fall into one specific category and were therefore not able to be classified.

In addition to the above, at an early point in the evaluation, we were made aware of the fact that one THU service user escaped from his nursing escorts whilst on leave to another hospital. Over the course of the evaluation, a number of other serious incidents occurred, including service users being found in possession of cannabis and some service users were found to have consistent positive urine drug screens. As a result, the team arranged for a police sniffer dog to be brought on to the unit for random inspections. A Clinical Governance review that was set up in response to these incidents concluded that there needed to be greater cooperation between the THU and the local police. Senior staff told us that improving the security of the unit was an important area for future service development.

Residential Services

Within the last year, staff informed us that there has been one incident of self harm although this was not major and the service user did not require hospital treatment. There has been one overdose in the previous year. Other incidents include minor incidents such as setting the smoke alarms off, although staff reported that many of these incidents have been committed by one particularly difficult service user.

Community Service

One service user was recalled to the THU due to increased risk and damage to his room and subsequently absconded from the THU (see above). Another service user was convicted (awaiting appeal) of sending empty bullet cases through the post to threaten a convicted rapist who had won a considerable sum of money on the lottery.

5.3.11 Findings from local research and audit

THU

At the time of the interim report, a number of research projects were being conducted on the THU. One of these projects included methodology that substantially overlapped with the evaluation (i.e. qualitative interviews with the service users to ascertain their views about the treatment programme). We were concerned about the impact of these other projects on the success of this evaluation (i.e. the possibility that the population of service users would become over-researched). When we shared our concerns with senior clinical staff, it emerged that not all senior staff were aware of the existence of these other projects. As a result of our shared concerns, a regular research meeting was set up to review the progress of existing research projects and to timetable future research endeavours on the Unit.

The Unit has since conducted a survey of all Lambeth residents serving 4 years or more in prison and it is hoped that this information will be used to recruit most future service users for the service. Senior staff have mentioned the possibility of future in-patients being almost exclusively prisoners and this would mean that their stay on the THU would fall entirely within their sentence. This would lead to clear exit pathways and have no effect on the length of sentence although as yet, time constraints have prevented the team from using the survey data.

Residential Services

We are not aware of any audit or research that was being carried out during the course of our evaluation. As a registered care home, Akerman Road was subject to regular unannounced inspection from the Commission for Social Care Inspection (CSCI) team with reports of inspection published. We were informed that since the inception of the service, the outcome of all inspections undertaken by the regulatory body had remained positive. CSCI demanded Annual Quality Assurance Assessments from the team and assessments were based on the standards and regulations set by the Secretary of State for Health. Bonham Road was also subject to the 'Supporting People' review for which the team did annual Quality Assurance Framework Returns. Penrose Housing Association also operated a quality assessment framework which supports regular monitoring and inspections.

Community Team

The manager had implemented an audit project to monitor how much time each staff member spent with each service user both during assessment and treatment phase. The main finding from this project was that staff spent as much time on assessment and advising other teams as they did on case managing a service user.

5.4. Is the programme working?

5.4.1 Qualitative evidence

5.4.1.1 The views of staff

When staff were interviewed for the first time, there was a general sense of great optimism about the treatment programme.

So it's very very clear and transparent and consistent and boundaried, which is what I think it should be. So I think that's good. S2 (baseline)

I think the package that we offer here is umm... pretty comprehensive…and I do think the programme that we're running is a really, really amazing programme and I believe in the people who are running it. S3 (baseline)

When interviewed one year later, staff were cautious in making inferences about whether or not the treatment was proving to be effective and most staff felt that insufficient time had elapsed to make an informed judgement about this. Nevertheless, there was some acknowledgement that successes so far had been variable. It was felt that the VRS scores of some service users had reduced and that for the some, the risk of offending had reduced. Staff told us that they valued the overall structure of the programme and that the VRP seemed to *'make sense'* to service users.

There are some people who've spectacularly failed at the end... there are people who are doing alright I think um so... I think overall hit and miss, but probably what you'd expect…the DBT I think didn't get off to a real proper start until we'd been doing it for at least 6 months and we didn't start doing it until maybe uh, you know, halfway through the first year or opening so I think you need a certain amount of trial and error to start with and you would um... I hope it would become more successful over time. S5 (follow-up)

I think we're on track you know. There are some people that are more in cluster A that I think are going to be more difficult to see it change but I think people's scores generally are going down. But I think in terms of the personality disorder we need to think a bit more about how we're going to measure that and what our expectations are and I think at the moment as a unit they're unrealistic. S2 (follow-up)

About fifty percent - acknowledging that we are working with a very difficult client group, you know, yeah about fifty percent. S9 (follow-up)

Some staff reported that there had been an increase in pro-social behaviour.

Whereas before they may have gone up to someone and screamed in their face, now they ask to see someone and shout at them but at least you know there's a bit of structure around it perhaps, or the fact is that they're asking to speak to someone about their emotional distress rather than withholding it and not acknowledging that it's a problem that needs to be dealt with. S2 (follow-up)

Staff from the residential service told us that they thought that there had been a reduction in the level of self harm.

Fairly successful because we've had, we haven't had any major re-offending as far as I'm aware... integration into community life, that's gone pretty well, people getting more comfortable opening bank accounts, taking part in daily life in the community, some people going to, having part time jobs, um... someone doing voluntary work, someone is doing the

VRP now because they came after the previous VRP finished so there's been lots of... they've learnt new skills, lots of new skills which they had not before. Like I said, in terms of people who had issues to do with self-harming, that's gone down. S8 (follow-up)

Across all three service components, key to treatment success was the quality of the relationship forged between staff and service users and the need for mutual respect. In this regard, usually permanent staff fared better, as they were more familiar to the service users and therefore more readily trusted.

I think it's also about just the atmosphere of the house where there's an expectation to sort of, take, participation in things.…just that sense of working together…I think if you see the staff who treat the clients with that level of respect I think you get it, get it back...you will always get that splitting, that complete splitting that you need to be aware of that there will be the good staff and the bad staff and how much of that is just a split, its fine as long as you're the good staff but you know not so nice if you're the bad one you know, um, yeah, so I think its establishing relationships with them...I think its also letting the residents know that we're fallible and we get it wrong too and that's alright. S9 (follow-up)

On the unit relationships pretty good with the people who actually deliver treatment… there's been a lot of difficult relationships with the day to day staff working on the unit, um, a lot of them are bank staff…the inpatient unit does seem to get quite confrontational. S10 (follow-up)

I think there are some staff who have some very positive relationships with patients, who are able to think more objectively and perhaps are able to withstand and contain negative emotions and feelings from the patients and contain negative emotions and feelings from the patients and are still able to process those and think about those and reflect on those and react in a more thoughtful, reflective way, then there are other staff who don't, who perhaps find it more difficult to be objective, to have the capacity to mentalise. S2 (follow-up)

Staff told us that the mixture of sex offenders and non sex offenders was sometimes problematic within the VRP. Nevertheless, it had proved possible to contain the problems generated by mixing offenders; we were informed of one group which had successfully allowed a service user who was a serial predatory paedophile to work alongside another service user whose index offence had involved killing a predatory paedophile.

For some staff, the initial glowing optimism that they had about the programme was beginning to fade and they told us about some of the problems that had arisen with the treatment programme. Rules and boundaries were not always consistently enforced by all staff and some service users (who had come from prison) complained that the VRP was *'going over old ground'*.

We don't act completely consistently… I mean, I think that's impossible but um... we do kind of say to patients that we respond to them as individuals which is appropriate and is the case but on the other hand we do the, we do have to act consistently with some rules, um, and it doesn't always happen. S2 (follow-up)

I think in 2006 they've, the patients have gotten angry and they feel betrayed, I don't think they feel that we've held up our end of the deal...I like the word collaboration, to co-labour, to work together - I think there's less collaboration, less working together, I mean that's not comprehensively true, I mean I can think of exceptions but it doesn't seem to me it's as smooth as it was. S4 (follow-up)

Staff at the residential service told us about some very practical problems that had arisen over the course of the evaluation in relation to the physical environment at Akerman Road. There

was limited space in which to work and occasionally staff meetings had been held in the service users' living areas. More recently, team meetings were held at a dedicated team meeting room at Bonham Road. In order to ameliorate the space problem at Akerman Road, an outhouse had been erected and we understand that there were plans to build an extension to the house.

Akerman Road's too cramped and claustrophobic and we should have realised early on trying to get people with personality disorder to share flats wasn't a good idea. S10 (follow-up)

There's one thing actually which is very difficult in Akerman Road…it's a sardine box…there's no staff space, there's only one tiny little office, and all staff spaced through it, so basically we overflow into the residents area into their kitchen and their lounge you know and they feel put upon by that you know, they feel intruded on, quite rightly so. S32 (follow-up)

The impact of the work on the staff

Staff thoroughly enjoyed the initial 6-week block of training – not only did they learn, but also the protected time afforded an opportunity to bond with colleagues. Nevertheless, staff told us that no amount of time spent training in the use of risk assessment tools prepared them for face-to-face work with personality disordered offenders.

But in terms of giving people practical skills of what to do when you're in a relationship with somebody, a therapeutic relationship with somebody that it um, it doesn't cover those things and I think…I feel that a lot of the people who work on this, this ward aren't prepared to work with the patients or weren't prepared, definitely weren't prepared by their training, um, and I don't know how much of the 6 weeks that we gave before we opened prepared them for this either. S5 (baseline)

There was a general feeling that staff had underestimated how difficult the clinical work was going to be. In the one-year follow up interviews, staff talked about how drained they felt by the constant demands of service users. Some staff talked openly about needing respite from the work, but this did not seem to be readily available.

I think there isn't enough respite for staff, you know I think sometimes they need… X *said 'I can't stand being on the floor for 8 hours, I just can't stand it, I don't have any place to go and yet I am expected to be there non-stop' and there's no respite for* X. *And I think you can't expect* X *to stop and think and have the skills to intervene when a patient is acting out if* X *doesn't have the space to stop and think and reflect.* S4 (follow-up)

I mean I was getting to the point where I was quite exhausted there… I must say, mentally, physically and quite drained and it had been quite stressful, like a rollercoaster sort of ride…I think maybe having the option to have time out from here like a little respite, like having a month out, being sent to another unit because it can be so intense there and so challenging. S3 (follow-up)

The verbal onslaught - it's just… its just that the constant verbal onslaught and you're thinking I'm doing the best I can. S9 (follow-up)

I have aged 10 years, seriously… I have really aged since I have taken the job. S6 (follow-up)

All the staff whom we spoke to recalled incidents when they had been afraid of the service users.

I did have one patient threaten to assault me and he was a psychopath but then he absconded and was taken back to prison so, that was certainly frightening but there have certainly been other times where I have walked onto the ward and felt quite apprehensive and was very sort of watchful about what was going on and the alarms are kind of a joke, I mean it would be nice to think if the alarms went off that you'd have, that if you were to use the alarm it would mean something, there's, for some reason they don't work and haven't worked. S4 (follow-up)

I was afraid of one…my, my patient, I was petrified of him and I actually washed my hands I said I can't work with him anymore… I felt quite intimidated, I felt he was very hostile towards, I felt scared of him, um and I can't change the way I felt. I tried really hard to work with him over a long time and in the end I couldn't do it, to the point I actually felt sick coming into work… really physically sick. S3 (follow-up)

For some staff, their sense of fear provided useful clinical information and helped them to remain constantly aware of the risks.

Some of the people, you know, deserve to be frightened of, you need to be cautious of them and if you don't have that sense of it then you're putting yourself at risk I think, you have to be careful… it's healthy that you don't forget that's what they've done and they could do again, so, I don't think it's unhealthy in any way and if you know that they make you feel frightened then that's useful in therapy. S10 (follow-up)

I think they'd be stupid not to be [scared], *you know, I think its really, I think working quite closely with…* [a service user], *I actually wasn't scared of him because I wasn't actually a target you know but another member of staff, and really I had to be very mindful about she was scared for a reason you know…I think you have to respect it if you feel nervous… I'd be worried if the staff weren't ever scared of this client group, you know because I think it makes you thoughtful about what you're doing and how you're being, you know.* S9 (follow-up)

5.4.1.2 The views of the service users

What has been helpful?

Several aspects of treatment were reported to be useful. Some service users felt that the overall structure was useful. Others pinpointed the educational aspects of the programme: they had learnt a great deal about their violent offending, their diagnoses and their problems with managing anger. They valued this new knowledge because they thought that it might help to improve their management of difficult situations in the future.

Well I've learned a lot about my diagnosis and how it affects me, you know what, how it's likely to affect me in the future and how I can work around that. You know, I've learned a lot about like, where my violent behaviour in the past came from, what led into it and how I can sort of head it off before it becomes a problem again. SU6

Well I know the danger points know the danger systems which I didn't before, which I have learnt in VRP…I am implementing all the time. SU8

At this stage I am deliberately implementing certain tools, certain skills. You can't undo what you are, you can't rub it off. You can't erase it. You can only build on it, know what I mean. SU7

Service users talked about the importance they placed on the relationship with staff. Successful relationships were characterised by mutual trust and respect and these invariably

occurred with staff who were professional, honest, tolerant and non-judgemental in their manner.

They respect me and I respect them, there's no pressure or anything, and we work as a team. And I like that, honestly I do like that. SU9

When you're having a blow up and there's shouting, talking to people actually helps more, and I find they do this a lot…I find the staff have more sort of tolerance for people you know, which is good. SU2

Service users told us that it was important to come to the service with a willingness to engage in treatment, or as one service user put it, being in *'the learning psychological frame of mind.'* You only benefited from treatment if you were willing to work with what was being offered.

What has been unhelpful?

The service users whom we spoke to clearly identified a number of areas of the treatment programme that they thought were problematic.

The mix of service users

Some service users reported that they felt that people were treated differently depending on where they had been prior to being admitted to the service; on the whole, the perception was that ex-prisoners were treated with less sympathy and respect compared to people admitted from a health facility.

What they have done is they have opened a unit and put psychiatric patients…with prisoners…and the difference is a mentally ill person stabs me in the back and is moved to a secure hospital and gets life… mental health patients, well they'll put it down as 'oh he'll be ok if he takes his medication'. You know, I mean, ok he's hearing voices or whatever, but that wouldn't work the other way - being a prisoner. SU3

You can cut it [the atmosphere] *with a knife sometimes…between the staff and patients. And patients and patients. Because you have a mixture of prisoners and mental health patients. Prisoners are treated with no real self importance. The mental health patients are treated like royalty… I've never really agreed with mixing prisoners, prison transfers, sex offenders and mental health patients together. I've seen the damage it causes.* SU5

Some service users expressed concerns about the possibility of their peers' mental health problems or offending profiles *'rubbing off'* on them.

The un-useful side is if you're a vulnerable person, even if you're not a vulnerable person and you listen to something so many times and have it drummed into you, it could make you sort of that way inclined. Because there's people in there for murder on one score and then on the other score people in here for paedophilia so... so if you're listening to these two people talking all the time everyday for twelve months, some of it is going to get into your subconscious you know…it's pissing me off really mixing with them kind of people, because I'm not saying I'm better than them or worse then them, but I'm saying it could have a subconscious effect on you, and it has because my family don't trust me, around children…well they don't trust me because of the facts you know – drugs, prison, sex offence. But with me you know, um... I'm beginning to believe it myself now that I could be that way inclined, if you see what I mean. SU1

Obviously mental illness will rub off on those who haven't got it. I mean, whether it'll be sitting shaking your legs or shaking your head, or laughing. You know what I mean? Maybe

this works, because you get attention…I says, I don't want to live with these people, mental health people. SU3

Returning to prison

Some service users told us that they thought it was pointless and unfair to admit someone to the VRP, only to return them to prison after treatment had finished.

I also think it's unfair that they should pick him to do the VRP yeah, when he's still got another long sentence to do…and then he's probably going to have to come back, do the VRP again. Home Office don't discharge him and he's still doing a prison sentence. Now I think that's unfair. I think they should wait until he's turned at least, on his last year, and then put him on to the VRP and see how he gets on…But if he goes back to prison, he's not going to get that treatment and I think that's a step back again. SU8

Some of the patients said that they could, well one of them said that he could go back… he's going to go back to prison after he's been here like sixteen or seventeen months more, he's got to go back to finish, to do the further two years in prison. I don't think, I find that pointless to be honest with you, I find that pointless because you're actually putting a lot in here and then they send you back to prison, I don't see the logic you know, I don't see no logic in that…because once you're in a mainstream prison you forget all this. SU2

Lack of clear understanding of what treatment involved

A further problem was being brought to the unit on 'false pretences' and (in the views of service users) not being given a clear explanation of the nature or consequences of treatment prior to being admitted.

False promises, when you are initially assessed to come here you are told that you know you will be released after 12 months if you have done the VRP and you will get community leave after 6, that's a technique that will get you into the group. And when you get here it's totally different. They say well maybe, another two weeks or the Home Office or whatever they say. To keep you here longer. SU1 (focus group)

*I came from …*X *and I was actually better off there in terms of what I could have, what opportunities there were for work and education and whatever. And I mean when I was assessed to come here I was given the impression by the person who assessed me that this place knocks sliced bread into you know, the corner as being the best thing…So all the work I did up there, you know, all the privileges I learnt have just been taken away from me and I've got this vague promise that in a few months time they might let me walk around in the car park for 15 minutes with 2 members of staff following me. You know what I mean? I can't speak for taking people from the prison system you know or from other hospitals but if they are taking people from special hospitals there needs to be more on the table. You know, like because you feel cheated when you come here…you know, as I say I mean until I got the un-escorted community leave, I was worse off than I was in the special hospital. Yeah, there needs to be you know, sort of some incentive to come here and do the work.* SU6 (focus group)

There's guys who has done all the groups, there is guys who should be going out unescorted into the community. And it's not happening. And the turnover and the success rate for here for people being released is not very good...I mean even the newest ones ain't pleased or happy with this place and didn't know what it was all about. SU3

The 'gate arrest'

Some service users talked about being transferred into the mental health system just prior to the end of their prison sentence. This was cynically viewed as a form of 'gate arrest' – a way of increasing the period of detention without being processed by the Criminal Justice System.

What I have a problem with is the situation that some people have talked about where you know, it's like the day before or your last day and you are expecting to go home and suddenly you get hijacked and carted off into the mental health system….and I think that is probably more psychologically damaging than whatever was wrong with them in the first place.
SU6 (focus group)

Rather than waiting at the gate arresting you, it's very true you are on your licence, get sent out, go back on recall, and 10 days before your release date, bang you're in a psychiatric hospital. It's a clever way of gate arrest. SU7 (focus group)

Of course I am trapped in the mental health system….But that's what happens with lifers like me. If you play up often enough and long enough they think somewhere along the line that there is some psychological problem and they just take, whip you out, and send you into the mental health system. SU5 (focus group)

Staffing problems

Some service users felt that that the ward was inadequately staffed to cover all their needs, such as going on escorted ground leave. As noted above, the staffing shortfall had been largely covered by bank staff. Service users generally felt that non-permanent staff were disinterested in them and consequently they would preferentially seek out permanent staff who could be 'bombarded' with requests.

*Unfortunately the good ones you have to go to, well everyone goes to them and therefore they are bombarded aren't they? And they would get stressed out and you know, start to get a bit snappy and you are thinking it ain't me, it's you…But unfortunately because of the incompetent ones who don't have a clue who just literally, you can't even talk to them and they are: 'go to your allocated nurse'.*SU7

In a place like this you really need regular staff who are there day in day out, who can build up a rapport with the patient and who the patients feel comfortable in approaching to talk to about problems. Here, you've got a lot of staff who you might see every couple of months, like because they are not the nursing bank. And you've also got a lot of the bank staff who basically aren't interested in doing anything other than the minimum amount possible and getting a pay packet at the end of the month… I feel that they are more committed to the pay packet than actually to you know, trying to help people. SU6

What I think is, as X said, they are very disinterested you know and er I think they should, they should really really seriously look at the bank staff. I think in a unit like this and others, like mainly I'm talking about a PD unit….you have got to actually know what you are actually doing in a job. It's not all about opening doors, getting water, you actually have to know what you are doing, so I don't, myself I would, with all these bank staff working, shouldn't be, I don't, I don't really have much trust in them at all. SU2 (focus group)

5.4.2 Evidence from the quantitative data: 6-month follow-up of service users managed by the service.

At six months, 16 of 22 participants recruited at baseline were still being managed by the service. Five participants had been transferred to prison and one participant was transferred to another medium secure unit after assaulting a member of staff. We obtained complete follow-up ratings on all 16 men who were still receiving treatment at the point of follow-up.

Behavioural disturbance (Table 9)

Over the 6-month follow-up period (May 2006-January 2007) one of the participants had engaged in absconding behaviour, five men engaged in one or more incidents of self-harm (all of whom had been self-harming in the 6 months preceding baseline interview), 7 men (32%) had engaged in one or more incidents of non-adherence with aspects of the treatment programme and 8 men (36%) were found in possession of contraband material (THU contraband included 2 participants in possession of drugs, 1 participant in possession of alcohol and another participant found in possession of a member of staff's keys; community participants' contraband included drugs and a knife). Five participants engaged in one or more incidents of violence over the follow-up period and 10 participants (46%; 8 of whom were from the THU) damaged property.

General function (Table 10)

The mean WSAS score at follow-up for the overall SLAM group had decreased (improved) from 15.9 to 14.0. However, the difference between baseline and follow-up score was not statistically significant (paired t-test p= 0.2).

Therapeutic alliance (Table 10)

The mean service user–rated alliance score for the overall SLAM group had decreased (deteriorated) 59.3 to 56.7 at 6-month follow-up; a non significant change (p=0.1). The mean staff –rated alliance score had also decreased from 59.7 to 56.7, however, again the difference in scores was non-significant (paired t-test p= 0.2)

Belief about personality disorder diagnosis (Table 3)

Eleven of the 12 men who thought that they had a PD at baseline continued to hold this belief at follow-up.

Table 9. Behavioural disturbance* at 6-month follow-up in the SLAM sample

Variable	THU N (%)	Residential N (%)	Community N (%)	TOTAL N (%)
Use of non-prescribed substance				
Yes	4 (33)	0 (0)	1 (17)	5 (23)
No	6 (50)	3 (75)	2 (33)	11 (50)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)
Use of alcohol				
Yes	0 (0)	0 (0)	1 (17)	1 (5)
No	10 (83)	3 (75)	2 (33)	15 (68)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)
Incidence of self-harm				
Yes	3 (25)	0 (0)	2 (33)	5 (23)
No	7 (58)	3 (75)	1 (17)	11 (50)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)
Incidence of violence				
Yes	3 (25)	1 (25)	1 (17)	5 (23)
No	7 (58)	2 (50)	2 (33)	11 (50)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)
Absconded				
Yes	1 (8)	0 (0)	0 (0)	1 (5)
No	9 (75)	3 (75)	3 (50)	15 (68)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)
Incidence of property damage				
Yes	8 (67)	1 (25)	1 (17)	10 (46)
No	2 (17)	2 (50)	2 (33)	6 (27)
Missing data	2 (83)	1 (25)	3 (50)	6 (27)
Found in possession of contraband material				
Yes	6 (50)	0 (0)	2 (33)	8 (36)
No	4 (33)	3 (75)	1 (17)	8 (36)
Missing	2 (17)	1 (25)	3 (50)	6 (27)
Incidence of non-adherence with treatment				
Yes	4 (33)	2 (50)	1 (17)	7 (32)
No	6 (50)	1 (25)	2 (33)	9 (41)
Missing data	2 (17)	1 (25)	3 (50)	6 (27)

* information taken from case records

Table 10. General functioning and alliance scores at baseline and 6-month follow-up

Variable	THU	Residential	Community	TOTAL
Mean WSAS score (SD) at baseline	15.2 (11.5)	12.5 (9.1)	19.7 (13.9)	15.9 (11.5)
Mean WSAS score (SD) at 6-mth follow-up	12.5 (9.2)	13.7	19.3 (17.0)	14.0 (10.4)
Results of paired t-test	*P*= 0.1	*P*= 0.5	*P*= 0.3	*P*= 0.2
Mean service user-rated alliance *score (SD) at baseline	61.0 (16.6)	68.3 (12.1)	49.8 (7.8)	59.3 (14.9)
Mean service user-rated alliance score (SD) at 6-mth follow-up	56.5 (17.2)	63.3 (16.6)	50.7 (2.9)	56.7 (15.2)
Results of paired t-test	*P*= 0.2	*P*= 0.3	*P*= 0.5	*P*= 0.1
Mean staff-rated alliance score (SD) at baseline	60.9 (9.5)	64.3 (12.0)	54.3 (10.9)	59.7 (10.5)
Mean staff-rated alliance score (SD) at 6-mth follow-up	56.4 (9.2)	64.0 (11.)	50.0 (14.7)	56.7 (10.8)
Results of paired t-test	*P*= 0.1	*P*= 0.7	*P*= 0.9	*P*= 0.2

KEY: WSAS: Work and Social Adjustment Scale (WSAS): Scores range from 0 to 40 with a greater score indicating a greater overall functional impairment

*Alliance scores: Scores range from 0 to 168, with higher scores indicating a better working alliance.

5.4.3 Individual costing

The services used by 22 service users in the SLAM service are given in Tables 11 and 12. Service use at baseline and follow up reflects location where for those in the MSU group, there was an average of 138 days in a secure unit at baseline, increasing to 180 days at follow up, whilst for those in the residential service there was an average of 145 days in residential accommodation at baseline, increasing to 181 days at follow-up. At baseline, some service users had spent time in prison and in the high secure hospital estate. The six community service users at baseline were predominantly accommodated in their own homes or in non-specialist hostel accommodation or had moved from prison to the community.

There were some general trends in the use of health care and community services. Service users in all settings used inpatient and outpatient hospital appointment services, and it should be noted that the hospital admissions and appointments were by no means all for mental health reasons; they were for a variety of physical problems. Unsurprisingly, keyworker and other community mental health services were higher in the residential and community groups, as these appointments were more likely to be recorded in the notes, rather than contacts taking place as part of the therapeutic programme of the MSU. At follow-up, there were higher rates in the proportion taking psychotropic medication in all groups.

Table 11. Service use over six months preceding baseline by service

	MSU (n=12)		Residential (n=4)		Community (n=6)	
	Mean	SD	Mean	SD	Mean	SD
Accommodation						
Own home (nights)	0.0	0.0	0.0	0.0	89.8	98.5
Hostel (nights)	0.0	0.0	145.3	76.8	60.8	94.2
MSU (nights)	137.8	60.7	0.0	0.0	2.0	4.9
Low Secure Unit (nights)	0.0	0.0	0.0	0.0	0.0	0.0
Prison (nights)	39.8	62.8	0.0	0.0	16.3	40.0
High secure hospital (nights)	4.8	13.0	37.5	75.0	0.0	0.0
Bed and breakfast (nights)	0.0	0.0	0.0	0.0	3.5	8.6
Health care/community services						
Inpatient stay (nights)	0.3	1.2	0.0	0.0	1.0	1.7
Outpatient appointment (attendances)	2.1	3.5	2.3	4.5	1.5	2.0
Accident and emergency (attendances)	0.4	0.7	0.0	0.0	0.2	0.4
General practitioner (contacts)	8.3	7.0	1.8	0.5	1.8	3.3
Practice nurse (contacts)	0.6	1.4	0.3	0.5	0.7	0.8
Key worker (contacts)	1.4	2.1	18.0	11.6	10.2	10.6
Psychiatric nurse (contacts)	17.0	51.5	7.5	12.5	2.5	3.9
Psychiatrist (contacts)	3.8	4.6	8.3	11.9	2.3	2.9
Psychologist (contacts)	7.3	6.5	21.5	23.1	5.3	10.2
Counsellor/Therapist (contacts)	3.0	4.2	6.5	13.0	0.2	0.4
Drug and alcohol worker (contacts)	2.6	6.1	1.5	3.0	0.3	0.8
Dentist (contacts)	0.9	1.2	1.0	1.2	1.0	1.7
Occupational therapist (contacts)	5.0	4.0	0.0	0.0	0.2	0.4
Sport therapist (contacts)	6.0	12.2	0.0	0.0	0.0	0.0
Social worker (contacts)	1.6	2.2	0.0	0.0	0.0	0.0
Day centre (visits)	0.0	0.0	3.0	4.7	21.7	53.1
Psychotropic medication (%)	67		50		30	
Criminal justice services						
Probation (contacts)	0.0	0.0	3.3	6.5	4.7	10.5
Solicitor (contacts)	6.2	7.8	0.0	0.0	4.2	5.5
Police (contacts)	0.2	0.4	0.8	0.5	2.8	2.5
Police custody (sessions)	0.0	0.0	0.3	0.5	0.3	0.5
Court appearance (per case)	0.2	0.6	0.0	0.0	0.2	0.4
Public protection unit (per session)	0.0	0.0	0.0	0.0	0.5	1.2

Table 12. Service use over six months follow-up by service

	MSU (n=10)		Residential (n=4)		Community (n=3)	
	Mean	SD	Mean	SD	Mean	SD
Accommodation						
Own home (nights)	0.0	0.0	0.0	0.0	60.3	104.5
Hostel (nights)	0.0	0.0	181.3	0.5	76.0	94.6
MSU (nights)	180.9	1.4	0.0	0.0	0.0	0.0
Low Secure Unit (nights)	0.0	0.0	0.0	0.0	0.0	0.0
Prison (nights)	0.0	0.0	4.3	8.5	0.0	0.0
High secure hospital (nights)	0.0	0.0	0.0	0.0	0.0	0.0
Bed and breakfast (nights)	0.0	0.0	0.0	0.0	45.7	79.1
Health care/community services						
Inpatient stay (nights)	0.9	2.8	0.0	0.0	8.3	9.1
Outpatient appointment (attendances)	2.8	3.6	4.0	7.3	2.7	4.6
Accident and emergency (attendances)	1.4	2.9	0.0	0.0	0.7	0.6
General practitioner (contacts)	7.1	9.2	2.5	4.4	4.7	4.2
Practice nurse (contacts)	3.0	5.4	1.5	3.0	2.0	3.5
Key worker (contacts)	13.7	17.9	32.5	13.0	65.0	56.7
Psychiatric nurse (contacts)	5.2	16.4	13.0	15.0	20.3	30.2
Psychiatrist (contacts)	6.4	7.5	1.8	1.7	1.7	2.1
Psychologist (contacts)	19.7	17.3	26.0	21.2	20.3	27.6
Counsellor/Therapist (contacts)	21.2	57.4	19.5	24.9	0.0	0.0
Drug and alcohol worker (contacts)	0.0	0.0	0.0	0.0	2.0	3.5
Dentist (contacts)	1.7	3.1	2.8	2.5	0.7	1.2
Occupational therapist (contacts)	1.8	3.8	5.0	10.0	0.0	0.0
Social worker (contacts)	0.1	0.3	0.0	0.0	0.3	0.6
Day centre (visits)	0.0	0.0	32.3	64.5	40.0	69.3
Psychotropic medication (%)	80		50		67	
Criminal Justice services						
Probation (contacts)	0.3	0.7	0.0	0.0	0.0	0.0
Solicitor (contacts)	6.2	9.2	0.5	1.0	0.7	1.2
Police (contacts)	0.0	0.0	2.5	2.9	1.3	1.5
Police custody (sessions)	0.0	0.0	0.3	0.5	0.0	0.0
Court appearance (per case)	0.1	0.3	0.3	0.5	0.0	0.0

Total costs for the six months preceding baseline and over the six months between baseline and follow-up are shown in Tables 13 and 14. At follow-up average total costs over six months were £100,981 in the MSU group, £68,503 in the residential services group and £8,468 in the community service group. Costs were higher for all groups at follow-up (p=0.072), which reflects the greater amount of time spent in the more intensive service.

Table 13. Costs over six months preceding baseline by service

	MSU (n=12)		Residential (n=4)		Community (n=6)	
	Mean	SD	Mean	SD	Mean	SD
Social services	0	0	110	193	4,600	6,694
NHS	75,885	34,015	68,154	22,699	1,888	2,616
Voluntary services	0	0	9	17	12	18
Criminal justice	3,945	5,832	230	425	1,969	3,072
TOTAL COST	79,830	28,577	68,503	22,497	8,468	5,665

Table 14. Total cost over six months follow-up by service

	MSU (N=10)		Residential (N=4)		Community (N=3)	
	Mean	SD	Mean	SD	Mean	SD
Social services	0	0	645	1,290	6,621	6,114
NHS	99,611	1,300	54,642	1,714	16,114	9,554
Voluntary services	0	0	0	0	0	0
Criminal justice	1,370	3,361	576	1,066	67	61
TOTAL COST	100,981	4,297	55,863	2,670	22,802	11,571

5.4.4 Summary

Strengths

- This was the only service to explicitly state the aim of integrating service components.
- The service employed a coherent treatment model that 'made sense' to staff and service users.
- The service employed rigorous recruitment and training processes.
- Staff and service users perceived positive effects of treatment including increased pro-social behaviour and a reduction in self-harm.

Suggestions for future service development

- The in-patient unit needs to be less reliant on bank and agency staff.
- There is a need for improved communication between the clinical staff and the management team
- Consideration should be given to selecting a more homogenous group of in-patient service users in order to optimise group cohesion.
- There is a need to improve the quality of information provided to in-patient service users.

CHAPTER 6: DISCUSSION

6.1 Overview of study findings

6.1.1 The organisations

The case studies provide a detailed picture of the initial development of the three pilot forensic services. By spring 2007, all of the pilot services were operational and were accepting and treating a relatively homogenous group of extremely challenging service users. Despite differences in the organisation and content of interventions provided, there were strong areas of common ground between the services. All the services were characterised by the following:

1. Each employed clear (and generally similar) inclusion and exclusion criteria.
2. The primary focus of the clinical work at all three services was on diminishing the risk of harm towards others.
3. Each service employed lengthy assessment procedures.
4. Each service anticipated working with service users over long periods of time
5. Each service had an underlying treatment 'model': therapeutic community (ELCMHT), the Violence Reduction Program (SLAM), and a largely cognitive behavioural programme (NTW).
6. Psychological treatment (group and individual) was at the heart of each programme
7. All the teams were multidisciplinary and each had complex hierarchies of staff and line management structures
8. All three services were engaged in their own process of research and audit.

Areas of divergence included:

1. The core components of each service
2. The amount of external training provided. This was an established part of the working practice of some teams but more an area for future development for other teams.
3. The degree of integration between components of each service.
4. The extent of service user involvement. All three teams strongly encouraged service users to get actively involved in decisions about their own care, but provision for service user involvement at levels beyond their own care varied considerably.

The speed with which pilots developed varied considerably and reflected a number of problems including recruiting and retaining staff, negotiating operational arrangements with local Trusts, and moving premises during the course of the evaluation. Many of the challenges faced in setting up the pilot services were generic to setting up any new service. Other challenges were more specifically related to setting up dedicated PD services. Each service experienced untoward incidents over the course of the evaluation and these had significant ramifications for the organisations, staff and service users concerned. Communication between the three services was limited. Although staff at all three sites thought that they might be able to usefully learn from each others' experience, the sheer size of each team's respective workload, coupled with the fact that the teams were separated by large distances inevitably meant that contact was limited.

6.1.2 The service users

The quantitative survey showed that the majority of service users had experienced childhood maltreatment and educational disadvantage. The prevalence of substance use problems and self-harm was very high and was certainly consistent with prevalence figures derived from cross-sectional studies of prisoners (3). As anticipated, both violent and sexual offending were highly prevalent among the recruited sample; in many cases violence had been characterised by extreme cruelty towards the victim. Less anticipated were the findings of comparatively low intelligence (mean full scale IQ in the recruited sample: 90) and low Psychopathy Checklist Scores (mean PCL-R score in the recruited sample: 19). Nevertheless, these scores need to be cautiously interpreted (see section 6.2.2).

The six-month quantitative follow-up surveys revealed that across all three services, the majority of men (78%) who had been recruited six months earlier were still under the care of the services. Behavioural problems in the form of violence, self-harm, absconding behaviour and non-adherence with treatment continued in all three services. Moreover, there were no significant changes in the overall level of functioning in the service users and no significant changes in the working alliance between staff and service users over six months.

Across all three sites the service users seemed to appreciate the help being offered and many perceived that they were making important changes in the following domains:

- Anger management
- Improved communication with others
- Improved interpersonal skills
- Reduction in self-harming behaviour
- Increased self confidence and enhanced self esteem.
- Greater understanding about the nature of their psychopathology.

Service users at all three sites shared the view that potential service users had to be motivated and *"want to be there"*. Lack of engagement (or *"faking"* as it was described at one site) invariably predicted treatment failure and was identified as being disruptive for the other users of the service. Many service users found the experience of talking about their lives and sharing their feelings with others to be overwhelming. Both staff and service users highlighted the importance of their relationships in undertaking successful work. Successful relationships were characterised by mutual trust and respect and these invariably occurred with staff who were (in the views of service users) honest, tolerant and non-judgemental in their manner.

Across all three sites, service users identified a number of areas where they felt that the treatment programmes might be improved:

1. The assessment process

Service users at all three services told us that they thought that the assessment process was too long. Many described having a series of interviews with various members of the multidisciplinary team where it felt like they were repeatedly going over the same ground. Moreover, during this phase, they were in the words of one service user *"left to your own devices"* – there was no active therapy on offer, and many would have preferred some form of activity outside of assessment sessions. This theme converged with the view of staff at all three sites, who told us that the assessment battery was unwieldy. Some staff lacked confidence in the choice of measures and others were

concerned that the lengthy assessment acted as a barrier to engaging service users in future treatment.

2. The mixture of offending profiles and mental health needs among service users

The fact that each treatment programme accepted people with a mixture of offending profiles and mental health needs was felt to be problematic. Some service users reported the existence of tension between 'ex-prisoners' and 'mental health patients'. Ex-prisoners felt that they were treated with less sympathy and a few even expressed concerns about the possibility of their peers' mental health problems or offending profiles '*rubbing off*' on them.

3. Temporary or inexperienced staff

Service users had particular difficulties trusting non-permanent staff and consequently they would preferentially seek out permanent staff and 'bombard' them with requests. Frequent changes in the staffing structure were perceived to be particularly unhelpful and hampered the formation of trusting therapeutic relationships. Newly trained staff were perceived to be naïve, vulnerable and therefore, easily manipulated.

4. Better information

Service users at all three sites told us that information about treatment could be improved. Some service users told us that they had not been given a clear explanation of the nature or consequences of treatment prior to being taken on by the service. Others said that they were not fully aware that they might be returned to prison at the end of treatment. When service users reported receiving information and pre-admission visits to in-patient units, these were perceived to be helpful.

5. The need for a busy programme of treatment

Whilst they appreciated that the services were still in an early stage of development, service users at all three sites told us that they wanted to be kept busy and some complained of boredom. On the in-patient units, community groups were highly valued, and there many suggestions for other groups, particularly in the areas of substance misuse and practical skills groups where they might learn a trade. Staff at

all three sites were aware of this issue and at the time of preparing this report were further developing the group programmes.

6.1.3 The staff

Across all three sites we were struck by the energy, courage and optimism displayed by the staff. The experience of undertaking the clinical work was extremely stressful, particularly for those engaged in regular face-to-face contact with service users in an in-patient setting. The work came at a personal cost and many reported feeling exhausted, drained and occasionally frightened by the work. Each site experienced difficulties in recruiting and retaining skilled staff and this was particularly the case for all three medium secure units, where the daily working environment was particularly stressful. Staff at all three sites told us that there was a distinct lack of suitable candidates for posts and over the course of evaluation, it became clear that professional qualifications alone were insufficient predictors of who could undertake this type of clinical work. The senior clinicians and service managers working at all three services had the difficult task of containing anxiety at many levels: that of individual staff and their teams, local organisational anxiety and also anxiety from commissioners who were keeping a keen eye on levels of service activity. In addition, senior staff at all three sites were heavily burdened with administrative tasks (a problem compounded by poor administrative support at some sites). Some senior staff told us that clear steering guidance from the Home Office with regard to the aims and day-to-day operation of the services was lacking. Over the course of the evaluation, senior staff departed from all three services and this inevitably had an unsettling effect on team morale.

Across all three services, staff described the existence of inter-disciplinary disputes over clinical leadership and the vision for the service. Bateman and Tyrer (35) state that in order to achieve effective teamwork within a specialist PD team: *"the team has to be willing to assign the responsibility of leadership to one of its members and that member must be willing to undertake the leadership role. Underlying rivalries within a team will inevitably bring with them inconsistency as individuals attempt to develop greater influence. For effective teamwork, the natural tendency of any one person to want to make an individual contribution has to become subordinate to the contribution of the whole team."* Bateman and Tyrer go on to highlight the fact the

effective team working can be achieved through, *"an iterative process of decision-making… in which the individual members move towards a consensus that is then held by the team itself."* Given the fact that we were evaluating services at a very early stage in their development, it did not surprise us to find that some of the teams were still at the stage of assigning responsibility of leadership and going through the 'iterative process of decision-making.' This is most graphically illustrated by the events that took place on Oswin Unit, where the adoption of a so-called *"flat management structure"* proved to be unsuccessful. Very similar issues were talked about by staff working on Millfields Unit in ELCHMT and also within the Tony Hillis Unit in SLAM. The important point to emphasis here is that this process is essentially a normal one - it takes time for the culture of any working group to establish and it would be premature to arrive at firm conclusions about how 'healthy' and successful any of the teams are at this very early phase in their development.

6.1.4 The economic cost

The aggregate costing analysis found the cost per service user per year for the MSU services was between £192,978 and £199,696, a cost slightly higher than a non-specialist MSU (NHS £155,597, Private £168,015), but below that of the high secure personality disorder services (£226,455) [source: personal communication with St Andrew's Healthcare]. Many service users had come from the criminal justice services and this type of NHS provision costs substantially more than a prison place (£21,976 to £43,904) [source: HM Prison Service Annual Report]. The residential service costs were between £111,943 and £162,752 per year. These costs are substantially higher than existing estimates of the cost of specialist hostels such as bail hostels (£27,916) [source: Audit Commission], though it is important to note that the residential services include the hostel provision and supervision from the specialist teams at the MSUs. The estimates of the cost per place depend on the occupancy levels of the services; all costs above assume that all places are filled at all times. During the evaluation period this was not the case, and therefore the cost per service user was in fact higher for all services.

The service use data for the sample of service users from the three sites showed a range of primary and secondary health care contacts. Service users had hospital appointments and occasional admissions for a range of health problems. There was

good evidence that key workers and mental health professionals had regular contact with those in the residential and community services. In most cases, over half the service users were on some form of psychotropic medication, and the proportion on medication in the community was consistently over 50% by follow-up.

From the service use data we are also able to see where the service users being supervised in the community were accommodated. For the most part, service users in the community lived in their own homes (usually rented from the local authority or a housing association) or in non-specialist hostel accommodation. However, we found some evidence of service users using less stable forms of accommodation such as bed and breakfast, staying with friends and on one occasion sleeping rough.

An analysis of individual economic data showed that although the specialist services were predominantly run by the NHS, there were also considerable economic burdens to other service providers, notably social services, who were responsible for social housing for service users in the community and the criminal justice system, for prison costs and any court costs, which could be substantial. On the whole, costs for the six months post baseline were significantly higher than the costs for the six months preceding baseline, reflecting the greater amount of time at follow-up in a more resource-intensive service.

6.2 Methodological considerations

6.2.1 Strengths of the study

We consider the greatest strength of this study to be the collection of both qualitative and quantitative from staff and service users. Having collected data from a range of different perspectives we have been able to capture key learning points from the development of these services. We collected individual quantitative data from both case records and service users and where necessary filled gaps in the data by speaking to staff. Detailed quantitative data were gathered in multiple domains (health, criminal and economic) at two time points. The rate of attrition at follow-up was low (less than 30% lost to follow-up across all three services).

Regarding the qualitative data, efforts were made to maximize the rigor of the data collection process and analysis. First, interviews were carried out using topic guides

the wording of which was scrutinised by the Project Advisory Group. The guides were also revised in the light of emergent themes. Second, two sources of qualitative data were used: data derived from interviews with service users and data derived from interviews with a range of staff. This process enriched the data and allowed examination of common themes emerging between those being helped and those delivering that help. Third, examining the agreement between independent coders tested the consistency with which themes were identified. Fourth, all interviews were audio-taped and transcribed to enhance trustworthiness of the data, and verbatim accounts with details of sources have been presented throughout the report. Fifth, for both staff and service user data, we used focus groups in order to validate the themes that had emerged from initial interviews and discussed these emergent themes at Project Advisory Group meetings. Finally, we remained in touch with service leads from all three services throughout the evaluation and fed back findings as they emerged. We also gave staff the opportunity to comment on a draft version of their service's case study.

6.2.2 Limitations of the study

1. The timing of the study

The timing of this study coincided with the first two years of the operation of the pilot services (with the exception of the NTW community service which had been in operation since 2003). While this meant that we were able to track some of the challenges services faced and report on the steps they subsequently took to manage these challenges, it is important to note that services were in different stages of transition and that some of the problems that we identified may have been resolved in the period after data collection stopped. Recent correspondence with staff and service users in the pilots suggests that service development has continued since data collection ceased and it is therefore important to note that these data may not describe services as they are currently being delivered. This is equally true for both the qualitative and quantitative data collected (including data on service activity, which represent a snapshot of service activity levels at an early stage of the development of these services). Whilst the on-going development of each service is both laudable and exciting, it made our task particularly difficult – very often we were evaluating a moving target.

2. *Information bias*

The possibility of both staff and service user response bias needs to be taken into account when interpreting study findings. Those working in the pilot services may have viewed this study as part of a process of evaluation that would influence future funding decisions. In this context it is likely that service providers, may have felt they needed to present their service in the best possible light. Equally, it is important to bear in mind the fact that many of the service users had psychopathology which included dichotomous thinking (a tendency to see things in black and white terms e.g. 'good staff' *vs.* 'bad staff'), and a tendency to distort information. Moreover, some service users had been admitted from DSPD sites and had been part of other service evaluation projects which may have influenced the responses they gave during interviews. We also need to consider the possibility that the responses given to us by service users (who were all men) were influenced by the sex of the interviewers, both of whom were women.

Finally, there is evidence to show that negative information more strongly influences evaluations than positive information (36). In the course of interviews with staff and service users, we were sometimes left with the impression that the interviews and focus groups became forums for airing problems, as opposed to evenly discussing both positive and negative aspects of the services. It is therefore possible that in the case studies, we have tended to focus more on the problems, as opposed to highlighting the many positive features of each service.

3. *The sampling strategy for the qualitative interviews*

The sample of staff and service users used in the qualitative interviews was non-random. Whilst efforts were made to sample a wide range of service users and staff, it is probable that we missed staff and service users who did not share the opinions of those expressed in the case studies; this might limit the generalisability of the findings. However, a number of problems have been identified in applying probabilistic sampling methods to qualitative research (37). One of the strengths of qualitative research is that it aims to work with small samples *'nested in their context and studied in depth'* (38) and seeking to obtain findings that can be generalized to the other populations is not usually the point of undertaking such research.

4. The use of respondent validation

Although we used respondent validation (otherwise known as 'member checking') as a means of establishing the validity of the findings of qualitative research (37), this strategy is not unproblematic. Some authors have questioned whether such methods provide a good test of validity: member checks occur within an organizational context and it therefore cannot be automatically assumed that respondents will act as unbiased assessors when asked to comment on findings from a study (38). For example, if some service users were intimidated by others, or overly dominant in the focus groups, we may have failed to achieve robust validation of themes. In addition, membership of the focus groups did not reflect the diversity of service settings in which individual interviews had been conducted; for practical reasons, each focus group consisted of a larger proportion of service users from the MSUs and there was under-representation of service users from residential and community teams.

5. The quantitative baseline surveys

We recruited convenience, non-random samples of service users from each of the three services for the quantitative surveys. Although we recruited almost complete samples of active service users from two of the sites (ELCMHT: 92%; SLAM: 85%), response at the NTW site was poor (40%), due to difficulty recruiting community-based service users living over a very wide geographical area. (Interestingly, the NTW community team experienced similar recruitment problems in the course of their own research). The fact that we surveyed non-random selected samples of service users raises the possibility of selection bias. In addition, the recruited sample size per service was small and we only recruited a total of 54 service users from all three services. Given this, the fact that we were unable to detect any statistically significant differences in clinical outcomes (global functioning and therapeutic alliance) at follow-up might be attributed to Type 2 statistical error (i.e. insufficient power).

Our reliance on minimum dataset measures to define the descriptive characteristics of the sample proved problematic because the completion rate for the minimum dataset was low (for reasons described in detail in each case study). For example, IQ and PCL-R data were only obtained on a subsample of men. It is also possible that IQ

tests were more likely to be performed on men where there was a clinical reason to query intelligence, thus raising the possibility of selection bias. In hindsight, the only way to have achieved a more complete dataset would have been to have administered the measures ourselves. Nevertheless, service users were unhappy with the length of the standard service assessment, and it is likely that if we had added further assessments to our interviews, the study might have suffered from recruitment problems.

6. The quantitative follow-up surveys

Six months is not long enough to evaluate whether services are producing clinically significant forensic outcomes among a group of service users with severely disturbed personalities. Our knowledge of the literature, together with the views expressed by the staff in this study, strongly suggests that any significant health or forensic gains made as a result of treatment within these pilot services are likely to occur over a much longer time frame, possibly decades (39).

7. Anonymisation of the case studies and the quotes derived from the interviews

Although the Project Advisory Group considered the option of anonymising the services described in the 3 case studies, we rapidly concluded that each case study included certain details and descriptions that would have rendered such an exercise superfluous. In order to protect the identity of individual participants we referred to 'staff' (denoted S when associated with a quote) and 'service users' (denoted SU when associated with a quote) in the case studies. We hoped that this system protected the identity of individual participants, although during the course of obtaining feedback from service leads, we were made aware of the fact that the system was not infallible. As a result of feedback given by service leads, we removed some quotes and edited others to remove information that may have linked individuals to their quotes. Nevertheless, for practical reasons, we were not able to show all participants the case studies and check that everyone was happy with the final document.

6.3 Implications of the findings

Our findings have organisational and service delivery implications for each of the services; these implications are stated below in the knowledge that each service is reviewing and adapting the services it provides.

Organisational implications

1. The need for closer working relationships between service components

All three services were trying to establish the best way to integrate service components, however, only SLAM explicitly stated (in operational documents) the aim to run an 'integrated service' and even in this service, staff had encountered problems integrating components. Nevertheless, integration per se would seem to be a sensible goal for services whose ultimate aim is to safely rehabilitate the majority of service users back into the community. Integration requires explicitly stated care pathways both into and out of each care setting and also necessitates close working relationships between staff working in different components of the service. Each service has identified the need to more clearly define care pathways and also to establish closer working relationships between staff working in different components.

The study also highlights the need for co-operation between agencies. Whilst the specialist PD services are NHS-based, the service use data clearly demonstrated that other sectors such as the social and voluntary sector, local authorities and criminal justice are involved in providing services to these service users. Information sharing and joint working should ensure that service users receive a joined up and coherent service across the different sectors.

2. The challenge of staff recruitment and retention

The recruitment and retention of high quality staff is a challenge for any organisation, but brings its own set of particular difficulties for specialist PD teams. Bateman and Tyrer acknowledge that *"not everyone can treat patients with personality disorder"*. Staff working in PD units need to be emotionally resilient, clear about personal and interpersonal boundaries, and have an ability to tolerate the intense emotional impact that the PD service users can have on them (40). Staff in this study were not only having to deal with the splits, projections and countertransference reactions that are part of everyday clinical work in a PD service, but they also had to deal with the fact

that many of the people they cared for had committed disturbing criminal acts and were extremely dangerous. The fact that it proved hard for some sites to find the 'right staff', therefore comes as no great surprise. Nevertheless, the finding underscores the importance of training (which was highly valued by staff in this study) and regular high quality supervision (which was less well developed in some of the sites and is an area for important future development). Staff most vulnerable to burn-out worked on the medium secure units. One way of alleviating the constant strain of working within an MSU would be to occasionally rotate staff between service components. It would also have the advantage of disseminating skills throughout the entire workforce. This suggestion was actually raised by some of the MSU staff that we spoke to, although it is unclear whether such a proposal would be popular with staff working in the community, or feasible for staff working in residential settings.

3. The use of bank staff

An important aspect of the underlying ethos of a PD service is that it should provide some form of constancy. This is because frequent changes in professionals can easily reawaken feelings of loss, abandonment and despair that have usually characterised patients' relationships (41). The use of bank staff within these services was unpopular and is not consistent with the need to provide constancy. We therefore strongly recommend that the use of bank staff within the services should be kept to an absolute minimum.

4. The need for better administrative support for senior clinicians

Senior clinicians at all three services told us that they were over-burdened by the amount of work that they had to undertake whilst the pilot services were being set up – everything had to be done *"from scratch"*. Moreover, the need to complete administrative tasks sometimes competed with heavy clinical commitments or the supervision of junior colleagues. At one of the services administrative arrangements were described as having 'collapsed'. It was our impression that the administrative support provided to senior clinical staff working in some of the teams could be improved.

5. Contact between the service providers and the commissioners

The government has invested large sums of money into the new services and it is essential that commissioners keep a watchful eye on their performance. This is because the study clearly highlights the importance of filling places: the cost per place in each of the services is heavily dependent on the occupancy of the services at any one time. If commissioners want to ensure an efficient use of resources, they must ensure that beds are occupied and places in residential and community services are filled appropriately.

The interviews with staff showed that the level of scrutiny by the commissioners was variable. Some staff told us that they felt intruded on by commissioners whilst others had the opposite experience and told us that they would have appreciated more regular interest. It was our impression that further work needs to be done in order to optimise the working relationship between service providers at all three sites and their commissioners; this would be best achieved through regular planned face-to-face meetings.

Implications for service delivery

1. Refinement of the assessment process

Both staff and service users found the lengthy assessment process and particularly the minimum dataset to be unwieldy. At the THU it was estimated that the assessment battery took between 2-3 whole days per service user and when interview time, file time, scoring, write up and third party checks were included, the team estimated that a full minimum data set battery took up to 41 hours to complete. At NTW, staff were concerned that the assessment process was actually a potential barrier to engagement in psychological work with service users. Some staff lacked confidence in the choice of measures and questioned their inclusion in the assessment battery.

There is a clear need for staff to carefully select appropriate candidates for treatment and there were adverse consequences for service users and staff when unmotivated or inappropriately placed individuals were admitted to programmes. Careful assessment is time-consuming; nevertheless, we were unclear why certain measures had been included in the assessment process/minimum dataset. For example, the IPDE is the most time-consuming PD assessment measure available and there are perfectly

acceptable shorter alternatives which would provide equally comprehensive clinical information. Similarly, we know of no good evidence to show that the assessment of risk is improved by the inclusion of multiple risk measures. There are six risk assessment tools in the last edition of the Planning and Delivery Guide, not including two versions of the PCL (18). Whilst we strongly support the need for a common dataset as part of the process of forming an evidence base for treatment, we recommend that this dataset should be shortened, particularly in terms of the number of standardised risk assessments.

Although selection bias might explain the finding of low IQ in the quantitative survey, it remains possible that the mean IQ of service users within the services is indeed low. If this is the case, some service users might not be intellectually capable of participating fully in a psychological treatment programme which requires the performance of complex cognitive tasks (42). For this reason, as part of the process of refining the common dataset, we suggest that IQ testing should be routinely carried out on all service users. This would provide not only an assessment of the service user's intellectual ability to use the treatment programme, but it would also highlight whether there are intellectual difficulties requiring specific attention. Conversely, it would also highlight whether some service users have intellectual skills which could be put to better use as part of their rehabilitation.

2. The need to develop drug and alcohol treatment modules within the programmes

The prevalence of drug and alcohol misuse among service users in the quantitative surveys was extremely high, as was the prevalence of drug and alcohol problems being linked to an index offence. Nevertheless, many of the teams had yet to set up specific alcohol and drug treatment programmes and some had yet to formalise links with local drug and alcohol services. In order to best meet the health needs of the service users, this is an important area for service development.

3. The need for self-harm treatment protocols

A similar issue arose in relation to self-harm, the prevalence of which was extremely high in our surveys. Although staff generally reported that self harm was being effectively managed, some of the teams had yet to set up clear treatment protocols and were aware that this was an issue for on-going service development.

4. The need for clear information for potential service users

Some service users told us that they did not have a clear understanding about the nature or consequences of what they were letting themselves in for when they agreed to be admitted by the services. Potential service users need to be given clear precise information about the assessment and treatment – a point highlighted in the Planning and Delivery Guide (18). This should include being told that during assessment, they might not be undertaking treatment and also that if the assessment identifies particular problems (for example a lack of motivation to engage in treatment or low IQ), they might be returned to their referrer. If admission involves transfer from another hospital, it should be explained that their leave status might be affected by the transfer.

5. The need for a full programme of activities

Service users at all three sites expressed frustration about the limited range of group activities that had initially been available and some complained of feeling bored. Many highlighted the need for a balance between talking about their feelings *vs.* physical and skills-based activities, where one could 'switch-off' from the strain of therapy. Notwithstanding, senior staff were mindful of this and highlighted the expansion of the group programmes as one of their priorities for future service development.

Research implications

The evidence-base for the treatment of personality disordered offenders is weak and the services are uniquely placed to expand this. The services employ highly skilled staff, who are capable of dealing with extremely challenging service users and they are pioneering novel and expensive treatments. All three services were aware of the need for on-going research and audit, however, the extent to which this was going on during the course of the evaluation varied considerably. The use of a minimum dataset represents an opportunity to further explore the predictive utility of a range of measures covering the domains of personality, risk, intelligence and psychiatric symptoms. However, in the light of the aforementioned problems, and in order to optimise this process, the dataset needs refinement and data needs to be pooled across the services.

The ability of this evaluation to detect meaningful change in the lives of the service users was seriously constrained by a) the timing of the study and b) the short length of time we had for follow-up. A further 18-month follow-up of the service users is planned; however, there are no plans to follow-up the recruited cohort beyond 2008. Given the financial commitment that the Home Office and Department of Health has made to the services, we recommend that they seriously consider committing funding for further waves of follow-up, in order to examine longer-term clinical and forensic outcomes.

7. CONCLUSIONS

The three forensic pilot services that we evaluated are succeeding in engaging and retaining a challenging group of service users in treatment. The service users have extensive criminal histories and high rates of psychiatric morbidity, substance misuse and self-harm. All three services anticipate the need to work with service users over long periods of time and it is too early to tell whether they are succeeding in stimulating sustained change in the behaviour of the service users. The treatments being offered are complex interventions and if effectiveness of treatment is eventually demonstrated, further research will be required to establish the effective ingredients of treatment. Charting any changes in patterns of re-offending will require much longer periods of follow-up. In order to ensure an efficient use of resources, the services must ensure that beds are occupied and places in residential and community services are filled appropriately. From an organisational perspective, within each service, there is a need to foster closer working relationships between service components. Each service also needs to find a way of meeting the on-going challenges of recruiting and retaining high quality staff. All three services are engaged in continuing service development and this should include refinement of the processes of assessment and information-giving to potential service users.

ACKNOWLEDGMENTS

We are indebted to the service users and staff of the three pilot services for their time and support. The project took place at a time when staff were simultaneously developing and delivering their services and we want to acknowledge the time they took in providing data, reviewing draft case studies and facilitating collection of data.

We are particularly grateful to Nick Benefield (Department of Health) who was a member of the Project Advisory Group. Throughout the duration of the project, Nick actively helped us to maintain collaborative networks with the service providers.

Project Advisory Group Members

David Armstrong, Barbara Barrett, Amory Clarke, Jeremy Coid, Mike Crawford, Susanne Fenner, Zoë Fortune (research staff), Paul McCrone, Paul Moran (chair), David Mudd, Diana Rose, Mike Slade, Ruth Spence (research staff), Celia Taylor, Peter Tyrer

APPENDICES

A. BUDGET QUESTIONNAIRE

Name of organisation	
Contact name	
Address and telephone number	
Managing Trust	

Instructions

This questionnaire should be completed at every DSPD pilot site. The best source of information is likely to be the centre accountant or centre manager.

About the facility

How many places are currently:

Available	
Occupied	

Staffing

Please use the following table to list all the staff involved in providing care to clients.. Include the clinical service manager or team leader (i.e. the person responsible for day to day operation of the service, usually based within the service). Please include vacant posts, but do not include students or trainees.

Job title *e.g.service manager, staff nurse, project worker, music therapist*	**Professional Background (if any)** *e.g. Nurse, social worker, group analyst*	**Grade (if applicable)** *e.g. D grade if a nurse, Senior 1 if an occupational therapist*	**Status** *Please use these codes:* *1= Filled by substantive postholder* *2= Filled by agency/locum staff* *3 = Vacant post* *4= Sessional worker, paid for sessions rather than as employee.*	**Full time equivalents** *e.g.* *1.0 if full-time,* *0.5 if half-time*

How many full time equivalent administrative staff are employed to support the staff who deliver care in your service?

Charges and expenditure

Using expenditure accounts, please estimate the total annual recurrent cost of the facility (all non-staff costs, utility bills etc). Please exclude any rent paid or any other major recent capital expenditure.

Description of cost	Value

For financial year 200_

What is the current value of the property and land for this facility?

Total value £

For financial year 200_

B. SERVICE SPECIFICATION QUESTIONNAIRE

A. Description of Service

1. When did this service open?
2. When did your first service user arrive?
3. What are the hours of operation?
4. What is the duration of treatment?
5. What are the objectives of your service?
6. What does the treatment programme offer? *(List types of care)*
7. What are the planned outcome measures? *(e.g. SCID, Risk assessment, change, engagement, recidivism).*
8. What would your service consider to be a good outcome for this service user population?
9. What user/ carer involvement is there in the management/ provision of this service?
10. How does you service handle complaints from:
    a. Service users
    b. Others

B. Assessment, Referral and Service Provision

11. Which boroughs does your service take referrals from?
12. What are your referral criteria?
13. Do you use any exclusion criteria for new referrals? If so, what are these?
14. What is your assessment process?
15. What information is given to service users?
    i. Generic information about the service?
    ii. Specific information about personality disorder?
16. What information is given to carers:
    i. Generic information about the service?
    ii. Specific information about personality disorder?

C. Staffing

17. What personal attributes are you looking for in staff that you recruit to your service?
18. Do you have all the staff you need to run this service? If not, what is your shortfall?
    a. b. If there is a shortfall of staff, why do you think this is?
19. What is the line management structure?
20. What supervision is available for staff?
21. What support is available for staff?
22. What opportunities are there for further training/ CPD?

D. Staff Training

23. How is the training for new staff structured?
24. How long is the training programme for new staff?
25. What skills are taught in the training programme for new staff?
26. What are the main focuses for training?
27. Do you have a system for assessing the ongoing training needs of staff? If so, please describe.
28. How do you assess the different training needs of staff?
29. How is the training supported? *(e.g. Separate budget or money from Trust)*

30. Has any service user involvement been taken into account when devising the training programme?
31. What training do you offer? *(To staff in other services)*

E. Links with other organisations

33. What is the nature of the Unit's links with each of the following services?

a. Criminal Justice System
b. Prison
c. Probation service
d. High secure services
e. Medium secure services
f. Low secure services
g. Open wards
h. MAPPPs
i. General mental health services/ CMHT
k. Other

C. PARTICIPANT INFORMATION SHEET FOR STAFF

We would like to invite you to participate in this research study. Before you decide it is important that you understand why the research is being done and what it will involve. Please take time to read through this information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Thank you for reading this

What is the study about?
People with personality disorders have long-standing problems in the way that they relate to other people and experience the world. Some personality-disordered people experience particular problems through breaking the law. It is unclear how to best meet the needs of this group of people, although it is now widely accepted by both service users and health professionals that they are not currently well served by mental health services.

The government has recently funded three new services for people with personality disorders in whom there are concerns about their risk towards other people. The purpose of this research is to examine these services in detail over the next two years.

Why have I been chosen?
You are working within one of the new services. Your manager would like you to discuss taking part in this study with a member of the research team. If this is OK, a member of the research team will contact you within the next week.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your employment within the service.

What will happen to me if I do take part?
You will be involved in the research for six months.

You may be asked to take part in an interview with a research worker. This interview will last for about one hour and will be arranged at your convenience. During the interview you will be given the opportunity to talk about your experience of working with personality-disordered patients and your beliefs about the service. The interview will be recorded by audiotape. We shall also be interviewing some service users in order to determine their beliefs about the impact of the service on their mental health. Your individual views will not be discussed with service users.

Six months later, you may be invited to take part in a follow-up interview with a research worker in which you will be given an opportunity to talk about your experience of working within the service. This interview will also be recorded by audiotape.

Finally, you will be invited to attend a group discussion, in which the researchers will give you and other staff participants an opportunity to hear about the results from this study.

What do I have to do?
You do not have to observe any lifestyle restrictions whilst taking part in this study.

What is being tested?
The purpose of this research is to examine the three new forensic services for people with personality disorder. The research aims to find out about:

1. the types of people who are admitted to the services and the range of problems that they have
2. the resources within each of the services
3. the attitudes of the staff involved in providing the new services
4. the views that service users have about the new services

What are the possible disadvantages and risks of taking part?
The main disadvantage of taking part will be that you will have to give up time to take part in meetings with researchers.

What are the possible benefits of taking part in the study?
We do not know very much about what sorts of people will be using the services or what the most effective parts of treatment to be provided by these services might be. We hope that this study will find this out. The information we get from this study may help us to treat people with personality disorder in the future.

Confidentiality
All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you that leaves the team base will have your name and address removed, so that you cannot be recognised from it. You will not be identified in any report or publication arising from the study, although the researchers may decide to include some of your interview comments in their final report. If the researchers include any of your comments, it will be done anonymously, so that it will not be possible to identify who made the comments.

What will happen to the results of the study?
You will be invited to attend a group meeting with other study participants, at which the results of the study will be fed back to you. We will be interested to hear your reaction to the results and will incorporate participants' views in the final report. The results of the study will be written up in a report and should also be published in a scientific journal. You will not be identified in any report or publication arising from the study, although the researchers may decide to include some of your interview comments in their final report. If the researchers include any of your comments, it will be done anonymously, so that it will not be possible to identify who made the comments.

Who is organising and funding the study?
The research has been funded by the NHS Service Development and Organisation (SDO) Programme and has been organised by King's College, London. The senior clinicians and managers are not being paid anything extra for including you in the study. <u>Indemnity for participating patients and staff is through NHS indemnity or King's College London. Any complaints about the study should in the first instance</u>

be directed to Dr Paul Moran (c/o Institute of Psychiatry, King's College London, Denmark Hill, SE5 8AF)

Where can I get further information about the study?

If you would like further information please contact:

Dr Paul Moran Tel 020 7848 0150

THANK YOU FOR READING THIS INFORMATION SHEET.

D. CONSENT TO PARTICIPATE IN STUDY
(STAFF VERSION)

Staff Identification Number for this study:

Title of Project: Forensic Personality Disorder Service Evaluation

Name of Researcher: Paul Moran

Please initial box

1. I confirm that I have read and understand the information sheet dated .... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that I may be asked to take part in a recorded interview with a research worker and that the researchers may wish to use some of my interview comments. I give permission for my anonymised direct quotes to be used by the research team. ☐
4. I agree to take part in the above study. ☐

Name of Staff member	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

E. TOPIC GUIDE – BASELINE STAFF INTERVIEW

1. YOUR WORK

Start off by telling me about your work…

- What sort of settings have you worked in?
- What is your previous experience of working with service users with PD?
- Can you give me some idea about your current caseload?
- What do you think about the term personality disorder?
- What sort of person comes to mind when you hear the term personality disorder?
- Do you use the term personality disorder freely with the service users?
- What attracted you to working with this client group?
- What do you hope to get out of this work?

2. YOUR SERVICE

- What do you think about specialist PD services? Do you think they are a good idea?

- What are the good things about the new service?
- What are the bad things about the new service?
- What are the main challenges for the service?
- What do you think about the links your service has with other services?

PROBE: Probation, Police, General mental health services

Other PD Pilot sites

- Where do you think the links with other services could be strengthened?
- How well do you think the staff function as a team?

- How safe do you feel in the unit?
- How safe do you think the service users feel on the unit?

3. EXPECTATIONS ABOUT TREATMENT AND THE SERVICE

- What do you hope to achieve with service users who are going through this service?

PROBE: For the service user:

Recidivism reduction?
Symptom reduction? (e.g. self-harm, depression, drug abuse eating disorder)
Improved social functioning?
Improved relationships?
Practical issues? (e.g. housing, finance, daytime activities)

- How successful do you think this pilot service has been so far at achieving these goals?
- How well do you think this service meets the needs of the service users?

4. GUIDELINES

Can you tell me a bit about the new guidance from NIMHE and the Home Office…

- What are the good things about the guidance?
- What are the bad things about the guidance?
- How closely does your service adhere to the guidance?

5. THINGS THAT HELP ME WORK WITH PD SERVICE USERS

Tell me a bit about the training that you have received…

- What are the strengths of the training?
- What are the weaknesses of the training?
- How do you think the training can be improved?
- How prepared did you feel after the training to work on the unit?
- How supported do you feel in your position?
- Do you feel the support and supervision is adequate?

Is there anything else you would like to say?

Do you have any advice you would like to give to the people commissioning these services?

Thank you very much for your participation.

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The government has recently funded new services for people with personality disorders in whom there are concerns about their risk towards others. The purpose of this research is to examine these services in detail over the next two years.

Why have I been chosen?
You have been referred to one of the new services for people with personality disorders. Your care coordinator has suggested that you might wish to take part in this study and talk to a member of the research team. If this is OK, a member of the research team will contact you within the next week.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I do take part?
You will be involved in the research for six months.

First, you will be invited to meet with the researcher at the team base. This meeting will take about ½ an hour. At this meeting you will be asked some questions about yourself, and your use of services. You will also be asked to complete a questionnaire on your views about your relationship with your care coordinator in the forensic team. This information will not be shared with your care coordinator. If you take part in this interview, you will be paid £5 for giving up time to take part in the interview. The researcher will ask your care coordinator to complete a questionnaire on their views about their relationship with you. This information will not be shared with you. The research worker will need to examine your case records, in order to obtain further information about you, including details of the clinical team's assessment of you.

Six months later, you will be contacted through your care coordinator. Another meeting will be arranged with the research worker. This meeting will take about ½ an hour and will take place at the team base. In this meeting, you will be asked some questions about your use of services over the previous 6 months. You will also be asked to repeat the questionnaire on your views about your relationship with your

care coordinator in the forensic team. If you take part in this interview, you will be paid £5 for giving up time to take part in the interview.

You may also be asked to take part in an interview with a research worker. This interview will last for about one hour. During the interview you will be given the opportunity to talk about your experience of using the new forensic service. The interview will be recorded by audiotape. We shall also be interviewing members of staff in order to find out what they think about the effect of the service on patients' mental health. Your individual case will not be discussed in the staff interviews. Finally, if we ask you to take part in this interview, you will be invited to attend a group discussion, in which the researchers will give you an opportunity to hear about the results from this study. If you take part in this interview, you will be paid £10 for giving up time to take part in the interview. If for some reason you leave the service before the researcher is able to interview you at six months, the researcher may ring you in order to have a brief audio-taped telephone interview with you. The purpose of this interview would be to obtain your views about the care you received from the service.

What do I have to do?
You do not have to observe any lifestyle restrictions whilst taking part in this study. If you are taking regular medication, you should continue to take this during the study.

What is being tested?
The government has recently funded three new forensic services for people with personality disorders. The purpose of this research is to examine these services in detail. The research aims to find out about:

1. the types of people who are admitted to the services and the range of problems that they have
2. the resources within each of the services
3. the attitudes of the staff involved in providing the new services
4. the views that service users have about the new services

What are the possible disadvantages and risks of taking part?
The main disadvantage of taking part will be that you will have to give up time to take part in meetings with researchers.

What are the possible benefits of taking part in the study?
We do not know very much about what sorts of people will be using the services or what the most effective parts of treatment to be provided by these services might be. We hope this study will find this out. The information we get from this study may help us to treat people with personality disorder in the future.

What happens if new information becomes available?
Sometimes during the course of a study new information becomes available about the treatment that is being studied. If this happens, your care coordinator will discuss this with you and ask if you want to continue in the study. If you decide to withdraw, your care coordinator will arrange for your care to be continued in the usual way. If you decide to continue, you will be asked to sign an updated consent form.

Confidentiality
All information that is collected about you during the course of the research will be kept strictly confidential. The only exception would be if the interview revealed a

significant risk of harm to yourself or others, or if you make a new criminal disclosure to the research worker, in which case information would be fed back to your care coordinator in the service. Any information about you that leaves the team base will have your name and address removed, so that you cannot be recognised from it. You will not be identified in any report or publication arising from the study, although the researchers may decide to include some of your interview comments in their final report. If the researchers include any of your comments, it will be done anonymously, so that it will not be possible to identify who made the comments.

What will happen to the results of the study?

You will be invited to attend a group meeting with other study participants, at which the results of the study will be fed back to you. We will be interested to hear your reaction to the results and will incorporate participants' views in the final report. The results of the study will be written up in a report and should also be published in a scientific journal. You will not be identified in any report or publication arising from the study, although the researchers may decide to include some of your interview comments in their final report. If the researchers include any of your comments, it will be done anonymously, so that it will not be possible to identify who made the comments.

Who is organising and funding the study?

The research has been funded by the NHS Service Development and Organisation (SDO) Programme and has been organised by King's College, London. The staff looking after you are not being paid anything extra for including you in the study. Indemnity for participating patients and staff is through NHS indemnity or King's College London. Any complaints about the study should in the first instance be directed to Dr Paul Moran (c/o Institute of Psychiatry, King's College London, Denmark Hill, SE5 8AF)

Where can I get further information about the study?

If you would like further information please contact:

Dr Paul Moran Tel 020 7848 0150

THANK YOU FOR READING THIS INFORMATION SHEET

G. CONSENT TO PARTICIPATE IN STUDY (SERVICE USER VERSION)

Title of Project: Forensic Personality Disorder Service Evaluation

Name of Researcher: Paul Moran

Please initial box

1. I confirm that I have read, or have had read to me, and understand the information sheet dated .... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from King's College, London or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐
4. I understand that I may be asked to take part in a recorded interview with a research worker and that the researchers may wish to use some of my interview comments. I give permission for my anonymised direct quotes to be used by the research team. ☐
5. I agree to take part in the above study. ☐

______________________	______________	__________________
Name of Patient	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
______________________	______________	__________________

H. TOPIC GUIDE - SERVICE USER INTERVIEW

1. INTRODUCTION + PERCEPTION OF THEIR HEALTH

If you could just start off by saying a little bit about yourself, and in particular any difficulties you have with your health currently. Please could you tell me about this?

PROBE: physical/ mental health

2. PREVIOUS EXPERIENCES OF BEING HELPED

I'm interested to hear about your previous experiences of using health services (including – if relevant – prison health services), prior to coming here. Please could you tell me about this?

PROBE: CMHT/ Hospital/ High or low secure

3. INFORMATION

- Can you tell me about how you first heard about this service?
    - When was this?
    - What information did you receive? Written/ verbal?
    - Who were you able to talk to/ ask questions about it?
    - How useful was the information you've received?

PROBE: quality/ language

4. DECIDING TO USE THIS SERVICE

- Did you have a choice about whether to use this service?
    - What were you looking for from this service?
    - What made you think it might be helpful?
    - What might have put you off or worried you?
    - Who else was involved in making this decision?
    - What did they do/ say?

5. COMING IN

- What processes did you have to go through before being accepted to this service?
    - What happened?
    - Who was involved?
    - How did this feel at the time?
    - How long did it take?
    - Do you think there is any way this process could be improved?

6. SUPPORT OFFERED / RECEIVED

- Since coming to this service, what kinds of support (activities/ therapies or treatments) have you been offered?

    - Which of these have you used or received?
    - How helpful have they been? What did you find helpful?
    - What other types of support do you think would be helpful?
    - What has been unhelpful?
    - What other support have you been helped to access?
    - What do you personally want to achieve from being in this service?
    - What motivates you to engage in the treatment programme?

7. THE SERVICE

- What have your experiences of dealing with staff been like?
- What do you think about the environment in general?
- How safe did you feel before using this service?
- How safe do you feel now you are using this service?

PROBE: physically/ with other service users/ emotionally

8. THE EXPERIENCE OF STIGMA

- Have you experienced feeling stigmatised or labelled as a result of becoming a user of this service? Please could you tell me about this?

PROBE: By family/ friends/ other people

9. OUTCOMES / CHANGES

- Can you tell me about any changes, both good and bad, that you have experienced in your life as a result of being in contact with this service?

- Anything you've learned?

    - What is it about this service that has led to these things?
    - Can you tell me about any things that you still want to work on?
    - To what extent have your expectations been met?
    - In what coming to this service has made life more difficult for you?

10. IDEAS FOR IMPROVEMENTS

- Could you tell us anything that you would like to change or improve about this service?

11. OVERALL POINTERS

- What do you think makes a good service?
- Is there any advice that you would like to give to mental health professionals working with people like yourself?
- Is there any advice that you would like to give to people at the Home Office about setting up services for people with personality disorder?
- Do you know of other people who would benefit from this service but have not been able to access it?
- How would you describe this service and what it does to them?

Thank you very much for your participation

I. TOPIC GUIDE – FOLLOW-UP STAFF INTERVIEW

LEAVERS

- How long were you with the service for?
- What were the reasons behind your decision to leave the service?
- What would have kept you working for the service?

1. THE SERVICE USERS

- How successful would you say the treatment program has been so far?
- Which parts of the treatment programme do you think have been of benefit to the service users?
- Which parts of the treatment programme do you think have been unhelpful or should be reviewed or changed?
- What changes, if any, have you noticed in the service users?

PROBE: changes for the better and for the worse

- Can you tell me what the relationships have been like between service users s and staff?

PROBE: *positive aspects?*
any difficulties? how were they resolved?
are there any issues which you think have not been resolved?

- In your experience have there been any difficulties maintaining boundaries with service users?

Could you tell me more about this?

- Do you think any of the staff have ever been afraid of the service users?
- Have there been moments when you have been afraid of any of the service users in this service?

2. YOUR EXPERIENCE OF THE WORK

- What has been most draining for you individually about the work?
- What kept you going in the work over the past year?
- How supported have you felt in your job?

PROBE: What support mechanisms are available?

- What do you think you have achieved in this post and how has it helped your career?
- *Have you been disappointed by any aspects of the job?*

3. THE STAFF TEAM

- How well would you say the team is functioning?

  PROBE: *What are relationships like between the staff?*
  In what way could things be improved?
  What are relationships like between staff and management

- What do you think the main staffing problems have been?

  PROBE: *Why do you think some staff have left / are leaving?*
  What keeps you here?

- What do you think would improve staffing, recruitment and retention?

For some services: Some of the service users have commented on what they perceive to be a high use of bank staff do you have any thoughts about this?

4. ORGANISATIONAL ISSUES

- How well do you think this service is working alongside other services?

  PROBE: *MAPPA, probation, CMHTs, other secure units, HO, other components of own service e.g. residential, MSU, community*

- Do you have any advice you would like to give to the people commissioning these services?

Thank you very much for your participation.

J. Summary of findings from a meeting between service users from the Millfields Unit and staff from the Ministry of Justice/ Department of Health

The following details are taken from a letter dated 22nd May 2007 addressed to the 'Community members' from Nick Benefield and Debra Jeffrey. Overall, service users were satisfied with the prevailing culture and the way that the Unit was being run. However, the service users highlighted a number of areas where they felt that improvements could be made:

- The service users wanted to have more details about the treatment prior to being offered a place in the service. Lots of questions and uncertainties only came to light after people arrived to stay at the unit. Everyone felt that a pre-visit from prison would help facilitate the process of being admitted.
- Some service users felt that they were admitted to the service under false pretences
- The information pack was felt to be useful, although not everyone remembered getting it. Receiving it in advance of being visited would also help with getting the right questions asked by someone likely to join the TC.
- It was agreed that there were lots of opportunities for service users to contribute to life on the unit. However, service users felt that it was not always clear when or why decisions were being made and there was some confusion about why some decisions were in the control of the 'community' whilst others were not.
- Lack of privacy with regards to use of telephone and receiving visitors was cited as the biggest problem on the unit. The requirements for professional monitoring in the interests of safety were understood, but it was felt that the location of the phone is problematic as service users always felt overheard.
- There was concern, puzzlement and irritation that some visitors had had to experience a further period of security clearance when they had already been cleared for High Secure or prison visiting. This policy was not understood and was felt to be disrespectful to relatives or friends. Service users raised the possibility of sharing the clearance agreed by the previous facility.
- There was strong criticism of the Trust's practices in responding to service users complaints or formally expressed concerns. It was felt that the time taken to respond was too slow.
- There was not enough time given for ground leave.
- The unit was felt to be physically small and ventilation was a significant problem.
- There was not much access to work, employment or skills development in preparation for employment and this was seen as a shortfall.

K. Unit costs for individual costing

Unit cost	Source	£
Bed and breakfast (per night)	Local source	57
Specialist PD hostel accommodation (per night)	Budgets	253-446
Other hostel accommodation (per night)	Curtis & Netten 2006	40-56
Bail hostel (per night)	NAO report "Facing Justice"	76
Specialist PD medium secure unit (per night)	Budgets	528-547
Other medium secure unit (per night)	NHS Reference costs 2005-06	426
Low secure unit (per night)	NHS Reference costs 2005-06	370
Prison (per night)	Prison service annual report	58-181
DSPD - prison (per night)	CODES report (unpublished)	323
Secure hospital (per night)	NHS Reference costs 2005-06	620
Day centre (per session)	Curtis & Netten 2006	20
Inpatient stay (per night)	NHS Reference costs 2005-06	188-242
Outpatient appointment (per visit)	NHS Reference costs 2005-06	28-156
Walk-in clinic (per visit)	NHS Reference costs 2005-06	43
Accident and emergency (per attendance)	NHS Reference costs 2005-06	80
Ambulance (per attendance)	NHS Reference costs 2005-06	161
General Practitioner (per contact)	Curtis & Netten 2006	18
Practice nurse (per contact)	Curtis & Netten 2006	8
Key worker (per contact)	Curtis & Netten 2006	40
Psychiatric nurse (per contact)	Curtis & Netten 2006	40
Psychiatrist (per contact)	Curtis & Netten 2006	96
Psychologist (per contact)	Curtis & Netten 2006	66
Counsellor/therapist (per contact)	Curtis & Netten 2006	48
Drug and alcohol worker (per contact)	Curtis & Netten 2006	40
Occupational therapist (per contact)	NHS Reference costs 2005-06	57
Social worker (per contact)	Curtis & Netten 2006	60
Physiotherapist (per contact)	NHS Reference costs 2005-06	36
Probation officer (per contact)	Curtis & Netten 2006	60
Solicitor (per contact)	Legal Services Commission	47
Police (per contact)	Metropolitan Police Ready Reckoner	26
Police custody (per session)	Finn et al.	60
Magistrates court (per session)	Harries et al.	679
Crown court (per case)	Harries et al.	10611

L. Timetable of research activities

Research Activity	Date
Collection of baseline quantitative ratings	November 2005 – July 2006
Collection of follow-up quantitative ratings	May 2006 – September 2006
Staff baseline interviews	September 2005 – December 2005
Staff focus groups	May 2006 and June 2006
Staff follow-up interviews	November 2006 – December 2006
Service user interviews	June 2006 – March 2007
Service user focus groups	August 2006, January and April 2007

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